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Building an Effective Research Collaboration Between The Center for Public Policy At Temple University and The Pennsylvania Department of Corrections: Final Report to the National Institute of Justice

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June 17, 2002

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FINAL REPORT
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EXECUTIVE SUMMARY

Building An Effective Research Collaboration Between The Center For Public Policy At Temple University And The Pennsylvania Department Of Corrections: Final Report To The National Institute Of Justice

The purpose of this project was to develop a collaborative research partnership between Temple University's Center for Public Policy (CPP) and Pennsylvania Department of Corrections (DOC), with a demonstration research project that included three main elements: 1) a descriptive assessment of Drug and Alcohol (D & A) programming (through surveys and a "mini conference" of D & A staff), including identification of critical service delivery components and goals, 2) an intensive on-site process evaluation of representative drug and alcohol programs at two institutions, and 3) design of an outcome evaluation research design based on analyses of data collected at stages 1 and 2.

We emphasized throughout this project an interactive approach that involved key stakeholders in the identification of all needs, goals, and research activities. While the demonstration project itself was certainly important, we saw the development of an ongoing working research relationship between DOC and Temple University as the primary outcome of this grant, increasing the capacity of both agencies to produce and exploit useful knowledge.

A two-pronged approach (development of the research partnership and implementation of a specific research project) was specified in the NIJ solicitation for this project. In order to be responsive to the directives of the solicitation, we describe key stages in the development of the partnership, but we also provide a detailed summary and discussion of results from the demonstration project, a statewide assessment of prison-based drug treatment. We provide a thorough description of the development of the partnership, so that others may hopefully benefit from our experience. In addition, we believe that our demonstration research project identified a number of critical issues regarding prison-based drug treatment program planning and evaluation. Some issues and recommendations are specific to the particular correctional system examined (Pennsylvania); most are generalizable to other jurisdictions as well. For a research partnership to develop and grow, research results must to some degree be localized, short-term, timely, useable, and policy-relevant. For the results to be of wider interest, though, more general principles and recommendations must also be generated. We also identify critical issues more widely applicable to prison-based drug treatment in general.

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During the 1999 calendar year, we conducted a broad, descriptive assessment and process evaluation of drug and alcohol programming offered by the Department of Corrections. Accomplishments included the following:

- The Steering Committee began meeting regularly in January of 1999. We emphasize an interactive approach that involves key stakeholders in the identification of research needs, goals, and procedures.
- A demonstration research project during the first year of the partnership focused on Drug and Alcohol programming, including three main elements: 1) a descriptive assessment of D & A programming (via program surveys and a one-day symposium staff), 2) an on-site process evaluation of D & A programs at two institutions, and 3) design of an outcome evaluation design based on analyses of findings from the process evaluation.
- We designed a survey of DOC drug and alcohol treatment programs (N = 118). Surveys collected three types of descriptive information: 1) program content (e.g., type, duration), 2) staff characteristics (e.g., duties and responsibilities), and 3) inmate characteristics (e.g., eligibility, intake procedures).
- A one-day symposium with D & A treatment personnel was held June 2, 1999 at the Department of Corrections Training Academy in Elizabethtown, PA. We presented survey results, including similarities and differences in D & A programming across institutions, and discussed implications for D & A programming and evaluation.
- Using process evaluation methods (e.g., observing programs in action, interviewing staff and inmates, and reviewing inmate files), we conducted in-depth, on-site assessments of D & A programming at two State Correctional Institutions (SCI's) selected by the Steering Committee: SCI - Huntingdon and SCI - Houtzdale.
- As a result of a second grant award awarded by the National Institute of Justice (Grant #99-CE-VX-0009, *Evaluation of Prison-Based Drug Treatment in Pennsylvania: A Research Collaboration Between the Pennsylvania Department of Corrections and the Center for Public Policy at Temple University*), outcome evaluation began in January, 2000. The Steering Committee continues to provide oversight of the research process.

Establishing the Research Partnership

A **Steering Committee** of senior correctional policymakers, research and treatment personnel from the central administration of the Pennsylvania Department of Corrections, and Center for Public Policy

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staff was formed in January of 1999 to guide joint research activity. This group focused on issues of building the collaborative, reviewing research plans and designs, and providing oversight of the research process. They also considered the larger organizational and policy issues that the collaborative raised within the Department of Corrections. Part of the mission for this committee was to discuss the findings of research completed through the partnership, suggest possible explanations for results, and further develop a systematic agenda for process and outcome evaluation of correctional programming. The Steering Committee participated in the design and administration of a statewide survey of drug and alcohol programming at 24 institutions, and organization of a statewide meeting with Drug and Alcohol Treatment Specialists to explore drug and alcohol related programming within the DOC.

We have received very positive feedback from DOC personnel about our research and partnership activities. We have since cooperated on several additional grant proposals, including an outcome evaluation of therapeutic community drug treatment programs at five institutions. The latter proposal was circulated to Steering Committee Members for review and discussed at Steering Committee meetings in May and June. The proposal was submitted to NIJ on June 30, and subsequently funded (January, 2000 - June, 2002, Grant #99-CE-VX-0009).

Partnership Goals and Objectives

An essential part of NIJ's overall evaluation strategy has been the development of greater research and evaluation capacity within State and local criminal justice systems in order to increase data-driven decision-making and policy development. Recognizing that most agencies do not have substantial in-house research and evaluation expertise and resources, NIJ encouraged partnerships between correctional agencies and research institutions that can provide such expertise specifically tailored to meet State and local needs. The purpose of these NIJ-supported partnerships was to stimulate collaborative efforts that would develop into lasting, productive relationships.

Seven partnership goals were identified by the Pennsylvania Department of Corrections: (1) development of an ongoing, working relationship with a major Pennsylvania research university, which will facilitate the production of useful knowledge for the department, (2) demonstration of ability of doc to utilize external research expertise and to secure funding for needed studies, (3) expansion of department's capacity to produce and use high quality, applied public policy research, including program evaluation, (4) development of a thorough understanding of the content and process of doc drug and alcohol treatment

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programs, (5) development of a design for a rigorous outcome evaluation of selected drug and alcohol programs, (6) continued collaboration on funded drug and alcohol program evaluation, based upon groundwork laid by partnership, and (7) production of information that is responsive to legislative and other demands for reporting on doc program performance.

Research Products

First, this project produced a **comprehensive database** on a 118 prison-based drug and alcohol treatment programs at different institutions, including descriptions of program content and structure (e.g., duration, intensity, service delivery components), inmate characteristics (e.g., target eligibility criteria) and staff (e.g., background and responsibilities). Such data are essential to properly design program outcome evaluations. Such data provide researchers the opportunity to better understand these interventions and plan outcome evaluations, while at the same time serving departmental interests of program refinement and improved measurement of outcomes.

The project resulted in a **final report** that provides correctional policy makers, in Pennsylvania and elsewhere, with a clearer picture of how these interventions take shape, how they are implemented (e.g., service delivery, goals, participation) and with what range of expected effects. Information from this analysis has also assisted the Pennsylvania Department of Corrections in further reviewing policies pertaining to drug and alcohol intervention programs throughout the Commonwealth. The project has also produced analysis (e.g., *results of program surveys and process evaluations*) and discussion (e.g., *critical issues in the development of a collaborative research partnership)* useful to the wider correctional practitioner and research communities. Researchers from Temple University, in consultation with DOC staff, are writing up summary results for publication in academic journals, and have presented results to both academic and professional audiences at numerous conferences including the Academy of Criminal Justice Sciences (New Orleans, March, 2000), the National Institute of Justice Research and Evaluation Conference (Washington, July, 2000), the American Correctional Association (San Antonio, August, 2000), and the American Society of Criminology (San Francisco, November, 2000).

Establishing A Framework for Global Assessment of Drug and Alcohol Programs

In cooperation with members of the Steering Committee, the Principal Investigator designed a census of DOC drug and alcohol treatment programs. The respondents were DOC personnel responsible for directing programs at each state institution. One survey was completed for each program. Surveys

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collected three types of descriptive information: 1) program content (e.g., what type, duration), 2) program staff (e.g., duties and responsibilities), and 3) inmates (e.g., eligibility, intake procedures). Three major goals of the survey included: 1) Identification of critical service delivery components and goals, 2) Building a statewide database and capacity for further studying these efforts, and 3) Facilitating discussions about characteristics of effective D & A programming (e.g., a 1-day symposium held in June with a representative sample of treatment staff).

We received completed surveys from all 118 DOC drug and alcohol programs identified by the steering committee. We excluded only privately contracted programs and ancillary (inmate-led) programs, choosing to focus on the full range of D & A programs administered by the Department across its 24 state institutions. Ten major findings from the program survey are summarized below. More detailed data analysis and discussion is found in the text of this report.

Point #1: Except for TC's, there was considerable variation in program duration and intensity. TC's last much longer (mean = 46 weeks) and provide many more total hours of programming per week (mean = 29.5) than other programs.

Point #2: Although programs varied in terms of their duration and intensity, there was more consistency in treatment approach (primarily cognitive and cognitive-behavioral).

Point #3: The importance of different criteria for program completion (e.g., knowledge test, measures of attitudinal and behavioral change) varied according to program type.

Point #4: Several criteria for unsuccessful discharge (e.g., Violation Of Program Rules, Institutional Rules, and Security Concerns) were very consistent across programs. Other criteria (e.g., Inadequate Attitudinal or Behavioral Change) varied across programs.

Point #5: Some specific types of program content (e.g., Impacts of Drug Use, Thinking Errors, Obstacles to Treatment, Antisocial Peer Associations, Family Issues, Criminality/Antisocial Attitudes) were used very consistently across the four program types.

Point #6: However, the use of some types of program content (e.g., Problem Solving Skills, Pharmacology) varied enormously within program type.

Point #7: The importance of different program admission criteria (e.g., Level Of Drug Involvement, Level Of Motivation, Institutional Record Of Drug Use) varied considerably across programs.

Point #8: Some specific program admission criteria (e.g., Type Of Offense, Time Served In Current Sentence, Criminal History) are used rarely.

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Point #9: The percentage of time that staff spent on different activities (e.g., Direct Treatment Or Service, Program Planning Activities, Administrative And Managerial Functions) varies depending upon program type. Overall, staff have many other responsibilities that distract from their treatment duties.

Point #10: Staffing ratios varied considerably across programs. TC had the lowest average inmate/staff ratio (17:1); DATU had the highest (30:1). Outpatient (17:1) and Education (20:1) were similar.

Symposium With Drug & Alcohol Treatment Personnel

We then planned a *one-day symposium* with Drug & Alcohol treatment personnel, held June 2, 1999 at the Correctional Academy in Elizabethtown, PA. We set three major goals for this *miniconference:* (1) present survey results, including similarities and differences in D & A programming across institutions, (2) discuss implications for D & A programming and evaluation, and (3) discuss and prioritize elements of effective treatment.

Four highlights from the Symposium included the following. First, in his opening remarks, Secretary Martin Horn focused on the importance of drug treatment and evaluation. Second, as a result of input from 44 DATS representing 24 institutions, we were able to focus upon explaining some of the similarities and differences in treatment programming identified by the surveys. Third, after an overview of standardization plans within DOC, we had a Q & A session between DATS in the audience and DATS who currently sit on the Department's standardization committee. Finally, we discussed a broad approach for evaluating prison-based drug treatment programs.

Evaluability Assessment and Process Evaluation

A survey of treatment programming, no matter how well done, provides valuable but limited information. To more fully describe the breadth and depth of prison-based D & A programming, researchers spent time on-site observing programs in action, interviewing staff and inmates, and reviewing case files. Researchers visited and assessed drug and alcohol programming in depth at two institutions selected by the Steering Committee: SCI - Huntingdon (Level 4: maximum security, population = 1,888) and SCI - Houtzdale (Level 3: medium security, population = 1,500). Each offered a full range D & A programming (e.g., Education, Outpatient, and Therapeutic Community programs).

Prior to implementing a formal outcome evaluation research design (i.e., collecting outcome data for program participants and comparison groups), researchers seek programs with **clearly specified**

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treatment activities, well-articulated, measurable objectives, and **useful information systems** (e.g., inmate intake and monitoring data). Data collected from evaluability assessments and process evaluations help to **describe the chain of critical elements that influence treatment program design, implementation and effectiveness, and develop suitable measures and research designs** for assessing the impact of treatment efforts. Three main areas were examined: (1) programming (e.g., content and structure), (2) inmates (e.g., target selection and eligibility), and (3) staff (e.g., training, experience, duties and responsibilities). The final products of process evaluation included descriptive program reports and recommendations for strengthening each program.

We used four forms for process evaluation developed by the Principal Investigator with the assistance of the Steering Committee: (1) a staff interview form, (2) an inmate interview form, (3) an observer checklist, and (4) a case file review form. Each method gathers data about program activities, staff, and inmates. Prior to our visits, we also acquired various program documents (e.g., statement of program/treatment unit rules or policies, unit and/or program handbooks, curricula, intake forms, etc.) to assist us in developing written program descriptions (e.g., goals, activities). At the two institutions, we conducted a total of 44 program observations, 18 staff interviews, 31 inmate interviews, and 5 case file reviews.

Separate program reports describing each D & A program observed at Huntingdon and Houtzdale (i.e., education, outpatient treatment, and TC) were also completed; these have closely informed our data analyses and reporting (see Appendix 6). In Appendix 7 (bound separately from this report), we provide transcripts of all inmate and staff interviews, program observations, and case file reviews. The latter have been assigned code numbers to facilitate references to specific examples cited in this report (with all individual identifiers removed to protect respondent anonymity).

A number of specific recommendations regarding prison-based drug treatment were supported by our findings. Below, we summarize our major recommendations in two categories: (1) ***short-term, feasible strategies***, and (2) ***longer-term, systemic issues and policies*** that deserve careful review. Data supporting each recommendation are discussed and referenced in the full body of this report

Short-Term, Feasible Recommendations

Recommendation #1: Standardized instruments for assessing inmates' level of need for treatment, readiness for treatment, and psychological functioning should be used to (a) improve program selection and

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placement decisions, (b) inform treatment planning, and (c) construct comparison groups in valid evaluation research designs.

Recommendation #2: Delegate a subcommittee to make recommendations about the use of specific **clinical assessment tools** to be used for prison-based drug treatment programs. A variegated battery of clinical instruments are often administered (mainly to TC inmates), but only *after* an inmate is admitted to a program. These assessments take some time to administer, but they seem to have little observable influence on individualized treatment planning.

Recommendation #3: Correctional agencies should carefully examine the **staffing** of prison-based drug treatment programs. Understaffing may compromise the quality of treatment programming efforts (e.g., little individualized treatment planning or counseling), lower staff morale, and potentially increase staff turnover. There are two options: (1) Either staffing levels need to rise to the levels required by current program offerings, or (2) current programming priorities (e.g., educational programs) need to be reexamined.

Recommendation #4: Ensure that all prison-based drug treatment staff have the opportunity to advance their training and education to remain current with the latest standards in the addictions counseling field. This is especially critical for staff working in intensive treatment settings, such as TC's. Professional standards for prison-based TC's also recommend that clinical staff include substance abusers in recovery, preferably with a thorough knowledge of TC theory and methods. Cross training of Correctional Officers who work on drug units is also recommended.

Recommendation #5: Treatment staff in each program should have a clear, shared understanding of the program's goals, objectives, and structure. Correctional agencies should also develop a program rating system that adequately reflects variations in the intensity level of drug and alcohol programs offered to inmates at each institution. For example, written policies and procedures should in some cases be more clear or complete. Drug treatment staff would benefit greatly from increased staff development time allocated toward discussing these and other concerns.

Recommendation #6: Review and revise procedures for "pull-ups" within prison-based TC programs. There is considerable variability in how these activities are conducted in different programs at different institutions. Such activities may benefit from (a) better inmate training, (b) better staff supervision, (c) more consistent procedures and sanctions, (d) less attention to trivial behaviors.

Recommendation #7: Physical plant problems that potentially influence treatment process and outcome of prison-based drug treatment should be addressed. The treatment setting is one of many variables that significantly affect an inmate's perception of correctional treatment and his/her reaction to it. For example, "The atmosphere within the TC facility should be one of safety, identification and caring . . . It is important that the physical space reflect the care and concern which program participants in the TC demonstrate toward each other. When something is broken it should be fixed immediately (ONDCP, 1999, Appendix B:8)."

Recommendation #8: Correctional agencies should design, implement and update (on an annual basis) a Drug & Alcohol Program Census, in order to create and maintain a current program database. We need current, reliable, basic information about program structure to better understand how program process (e.g., program duration, treatment approach) influences outcome. Otherwise, program participation

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becomes a "black box" that defies easy description. . In order to demonstrate that a "program" (X) produces any specific outcome (Y), we must be able to specify what "X" was in the first place.

Recommendation #9: Correctional agencies should develop and establish a computerized, offender-based treatment database, and develop overall information system capacities regarding offender program participation. Basic information on offender participation in programs is vital for program monitoring, management and evaluation. At a minimum, a useful D & A treatment database would include an inmate's name and number; date of each D & A program admission and discharge; name, location and type of program; and reason for discharge (e.g., successful v. unsuccessful). Such information is a necessity for any state correctional agency that wishes to effectively monitor and evaluate its offender programs.

Systemic Issues and Policies In Need of Review

Recommendation #1: The mission of drug and alcohol education and outpatient treatment programs within the full spectrum of D & A programming offered by correctional agencies deserves careful consideration and review. Little impact on inmate relapse or recidivism is to be expected from education and outpatient treatment programs that offer a total of ten hours or less of group programming, although such programming may serve other purposes.

Recommendation #2. Correctional agencies could profitably examine treatment staff morale and job satisfaction (e.g., perceived supports v. obstacles; perception of reward structures). Our interviews with DATS staff, supported by written comments on the ***D & A Program Survey*** and feedback obtained from DATS personnel at the ***1-day D & A Symposium*** held in June, 1999, suggested somewhat low levels of D & A staff morale. Several excellent survey instruments are available for assessing staff perceptions of organizational climate, job satisfaction, stress, and so on.

Recommendation #3. Correctional agencies should conduct research to learn more about what aftercare treatment options are available to D & A program graduates, what resources are required by released offenders, and level and quality of participation in aftercare. A program database of aftercare containing basic information about aftercare treatment options would be invaluable. Research should examine the entire range of aftercare options available to inmates, and gradually build information about aftercare program participation and graduation into program evaluation studies.

Recommendation #4. Correctional agencies should consider training and using inmates as peer facilitators to assist in specific aspects of treatment programming. Such efforts, if properly supported with required staff positions and adequate resources for training, development, and supervision, can provide constructive treatment activities for inmates as well as valuable assistance for treatment programming.

Conclusion

A successful university-agency research partnership has developed, as witnessed by highly positive member feedback and by an ongoing relationship that continues to produce funded grant proposals and an

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active research agenda. The research partnership Steering Committee included critical representation from four areas: (1) executive personnel who were capable of making important programmatic and policy decisions, (2) data systems specialists who were capable of addressing diverse research needs, (3) clinicians and drug treatment specialists who were familiar with the inmate populations and treatment approaches used in different programs, and (4) researchers who were familiar with the relevant correctional, evaluation and drug treatment literature, as well as the scientific, ethical and professional issues that must guide all research conducted with inmate and ex-offender populations.

A successful research partnership requires investment of time and resources on the part of both a public agency and a university. Active participation by agency personnel with focused expertise and decision-making authority is a necessary but not sufficient condition for success. Strong leadership by key DOC personnel and the formation of mutually rewarding work relationships have likely made the biggest difference to the success of this partnership so far.

We discussed similarities and differences in D & A programming provided at different institutions, and we used this information to design subsequent evaluation studies. Four types of Drug treatment programs were examined: Education, Outpatient, DATU (Drug and Alcohol Treatment Unit), and Therapeutic Community (TC). In several areas (e.g., primary treatment approach), we found high levels of consistency. In other areas (e.g., program duration, intensity, and staffing), there were substantial variations across institutions and programs, and some procedures (e.g., criteria driving target selection and program placement decisions) were vague. Specific findings and recommendations were discussed.

Next, we focused on providing detailed descriptive assessments of the four types of drug and alcohol programming, assessing strengths and weaknesses, and making recommendations for strengthening programming. In addition to the large body of data that informed our process evaluation (nearly 100 staff and inmate interviews, program observations, and case file reviews), our conclusions were informed by the Drug and Alcohol Program Surveys (N = 118) obtained from 24 DOC institutions, program and policy documents submitted by each institution, and feedback provided by 48 treatment specialists who attended a special 1-day symposium on Drug and Alcohol Programming held in June, 1999.

One major conclusion was that TC programming alone was of sufficient clarity, intensity and duration to warrant full-scale outcome evaluation at this time. Procedures and policies regarding other

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types of D & A programming (esp. education and outpatient) deserve careful review. Following summary and discussion of major findings from process evaluation, ten short-term recommendations and four systemic recommendations regarding prison-based drug treatment programming and policies were presented.

It is unlikely that the strengths and weaknesses in prison-based drug and alcohol programming reported in this paper are unique to Pennsylvania. Process evaluations of prison-based drug and alcohol treatment in other states have reported numerous implementation problems including inadequate numbers of trained and experienced counseling staff and lack of standardized screening, assessment, and selection processes (e.g., Inciardi, Martin, Lockwood, Hooper and Wald, 1992; Martin, Butzin and Inciardi, 1995). While the present study is to some degree a modified replication of previous studies, few studies have attempted the scope and detail described here. In spite of recommendations that evaluators of correctional treatment effects need to more precisely measure and enter programmatic variations as predictors in outcome evaluations (Palmer, 1992, 1995), evaluators rarely do so. Rarely is any attempt made to measure critical programmatic variations or to use such information to inform drug treatment program design, policies or evaluation.

Most prison-based drug treatment programs remain unevaluated and relationships between inmate characteristics, treatment process and outcomes remain only poorly understood (Lipton and Pearson, 1998; NIDA, 1981, 1999). Surprisingly little information is available about variation in the content, structure and process of such programs (e.g., intensity, duration, treatment approaches). For example, say that Inmate A receives 6 weeks of group counseling consisting of two one-hour sessions per week for a total treatment exposure of 12 hours, while Inmate B completes a one-year, residential drug treatment program consisting of 30 hours of individual and group counseling per week for a total treatment exposure of 1,560 hours. Estimates of inmate participation in treatment and program availability do not adequately distinguish between different programs (and inmates), and program evaluations only rarely account for such critical variations in programming.

Toward this end, we hope that that other states and localities may learn from the research methods, data and conclusions presented here. Through program surveys and process evaluations, we focused on providing detailed descriptive assessments of treatment programming, assessing strengths and weaknesses, and making recommendations for program planning, implementation and evaluation.

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In particular, detailed process evaluations (including assessment of programmatic characteristics such as intensity, duration, and treatment approach) should precede and inform any meaningful outcome evaluation of drug treatment effects (Welsh and Harris, 1999). Despite the widespread proliferation of prison-based drug treatment, little research has considered how critical variations in programming may influence treatment outcomes. Results of our program census indicated considerable variability in programming across institutions and program types. We discussed the implications of these findings for program development and evaluation, focusing on how the research has impacted on drug treatment policies within the Pennsylvania Department of Corrections. It is equally true, however, that efforts to design, monitor and evaluate prison-based drug treatment programs nationwide must pay more careful attention to mapping critical dimensions of program structure, content and process than has previously been the case (Welsh and Zajac, 2001).

The Pennsylvania Department of Corrections is to be highly commended for its active participation as partners in this research enterprise and for its willingness to constructively examine its programming for inmates with drug and alcohol problems. The evaluation research undertaken through this project represents an exercise in *organizational learning*, where the agency inquires into the operations of its programs and uses the knowledge gained from this inquiry to inform efforts to improve its programs (Argyris, 1982). More importantly, this learning activity was not simply a reflexive or coerced exercise undertaken in response to some identified problem within the organization, but instead remains a proactive attempt at organizational development and growth. This represents the highest manifestation of organizational learning, where voluntary inquiry driven by valid information leads to a commitment to program enhancement (Zajac and Comfort, 1997).

In addition to providing a replicable framework for developing a constructive university/agency research partnership and gathering useable, policy-relevant data, these reports were also intended to provide DOC with specific information useful for program management and monitoring. Such information has already proven vital for informing the research design of outcome evaluation efforts (e.g., designing appropriate treatment and comparison groups for outcome evaluation) and for revising drug treatment programs and policies (e.g., greater program standardization, greater attention to screening and assessment procedures). It is in the spirit of continued cooperation between researchers and correctional professionals, constructive feedback and discussion, and ongoing development of effective programs that we present our experience to others.

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BUILDING AN EFFECTIVE RESEARCH COLLABORATION BETWEEN THE CENTER FOR PUBLIC POLICY AT TEMPLE UNIVERSITY AND THE PENNSYLVANIA DEPARTMENT OF CORRECTIONS: FINAL REPORT TO THE NATIONAL INSTITUTE OF JUSTICE

I. PROJECT OVERVIEW

Introduction

Like other states, Pennsylvania has experienced rapid growth in its correctional population and capacity since 1980. Like other states, correctional issues in Pennsylvania command greater budget and policy attention than ever before (see Welsh, 1993; 1995). Like other states, Pennsylvania lacks the necessary resources to evaluate the wide range of treatment programs offered to thousands of inmates within its institutions. There is an increasing need for evaluative research, to determine which programs work for which offenders under which conditions, to improve programming to reduce recidivism and increase public safety, and to demonstrate accountability to state and federal funding sources, as well as the citizenry of Pennsylvania. In particular, high numbers of drug-involved offenders are treated annually, but research is sorely needed to examine effective elements of service delivery and treatment outcomes.

The purpose of our project was to develop a collaborative research partnership between Temple University's Center for Public Policy (CPP) and the Pennsylvania Department of Corrections (DOC), with a demonstration project that included three main elements: 1) a descriptive assessment of Drug and Alcohol programming (through a treatment program census and a "mini conference" of D & A staff), including identification of critical service delivery components and goals, 2) an intensive on-site process evaluation of representative programs at two institutions, and 3) design of an outcome evaluation research design based on analyses and discussion between Temple and DOC. We emphasized an interactive approach that involves key stakeholders in the identification of all needs, goals, and research activities. Our purpose was to facilitate a general program planning and development agenda that includes but is not restricted to outcome evaluation. In so doing, we emphasized a research agenda driven by Department of Corrections needs, with a long-term goal of developing internal research capacity. In this report, we describe key stages in the development of the partnership, and we provide a detailed summary of results from the demonstration project, a statewide assessment of prison-based drug treatment.

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Background

Pennsylvania Department of Corrections

As of May 30, 1999, The Pennsylvania Department of Corrections operated 24 state correctional institutions, one motivational boot camp, and 15 community corrections centers. Pennsylvania consistently ranks within the ten highest prison populations in the country (Gilliard and Beck, 1998). The Department housed 36,603 inmates as of April 30, 1999. Overall, offenders are housed at 149% of the system's design capacity, with fourteen facilities housing offenders in excess of 150% of design capacity. Males represent 96% of the inmate population, with females accounting for 4%. The inmate population consisted of 33.9% Caucasians, 55.9% African Americans, 9.6% Hispanics, with less than one percent accounted for by other racial groups. The average age, as of May 31, 1999, was 35 years old, ranging from 15 to 89 years. On average, offenders are serving a minimum sentence length of 6.4 years and an average maximum length of 14.0 years (average does not include lifers, capital cases and parole violators). During the 1997-98 fiscal year, the Department placed 14,140 inmates in drug and alcohol programming.

The Department of Corrections General Fund Budget for Fiscal Year 1998 was $1,087,970,000. This represents 5.1% of the total state budget. The overall operational cost per inmate for fiscal year July 1, 1997 - June 30, 1998 averaged $24,505 or 67.14/day. This figure includes associated institutional and departmental administrative costs. For the same period, there were 13,222 employed staff. Correctional staff accounted for 56% of the total departmental complement. Males represented 92% of the correctional staff. As of April 1,1999, the inmate to correctional officer staff ratio in Pennsylvania averaged 5.0 to 1, compared to a national ratio of 5.6 to 1.

Drug and Alcohol Programs Administered by DOC

The Department's approach to drug and alcohol programs is informed by the Chronic Disease Model of substance abuse, which treats substance abuse as a long-term behavioral and physiological problem, rather than a short-term failure. Under this model, substance abuse requires ongoing intervention, and is not typically amenable to a one-time fix. Thus, success in treatment can be indicated by incremental improvements in what may be a long-established pattern of self-destructive and socially dysfunctional behavior. Long-term goals are to reduce recidivism, drug dealing and use, and increase the prospects for successful inmate reintegration into society.

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The Department's drug and alcohol programming is grouped into four major categories: (1) Drug and Alcohol Education Programs offered by the Department to inmates identified as having any level of drug and alcohol involvement; (2) Outpatient Treatment Programs offered to inmates who are in need of more intensive, intermediate levels of intervention, including individual and group counseling sessions; (3) Therapeutic Communities offered to inmates identified as needing intensive substance abuse intervention; and (4) Ancillary Groups, such as self-help, peer counseling and relapse prevention, offered to inmates as a supplement to other treatment, or when slots are not available in the more intensive treatment modalities. Inmates are assigned to specific treatment programs on the basis of comprehensive diagnostic and needs assessments applied to all inmates.

Substance Abuse Education provides participants with a fundamental overview of the social, physical and behavioral effects of drug and alcohol/addiction. Participants learn the benefits that result from a drug free life style. Education groups cover the following: The Disease Concept, pharmacology of drugs, physical, psychological, social and financial impacts of use, self-assessment treatment options, role of self-help groups and relapse prevention. Each institution has the flexibility to determine the length and presentation style for the group. Substance Abuse Education groups function as the "entry level" treatment for the general population. The treatment approach and information presented act as a motivator for continued treatment. The Spanish version of substance abuse education is available to correspond to prison demographics and inmate demand.

Outpatient Treatment provides services to inmates identified as having moderate to severe substance abuse problems. In this phase of treatment, Departmental Drug and Alcohol Treatment Specialists (DATS) work directly and intensively with inmates to help them recognize and address their dependency problems. Treatment offered can include twelve step approaches, individual and group intensive counseling, rational/emotive therapy, cognitive restructuring therapy, and other services rendered by Departmental drug and alcohol treatment specialists. Where clinically indicated, detoxification services are also offered. These treatment programs are integrated into the other activities that make up the inmate's day, such as work, education and recreational activities. An inmate in this phase of treatment will typically receive treatment for at least one hour per day.

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Therapeutic Communities provide a residential treatment environment, separate from the general prison population. The Department of Corrections has instituted several therapeutic communities to treat a wide spectrum of substance abusing offenders. The TC model involves a long stay, usually ranging from 12 to 24 months. The TC incorporates comprehensive substance abuse treatment programs. The aim of the TC is total life-style change, including abstinence from drugs, elimination of antisocial behavior, and development of prosocial attitudes and values. The Department of Corrections currently operates therapeutic communities at SCI-Cresson, SCI-Dallas, SCI-Graterford, SCI-Houtzdale, SCI-Huntingdon, SCI-Muncy, and SCI-Waymart for severely addicted inmates. All therapeutic communities incorporate several treatment models and approaches for the treatment of substance abusing inmates. Individual and group counseling, encounter groups, peer pressure, role models, and a system of incentives and sanctions form the core of treatment interventions in these therapeutic communities. Inmate residents of the TC live together, participate in self-help groups and take responsibility for their own recovery. All TC's have a defined structure and daily activities to reinforce the belief and mission of the TC. The main emphasis of the TC is on healthy, positive development of all aspects of inmate life.

Ancillary Groups supplement prescriptive substance abuse programs in all state correctional institutions. Currently, institutions provide a wide range of ancillary services. The ancillary groups include, but are not limited to, music therapy, peer groups, miscellaneous groups, 12-step groups, advanced codependency group, assertiveness group, survivor's group, transitional services, self-esteem group, aftercare group, breaking barriers group, long term support group, denial group, decision making and coping skills group, lifers group, parole violators group and pre-release groups. Inmates with moderate to minimum substance abuse problems are provided opportunities to participate in these groups during the time they are waiting to participate in structured drug and alcohol programs. Ancillary groups utilize a wide variety of educational, treatment and self-help approaches. Lifers and inmates with very low motivation are encouraged to participate in ancillary groups. The goals of the ancillary groups include recovery from addiction, personal growth and self-esteem, integration into the community through readiness and pro social skills training, and the reduction of recidivism. In addition, ancillary groups help to maintain institutional security, minimizing disciplinary problems, controlling inmates' drug dealing and use, improving relationships between inmates and correctional staff by creating a positive climate for inmates and staff.

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Statement of the Problem

The criminal justice system is flooded with substance abusers (Lipton, 1995). Substance abusers who have a severe drug problem are responsible for a high proportion of crime (Ball et al., 1983; Chaiken, 1989; Inciardi, 1979). Many of these drug-abusing offenders are repeatedly incarcerated, but untreated, with the result that a high proportion relapses into drug use and crime after release. The time that drug-involved offenders are incarcerated presents a unique opportunity to provide them with treatment. Prison-based drug treatment shows great promise in reducing drug use and offender rearrest rates (Lipton, 1995). While there is yet little consensus about what types of treatment work best for what types of offenders in what settings, several studies have demonstrated that in-custody treatment can be effective in reducing relapse and recidivism among seriously drug-involved offenders.

Little formal work has been done to evaluate DOC drug and alcohol programs to date. Several forces drive an increased interest in evaluation. First, the legislature has an increasing interest in seeing agencies produce evaluation information. Questions on program performance come up at budget hearings. Second, funding agencies, especially the federal government, are increasingly interested in accountability. For example, federal and state money received by the department for drug and alcohol programming is increasingly conditioned on an evaluation of these programs. Third, evaluation information can assist the department in understanding and improving its programs. For example, the current effort by the DOC to standardize its D & A programs can be aided by a better understanding of "what works and why".

The proposed research collaboration aimed to identify critical elements of building a successful research partnership through the methods described below, and to advance research and policy regarding the design, implementation, and evaluation of effective prison-based substance-abuse treatment. This study of drug and alcohol treatment interventions provided through the Pennsylvania Department of Corrections provides one of the first opportunities in Pennsylvania to systematically investigate these interventions, while at the same time building a statewide data collection and analysis capacity for further studying and refining these efforts. The information realized through this endeavor has been useful to correctional managers and researchers alike, as they design, implement and track the effects of such interventions.

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II. LITERATURE REVIEW

University and Public Agency Collaboration: Issues and Concerns

Today it is rather easy to find extensive discussion on how to make public institutions work better and be more accountable, although the methods for achieving such ends are not always clearly specified (Gore, 1993; Osborne and Gaebler, 1992; Peters and Waterman, 1982; Schachter, 1995). This is especially the case within the public sectors of education, human services and welfare, where there is considerable public expenditure, often conflicting values and ends, and where the stakes are so high (Zajac, 1997; Zajac and Al-Kazemi, 1997). Current thinking about improving government services suggests that at a minimum public institutions must do three things: 1) work smarter, particularly with better information; 2) constantly monitor the shifting demands of constituents and clients; and, 3) link themselves with other agencies and support functions. Such efforts provide a way for agencies to make sense out of their efforts, outputs and impacts (Weick, 1995).

Pressures on government institutions for more efficient operations and effective impacts have created a need for research collaborations, often to build better understanding of agency efforts, outputs, and intended and unintended consequences. This has led in recent years to greater receptivity among government agencies for linking their analysis needs to universities and other research-based organizations.

Currently, many universities have renewed for themselves an active role in shaping and enacting public policy choices affecting government as well as local communities. Historically, universities have had long standing cooperative relationships with communities, as well as public and private agencies. The notion that collaborative relationships between university researchers and public agencies can assist in formulating more rational and effective public policies is now an integral part of the current research and policy development process.

Despite a renewed interest in university/public agency collaboration, there are a number of obstacles to building effective relationships between these types of institutions. Cooperative relationships between universities and government agencies are at times made more difficult by a number of cross-institutional constraints and orientations. First, differences in the time horizon between universities and government agencies complicates these relationships to the degree that within the academic community, policy proposals are often examined in a careful and sometimes lengthy process, whereas in the time sensitive, action-oriented public sector, analysis must be swift and focused. Second, these institutional

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constraints are often revealed in who defines the problem for investigation, and what data collection and analysis follow this decision. Often universities seek to define problems independently from government agencies, while testing broad theories about social, political and economic life (Lindblom and Cohen, 1979). By contrast, public agencies must often rely on incomplete data, which is politically sensitive in order to address an ever pressing political, and economic question, "Does this program work?"

Third, and alluded to above, there are also a number of political obstacles to cooperation between university researchers and public agency decision-makers including the perceived insularity of the "ivory tower", and the real and consequential political constraints of public policy decision makers. Moreover, university researchers are also at times faced with the fact that public agency personnel may apply only a small, politically expedient portion of the research report; thus making academic researchers question whether the relationship is worth the time and effort often required of high level social research. Finally, the theoretical and practical expertise generated by university researchers often goes untested by public agencies because of a general failure to create effective and understandable linkages. In essence, a lack of political knowledge precludes proper linkage because of an expedience orientation on the part of public agencies, and the excessive priority placed on theoretical and methodological rigor on the part of the academic community.

Most of the research surrounding institutional cooperation involves the failure of public agencies and university researchers to develop linkages necessary to develop joint policy development and evaluation programs. In a phrase, the failure of these institutions to "get on the same page" often inhibits any efforts on either part to solve service delivery problems.

This project embraced the philosophy and practice of university/government agency collaboration by establishing a relationship to sharpen the assessment of drug and alcohol treatment programs conducted through the Pennsylvania Department of Corrections. We viewed this initial emphasis on drug and alcohol programming as part of a more general approach that emphasizes program planning and development, and building internal department capacity. Eventually, we wish to extend this approach to examine a wide range of DOC programming, including educational and vocational training (e.g., life skills, job readiness skills) and psychological treatment (e.g., anger management, stress management, social skills training).

The collaboration between the Center for Public Policy at Temple University and the Pennsylvania Department of Corrections addresses the (at times) conflicting nature of academic and action-focused research by building a research and demonstration project cooperatively undertaken by the two

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organizations. Moreover, linking research capacity with agency policy questions requires an open dialogue and a methodology for including both the research and policy making communities in: 1) problem definition; 2) data collection and analysis; 3) data interpretation; and 4) action following analysis.

The Nature of Effective Collaborative Frameworks

Successful collaborations are built upon a foundation of mutual understanding and trust, as well as effective communication. Building that foundation, however, requires that the participants to the collaboration engage in several activities each of which is designed to strengthen the collaborative, thereby producing a useful working relationship within the collaborative (Weick, 1995).

From the perspective of collaborations that support policymaking, it is important to first recognize that the aims of the collaborative are focused on the policy domain in question, not singularly on the particular interests and/or strengths of those participating. That is to say, those engaged in the collaborative do so to the extent that their interests in the policy question(s) at hand are addressed in the collaborative. In building effective collaborations between researchers and government agencies this means that the collaborative must focus on the problems and/or needs of the participating agencies, as these are generally in need of the timeliest response. In the initiation of the collaborative an "Action Research Frame of Reference" is required, such that the collaborative adjust both the range of issues confronted and the methodologies used to explore those issues to the ongoing needs of the policymakers. Initially this tends to take the form of a Data and Problem Reconnaissance, wherein agency needs are explored, classified and prioritize and available data to address the prioritized needs are identified and assessed with respect to their quality, validity and reliability.

Effective collaborations typically require mutual understanding of the problem, and the creation of a role in both shaping the collaborative and addressing the problems chosen for each participant in the collaboration. This involves the sharing of tasks, information and analysis. Of necessity, collaborations must include as many stakeholders as possible to be effective, as stakeholders are part of the analysis and action necessary to address a problem; they are both the source of information and action.

A critical dynamic within effective collaborations lies in their ability to communicate vertically and horizontally. Horizontal communications effectively link the members of the collaborative to one another,

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while vertical communications link the collaborative to the wider policy and organizational environment. In the correctional drug and alcohol treatment environment this means linking the research interests of the central administration to the operational and program needs of individual correctional institutions. In building relationships and problem consensus within the collaborative communications become more open and direct. This, in turn, strengthens the collaborative. Feedback is essential for the collaboration to assess its own dynamic as well as progress on issues being addressed. Feedback also provides the collaborative with information upon which a common language and conceptualization can be built. Such feedback helps to increase the connection participants associated between the collaborative and themselves.

While collaboratives seek to involve as many stakeholders as possible, recognizing the action frame of reference of policy making and policy analysis, they build on the complementary strengths that the policy world and the research communities bring to the collaboration. Agency-based participants, for example, are an important source of information and critique on problems, programs, strategies, policies and decisions, all of which affect the policy domain in question. University-based participants to the collaborative bring a complementary set of skills to the collaborative in the form of broad-based social science knowledge, research methodology and expertise, analytic capacity, data analysis and integration capability.

When operating within an action-oriented model of research and policymaking it is essential that the collaborative establish workable concepts and time frames. Goal and concept consensus is a critical initial step, while performance timetables and standards must also be accepted within the collaborative. An important goal of the collaborative should be to establish a system capable of replication. That is to say, the goal of the collaborative should be to design and implement a system that can be of continuing value to the agency, producing reliable and valid research results.

Finally, and perhaps most essential to effective collaborations between researchers and the agency world is the need to design and conduct research that produces and/or increases "usable knowledge" (Lindblom and Cohen, 1979). By "usable knowledge" many things are meant. First, usable knowledge requires that the information be actionable by the focal agency. Second, useable knowledge should produce a foundation upon which organizational learning and research systems can be build and refined over time. Indeed, such knowledge is necessary to move toward what Morgan (1997) and Argyris (1982) have termed "learning organizations," capable of reading and responding to changes in their environments. Third,

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useable knowledge must take into consideration the policy and practical constraints affecting the agency (Zajac and Comfort, 1997), and the resources available to address the targeted problem.

Finally, to be useful the collaborative needs to focus on "small wins", while building an information and analytic infrastructure in support of subsequent policy and decision-making. "Small wins" refer to creating confidence within the collaborative by achieving interim milestones that demonstrate the effectiveness of collaboration. As should be obvious, if effective research agency collaborations are to be accepted, they need to address pressing, visible needs and problems. Our demonstration project focuses precisely on such needs. There is a mandated need and a tremendous opportunity to provide drug and alcohol treatment to drug-involved offenders while incarcerated. However, current knowledge about which types of treatment work best for which offenders is scarce.

Effectiveness of Prison-Based Drug and Alcohol Treatment

Substance abusers who have a severe drug problem are responsible for a high proportion of crime (Ball et al., 1983; Chaiken, 1989; Inciardi, 1979). The Drug Use Forecasting program (DUF) showed that the proportion of all arrestees who test positive for substance abuse has never fallen below 60 percent and has been as high as 85 percent (Wish and O'Neil, 1989; National Institute of Justice, 1994). These offenders are typically users of many drugs. At least 45 percent of arrestees charged with violent crimes or income-generating crimes in 1988 tested positive for use of one or more drugs. The National Center on Addiction and Substance Abuse (1998) reports that 80% of all prison inmates (federal, state, and county) have been involved with drug use or drug-related crimes in some fashion. For chronic users, activities and behaviors surrounding drug acquisition and use pervade their lifestyle (Johnson et al., 1985; Walters, 1992). Many of these drug-abusing offenders are repeatedly incarcerated, but untreated, with the result that a high proportion relapses into drug use and crime after release. Drug-using felons are a primary source of failure on parole (Wexler et al., 1988).

The time that drug-involved offenders are incarcerated presents a unique opportunity to provide them with treatment. Most drug-involved offenders have avoided treatment while in the community, although many have experienced detoxification. More than 70 percent of active street addicts have never been in treatment nor intend to enter treatment for their addiction (Lipton, 1989; Peyton, 1994). The need for expanding drug abuse treatment was recognized in the Violent Crime Control Act of 1994, which for the first time provided substantial drug treatment resources for Federal and State jurisdictions. Available

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research suggests that prison-based drug treatment shows great promise in reducing drug use and offender rearrest rates (Lipton, 1995).

In 1979, there were 160 prison treatment programs serving about 10,000 inmates--4 percent of the Nation's prison population (NIDA, 1981). Of 160 programs, 49 programs (32 percent) were based on the TC model and served about 4,200 participants (or 42 percent of all participants). Ten years later, the percentage of inmates in drug treatment programs had risen to an estimated 11 percent (Chaiken, 1989). Although the increase has been sizable, the majority of inmates with substance abuse problems still do not receive treatment while in prison (Lipton, 1995). More than half the States offer assessment procedures, education programs, counseling, other programs, or some combination (Lipton, 1995).

While there is yet little consensus about what types of treatment work best for what types of offenders in what settings, several studies have demonstrated that in-custody treatment, especially the therapeutic community (TC) model, can be effective in reducing relapse and recidivism among seriously drug-involved offenders. Effectiveness is related specifically to the length of time an individual remains in treatment, regardless of the type of treatment provided (Lipton, 1995). Evaluations of New York's Stay'n Out program (Wexler, Falkin, and Lipton, 1990; Wexler, Falkin, Lipton, and Rosenbaum, 1992), Oregon's Cornerstone Program (Field, 1984, 1989), Delaware's Key-Crest programs (Inciardi, 1995, 1997), and California's Amity Prison TC program (Wexler, 1995) illustrate the potential of prison-based therapeutic communities.

In New York, for example, inmates in a therapeutic community program showed the lowest recidivism rates of several carefully constructed comparison groups, followed by inmates in milieu therapy, a group that received traditional counseling, and lastly, a no-treatment control group (Wexler, Falkin, and Lipton, 1990). Studies in the Delaware prison system have confirmed the efficacy of prison-based drug treatment, especially a therapeutic community combined with a TC-based work release component (Inciardi et al., 1997). Drug-involved offenders who participated in prison-based treatment (the Key) followed by treatment in a work-release center (Crest) had lower rates of drug use and recidivism than drug-involved offenders who participated in a shorter treatment program. At 18 months after release, drug offenders who received 12–15 months of treatment in prison followed by an additional 6 months of drug treatment and job training were more than twice as likely to be drug-free than offenders who received prison-based treatment alone. Offenders who received both forms of treatment were much more likely than offenders who received

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only prison-based treatment to be arrest-free 18 months after their release (71 percent compared to 48 percent).

The most recent and state-of-the-art research on prison-based drug treatment was reported in two 1999 special issues of the Prison Journal (Volume 79, Numbers 3 and 4). Evaluations of prison-based treatment outcome were reported for three states that have mounted major treatment initiatives in correctional settings: California, Delaware, and Texas. The three evaluation studies in the special issue all used a common time interval (3 years) for tracking follow-up outcomes, including performance indicators extracted from official criminal justice records in each state.

The overall consistency of findings from these three independent evaluations strengthens the case for treatment effectiveness in correctional settings. Each found that graduates of prison TC have lower rates of rearrest, drug relapse, and return to custody than comparison samples, especially when prison TC was combined with structured aftercare following release from prison. In Delaware, for example (Martin et al., 1999), 3-year follow-ups showed that rearrest rates were lowest for those who graduated prison TC and successfully completed an aftercare program (31%). Those who completed TC but no aftercare still did significantly better (45%) than those who dropped out (72%) or those who received no treatment (71%). In California (Wexler et al., 1999), those who successfully completed prison TC plus aftercare showed a rearrest rate of 27% in 3-year follow-up studies, compared to 75% for a no-treatment comparison group. In Texas (Knight, Simpson and Hiller, 1999), those who completed TC plus aftercare had a 3-year rearrest rate of only 25%, compared to 42% of a no-treatment comparison group. A comprehensive review of almost 30 years of research (Pearson & Lipton, 1999) further supported the positive impact of intensive therapeutic community programs (but not of boot camps or periodic drug-related group counseling).

Griffith et al. (1999) examined costs for prison-based treatment in Texas. Adding prison-based treatment and aftercare raised the base costs for prison incarceration and 3 years of parole supervision (approximately $18,000) by about 25%, an increase that was shown to be highly cost effective for inmates with serious drug-related problems and who completed treatment.

While evaluation results are promising, many studies of prison-based drug treatment have been vulnerable to criticisms of inadequate research design, unknown or compromised program implementation, and/or inadequate measures of treatment process and outcome (Austin, 1998; Fletcher and Tims, 1992).

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"Self selection" is the main guide inmates use to navigate through treatment options, which complicates the clarity of scientific interpretations (Simpson, Wexler, and Inciardi, 1999). We need to know more about risk factors that represent barriers to treatment participation and completion (Hiller et al., 1999) as well as ways to engage inmates in the treatment process more effectively (Blankenship et al., 1999). Numerous questions remain about what kinds of inmates are most likely to benefit from prison-based drug treatment programs, how treatment needs are assessed, how need assessments influence program placement decisions and treatment planning, and how elements of the treatment process (program content, staffing, and inmate processing) influence outcomes (Inciardi et al., 1992).

Researchers need more precise, reliable information about program structure to better understand how program process (e.g., program duration, treatment approach) influences outcome. Otherwise, program participation becomes a "black box" that defies easy description (Hiller, Knight, Rao and Simpson, 2000). Significant variations typically exist in education, outpatient and inpatient drug treatment programs across different sites (Welsh et al., 2001; Welsh and Zajac, 2001). How can we say that a "program" (X) produced a specific outcome such as recidivism (Y), if we have no idea what "X" was in the first place (Welsh, 1998; Welsh and Harris, 1999)? How do we know what was actually delivered, or which significant aspects of treatment (which can vary considerably across different institutions) influenced observed outcomes?

Programmatic variations in either prison-based or community-based AOD treatment programs, where they exist, need to be better assessed and recorded. In this way, inmates participating in different treatment programs can be linked with a specific set of program descriptors (e.g., duration, intensity, primary treatment approach, program performance measures, etc.). This accounting of program content and structure should become a regular feature of AOD program monitoring and evaluation.

III. METHODS AND ANALYSIS

Goals and Objectives

The partnership's initial agenda addressed four main **goals**: 1) build an effective, long term research partnership; 2) develop and facilitate an ***overall evaluation approach*** that emphasizes program planning and development, and building internal department capacity, 3) apply that approach to ***describe critical service delivery elements and goals*** of ***drug and alcohol programs*** currently carried out by the Department of Corrections, and 4) identify two institutional sites to carry out ***on-site process and outcome***

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evaluation. Four specific sets of **objectives** were operationalized to achieve each goal: 1) Create a ***steering committee***; make and record contacts between partnership members (e.g., collect minutes of the Steering Committee's meetings; compile communications using an e-mail ListServ); collect working documents initiated by the collaborative; assess expectations for what behavior is expected from collaboration members; assess benefits resulting from collaboration; and assess obstacles to collaboration; 2) discuss the current state of program planning and evaluation at PA-DOC and create an ***action agenda***, using the 7-stage model illustrated in **Figure 1** as a guide; 3) conduct a program ***census*** to assess institutional variations in treatment; hold a ***one day mini-conference*** with drug and alcohol treatment staff to discuss and prioritize elements of effective treatment; and 4) select two institutions to conduct ***intensive process evaluation***; and develop a research design and instruments for ***outcome evaluation.***

Overall Research Design

We adopted a broad, systematic approach to evaluating prison-based programs for drug-involved offenders. Program evaluation, in our view, is best viewed as but one stage of a more comprehensive approach to program and policy planning. Our partnership employs state-of-the art scientific methods to achieve mutual goals: to evaluate, strengthen, and plan effective prison-based treatment programs aimed at better achieving the goals of justice (e.g., reduced recidivism and improved life opportunities for released offenders). The model presented here is based on the 7-stage "Systematic Approach to Program and Policy Development and Analysis" developed by Welsh and Harris (1999) (i.e., developing and strengthening interventions through a careful process of analysis and planning). A summary is provided in **Figure 1.**

This 7-stage model clearly specifies the sequence of steps required for (1) analyzing a problem, (2) setting goals and objectives, (3) designing (or revising) an intervention, (4) action planning and implementation, (5) monitoring actual program service delivery, (6) evaluating program outcomes, and (7) interpreting and discussing results with partners and key stakeholders. This model may be used to plan new interventions, analyze existing interventions, or both (e.g., revising a current program). In the first case, certain critical activities can be enacted (or avoided) so as to increase the likelihood that a proposed intervention will effectively produce a desired change in a specific problem. In the second case, critical activities and decisions that informed the planning process can be identified and analyzed so as to help us to understand why a particular intervention did or did not produce effective results.

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Stage 1. **Analyzing the Problem**	**Stage 2.** **Setting Goals and Objectives**	**Stage 3.** **Designing the Program or Policy**	**Stage 4.** **Developing an Action Plan**	**Stage 5.** **Monitoring Program/ Policy Implementation**	**Stage 6.** **Developing a Plan for Evaluating Outcomes**	**Stage 7.** **Initiating the Program or Policy Design**
Document the need for change	Write goal statements	Choose from different intervention options	Identify resources needed	Design instruments to collect monitoring data	Develop outcome measures based on objectives	Initiate the action plan
Describe the history of the problem	Write specific outcome objectives for each goal	Program Design: · Define the target population	Plan to acquire or reallocate resources	Designate responsibility to collect, store, and analyze data	Specify the research design to be used	Coordinate program or policy activities
Examine potential causes	Seek participation in goal setting	· Define client selection procedures	Specify dates to complete implementation tasks	Develop information system capacities	Identify potential confounding factors	Begin monitoring program/policy implementation
Examine previous interventions	Specify an impact model	· Define program components (service delivery)	Develop mechanisms of self-regulation	Develop mechanisms to provide feedback to stakeholders	Identify users and uses of evaluation results	Make adjustments to program or policy design as gaps are found
Identify relevant stakeholders	Identify compatible and incompatible goals in the larger system	· Write job descriptions of staff and specify skills required	Specify a plan to build support		Reassess the entire program/policy plan	Determine whether program or policy is ready to be evaluated
Conduct a Systems Analysis	Identify needs for interagency collaboration	Policy Design: · Define the target population of the policy				Collect and analyze evaluation data
Identify barriers and supports		· Define the provisions of the policy				Provide feedback to stakeholders
		· Identify the responsible authority · Delineate the procedures to be followed				Reassess the entire program/policy plan and make necessary modifications to increase fit with decision environment

Figure 1. A Systematic Approach to Program Development and Evaluation

Adapted From: Wayne N. Welsh and Philip W. Harris (1999), *Criminal Justice Policy and Planning*. Cincinnati, OH: Anderson Publishing Co. ©All rights reserved.

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The establishment and implementation of a generic, internally driven research agenda for the Department of Corrections should undoubtedly be served by this approach. Also, there were many similarities between the Department's strategic planning process and the structure we proposed for developing the partnership. For example, one goal of the partnership planning process was to map the program and policy environment surrounding drug and alcohol programming. An intensive process evaluation of DOC drug treatment programs accomplished much of this sort of mapping.

Aside from formulating specific evaluation projects, such as a D & A evaluation, DOC has begun to think about the more general problem of establishing the *capacity* to do, or at least support, evaluation within the department. DOC expects to extend learning from the partnership to examine other programs offered to inmates, including education and vocational training. Several specific methods were used to develop the partnership and cooperatively implement our systematic examination of drug and alcohol programs.

Creating the Steering Committee

A Steering Committee of senior correctional policymakers, research and treatment personnel from the Pennsylvania Department of Corrections and Center for Public Policy research staff was formed in January 1999 to guide joint research activity. The Committee included critical representation from four areas: (1) executive personnel who were capable of making important programmatic and policy decisions, (2) data systems specialists who were capable of addressing diverse research needs, (3) clinicians and drug treatment specialists who were familiar with the inmate populations and treatment approaches used in different programs, and (4) researchers who were familiar with the relevant correctional, evaluation and drug treatment literature, as well as the scientific, ethical and professional issues that must guide all research conducted with inmate and ex-offender populations. This group focused on issues of building the collaborative, reviewing research plans and designs, and providing oversight of the research process. They also considered the larger organizational and policy issues that the collaborative raised within the Department of Corrections. Part of the mission for this committee was to discuss the findings of research completed through the partnership, suggest possible explanations for results, and further develop a systematic agenda for process and outcome evaluation of correctional programming. The Steering Committee participated in the design and administration of a statewide census of drug and alcohol programming at 24 institutions, and organization of a statewide meeting with Drug and Alcohol Treatment

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Specialists to explore drug and alcohol related programming within the DOC. Steering Committee Members as of June 1, 2000 (when the project was completed) are listed below.[1]

Senior Staff

- William J. Love, Deputy Secretary for Specialized Facilities and Programs.
- John S. Shaffer, Ph.D., Deputy Secretary for Administration.

State Correctional Institutions

- Harry Wilson, Superintendent, SCI-Cresson.
- David Close, DATS[2] Supervisor, SCI-Houtzdale.
- Harry Davis, DATS Manager, SCI-Muncy.
- Howard West, DATS II, SCI-Huntingdon.

Bureau of Inmate Services

- William A. Harrison, Director.
- James Tice, Chief, Treatment Division.
- Babu Suseelan, Ph.D., Drug and Alcohol Treatment Program Manager.

Bureau of Management Information Services, Division of Planning, Research and Statistics

- Kathleen Gnall, Chief.
- Gary Zajac, Ph.D., Research and Evaluation Manager.
- Bob Flaherty, Security Data Analyst.

Steering Committee Members from the Center For Public Policy, Temple University

- Wayne N. Welsh, Ph.D., Associate Professor of Criminal Justice (Principal Investigator)
- Jack R. Greene, Ph.D., Director of Center For Public Policy
- Judy Rushall, Graduate Research Associate (January - August, 1999)
- Kelley Klick, Graduate Research Associate (September, 1999 – August, 2001)

We viewed ongoing communication between researchers and Department of Corrections representatives and staff as vital to the success of this project. Communication strategies included regular (aprox. monthly) fax updates to keep all stakeholders at Central Office and the 24 correctional institutions abreast of our activities and progress. We asked Superintendents to copy this fax and distribute it to all Drug & Alcohol Treatment personnel at their institutions. Other communication strategies included written

[1] Membership shown here reflects the committee membership and positions at the time this project was completed in June of 2000. Several committee members have since changed positions or job titles.
[2] *DATS* is an acronym for the job title, "Drug and Alcohol Treatment Specialist."

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memos and progress reports, an e-mail discussion group (listserv) for committee members, and a public web page featuring information on project activities and resources for prison-based drug treatment.

Bi-monthly meetings began on schedule in January. The committee met twice before the project even officially started to begin planning, then met twice monthly from January through April. From May to December of 1999, the Committee continued to meet monthly, although several additional meetings were also conducted to plan for the one-day symposium with drug and alcohol treatment staff.

We have received very positive feedback from DOC personnel about our research and partnership activities. We have since cooperated on two additional grant proposals, including a project to develop and implement a new employee stress reduction program (not funded), and an outcome evaluation of therapeutic community drug treatment programs at five institutions. The latter proposal was circulated to Steering Committee Members for review and discussed at Steering Committee meetings in May and June. The proposal was submitted to NIJ on June 30, and subsequently funded (Grant #99-CE-VX-0009).

Developing Partnership Goals and Objectives

An essential part of NIJ's overall evaluation strategy has been the development of greater research and evaluation capacity within State and local criminal justice systems in order to increase data-driven decision-making and policy development. Recognizing that most agencies do not have substantial in-house research and evaluation expertise and resources, NIJ encouraged partnerships between correctional agencies and research institutions that can provide such expertise specifically tailored to meet State and local needs. The purpose of these NIJ-supported partnerships was to stimulate collaborative efforts that would develop into lasting, productive relationships.

Seven partnership goals were identified by the Pennsylvania Department of Corrections: (1) development of an ongoing, working relationship with a major Pennsylvania research university, which will facilitate the production of useful knowledge for the department, (2) demonstration of ability of DOC to utilize external research expertise and to secure funding for needed studies, (3) expansion of department's capacity to produce and use high quality, applied public policy research, including program evaluation, (4) development of a thorough understanding of the content and process of doc drug and alcohol treatment programs, (5) development of a design for a rigorous outcome evaluation of selected drug and alcohol programs, (6) continued collaboration on funded drug and alcohol program evaluation, based upon

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groundwork laid by partnership, and (7) production of information that is responsive to legislative and other demands for reporting on doc program performance.

Documenting the Partnership

As this effort sought to create an effective partnership between the Pennsylvania Department of Corrections and the Center for Public Policy at Temple University, a system for monitoring the ongoing progress of the partnership was designed and implemented. Information from this process was used to provide regular feedback to the Steering Committee and discuss partnership progress. Essentially the monitoring system included three elements: 1) *making and recording contacts between partnership members*; 2) *assessing benefits resulting from collaboration*; and 3) *identifying potential obstacles to collaboration*. Materials for analysis included Minutes of the Steering Committee Meetings, E-Mail (Listserv) Communications, and Working Documents initiated by the collaborative (e.g., Agenda and Handout for each meeting), and Surveys of Steering Committee members to assess perceived benefits and obstacles encountered in the partnership.

Making and recording contacts between partnership members included documenting the first meetings of the collaborative, arranging for follow-up contact, identifying potential benefits to participant agencies, delegating responsibilities to each agency, and exchanging information about agencies. Minutes of the Steering Committee's meetings were recorded and an e-mail ListServ (discussion group for all partnership members) was created for effectively communicating these minutes and for establishing an open forum for communications between DOC and Temple. In addition, the agenda and goal statements created by the Steering Committee guided the recording effort, as we collected working documents initiated by the collaborative. Participants needed agreement about what they were trying to achieve, and *why*. Moreover, expectations for what behavior was expected from collaboration members was continually monitored and recorded. We followed three guidelines essential for effective program and policy analysis (Welsh and Harris, 1999): 1) clearly articulate the specific tasks and activities that need to be accomplished, 2) clearly assign responsibility for each specific task to one or more individuals, and 3) agree upon a specific date by which each task is to be completed. Such efforts helped the collaborative communicate a clear message about the rationale, values, and intent of all efforts.

To assess perceived benefits resulting from the partnership, we posed several questions to Steering Committee members in an anonymous survey (described further in the *Results* section). Examples of items

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included the following: Has professional expertise been identified and provided on specialized topics? Has an improved public image resulted from specific partnership efforts? Has reduced fragmentation of drug and alcohol services been achieved? Has greater efficiency and effectiveness of services resulted? Have information systems available for monitoring and evaluation data improved?

As part of this assessment, we also surveyed Steering Committee members about *perceived obstacles to collaboration encountered in the partnership*. Examples of items included the following: Has crisis operation (shrinking budgets, etc.) ever impeded partnership planning and products? Has inflexibility been a problem (e.g., is there a willingness to adapt to each other's perspectives and "operating procedures"?) Has turfmanship impeded effective collaboration (e.g., interdepartmental competition for resources)? Does bureaucracy ever impede partnership efforts (e.g., centralized decision-making authority)?

Mapping The Program And Policy Environment

Although we recommend the comprehensive approach to evaluation developed by Welsh and Harris (1999) **(see Figure 1)**, it takes time to implement and stabilize such an approach. In particular, initial discussions with DOC staff and officials indicated considerable diversity in correctional drug and alcohol treatment programs. Programs were thought to vary considerably in their focus and intensity, and little standardization existed across different institutions (e.g., a therapeutic community at one institution is not necessarily the same as a therapeutic community at another institution). To apply key elements of our evaluation approach to drug and alcohol programs, we adopted a focused research program that can be summarized in eight key steps **(see Figure 2).**

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Research Components	Research Activities
1. **Problem Analysis**	Examine data and interview key persons to identify drug-involved offender needs and resources.
2. **Target Identification**	Define needs and characteristics of the proposed targets of drug and alcohol programs. How is eligibility determined?
3. **Assessment of Intake/Referral System**	Examine how clients are referred, recruited, and integrated into the program. Identify referral sources and assess relations with other departments and agencies involved in offender case management.
4. **Evaluability Assessment**	Develop a program model that articulates linkages between broad goals, specific activities, and intended objectives. Are objectives clear? Measurable? Are stakeholders in agreement about intended objectives?
5. **Information Systems: Assessment and Development**	Based on analyses in steps 1-4, assess current sources of information available for tracking offenders, and identify information needs, both intra-agency (e.g., current inmate classification system and inmate data management systems) and inter-agency (e.g., parole).
6. **Process Evaluation**	Through on-site visits, interviews, and observations, examine service delivery: who does what to whom in what order, and how much? Are there variations or gaps in implementation? Document the integrity of service delivery step as an essential pre-requisite to outcome evaluation. Process evaluation also aids in strengthening program design and interpreting outcome results.
7. **Description of Client Performance**	Examine client progress and provide feedback to program staff and stakeholders.
8. **Reassessment and Stabilization**	Re-assess the entire program model. Are modifications in intake, service delivery, or objectives needed? If so, obtain agreement on action needed, re-assess, then develop outcome measures and research design for outcome evaluation.

Figure 2. Research Plan for Evaluating DOC Drug and Alcohol Programs

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The main purpose of this component of the partnership was to document and summarize major program elements (e.g., target selection and eligibility; nature and quantity of service delivery; staff training and backgrounds) across institutions. That information was then used to analyze, strengthen and standardize treatment programs (part of a current initiative within DOC), and to inform the design of a valid outcome evaluation spanning five specific institutions. Key steps on the road toward a useful outcome evaluation are *evaluability assessment* (Rutman, 1980; Smith, 1989; Wholey, 1979), *process evaluation* (Palmer, 1992, 1995; Pawson and Tilley, 1996; Rossi and Freeman, 1989), and *information systems assessment and development*.

Evaluability assessment requires collaboration between researchers, program staff and directors to determine exactly what program activities are provided and what the intended outcomes are. This is a critical step toward designing an outcome evaluation: service delivery and objectives must be clear, measurable, and agreed upon by key stakeholders. It also provides a useful arena for developing rapport between evaluators and program staff to aid in the design and conduct of an outcome evaluation.

Process evaluation, or "monitoring," is a necessary prerequisite to outcome evaluation (Palmer, 1992; Pawson and Tilley, 1994; Welsh, Jenkins, and Harris, 1996; Welsh and Harris, 1999). Process evaluation refers to the collection of information to determine to what degree the program or policy *design* is being carried out as planned. Is the intended target population being reached? Are program/policy activities or provisions actually being carried out as planned? Are appropriate staff or responsible authorities selected and trained, and are they carrying out their assigned duties? Process evaluation involves a detailed analysis of the organizational and programmatic processes that influence treatment services. While outcome evaluation tells one whether or not a given program is achieving results, process evaluation sheds light on *why* a given outcome is being produced.

Doing process evaluation prior to outcome evaluation provides researchers and correctional managers with much useful information needed to design a meaningful and valid outcome study. This direction is supported by many funding agencies (e.g., the NIJ-sponsored national evaluation of Residential Substance Abuse Treatment (RSAT) programs). Thus, a primary focus of our demonstration project was an overall description and examination of DOC drug and alcohol programming, with a more detailed process evaluation of programming at two institutional sites. This research step was especially important given the expected programming variability between institutions. An outcome evaluation would be of

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limited validity and generalizability absent a rigorous mapping of the operations of D & A programming across institutions. Further, results from process evaluation may contribute to the refinement of existing departmental datasets and information systems related to inmates.

Several illustrative dimensions of process evaluation are identified by the *Correctional Program Assessment Inventory* (CPAI) (Andrews, 1995). The *CPAI* was designed to assess, in a structured and objective manner, the degree to which a program has been adequately designed and implemented (Andrews, 1995; Gendreau and Andrews, 1994). It is sensitive to the three principles of risk, need, and responsivity[3] derived from empirical research. The CPAI assesses a specific program by tabulating the presence, number, and variety of the best-validated elements of effective correctional programs. A variety of data sources common to process evaluations are used: program site visits, file reviews, interviews, and responses to structured questionnaires. Nine program dimensions are assessed:

1. ***Program Description/Demographics***: e.g., number of years in operation, physical setting--institutional/community, number of clients, number of staff, program budget, authority--government/private).

2. ***Program Implementation***: e.g., qualifications and experience of Program Director; whether a thorough literature review has been conducted to identify relevant program design features; whether a need for this program has been documented; whether program values are consistent with existing values in the larger institution or community; whether funding is adequate for the task and goals of the program.

3. ***Client Pre-service Assessment***: e.g., whether a reasonable assessment of risk factors and criminogenic needs is undertaken; whether risk factors and needs are assessed with recognized psychometric scales or tests; whether assessed offender risks and needs are appropriate to the style and method of treatment offered).

4. ***Program Characteristics***: e.g., the degree to which the program targets 19 specific criminogenic behaviors and attitudes; the type of treatment approach used (e.g., social skills therapy, family therapy, cognitive restructuring); whether printed treatment manuals are available.

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[3] First, effective programs clearly differentiate between **low risk** and **high risk** clients (Andrews et al., 1990; Bonta, 1996; Gendreau, 1996; Jones, 1996). High risk cases should receive high levels of intervention and services; low risk cases should receive minimal intervention. Second, criminogenic ***needs*** are dynamic (i.e., changing) risk factors that are predictive of recidivism (e.g., antisocial cognitions and emotional states, association with antisocial peers, substance abuse, weak self-control and problem solving skills). Programs that effectively target and reduce such individual needs accomplish larger decreases in re-offending. Third, programs that ***appropriately*** target the specific needs and learning styles of their clients are more effective.

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5. ***Therapeutic Integrity***: e.g., whether program participants are separated from the rest of the institutional population; whether clients participate in treatment services regularly and frequently; whether intensive service is provided for high-risk cases; whether staff are assigned to clients they work most effectively with; whether clients have any input into program structure; whether a variety of rewards are available.

6. ***Relapse Prevention***: e.g., whether the client is trained to observe and anticipate problem situations; whether the client practices and rehearses alternative prosocial responses; whether the client is referred to other services to aid in readjustment; whether "booster sessions" are provided to relearn/reinforce skills taught in the formal treatment phase.

7. ***Staff Characteristics***: e.g., education, experience, and training of staff; whether staff turnover is low or high; whether staff are assessed yearly on clinical skills related to service delivery; whether staff have any input into program structure or specifics.

8. ***Evaluation***: e.g., whether clients are periodically assessed on target behaviors; whether a management audit system is in place; whether client satisfaction is assessed; whether client re-offending data are gathered at 6 months or more after leaving the program; whether an acceptable research design has been used to evaluate outcome.

9. ***Other*** (4 items): e.g., whether ethical guidelines for treatment are recorded and practiced; whether positive changes in the program are planned or underway; whether community support is positive and stable.

Guided by previously identified dimensions of effective programs (Welsh and Harris, 1999) and effective correctional treatment (e.g., Andrews et al, 1990; Pearson and Lipton, 1999), we designed, in collaboration with DOC officials, an abbreviated *program census instrument* to distribute to drug and alcohol programs at each of the 24 DOC institutions. This instrument assessed the presence or absence of various programming elements, and gathered descriptive information about clients, staff, and treatment services. We assessed critical variations in client eligibility, selection, processing, nature and quantity of treatment services provided, staffing, attrition and retention, and graduation. Descriptive statistical techniques such as frequencies and cross-tabulations were used to summarize the data. We also held a ***one-day symposium*** where representatives from treatment programs at each of the 24 institutions assembled to discuss program census results. In particular, we wished to inform and facilitate DOC's current initiative to standardize treatment programming across institutions. The *census* allowed us to point out major differences across programs, but live *discussion* with treatment staff allowed DOC and Temple to identify and *prioritize* among different choices regarding client processing, treatment, and aftercare. The conference was held at a central location, the Correctional Training Academy in Elizabethtown, PA, to facilitate access for the greatest number of DOC staff. Based on results from the program census and the symposium, a

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more intensive ***on-site process evaluation*** of drug and alcohol programs was then conducted at two institutions chosen in collaboration with DOC officials.

Once the program and policy environment of D & A service delivery throughout DOC was examined, and specific strengths and weaknesses identified and discussed, an outcome evaluation design was developed. Two prerequisites for evaluation had to be met: (1) program objectives had to be clearly defined and measurable, and (2) programs targeted for outcome evaluation had to be sufficiently well designed and well implemented. In our regular monthly meetings with DOC staff and officials, we continuously presented results as they came in, we discussed how results could be most efficiently communicated, and we discussed how results could be used. Such a process facilitates meaningful, valid evaluation results where actual objectives and measures of outcome have been agreed upon well in advance.

Information Systems Assessment and Development

Based on discussions with DOC, one of the initial efforts of our partnership involved a "data reconnaissance": carefully and collaboratively examining existing DOC databases for completeness and usefulness for program planning, development, and evaluation (**see Appendix 1**). Temple personnel worked with DOC personnel to identify critical data elements *present* and critical elements *needed* to facilitate program planning and evaluation. Initial discussions centered around two specific informational projects: 1) strengthening and facilitating an existing DOC project, i.e., building a "data warehouse," and 2) launching a new project aimed at creating a *treatment program* data base.

The DOC Data Warehouse was an "in-house" project. The purpose of the project was to make it easier for anyone in the Department to access the different (previously unlinked) databases (see Appendix 1). The warehouse provides entree to the *Inmate Record System, Misconduct Database, Classification Database, RISP Drug Testing Database*, and other databases that might be built in later (e.g., an Offender-Based Treatment Database). When the data warehouse is complete, one can easily complete relational data analyses that were previously difficult. For example: "How many inmates are in each institution who are age 25 or under, with 5 years or less on their minimum sentence, who are custody level 3 or lower, and classified as *Substance Dependent*?" With a completed data warehouse, information from different databases will be readily linked and accessible to program, planning, and evaluation staff. Thus, the data warehouse will not only provide for a smoother flow of information within the Department, but will provide

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considerable benefits to the systematic program planning, development, and evaluation research envisioned through this partnership.

A Census Of Prison-Based Drug And Alcohol Treatment Programs

Background and Purpose

A Drug Treatment Program Data Base was created via a statewide program census intended to assess critical dimensions of each program's content and structure (e.g., duration, treatment approach), staffing (e.g., background and duties), and target population (e.g., eligibility and assessment criteria). The database now includes, among numerous programmatic elements (see *Results* section), descriptors that reflect the intensity, duration and type of D & A treatment services provided by different DOC drug and alcohol programs throughout the state.

Four major goals of the program census included: 1) Identification of critical service delivery components and goals, 2) Building a statewide database and capacity for further studying these efforts, 3) Facilitating description and evaluation of prison-based D & A programming, and 4) Facilitating discussion about characteristics of effective D & A programming (e.g., a 1-day symposium held in June with a representative sample of treatment staff).

The census collected three types of descriptive information: 1) program content (e.g., what type, duration), 2) program staff (e.g., duties and responsibilities), and 3) inmates (e.g., eligibility, intake procedures). Survey items were identified from previous literature on process evaluation (e.g., Palmer, 1992, 1995; Pawson and Tilley, 1994; Rutman, 1980; Smith, 1989; Welsh and Harris, 1999; Wholey, 1979), effective correctional treatment (e.g., Andrews, 1995; Andrews et al., 1990; Cullen and Gendreau, 2000; Gendreau, 1996; Lipton and Pearson, 1999; Pearson and Lipton, 1999), and prison-based drug treatment (e.g., DeLeon, 2000; Hiller, Knight and Simpson, 1999; Inciardi et al., 1992, 1997; Lipton, 1995; NIDA, 1981, 1999; ONDCP, 1996, 1999). A total of 48 items were assessed **(see Appendix 2)**.

Respondents

This was a census of D & A programming provided across the 24 DOC institutions. Survey respondents were DOC personnel who were responsible for directing D & A programs at each state institution. One survey was completed for each program. Instructions emphasized that this was not an

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audit; it was not an evaluation; and it was not an endorsement of any department policy. DOC personnel on the Steering Committee for this project actively participated in survey design and administration. Researchers from Temple University took responsibility for data coding and entry, although data analysis and interpretation was seen as a shared task.

Programs were identified in cooperation with Bureau of Inmate Services. We excluded only privately contracted programs and ancillary (inmate-led) programs, choosing to focus on the full range of Drug & Alcohol programs administered by the Department across its 24 state institutions. To ensure that we began with an accurate census of programs at each institution, the initial list was modified somewhat after discussions with DATS Supervisors and Managers at each institution. On 26 March 1999, survey packages were mailed to Superintendents, who were asked to forward them to DATS Supervisors and Managers, who then either completed the surveys themselves or assigned appropriate staff persons to complete each program survey. By April 12, DATS Managers and Supervisors were requested to place completed surveys in a stamped return envelope and mail them.

We received (on time) completed surveys from all 118 (100%) drug and alcohol programs identified by the steering committee, across 24 state correctional institutions including the Quehanna Motivational Boot Camp. The 118 completed program surveys included 44 Education programs, 58 Outpatient Treatment programs, 10 DATU's (Drug Abuse Treatment Units), and 6 Therapeutic Communities (TC's) (see Table 1).

By May 7, we had entered all census data into SPSS data files and completed data checks and cleaning (e.g., examination of missing values and incomplete data). We followed up with respondents to obtain any missing program information, and we assigned all necessary value labels and variable labels. To ensure reliability of the data, we also identified any outliers or unusual responses, and we followed up with each institution in attempts to correct any discrepancies detected. The DOC Research and Evaluation Manager capably assisted us in these efforts. For example, one institution had mistakenly reported the total number of "inmates served" (survey item #21) in multiple sections of their D & A Education programs, rather than the number served in one group at one time. While the number of corrections made to program census data was not extensive, we wanted to ensure that the data were as accurate as possible, and that no outliers severely influenced subsequent data analyses.

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The Principal Investigator then began initial data analysis and prepared by May 17 a report for the steering committee that included a seven-page executive summary and 78 summary tables (**see Appendix 3**). This document generated extremely productive discussions at the next steering committee meeting, as we examined similarities and differences in treatment programming across the state, and formulated plans for our June 2 symposium with treatment staff.

Evaluability Assessment and Process Evaluation

Prior to implementing a formal outcome evaluation research design (i.e., collecting outcome data for program participants and comparison groups), we seek to document or develop programs with clearly specified treatment activities, well-articulated, measurable objectives, and useful information systems (e.g., inmate intake and monitoring data). Data collected from evaluability assessments and process evaluations help to describe the chain of critical elements that influence treatment program design, implementation and effectiveness, and develop suitable measures and research designs for assessing the impact of treatment efforts.

In the program reports generated by these methods, we provide results of evaluability assessments (i.e., summary descriptions of each program's activities and objectives accompanied by recommendations for evaluation), and results of process evaluations (i.e., detailed description of program components, staff, and inmates). Based on those results, the steering committee can then identify relevant needs for program planning (e.g., assessment of inmate needs) and program evaluation (e.g., information systems) preceding design of outcome evaluations. Based upon all research results (program census, evaluability assessments, and process evaluations), we can further develop appropriate research designs to evaluate D & A programs, identify reliable and valid outcome measures, and make recommendations for program planning and evaluation.

Evaluability Assessment

Evaluability assessment produces an essential model of program activities and objectives that can be used to examine or refine program structure and process, and to develop valid outcome measures for each program. It is an essential precursor to a formal outcome assessment.

The problems and pitfalls of inadequately designed evaluative research have been abundantly noted (e.g., Rossi and Freeman, 1990; Rutman, 1980). Among the more serious of these problems, particularly in

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the case of new, developing programs, are poorly defined program content and objectives, vaguely articulated causal or intervention theories, and poor implementation of program components (Welsh and Harris, 1999, Ch. 4-6). The purpose of the evaluability assessment, as a precursor to the design of a formal outcome assessment, is to create an accurate model of exactly what each program does (content) and what it attempts to achieve (objectives). Through analyses of program records and policies, interviews with program staff, and observations of program services, we describe and clarify different aspects of service delivery, program goals, and specific objectives (expected changes in attitudes, values, and/or behavior) associated with each program component.

Using program documents (e.g., program audits, published brochures or pamphlets, written program policies and procedures) we initially developed a full description of program activities and objectives. This initial model served as a basis for subsequent revisions. Through structured interviews with DATS personnel and supervisors, we obtained staff perceptions of broad program goals and intended linkages between specific activities and outcomes. Through interviews with DATS personnel and supervisors and inspection of program documents, we gained information about program components, objectives, staff responsibilities, and expected performance of clients. This information was used to revise the original program models, eventually resulting in "evaluable models" of the programs emphasizing program activities that were clearly specified, and objectives that were feasible and measurable.

In addition to the more pragmatic purposes described above, evaluability assessment actively involves staff in the design of program evaluations, and seeks to build trust and rapport between staff and evaluators. The ideas, judgments, and perspectives of program staff are solicited openly and candidly. We discuss program development and evaluation needs with program staff, supervisors, and superintendents. The *evaluable program models* developed through evaluability assessments serve several purposes:

- First, they articulate program activities and objectives as perceived by program directors and staff.
- Second, they provide a framework for ongoing program planning and development. Each program can periodically review its program model to ensure that it accurately reflects intended program activities and/or objectives.
- Third, the program models provide evaluators with the basic material needed to design a valid outcome study. From these models, evaluators assume that they have obtained a valid description of program activities and objectives. Reliable and valid outcome measures can then be designed to empirically assess program objectives.

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Process Evaluation

The *process evaluations* provide a rich description of program content and structure, staff duties and responsibilities, and inmate eligibility, screening, intake, and monitoring. Much finer detail is gathered than through the program census previously conducted. Process evaluation data elaborate on the program's content and structure, and provide a basis for documenting program implementation prior to developing outcome evaluation plans. Process evaluation results should be presented and discussed with program staff so as to obtain as clear a picture of the program as possible, and to support internal capacity for program development and planning.

The goals of a process evaluation are to describe the actual operations of a program in detail. In general, we attempt a more fine-tuned description of the three programmatic areas tapped by the Drug and Alcohol program census: 1) program content and structure, 2) inmate selection, monitoring, and discharge procedures, and 3) staff responsibilities and duties. Through on-site visits, reviews of program documents, interviews with staff and inmates, and observations, we collected data on the educational or treatment services actually delivered within each program. We sought answers to two general questions: 1) Who does what to whom in what order, how much, and how often? What is the nature, frequency, and duration of services provided? 2) Does the "evaluable program model" developed through evaluability assessment accurately describe program operations?

It is particularly important to develop precise definitions of the target populations of each program. This information is essential to develop valid treatment and comparison groups for eventual outcome evaluations. This information can also be used to compare intended target populations with those served by the program, and to identify which inmates are most likely to benefit from the program.

We also wished to describe relevant information systems. Information systems refer to procedures for collecting, recording, storing, retrieving, and summarizing information about inmates participating in the program. The purpose of examining information systems is to support program development efforts and to strengthen data collection for program monitoring and outcome evaluations. We examined the use of procedures and instruments for collecting intake data, monitoring data, and follow-up data. We assessed whether current practices of collecting and storing information fit the needs of each program.

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Research Sites

Selection of institutions for on-site evaluability assessment and process evaluation was based on five criteria: (1) a full range of drug and alcohol programs (including Therapeutic Communities) was offered; (2) institutional representatives on our Steering Committee could facilitate research support; (3) facilities were within a reasonable driving distance from Philadelphia (where researchers were based); (4) we desired a balance between newer, prototypical institutions and older facilities; and (5) we wanted to examine institutions of somewhat different security levels. Two institutions that best balanced these criteria were SCI - Huntingdon and SCI - Houtzdale. On-site research was completed during July and August of 1999.

Researchers visited programs at each institution to observe actual delivery of services. DATS Supervisors, Staff, and Superintendents were contacted in advance, and the reasons for the visits were explained in order to reduce resistance and reaction to the presence of observers. In addition to gaining first-hand information about program services, we attempted to build collaborative relationships with program personnel to aid future program development and evaluation efforts. Inmates were also informed in advance (e.g., to comply with unit procedures and therapeutic principles). Confidentiality of inmate and staff responses was emphasized and guaranteed.

Research Instruments

The primary output of an evaluability assessment is a working program model (activities and objectives) that everyone agrees upon; the primary output of a process evaluation is a detailed description of 1) program content and structure, 2) staff duties and responsibilities, and 3) inmate eligibility, admission, monitoring, and discharge procedures. Four main instruments were developed to collect evaluability assessment and process evaluation data (**see Appendix 4**): (1) Staff Interview Form, (2) Inmate (Program Participant) Interview Form, (3) Observation Checklist Form, and (4) Inmate Case Files: Observation Guide.

Staff Interview Form. Interviews with DATS personnel attempted a more fine-tuned description of program content and structure, inmate participants, and program staff. Sixteen questions were designed from previous literature on process evaluation (e.g., Rutman, 1980; Welsh and Harris, 1999; Wholey, 1979), correctional treatment (e.g., Andrews et al., 1990, Gendreau and Andrews, 1994; Gendreau, 1996,)

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and prison-based drug treatment (e.g., Hiller, Knight, Rao and Simpson, 2000; Inciardi, 1995; Inciardi et al., 1992, 1997).

Inmate (Program Participant) Interview Form. A valuable perspective of educational and treatment services provided can be obtained from the targets of the intervention. The advantage of this approach is that inmates have detailed, first hand knowledge of the program. The disadvantage is that the information they provide may be limited by subjectivity and their lack of familiarity with the observers. As a result, responses may be somewhat guarded or biased, depending on their personal experience and personalities. They may wish, for example, to make the program "look good" by exaggerating its positive benefits, or they may wish to make it "look bad" by exaggerating its negative features. Their views provide a supplemental source of information, however, that can be crosschecked against information obtained by other methods (observations, inspection of program documents, and staff interviews). Fourteen questions were designed from previous literature on process evaluation (e.g., Welsh and Harris, 1999) and prison-based drug treatment (e.g., Hiller, Knight, Rao and Simpson, 2000; Inciardi, 1995; Inciardi et al., 1992, 1997).

Observation Checklist Form. Structured observations of program efforts were conducted to obtain information about the content and structure of services delivered. The instrument was based upon a technique known as a "data guide" (Rossi and Freeman, 1990): observers were given a list of eight specific questions that they were required to answer from their observations. The Temple Research Team conducted observations of group therapy sessions and group meetings for each program. Researchers included the Principal Investigator (an Associate Professor of Criminal Justice with considerable professional and research experience in corrections), a full-time Graduate Research Associate (a Ph.D. candidate with extensive correctional experience), and a part-time Graduate Research Associate (a Ph.D. candidate with extensive D & A treatment experience).

Inmate Case Files: Observation Guide. Program records or information systems refer to procedures for collecting, recording, storing, retrieving, and summarizing information about inmates and delivery of services. The purpose of examining information systems is to ensure that procedures are adequate to support data collection required for program monitoring and outcome evaluations. For example, we examined how program information was collected on inmate referrals, drug and alcohol needs assessments, frequency and type of education or treatment services provided, and inmate responses to services (e.g.,

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inmate attendance and participation). The case file review form included eleven questions. We attempted to assess prior to outcome evaluation whether information currently being collected by programs was adequate and whether any new or revised instruments were needed to record delivery of educational or treatment services.

Reliability and Validity. At its most fundamental level, qualitative research involves sustained interaction with people being studied in their own language and on their own turf. While quantitative and qualitative methods differ in their procedures, both can be seen as special cases of measurement (Kirk and Miller, 1986). For both quantitative and qualitative research, reliability refers to the extent to which some measurement procedure yields the same answer however and whenever it is carried out; validity refers to the extent to which it gives the correct answer. In other words, reliability is the degree to which a given finding is independent of accidental circumstances of the research, while validity is the degree to which the finding is interpreted in the correct way (Kirk and Miller, 1986).

A measurement procedure has instrumental or criterion validity to the degree that it can be demonstrated that observations obtained by the procedure match those generated by an alternative procedure that is itself accepted as valid. Concurrent validity, on the other hand, requires only that the measurement procedure correspond to other criteria of the same phenomena (Kirk and Miller, 1986). Qualitative studies thus frequently utilize multiple methods and sources of data to explore a specific phenomenon, helping to establish reliability and validity (Yin, 1994). Combining multiple observers, methods, and data sources allows researchers to overcome the intrinsic bias that comes from a single-method study (Becker, 1970; Denzin, 1970; Fielding and Fielding, 1986; Zelditch, 1962). Asking the wrong question is the source of most validity errors in qualitative research; the strongest device to guard against asking the wrong question is diversity of method (Kirk and Miller, 1986). The ability to look at a social phenomenon from more than one angle allows researchers to gain an awareness of the "total significance of the findings" (Westie, 1957). Multiple-method designs create a built-in validity check, allowing researchers to compare data collected through each method, and examine common patterns or exceptions.

Reliability depends essentially on explicitly described observational procedures (Kirk and Miller, 1986). Three types of reliability can be distinguished in qualitative research: quixotic reliability, diachronic reliability, and synchronic reliability. Quixotic reliability refers to the degree to which a procedure

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continually yields a consistent measurement of the same phenomenon. In qualitative research, however, this type of information is often trivial, reflecting mainly superficial, automatic or rehearsed social behaviors. Diachronic reliability refers to the stability of an observation over time: are similar findings obtained at different times? The problem here is that most social behavior of interest to scientists is dynamic, not static. One must be careful not to deny change over time. Synchronic reliability refers to observations within the same time period. Here, one looks for observations that are consistent with respect to particular features of interest to the observer (for example, particular features of drug treatment programs that have been identified by previous research as important). Again, multiple methods help demonstrate this sort of reliability.

If the data obtained through different methods converges upon and supports consistent findings, the findings can be said to be reliable. If exceptions are found, that is, one method (e.g., inmate interviews) provides different conclusions than another (e.g., structured observations), then the researcher must examine whether potential bias is inherent in the instrument, the researchers, or the research subject(s). Well-designed instruments and well-trained researchers go a long way toward minimizing the first two types of bias; the third can be examined by comparing responses across research subjects (Yin, 1994).

Measurement procedures demonstrate theoretical or construct validity if there is substantial evidence that the theoretical paradigm correctly corresponds to observations (Cronbach and Meehl, 1955). Variables and questions for the interview and observational instruments were thus identified from relevant literature on process evaluation (e.g., Palmer, 1992, 1995; Pawson and Tilley, 1994; Rutman, 1980; Smith, 1989; Welsh and Harris, 1999; Wholey, 1979), effective correctional treatment (e.g., Andrews, 1995; Andrews et al., 1990; Cullen and Gendreau, 2000; Gendreau, 1996; Lipton and Pearson, 1999; Pearson and Lipton, 1999), and prison-based drug treatment (e.g., DeLeon, 2000; Hiller, Knight and Simpson, 1999; Inciardi et al., 1992, 1997; Lipton, 1995; NIDA, 1981, 1999; ONDCP, 1996, 1999). Items included individual-level variables preceding the inmate's entry into drug treatment, including motivation and treatment readiness; the inmate's experience in the treatment program, including program content, structure and process, peer support, use of rewards and sanctions, individual and group counseling techniques; and staffing (e.g., counselor methods and rapport with inmates).

While every attempt was made to make questions as clear as possible, researchers pilot tested all instruments during an initial visit to Huntingdon before the process evaluation began. Pilot testing included

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interviews with five inmates and two treatment counselors, structured observations in three treatment groups, and review of one case file. Several clarifications in wording were made, although all three researchers found the instruments generally clear and easy to use. The inmate interview was shortened somewhat to keep its length to about 30 minutes.

The three researchers were well experienced in conducting correctional research with inmates. The P.I. had extensive experience and publications in correctional treatment over a twenty-year period. Two Ph.D. graduate research students also brought unique experience to this project. One was a former correctional officer at San Quentin who had over 20 years of experience in prison and community corrections programs, was employed as a consultant for the National Institute of Corrections, and is currently the Director of Training for the Philadelphia Prison System. The other was a Certified Addictions Counselor (CAC) with over 25 years experience in community- and prison-based drug treatment, also employed as a private correctional consultant and an Adjunct Professor of Criminal Justice. Thus, all three individuals were highly qualified and experienced to assess prison-based drug treatment. While relevant research training and expertise rather than clinical experience was necessary to conduct the interviews and observations designed for this study (i.e., no clinical experience, judgments or assessments were required to answer any of the questions posed by the research instruments), it is clear that our team benefited from the participation of an active, experienced, and objective prison-based drug treatment counselor (who retained objectivity by virtue of employment in a county jail system rather than the state prison system).

The experience and qualifications of the three researchers enhanced the likelihood of obtaining reliable and valid qualitative data. All three researchers compared observation notes at the end of each day. Each wrote up their notes separately and submitted them to the group for discussion and possible revision. Few discrepancies in observations and interviews were found. Where they were, the group arrived at a decision by consensus regarding the validity or meaning of a given datum. For example, one researcher was critical of the content delivered in one of the treatment groups observed, but all three researchers agreed quite well on the facts recorded through structured observations (e.g., what was discussed in the treatment session, what were the reactions of inmates?).

Last but not least, providing access to the raw data (e.g., field notes of observations, interview responses) upon which original findings and conclusions were based facilitates reliability (Kirk and Miller, 1986). To the degree that researchers can provide detailed notes (or transcripts) of their observations and interviews, others can potentially scrutinize these data to see if they lead to the same conclusions. To the

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degree that researchers explicitly communicate the rules and principles used to code or interpret their data, and provide examples of observations that seem to fit particular coding categories, the potential for demonstrating reliability is further enhanced. In this regard, the more detailed the notes and examples provided by qualitative researchers, the better (Kirk and Miller, 1986). In this spirit, we do not simply interpret our own observations and interview notes; we provide (**in Appendix 7**) detailed summaries for others to peruse and (hopefully, but not necessarily) arrive at similar conclusions.

Sampling. At the two institutions, we conducted a total of 44 program observations, 18 staff interviews, 31 inmate interviews, and 5 case file reviews. We also examined program documents (lesson plans, handbooks, policy statements, etc.) for each program. We have prepared separate, detailed reports of each program observed at the two institutions (especially TC), including specific findings, sources of data, interpretations, and recommendations for program development and/or evaluation (**see Appendices 5 and 6**). Summaries are provided for each of three program types: therapeutic community, outpatient treatment, and substance abuse/addictions education. To facilitate dissemination and discussion of research findings, we have emphasized in the body of this report what we believe to be the most important issues and questions that surfaced from our research. These "key issues" are summarized in several charts (Figures 5-8). Data transcripts referred to in this report (i.e., inmate interviews, staff interviews, program observations, and case file reviews) are bound separately (**see Appendix 7**).

IV. RESULTS

A Census Of Prison-Based Drug And Alcohol Treatment Programs

We began analysis of the program census results by first asking all members of the Steering Committee to carefully review preliminary results and make suggestions for additions, deletions, clarifications, or any other requested analyses. While a great deal of data and results were available (see **Appendix 3**), we needed to focus on a small subset of critical issues to discuss at a 1-day symposium held with treatment staff in June of 1999.

The 118 completed surveys included 44 Education programs, 58 Outpatient Treatment programs, 10 DATU's (Drug Abuse Treatment Units), and 6 Therapeutic Communities (TC's). However, the actual number of cases used varied somewhat depending upon the specific analyses. For each analysis reported below, the reader is referred to the corresponding tables in Appendix 3, which provide detailed descriptive statistics including the sample means or frequencies, number of cases, standard deviations, and minimum

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and maximum values. Only representative findings are discussed in the text of this report; readers are encouraged to examine the broad range of descriptive results presented in Appendix 3. Results are broken down into three main parts: (1) *Program Structure and Content*, (2) *Inmates*, and (3) *Staff.* Ten key points guide our discussion.

Program Structure and Content

Point #1: Except for TC's, there was considerable variation in program duration and intensity. A large body of research on drug treatment (generally) and correctional drug treatment (more specifically) suggests that program duration and intensity are strongly related to successful treatment outcomes.

There was considerable variation in program duration and intensity (see Table 2; see also Figures 3 and 4). As expected, TC's lasted longer (mean = 46 weeks) and provided more total hours of programming per week (mean = 29.5). *However, the other three types of programs varied enormously.* For example, Outpatient Programs lasted from 4 to 36 weeks (mean = 13 weeks), and provided anywhere from 1 - 28 hours of programming per week (mean = 3 hr/wk). DATU's lasted from 8 to 52 weeks (mean = 22 weeks), and provided anywhere from 2 - 20 hours of programming per week (mean = 8 hr/wk). D & A Education Programs lasted from 4 to 32 weeks (mean = 12 weeks), and provided anywhere from 1 - 14 hours of programming per week (mean = 3 hr/wk).

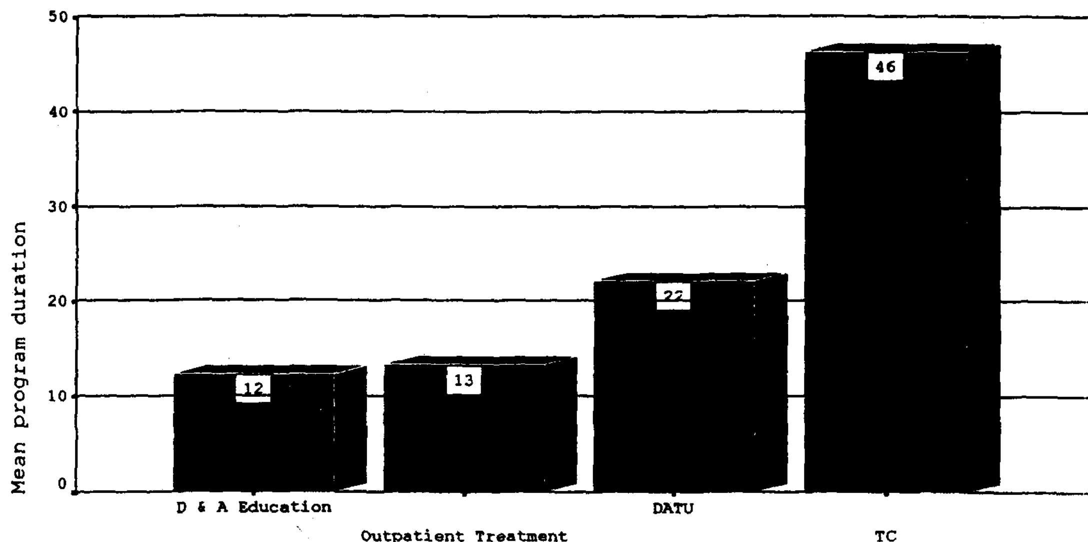

Figure 3. Mean Program Duration (Weeks) By Program Type

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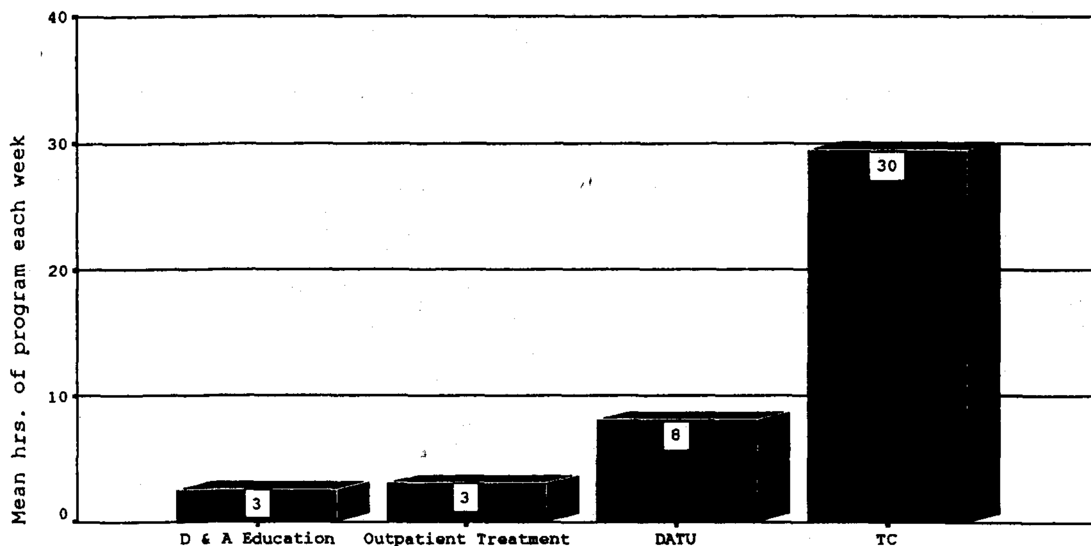

Figure 4. Mean Hours of Programming Each Week By Program Type

Except for TC's, where programs lasted 12 months, most (but not all) programs required completion of a specific number of hours. There was little difference between Education (mean = 14 hr.) and Outpatient (mean = 18 hr.) in this regard; DATU's required about twice as many hours (mean = 38 hr.) (Tables 3 - 4)

Point #2: Although programs varied substantially in terms of their duration and intensity, there was more consistency in overall treatment approach. Emphases on different treatment approaches varied considerably within program types, however.

Survey question #12 asked about emphasis on different types of therapy (Tables 5 - 13). Across all program types, reality therapy (44%), cognitive (49%) and cognitive-behavioral (53%) techniques were most frequently reported as a "primary approach."[4] Reality Therapy (Table 11) was widely (but not universally) reported as a "primary approach" for Outpatient Treatment (53%) and DATU's (70%), and to

[4] Discussions during survey development with Steering Committee members, including three Drug and Alcohol Treatment Specialists, indicated lack of consensus about the appropriate definitions and meanings of several approaches. Rather than offering complicated definitions of debatable validity in the survey instrument, we felt that is was best at this time to simply ask survey respondents to use "standard clinical definitions" of each approach. More appropriate forums for further discussion of different treatment approaches would be specific staff development or training events. DOC may also consider whether it

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a lesser degree, TC's (50%). Less likely to be used as primary approaches were rational emotive therapy (38%), behavior modification (20%), milieu therapy (16%), psychotherapy (13%), dual diagnosis (9%), or transactional analysis (1%). TC's were more likely to report psychotherapy (50%) and milieu therapy (50%) as primary approaches.

However, considerable variability existed within specific program types. Thirty percent of DATU's used traditional behavior modification as a primary approach, 40% used it as a secondary approach, and 30% did not use it at all. Twenty percent of DATU's used psychotherapy as a primary approach, 50% used it as a secondary approach, and 30% did not use it at all. Similar variability was observed within Outpatient programs. Fifty-three percent of Outpatient programs reported cognitive behavioral theory as a primary approach, but 35% reported it as a secondary approach, and 12% claimed that it was not used at all. Since cognitive behavioral techniques were a primary approach in the department, it was curious that 7 outpatient programs (12%) did not use them at all. Similarly, psychotherapy was reported as a primary approach for 17% of outpatient programs, and a secondary approach for 21% of programs, but 62% of programs did not use this approach at all.

Within D & A Education programs, little consistency was observed for any approach. Even though cognitive approaches were widely favored throughout DOC drug and alcohol programs, little consistency was found within Education programs. For example, 27% of Education programs reported Reality Therapy as a primary approach, 41% reported it as a secondary approach, and 32% claimed that it was not used at all (Table 11). For cognitive therapy, 38% of programs reported it as a primary approach, 36% reported it as a secondary approach, and 26% claimed it was not used at all (Table 5). For cognitive behavioral techniques, 45% of Education programs reported it as a primary approach, 36% reported it as a secondary approach, and 19% claimed it was not used at all. Widespread variation in use of different approaches was found regardless of which approach was examined (see Table 5-13).

Point #3: The importance of different criteria for program completion varied by program type.

Question #13 asked about the importance of different criteria for program completion (Tables 14 - 17). A *D & A Knowledge Test* was rated as "very important" by most (but not all) Educational programs

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would be useful, with further input from treatment staff, to apply standardized definitions to the various approaches that are offered within its D & A programs.

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(51%). Such criteria were of far less importance in other types of programs (Table 14). For the other three program types, *Measures Of Attitudinal And Behavioral Change* were more often rated as "very important" by the majority of Outpatient (56%) programs, DATU's (60%), and TC's (83%). *Case Progress Review* tended to be rated as "very important" for TC (100%) and DATU (70%), but not Outpatient (27%).

Point #4: Several criteria for unsuccessful discharge were very consistent across programs. Other criteria varied according to program type.

Question #14 asked about criteria for unsuccessful discharge (Tables 18 - 26). *Violation Of Program Rules, Institutional Rules, And Security Concerns* were all rated as "very important" regardless of program type (89 - 93% of programs rated each as "very important"). *Inadequate Attitudinal Or Behavioral Change* was rated as "very important" more often for DATU (60%) and TC (67%) than Education (16%) or Outpatient (29%) (**Figure 5**). *Not Attending Required Number Of Sessions* was rated as "very important" for all program types, but especially for Outpatient (97%) and Education (82%). *Inappropriate Classroom Behavior* was "very important" for Education (77%) and Outpatient (90%).

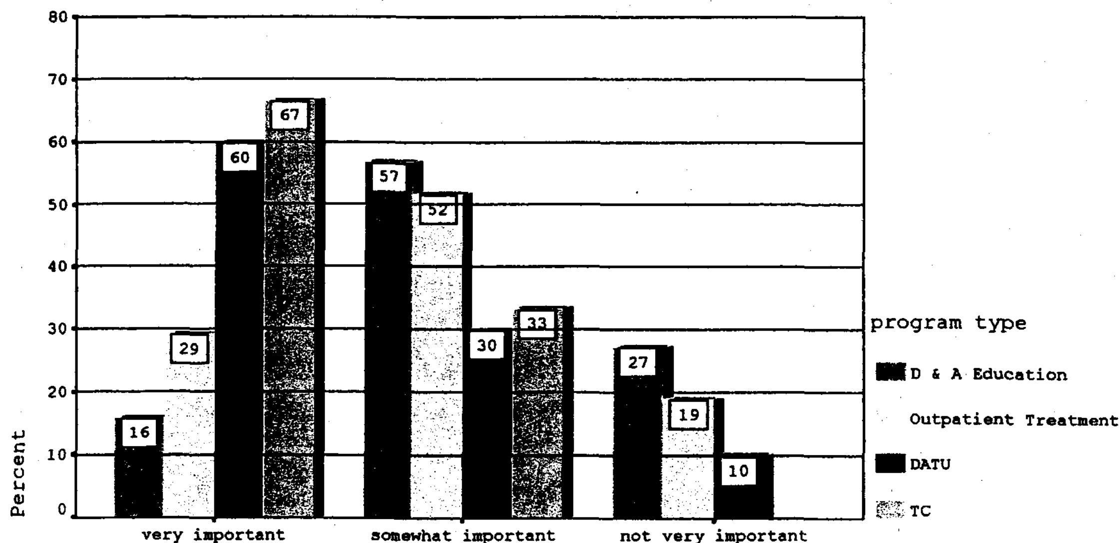

Figure 5. Importance of Inadequate Attitudinal or Behavioral Change for Determining Unsuccessful Discharge: Responses By Program Type

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Point #5: Some specific types of program content were used very consistently across the four program types.

Question #19 asked about specific types of program content covered in the different D & A programs (Tables 28 - 50). This was a particularly important question, given the concurrent discussion of a major program standardization initiative within the Department of Corrections. When we combined responses by those programs reporting that they spent "a great deal" or a "moderate" amount of time on each topic, program content was generally consistent (Figure 6), with a few exceptions (see point #6 below).

Percentage of Programs Reporting They Spend "A Great Deal" or "Moderate" Amount of Time on Each Topic:

Impacts of Drug Use	96%	Social/Communication Skills	79%
Thinking Errors	95%	Lifeskills	78%
Obstacles to Treatment	90%	Self Esteem	78%
Antisocial Peer Associations	89%	Anger/Temper Control	75%
Family Issues	89%	Focus on Harm Done to Victim	73%
Criminality/Antisocial Attitudes	88%	Stress Management	71%
Relapse Prevention	86%	Models of Addiction	66%
Working Steps Toward Recovery	85%	Job Issues	65%
Problem Solving Skills	84%	Assertiveness Training	65%
Addiction and Spirituality	83%	Pharmacology	52%
Interpersonal relationships	82%	AIDS/Infectious Diseases	38%

Figure 6. Amount of Time Spent on Different Types of Program Content (All Programs)

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Point #6: However, the use of some types of program content varied enormously within program type.

Several examples serve to illustrate the variability in program content observed within specific program types. For *Problem Solving Skills*, 27% of Education programs reported spending a great deal of time on this topic; 36% spent a moderate amount of time; 34% spent very little time; 2% spent no time on this topic (see Table 35, see also **Figure 7**). Much less variability was observed for other types of programs (Table 35).

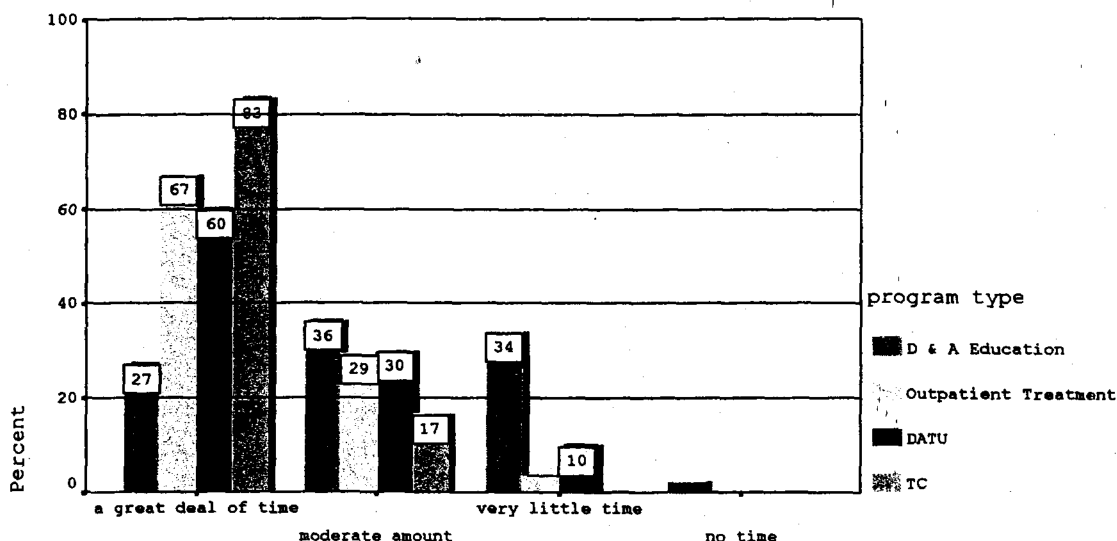

Figure 7. Amount of Time Spent on Problem Solving Skills: Responses By Program Type

Similarly, 28% of Education programs spent a great deal of time on *Pharmacology*; 29% spent a moderate amount of time; 29% spent very little time; and 12% spent no time on this topic (see Table 50). Similar variability was found for Outpatient Treatment programs. Two DATU's (20%) spent a great deal of time on this topic, 5 (50%) spent a moderate amount of time, and 3 (30%) spent very little time on this topic. Five TC's (83%) spent a moderate amount of time on this topic.

Two final examples illustrate the variability observed in program content within specific program types. Twenty-five percent of Education programs reported spending a great deal of time on *Lifeskills* (see Table 34); 39% reported spending a moderate amount of time; 32% spent very little time; 5% spent no time on this topic. Similar variability was found for Outpatient programs and DATU's. Even in TC's, some

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variability existed: 2 (33%) reported spending a great deal of time on this topic, 3 (50%) spent a moderate amount of time, 1 (17%) spent very little time.

Finally, twenty-seven percent of Education programs reported spending a great deal of time on *Stress Management* (Table 44); 32% reported spending a moderate amount of time; 30% spent very little time; and 11% spent no time on this topic. Similar variability was found for Outpatient programs. Even in DATU's and TC's, some variability existed. About half the DATU and TC programs reported spending a great deal of time on Stress Management, but others spent only moderate or very little time on this topic.

In addition to using different *types* of content, programs may also vary in terms of how they *present* that content. Survey Question # 18 asked about percentage of time using different *presentation or discussion formats* (Table 27). Lecture was the most popular format for Education programs (mean = 31%), but rarely used in TC (mean = 9%). Film or video was used much more frequently in Education (mean = 17%) than any other program type. Interestingly, written assignments were used less frequently in Education (mean = 9%) than the other three program types (range = 13 - 15%). Instructor-led group discussion was used more frequently in Education (mean = 26%) and Outpatient (mean = 24%). Use of peer-led discussion was similar for all program types (mean = 11%). As one would expect, individual and group counseling were more frequent for TC (15% and 28% respectively) and DATU (12% and 32% respectively) than the other two program types, although group counseling was also used frequently for Outpatient (mean = 25%).

Inmates

Several survey questions asked about the types of inmates targeted by different programs, as well as procedures related to inmate admission, treatment planning and discharge. We present some general descriptive results about the inmates targeted by D & A programs, then we make two additional points for consideration.

On average, D & A programs serve a maximum of 28 - 70 inmates at any one time (Table 51). Outpatient treatment programs had lower maximum limits (mean = 28) than the other three types. Interestingly, maximum enrollments were highest for the most intensive brand of drug treatment: TC (an average of 70 inmates per program). Individual programs reported a huge range in maximum enrollments, however. For education programs, the reported range was 8 - 240 inmates. For outpatient programs, the

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reported range was 10 - 180 inmates. For DATU's, the reported range was 10 - 180 inmates. For TC, the reported range was 36 - 128 inmates. Even allowing for some degree of potential measurement error (e.g., possible respondent bias or misunderstanding of the question), *these figures suggest a clear need to closely examine the appropriate number of inmates that can be effectively served by any one program at one time.*

Obtaining a signed *"consent to treatment form"* from an inmate was far from uniform for all program types except TC, where it was used in all programs (Table 52). For the other three program types, there was nearly an even split between those who use a signed consent form and those who do not. These figures may imply either a need for development of a more standardized policy regarding use of consent forms, or greater enforcement of existing policies.

With the exception of intensive Therapeutic Community programs (100%), individualized treatment plans were developed for inmates infrequently (12% for Education programs, 34% for Outpatient programs, 50% for DATU) (Table 62). D & A treatment planning, overall, was rarely individualized outside of TC.

Most D & A programs (74% - 100%) reported general goals for all participants, although this was least likely for Education programs (Table 63). The implications are that specific program goals can and should be operationalized for use in outcome evaluations. Indeed, process evaluations focused (in part) on documenting and explicating such goals.

Readmissions were permitted for almost all programs (range = 86% - 100%, Table 67). This raises a question about whether reliable and easily accessible data is available to treatment staff at the time of program placement: how do they know the inmate's previous treatment history? This information may prove critical toward making informed program placement and treatment planning decisions.

Inmates frequently had input into D & A program structure or activities (range = 58% for Education to 100% for TC, Table 65). Inmates also had some input into setting program rewards and sanctions, but mainly for DATU's (70%) and TC's (100%) (Table 66).

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Point #7: The importance of different program admission criteria varies considerably across programs, even programs of the same type.

One of the most important questions to ask about any program is "who is the target population?" What are the eligibility criteria, and how is eligibility and suitability for treatment assessed? Research by Andrews et al. (1990) suggests that such assessment is crucial for adequate program placement (matching inmate needs to appropriate treatment). *It is also essential for forming valid comparison groups in an outcome evaluation.* Further, is it possible to determine to what degree the targets intended for specific programs are the ones actually being treated? It is important to examine for any program exactly how eligible targets are actually recruited, selected and admitted (Welsh and Harris, 1999). Survey Question 27 asked about the importance of different admission criteria for prison-based D & A programs (Tables 53 - 61).

Use of different admission criteria varied considerably across programs. *Level Of Drug Involvement* was rated as a "very important" admission criterion for all TC's (100%); but only 63% of Education programs, 54% of Outpatient programs, and 50% of DATU's (Table 54). *Level Of Motivation* was rated as "very important" in 83% of TC programs, but only in 23% of Education programs, 44% of Outpatient programs, and 30% of DATU's (Table 53; see also **Figure 8**). *Institutional Record Of Drug Use* was more often rated as "very important" for Education programs (50%) and TC (50%) than the other two program types (e.g., 30% for Outpatient and 20% for DATU) (Table 59). Mandatory enrollment in a D & A Education program is a frequent policy response to institutional drug violations. *Institutional Record Of Violence* was rated as "very important" for 40% of DATU's and 67% of TC's, but only 7% of Education programs and 12% of Outpatient programs (Table 60). Results for *Other Institutional Misconducts* were very similar (Table 61).

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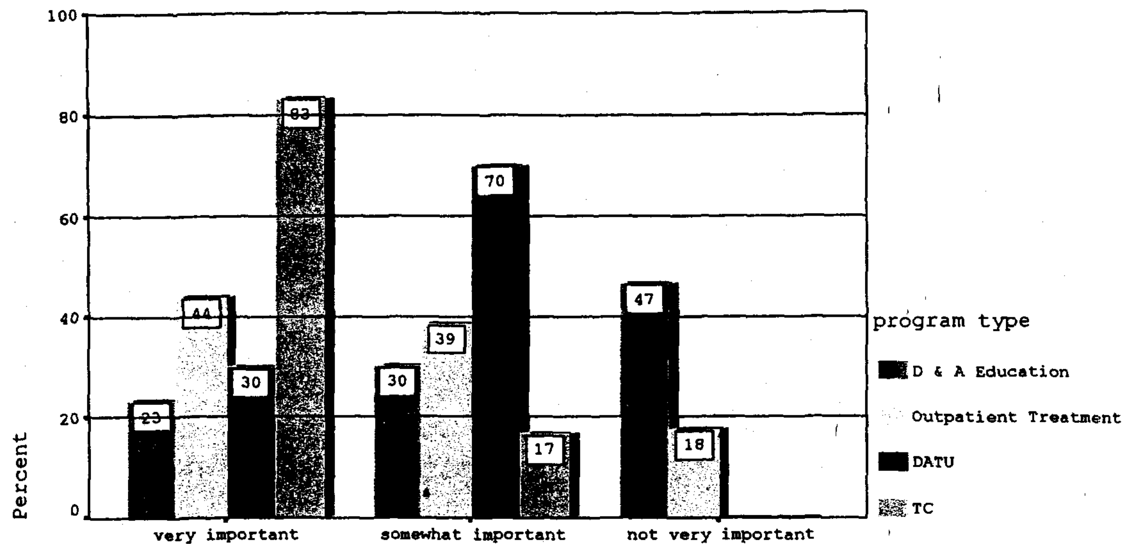

Figure 8. Importance of Inmate's Level of Motivation For Admission in Program: Responses by Program Type

Point #8: Some specific program admission criteria are used rarely.

Criteria involving an inmate's criminal history had very little influence on D & A program admission decisions. Unfortunately, the Parole Board pays a good deal more attention to such criteria, potentially contributing to a high level of expressed inmate frustration. For example, only 24% of all programs rated *Type Of Offense* as "very important." Only 24% of all programs rated *Time Served In Current Sentence* as very important. Only 14% of all programs rated *Criminal History* as very important. In addition, only 3% of all programs rated *Absence Of Medical Problems* as very important.

Staff

We begin with a general description of D & A staff characteristics and responsibilities. We then focus on two important points regarding staff duties and staffing ratios for D & A programs.

Formal procedures to evaluate staff performance were in place for about 2/3 of programs on average (Table 72), although such procedures were more likely for DATU (80%) and TC (83%) than the other two program types. It cannot be determined from survey responses, however, exactly what these procedures involved, or whether other procedures unknown to staff may be in place for other programs.

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Counselors were assigned to work with individual inmates in only 44% of programs (Table 73). Such arrangements, though, were most likely for the more intensive forms of treatment, DATU (70% of programs) and TC (83% of programs), and much less likely for Outpatient (50%) and Education (23%).

Specialized in-house D & A training for D & A treatment staff was frequently reported as available (mean = 65% of all D & A programs), especially for staff of TC programs (100%). Such training was reported less frequently by staff of Educational programs (mean = 60%), Outpatient programs (67%), and DATU's (50%) (Table 74).

Male treatment specialists outnumbered females by 226 to 145, a ratio of 1.6:1 (Table 76). Gender disparities were greatest for DATU (25:9 = 2.77:1) and smallest for Outpatient (86:75 = 1.14:1). Data on staff ethnicity are presented in Table 77. Caucasians comprised 333 (92%) treatment counselors. Only 26 African Americans (7% of the total) were employed as D & A treatment specialists; only 4 Hispanics (1%) were employed. No Asians or Native Americans were among D & A staff. These numbers were out of balance not only to the inmate population, where minorities make up large proportions of the prison population, but to the general (state) population as well.

Significant numbers of treatment staff considered themselves in recovery (Table 78): 35 (26%) of D & A Education staff, 58 (31%) of Outpatient Treatment staff, 12 (40%) of DATU staff, and 14 (56%) of TC staff. Although professional opinions vary as to the significance or meaning of such backgrounds, there is evidence in the D & A literature that this characteristic may enhance the quality of the therapeutic relationship (e.g., DeLeon, 2000; ONDCP, 1999).

Point #9: The percentage of time that staff spent on different activities varied depending upon program type.

Across all program types, staff spent a higher proportion of time on *Direct Treatment Or Service* (mean = 59%) than any other activity (**Figure 9**). Surprisingly, this figure was higher for Education (mean = 65%) than any other program type (range = 40 - 58%), perhaps because they had fewer responsibilities or distractions. In other program types, however, a considerable portion of staff time was devoted to other responsibilities. Interestingly, staff in the most intensive forms of treatment (DATU and TC) spent the least amount of time on direct treatment (49% and 40% respectively). *Program Planning Activities* (mean =

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11%) occupied a relatively small portion of staff time, but this portion was greater than for any other activity but direct treatment. *Clinical Case Reviews* took much more staff time in TC (mean = 11%) than other program types (mean = 3%). *Administrative And Managerial Functions* (mean = 9%) also occupied a good deal of staff time, especially in DATU (13%) and TC (23%), as did Special Duties in TC (13%).

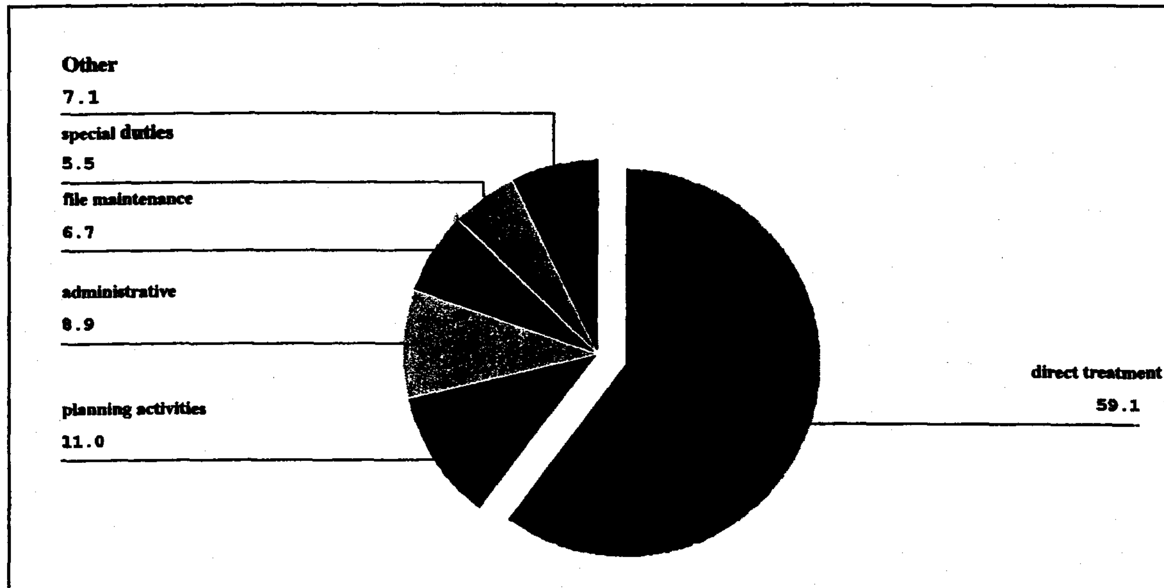

Figure 9. Percentage of Time D & A Staff Spend on Various Duties

Point #10: Staffing ratios vary considerably across programs.

Survey Questions 38 and 39 asked about staffing patterns (Table 68). There was enormous variation in staffing ratios within all program types except TC. Overall, the average inmate/staff ratio was 19:1. TC had the lowest inmate/staff ratio (17:1); DATU had the highest (30:1). Outpatient (17:1) and Education (20:1) were similar.

Considerable variation in staffing was reported for different programs.[5] Staffing ratios for Education programs ranged from a low of 5:1 to a high of 65:1. Outpatient staffing ratios ranged from a

[5] Note: To reduce the effects of outliers on reported staffing ratios, we dropped several extreme or implausible values (lowest and highest) reported for Education, Outpatient, and DATU (a total of thirteen cases were dropped for an overall N = 105). It is possible that some survey responses may have been unintentionally inflated in some cases (due to misunderstanding of the question) or deliberately inflated in other cases (e.g., to indicate hardship).

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low of 7:1 to a high of 60:1; DATU ratios ranged from a low of 8:1 to a high of 92:1, and TC's ranged from a low of 9:1 to a high of 26:1. Possible reasons for such disparities were further investigated through our 1-Day Symposium With D & A Treatment Staff (discussed shortly), and our process evaluation.

One-Day Symposium With Drug & Alcohol Treatment Staff

We then planned a *one-day symposium* with D & A treatment personnel, held June 2 at the Correctional Academy in Elizabethtown, PA. We set three major goals for this *miniconference*: (1) present program census results, including similarities and differences in D & A programming across institutions, (2) discuss implications for D & A programming and evaluation, and (3) discuss and prioritize elements of effective treatment.

We asked Superintendents from each institution to nominate two treatment staff to attend the conference. Nominees, we suggested, should have some authority for shaping D & A programming and policy decisions at their institution, and some interest in discussing both program design and program evaluation issues. The Steering Committee reviewed all nominations and issued formal invitations, including a letter from then-Secretary of Corrections, Martin Horn. We obtained a representative sample of staff from different institutions and different program types (education, outpatient, residential treatment, and Therapeutic Community).

We had a very productive meeting. Four highlights stood out. First, in his opening remarks, Secretary Horn focused on the importance of D & A treatment and evaluation. Second, as a result of input from 44 DATS representing 24 institutions, we were able to focus upon explaining some of the similarities and differences in treatment programming identified by the program census. We have incorporated these findings and interpretations into our final reports for DOC and NIJ. Third, after an overview of standardization plans undergoing development within DOC, we had a Q & A session between DATS in the audience and DATS who currently sit on the Department's standardization committee. Finally, we discussed a broad approach for evaluating D & A programs. Both Temple and DOC personnel emphasized that accurate program *descriptions* are essential precursors to outcome evaluations, and that treatment staff should be involved in the entire research planning process. The Symposium agenda is presented below.

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Agenda: Symposium on Drug and Alcohol Programming

8:00 – 8:30 Registration and Coffee
8:30 – 9:00 Welcome and Opening Remarks

- **Martin F. Horn, Secretary of Corrections**

9:00 – 9:15 Overview and Goals of Research Partnership Between DOC and Temple

- **Gary Zajac, Research and Evaluation Manager**
- **Jack R. Greene, Director of Center For Public Policy, Temple University**

9:15 – 10:15 Presentation of Drug Treatment Program Census Results

- **Wayne N. Welsh, Associate Professor, Temple University**
- **Jack R. Greene, Director of Center For Public Policy, Temple University**

10:15 – 10:30 Break
10:30 – 11:30 Reactions to and Discussion of Program Census Results

- **David Close, DATS Supervisor, SCI-Houtzdale**
- **Harry Davis, DATS Manager, SCI-Muncy**
- **Howard West, DATS Supervisor, SCI-Huntingdon**

11:30 – 12:15 Lunch
12:15 - 12:30 Comments and Discussion
12:30 – 1:30 Overview and Discussion of Standardization Plan

- **James Tice, Chief, Treatment Division**

1:30 – 2:00 Overview of Program Evaluation

- **Kathleen Gnall, Chief, Division of Planning, Research and Statistics**
- **Gary Zajac, Research and Evaluation Manager**

2:00 - 2:15 Break
2:15 – 3:00 Planning for Future Evaluation

- **Wayne N. Welsh, Associate Professor, Temple University**
- **Jack R. Greene, Director of Center For Public Policy, Temple University**
- **Kathleen Gnall, Chief, Division of Planning, Research and Statistics**
- **Gary Zajac, Research and Evaluation Manager**

3:00 – 3:15 Wrap-Up and Conference Evaluations

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Summary From Small Group Discussions With Treatment Staff

Following our presentation of census results in the morning session, the three treatment supervisors who sat on our steering committee organized participants into small groups and asked them to discuss several specific questions. Participants were then reconvened in the central meeting room where the three facilitators asked each group to give a 5-10 minute summary of their responses to each question. Responses from each group were written by facilitators on posters at the front of the room and displayed to the full group for discussion. Below we provide a summary of those questions and responses.[6]

Questions #1 and #2: Why is there so much variation in amount of programming provided, especially Education and Outpatient (see Tables 2 - 4)? Is this important in terms of impact on inmates?

D & A staff agreed that this was a critical issue in terms of impact on clients. Other responses were somewhat diverse, expressing a wide range of concerns that staff felt were equally important as or partially explicative of programming variations. Although explanations offered for programming variations were somewhat complex, four major types of explanations were reported.

First, staff suggested, each institution has a somewhat different environment that includes different security levels, history, and mission. To some degree, D & A programming must be responsive to local institutional needs. For example, D & A clients and staff are different at each institution, and staff need to best address the particular needs of their population with the particular staff available.

Second, D & A programming at each institution grew according to the particular orientation of the D & A staff at each site. Initial D & A program offerings were not guided by department-wide guidelines or policies. A lack of shared definitions of major program types appeared to be a source of some staff confusion and frustration. Some staff asked: "what is *your* definition of D & A Education?" D&A Education, they suggested, needs much greater standardization in terms of time frame and content. Staff generally seemed to agree that greater programming standards were now needed, but they also felt that such standards would be difficult to develop and manage. Communication between different institutions and between institutions and Central Office has not always been optimal, they suggested.

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[6] Related questions were in some cases paired together to facilitate discussion.

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Third, staff suggested, D & A programming is in some cases be mandated by the institution (e.g., mandated D & A programs for inmates caught using drugs within the institution) or the Parole Board. Some DATS stated that large variations in D & A programming were merely a reflection of the administration's wishes (which they may or may not share). Some staff suggested that they have to "jack up the numbers" just to fulfill the programming needs required by Prescriptive Program Planning (PPP).

The role of the Parole Board was a major source of resentment among D & A staff. Various dilemmas were suggested. At times, for example, the Parole Board dictates the level of D & A involvement required by any individual inmate. Parole Board recommendations often contradict institutional D&A recommendations (e.g., the institution recommends parole following successful completion of a D & A program, but the Parole Board then denies the inmate Parole and instructs him to re-enter another D & A program). Many DATS suggested that the Parole Board, in effect, "dictates" the proper treatment modality through issuance of "Green Sheets" (i.e., serving notice that an inmate must complete specific programming required by the Parole Board before considering a new application for Parole). Staff further emphasized the need for continuity of care upon an inmate's release from prison. There was a strongly expressed need for greater communication between DOC, Parole, and contracted release facilities around this issue.

Finally, many perceived unclear or inconsistent policies for D & A programming (e.g., no guidelines; inconsistent staffing ratios across D & A programs and institutions; adoption of "caseworker" v. treatment approach). There is often a considerable gap between the resources (physical plant, personnel, and materials) required for D & A programming versus those available. In particular, many DATS perceived that D & A *resources* vary widely across institutions largely in relation to differences in the degree to which any particular Superintendent considers D & A programming (rather than security and other diverse program needs) a priority. In addition to the quantity and type of D & A programming offered, staff suggested, staff motivation and qualifications affect inmate motivation. This comment appears to reflect some general frustration among staff about working conditions.

Questions #3 and #4: Why weren't measures of attitudinal and behavioral change rated as more important for program completion and/or unsuccessful discharge (see Tables 14 - 26) ? What other factors determine successful v. unsuccessful discharge?

Criteria vary greatly from one institution to another. The Boot Camp, for example, is very different from Laurel Highlands. **Criteria also vary depending upon program type.** Measures of attitude

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and behavior change are most important in the TC's. Only a very limited amount of time is spent with inmates in most programs, including education and outpatient. As one DATS stated, "We treat huge numbers, but we don't really know people." Thus, the ability to measure attitudinal or behavioral change is limited. Measuring inmate behavior in general population is very difficult. However, some staff asked, do we need to develop specific training programs addressing staff understanding and attitudes towards treatment of inmates?

Parole, once again, was seen by D & A staff as a major influence. Primarily, the promise of receiving a Certificate of Completion is what motivates inmates to participate in and successfully complete D & A programs. **Many D & A staff felt that the Parole Board dictates treatment (and perhaps graduation) decisions to a greater degree than the recommendations of D & A staff.** As one DATS stated, "We can't refuse to treat inmates." Parole is a primary motivating factor. The primary reason for compliance, many felt, is to achieve parole. Requesting further/other groups evidences true motivation. Voluntary group participation may demonstrate motivation.

Unfortunately, some staff felt, inmates can often expect to continue in treatment regardless of their behavior or attitude. In many cases, program admission decisions have already been made before D & A staff have been consulted. Only in certain cases are D & A staff allowed to say that they won't treat a specific inmate, and in many cases, they are acutely aware that any decision recording unsuccessful program completion means that the inmate will automatically be denied parole. Decisions about successful program completion are directly related to recommendations for parole, and are made with input from various other departments (e.g., medical, psychology, work supervisors).

Questions #5 and #6: Why do some types of program content (e.g., AIDS, pharmacology) receive much less emphasis than others (Tables 28 - 50)? Is this important? Why does this sometimes vary so much even within the same program type (e.g., Education?)

Staff reported three major types of responses. First, they suggested, there are simply no specific guidelines about what topics to include in various D & A groups. Institutions and individual D & A staff set group content, and this is (at least according to some) part of the natural group counseling process. Thus, content varies considerably across different groups as well as institutions. Some staff expressed curiosity about how treatment content might differ according to different prison security levels and program availability per prison. Once again, staff felt that there was a lack of continuity of programs from

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institution to institution. They also felt that more efforts were needed to integrate the Parole Board and aftercare into this continuity of care.

Second, staff suggested, some topics (e.g., AIDS) are covered in other programs (e.g., Peer Education), and there is simply no need to duplicate other program offerings. Information from the D & A Program Census, naturally, does not tap the full range of other programs provided by each institution or by DOC more generally. Adjunct programs may also provide services in some areas (HIV, Peer Education). DOC has an HIV/AIDS Education program offered through each institution's Medical Department. The D&A Department focuses on HIV/AIDS only in specific relation to D&A use and assessment.

In addition, inmates' intellectual levels drive program content to a considerable degree. Some inmates can't comprehend more complicated concepts such as pharmacology. Level of understanding, inmate attention span, and program time limits (e.g., 6 weeks) all set restrictions on program content. In addition, there is no apparent consensus among staff about whether specific topics (e.g., pharmacology) have a long-term value in the actual treatment of addiction.

Questions #7 and #8: Why isn't level of drug involvement and motivation more important for program admission in all programs (see Tables 53 - 61)? Why is time served not more important for admission – or is that decision made earlier in the process?

First and foremost, according to staff, **"Time Served" is not as relevant as "Time Remaining."** In other words, the amount of time remaining in an inmate's sentence until his minimum discharge date is a highly relevant criterion. While this distinction in semantics may seem minor to many, D & A staff insisted that the survey question failed to make this critical distinction. We agree, but there is little evidence that illustrates to what degree minimum release dates actually determine program admission decisions. In the course of our outcome evaluation, which began 1 January, 2000, inspection of data including minimum release dates for inmates in TC, Education, and Outpatient programs showed that such dates varied greatly, with many inmates either long past their minimum dates (in some cases by several years) or many years remaining. Regardless of how one interprets responses to this survey question, there are clearly other important criteria besides minimum release dates that drive program admission decisions.

Individual inmate needs should, according to D & A staff, dictate the type of programming recommended (e.g., Education vs. Therapeutic Community). This does not always occur, though. For example, it is usually difficult to make good program admission decisions based solely upon inmate self

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reports, which may be dishonest. External motivation is common in the early stages of parole, but staff may turn this external motivation into internal motivation given sufficient time and effort. In some institutions, staff claimed, D & A Education programs are mandatory and do not require any assessment at all. Because such large volumes of inmates are referred, virtually no D & A referrals are denied some form of education or treatment. The question remains, of course, what kind and how much?

Other important criteria for program admission include Parole Review Dates, available resources, and long-term sentences. In most cases, Prescriptive Program Planning (PPP) already requires D & A treatment regardless of any assessment made by D & A staff. If an inmate has been denied Parole, it is virtually impossible to deny him admission into a required D & A program. In many cases, no rationale is provided for Parole hits, and inmates enter D & A programs with a good deal of frustration and resentment. Resource decisions also influence when we can get any specific inmate into D & A programs. There may also be large waiting lists due to the limited number of staff and resources available. In some cases, staff feel that long term inmates need constructive programming to maintain a constructive focus in prison.

Ten Critical Issues Identified By Treatment Staff

Based upon discussion with the full group of DATS (N = 44), Temple researchers, and Central Office staff, we asked participants to prioritize their major concerns and comments, and articulate which issues they felt deserved attention at a future forum involving D & A staff, researchers from Temple University, and Central Office. Without repeating the previous discussion, we summarize 10 issues below.

1. Diverse populations need diverse programs.
2. There is a definite lack of standardized DATS/Inmate ratios. DATS feel an acute lack of support from administration. Administrative turnover was perceived as contributing to these concerns.
3. There is a strong need for greater continuity of care: DOC, parole, institutions, etc.
4. More effort is needed to minimize duplication of services.
5. There is a need to more seriously examine the links between non-D&A programs, as well as the motivations and outcomes of other DOC programs.
6. Involve the Parole Board in all phases of the process (e.g., research, planning, program implementation). Invite Parole Board to next D & A symposium.
7. Continue to carefully examine program Quality v. Quantity (e.g., volume, inmate motivation, behavioral factors).

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8. Consider individual inmate needs in relation to Institutional mission v. Departmental mission.
9. What is a DATS? What should DATS do? Examine relationships between inmate sentences, time at institution, and programming.
10. Examine links between Parole Board expectations and D & A programming, DOC resource allocation and D & A program resources.

Results Of Participant Evaluations

At the end of the day, participants were asked to complete written evaluations of the symposium. First, we present descriptive results from five objective rating scales (five-point Likert scales, with "1" reflecting the most positive ratings). We then present summaries of participants' responses to three open-ended questions and their general comments on the symposium.

The majority of attendees felt that the symposium was focused (mean = 2.42) and productive (mean = 2.58), and that our purpose was clear (mean = 2.62). Most (73%) felt that the pace was just right, although some (22%) felt that it was too slow. The majority of people (90%) answered either "yes" or "somewhat" to the question about whether everyone had a chance to participate. Similarly, most (93%) answered either "yes" or "somewhat" to the question about whether we made good progress on our agenda.

1. Our symposium today was:

	1	2	3	4	5	
Focused	1 (8)	2 (14)	3 (12)	4 (5)	5 (1)	Rambling
Productive	1 (6)	2 (10)	3 (19)	4 (4)	5 (0)	A Waste

2. The pace was:

Too fast	Just Right	Too slow
(2)	(27)	(8)

3. Everyone had a chance to participate:

Yes	Somewhat	No
(27)	(11)	(2)

4. Our purpose was:

	1	2	3	4	5	
Clear	(8)	(10)	(13)	(7)	(2)	Confused

5. We made good progress on our agenda:

Yes	Somewhat	No
(20)	(17)	(3)

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We provide representative responses to the three open-ended questions below. In general, we heard a clear desire for greater interaction between participants. Participants also raised several specific questions about survey results and evaluation plans, and requested more time to discuss the department's program standardization initiative.

6. "The Best Thing About Today's Symposium Was":

- Hearing and discussing survey results.
- Discussing standardization.
- Having Secretary Horn here (and other Central Office personnel).
- Face to face exchange of information between researchers and treatment providers is invaluable.
- Networking with other DATS.
- Handouts, interactive, well prepared.

7. "At Our Next Symposium We Should Do More Of":

- Working on standardization issues and questions.
- Invite parole to discuss various questions and issues surrounding treatment.
- Discuss evaluation plans and process more; where do we go from here?
- More interactive techniques, including discussion/networking/workshops/follow through.
- Problem solving and further discussion of issues identified at this meeting.

8. "At Our Next Symposium We Should Do Less Of:"

- Do not read from overheads; lecturing.
- Less focus on academics and statistics.

Steering Committee Members' Evaluation Of The Partnership

Following the end of the first year of the research partnership, the fourteen-member steering committee undertook a survey of its members. This survey queried committee members about the accomplishments of the partnership and the interpersonal dynamics of the committee. Responses were received from all committee members. The results are summarized and discussed below.

The members felt very strongly that the partnership was both ***focused*** and ***productive***. The members felt that the ***pace*** of the partnership was appropriate. The members expressed strong agreement that everyone on the committee had a chance to ***participate*** in the activities of the committee.

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All members strongly agreed that the ***purpose*** of the project was clear. The members agreed that good ***progress*** was made on the goals of the partnership. The members were in strong agreement that the partnership enhanced the ***capacity*** of the DOC to conduct evaluation research.

The members strongly agreed that ***professional expertise*** was provided on special topics. The members agreed that an ***improved public image*** has resulted from this partnership.

The members agreed that ***information systems*** improved as a result of the project, and that the partnership facilitated ***a broader range of research projects*** for the department. However, agreement on these two items was slightly less strong than agreement on others. The members strongly agreed that a ***spirit of cooperation*** was demonstrated through the project.

The members strongly disagreed that ***turf conflicts*** and ***crises*** impeded the work of the partnership. The members disagreed that ***bureaucracy*** impeded the work of the partnership, although opinions were slightly more mixed on this item.

On the whole, the DOC and Temple members evaluated the partnership similarly. Where differences did exist, they were small. For example, Temple was slightly more likely to perceive that the pace of the project was a bit fast, that progress on partnership goals had been made, and that a broader range of research projects had been facilitated. DOC was slightly more likely to perceive that an improved public image had resulted from the partnership.

This survey indicates that the partnership has been a success for both the department and the university. Perhaps most notably, the members felt strongly that excellent cooperation and consensus have been established.

The members were eager to see the results of the research applied to program planning within the department. They were also interested in seeing more opportunities for exchange of research findings with the field, such as the Drug and Alcohol Symposium. There was some degree of concern expressed about the travel demands imposed by the committee meetings. The committee may want to consider holding fewer, but longer, meetings.

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Responses to DOC-Temple Research Partnership: Evaluation Form

1. So Far, Our Partnership Has Been:

(Mean = 1.1)	Focused	1	2	3	4	5	Unfocused
(Mean = 1.3)	Productive	1	2	3	4	5	Unproductive

2. The pace of the demonstration research project (D & A programming) has been:

(Mean = 2.1)

Too Fast	Just Right	Too Slow
(3)	(2)	(1)

3. Everyone on the Steering Committee Has Had a Chance to Participate:

(Mean = 1.1)

Agree 1 2 3 4 5 Disagree

4. Our Purpose Has Been Clear:

(Mean = 1.1)

Agree 1 2 3 4 5 Disagree

5. We Have Made Good Progress on Our Goals:

(Mean = 1.3)

Agree 1 2 3 4 5 Disagree

6. Has the capacity of the DOC to understand, use and conduct program evaluation research been enhanced by this partnership so far?

(Mean = 1.4)

Agree 1 2 3 4 5 Disagree

7. Has professional expertise been identified and provided on specialized topics, if needed?

(Mean = 1.4)

Agree 1 2 3 4 5 Disagree

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8. Has an improved public image resulted from specific partnership efforts?

(Mean = 1.6)

Agree 1 2 3 4 5 Disagree

9. Have information systems available for program monitoring and evaluation data improved?

(Mean = 2.1)

Agree 1 2 3 4 5 Disagree

10. Has the partnership facilitated a broader range of research projects for the department?

(Mean = 1.7)

Agree 1 2 3 4 5 Disagree

11. Has crisis operation (e.g., shrinking budgets) impeded partnership planning and products?

(Mean = 4.1)

Agree 1 2 3 4 5 Disagree

12. Has a spirit of cooperation been demonstrated (e.g., is there a willingness to adapt to each other's perspectives and "operating procedures"?)

(Mean = 1.1)

Agree 1 2 3 4 5 Disagree

13. Have turf conflicts impeded effective collaboration (e.g., interdepartmental or institutional competition)?

(Mean = 4.8)

Agree 1 2 3 4 5 Disagree

14. Does bureaucracy ever impede partnership efforts (e.g., centralized decision-making authority)?

(Mean = 3.9)

Agree 1 2 3 4 5 Disagree

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15. One Thing Our Partnership Could Do More Of:

- Updates: Where things stand? What is next?
- Articulating clearly what a D & A "program" is and what treatment modality and approach is preferred.
- Focus more on program planning process.
- Look at evaluating other program areas.

16. One Thing Our Partnership Could Do Less Of:

- Less talk about the project and actually put the project or data to use.
- Much travel to meetings, perhaps hold fewer meetings that last longer.
- Just right, no critical comments.

17. Have there been any obstacles that have impeded partnership efforts and goals? If so, please specify:

- Some initial skepticism/fear of evaluation on part of DOC institutional staff. This was overcome by consensus-building activities of partnership.

18. Please Write Any Other Comments You Have About the Partnership:

- I have learned a lot about D&A treatment and about the functioning of a therapeutic community.
- Temple staff are always well organized, focused, and prepared.
- Consensus, cooperative, public understanding, and agreement on ends and means.
- I am not experienced in the Research or D & A field but I have learned a lot due to my participation with this group.
- Wishes to include more institutions in the "sharing of data".
- Communication is excellent. Everyone understands the goals and did a great job staying focused on what they were suppose to do and not get sidetracked with other topics. The temple partners are sensitive to the DOC's priorities.
- Would like to be involved in the development of Treatment Database to monitor D & A treatment and evaluate. Would also be useful for TC grant.
- Partnership builds on a culture that supports self-examination of programs. Committed group of high-caliber professionals working on the project.
- Symposium was a great success; need more of these activities.

Evaluability Assessment and Process Evaluation Findings

Program Content and Structure

Therapeutic Community. TC programs displayed a high level of structure closely identified with a well-known treatment model and theory of group process. While many group sessions took the form of 12-step meetings, we also witnessed more intensive group therapy carefully guided by professional, well-trained staff. Compared to other program types, there is much less variation in the treatment services

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provided in TC, although staff vary in their individual styles. Individual counseling is mandated on at least a monthly basis, and inmates are expected to take a good deal of responsibility for monitoring and supporting one another. Records of inmate participation, behavior, and response to treatment (e.g., individual and group psychotherapy notes) are indicative of a well-organized, coherent treatment model.

However, several issues surfaced from research. A summary of key issues at each TC is provided in Figures 10 and 11. For example, program placement decisions based on objective, standardized assessments of need for treatment were rare **[see Htz-01-3-4, Htz-05-3-4, Hun-06-3-4, and Hun-07-3-4].** Inmates can be self-referred or referred to any D & A program by DATS staff, other DOC staff, or Parole. Prescriptive Program Planning (PPP) is often the vehicle by which inmates are referred to D & A education or treatment. While voluntary in theory, many inmates feel coerced to participate in D & A programs that are recommended by their Correctional Counselors (based upon review of each inmate's custody and treatment records). There is little doubt that the desire for parole is a major motivating factor, at least for initial participation in D & A treatment.

Many experts (e.g., Lipton, 1995) agree that the time that drug-involved offenders are incarcerated presents a unique opportunity to provide them with treatment. Most drug-involved offenders have avoided treatment while in the community, although many have experienced detoxification. More than 70 percent of active street addicts have never been in treatment nor intend to enter treatment for their addiction (Lipton et al., 1989; Peyton, 1994). The need for expanding drug abuse treatment was recognized in the Violent Crime Control Act of 1994, which for the first time provided substantial drug treatment resources for Federal and State jurisdictions. Although available research suggests that prison-based drug treatment shows promise in reducing drug use and offender recidivism rates, inmates that lack adequate treatment readiness, motivation and engagement in treatment are at high risk of failure (Blankenship, Dansereau and Simpson, 1999; Hiller, Knight and Simpson, 1999).

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Programming	Staff	Inmates
• Unit physical setting, including meeting rooms, is bright, clean, pleasant. Meeting rooms are small for size of groups (18-20). • Very little time is spent on individual counseling. Many inmates perceive this as a problem; some claimed they rec'd less than once per month; case file reviews confirmed that monthly sessions do not always occur. • Even in TC, and even in small group, the 12-step approach dominates treatment (as perceived by inmates, confirmed by researcher observations). • Morning Meeting: impossible to hear at morning meetings due to the large, cavernous common room; bad echo, numerous announcements by CO. Too many inmates in too large a place to benefit from this technique. Inmates complain that it is hard to be open and honest with CO sitting right there. Researchers saw increasingly ritualistic, disinterested behavior over time. • Pull-Ups: Many inmates complained that pull-ups are poorly done: they can be legitimate and helpful, but far too often are trivial, vindictive, and unrelated to treatment. Researchers indicated that inmate committee conducting pull-ups was well organized and prepared, supportive, and gave constructive feedback (but a bit uncritical at times). Groups: researchers perceived that staff sometimes did not challenge inmates' statements when appropriate (e.g., statements that were misinformed, rude, self-serving, patronizing, etc.). • Inmate attendance and participation in groups was generally high. Inmates offer both praise and confrontation (less of the latter). Group discussion sometimes was business-oriented rather than group therapy (e.g., criteria for phase advancements, inmates asking about specific treatment assignments).	• Staff are young, energetic, and enthusiastic. • Staff are somewhat inexperienced on average. This inexperience may account for some of the less positive inmate and researcher reports. • Some concerns that staff too readily gave up "informational authority" to inmates; some questions about accuracy of information (e.g., disease concept). • Staff were perceived as being somewhat nondirective in group meetings. • Little staff consensus about TC mission or main treatment approach. • Staff display some unfamiliarity with different treatment approaches (e.g., psychotherapy, cognitive restructuring).	• Interviews, case file reviews suggest that some inmates do not have a serious drug problem. Some don't know why they are here. • PASCI drug assessment scores not always in treatment file (or DC-14); few staff reported paying attention to them. • Low levels of motivation reported by some inmates. Many report that parole or prescriptive plan is the only reason for TC participation. Some couldn't identify incentives or rewards. • Inmate committee conducted a well-organized orientation for new members. • Observations, interviews, and case file reviews suggest that advancement to phases sometimes occurs w/out any clear indication of improvement.

Figure 10. Houtzdale Therapeutic Community: Key Issues

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Programming	Staff	Inmates
• Unit physical setting, including meeting rooms, is drab (downstairs, old, no natural light). Meeting rooms are small for size of groups (12-15). Leaky plumbing. • Small group deals intensively with personal recovery issues; rated highly by inmates. Researchers generally noted a high level of involvement by inmates. • Phase classes focused on specific skills related to recovery. Lesson plans were well structured and clear. Inmates feel they are getting tools needed for recovery. • Staff and inmates stated that TC offers a "holistic approach." (e.g., Criminal Thinking rated very highly by inmates). • Inmates rate individual counseling highly. • Problem: one inmate claimed he hadn't had an individual session in 6 weeks; another had only 4 sessions in 12 months. Case file reviews and interviews confirmed irregular individual sessions. • Inmates rated sharing and support by others in TC as important. • Problem: Inadequate monitoring later in day, according to inmates: "after 4:00 p.m. it becomes a clown show in here." • Inmates stated that negativity, cynicism by some inmates was unhelpful. Some TC inmates just "aren't ready;" raises questions about selection process. • Interaction with inmates outside TC is a problem: gambling and drug abuse. • Some inmates suggest a need for greater feedback on treatment progress at the end of each phase, should be no surprises. • Morning meeting: Some inmates complain it is more "preaching than teaching." • Pull-Ups: some complaints. Most perceive pull-ups can be useful, but many think someone should talk to a guy before writing him up. Observers noted that inmate committee conducting pull-ups was orderly but not challenging. Staff acted as "chair." One "defendant" was aloof, confrontational (his behavior was unchallenged). No sanctions given.	• Inmates speak positively about staff: available, caring, patient, helpful, honest, fair, efficient, respectful, knowledgeable. • But: staff occasionally described as "too rigid;" some inmates complain about different counselor styles • Problem: most inmates perceive (correctly) that the unit is under-staffed. There is some laxness in monitoring, and many are behind in treatment. plans because required classes have not been offered. • Inmates would like to see some minority and female staff.	• Poor communication w/parole: causes resentment. Inadequate distinctions between low v. high intensity of treatment., or even education v. treatment. Green sheets and prescriptive plans are poorly informed. • Inmates usually hear about program at orientation or through other D & A programs. • Initially, parole is major motivation for many, but most report treatment. is useful. • Eligibility criteria for TC are very broad. • Inappropriate candidates may be placed in TC. In one case file, 5 of 6 staff voted "NO" for TC placement, but inmate was placed anyway. • Individual has to be mature, open to change. • Concerns about aftercare: what happens when inmates hit the street?

Figure 11. Huntingdon Therapeutic Community: Key Issues

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Once an inmate makes an application to participate in D & A treatment, according to treatment staff, D & A referrals are then prioritized according to their date of referral and their minimum release date. Case file reviews by researchers, however, indicated that the actual criteria used to determine inmate eligibility and make program admission decisions were in practice rather broad and somewhat subjective.

The *Procedures Manual for the Drug and Alcohol Department* at Houtzdale articulates eligibility criteria for TC; criteria for the Huntingdon TC were very similar. For example, inmates must be six months misconduct free, they must voluntarily enter the program, and they must have one or more of the following: a Psychoactive Dependence Scale Score reflecting a need for intensive treatment, a documented drug and alcohol history, drug and alcohol related charges, drug and alcohol related misconducts, admit to a drug and alcohol problem, previous drug and alcohol placements, admit to being under the influence at the time of the offense, or commission of a crime for monetary support of an addiction. The *Inmate Handbook* outlines additional entrance criteria. For example, inmates should evidence no psychosis or intellectual functioning that precludes comprehension of objectives or participation in activities; the inmate may not be using illicit drugs. A vote sheet system is then initiated to gain input from different institutional staff about the inmate's suitability and potential for treatment.

Actual inmate selection procedures for TC, however, were somewhat inconsistent across different institutions, and inmates were not necessarily selected on the basis of an objective instrument that assessed D & A treatment needs or readiness. Inmates sometimes reported that they were "pushed" into the program by a counselor or by parole board restrictions, and they sometimes reported no serious addiction (e.g., "I only used marijuana;" "my offense was not drug-related," etc.). Our data (inmate and staff interviews, observations, case file reviews) suggest that a non-negligible number of inmates in TC programs are insufficiently motivated or engaged in this form of treatment. Many inmates seemed to wonder openly why they were there, and our own data led us to ask similar questions. One case file review **[Hun-06-3-4]** indicated that an inmate with a lengthy record of institutional misconducts and previous treatment failures was admitted to the TC for reasons unknown to researchers. Vote Sheet records showed that 5 of 6 staff voted "no" regarding his application to TC (he was later terminated for failing to participate in treatment). Such program admission decisions might occasionally result from a discretionary decision by a DATS Supervisor to "give a guy a chance," but such decisions may also be influenced by organizational and political pressures (e.g., to avoid potential litigation). In either case, the most desirable goal is to offer

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scarce treatment resources to inmates who most need them ***and*** are able to benefit from them. Objective D & A needs assessments can improve such decisions.

Programming is provided in either three (Houtzdale) or four (Huntingdon) distinct phases which emphasize learning and applying specific skills, and meeting specific treatment objectives (detailed descriptions of programming are provided in individual program reports; see Appendix B). Treatment plans are administered and periodically updated for each inmate in the program. However, inspection of case files indicated that standardized treatment plans with the same pre-printed objectives were used for all inmates; there was little individualization in terms of needs, treatment, or objectives. In most cases, little more than "check-off dates" were entered next to each objective. While the general treatment package (specific skills, group therapy, peer support and confrontation) offered is certainly relevant, *there is little assessment or consideration of individual needs.*

Individual counseling in each TC occurs less in practice than the minimums mandated by unit policies (i.e., at least once per month). In our inmate interviews and case file reviews [e.g., Hun-30-2-3, Hun-31-2-3, Htz-37-3-3, Htz-03-2-4, Htz-01-3-4, Htz-05-3-4, Hun-06-3-4] we found examples of inmates who had not seen a counselor for more than a month; treatment records for one inmate documented the occurrence of only one-third the number of mandated individual counseling sessions [Htz-01-3-4]. At least part of this problem is likely related to understaffing (see below).

Understaffing is a concern at both institutions, with DATS staff expected to provide a wide range of general population services in addition to their rather demanding roles on the TC. Estimates of "caseloads" are somewhat misleading, since TC staff are also responsible for providing a wide range of D & A programming to general population inmates. Even when DATS general population duties (which are significantly demanding) are not considered, inmate/staff ratios for TC alone were no less than 26:1 for Houtzdale, and 12:1 for Huntingdon. Development of organizational strategies to further enhance the recruitment and retention of experienced D & A staff may also be worth considering. At Houtzdale, of the seven staff who were present in March of 1999 when we conducted program surveys, three had less than one year of experience with DOC. One of the four DATS who was employed at Huntingdon as of March of 1999 was no longer employed with DOC as of July of 1999.

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These staffing issues can be explained *in part* by the rapid growth in the department over the past decade. The department has opened sixteen new correctional facilities since 1987 (more than half of Pennsylvania's 26 state facilities), in response to an increase in the prison population from 16,302 in 1987 to 36,452 as of April 2000. This growth has resulted in a great demand for new correctional staff (including DATS), and has created promotional opportunities for existing DATS. These promotions sometimes take DATS out of the domain of direct treatment. As one of the newest institutions, Houtzdale has experienced these problems of growth most directly. Thus, in addition to normal turnover experienced by any organization, the department is faced with a steadily increasing demand for professional services within a very competitive labor market.

Criteria for successful and unsuccessful discharge were generally quite clear for both TC programs (further articulated in individual program reports; see Appendix B). However, staff interviews and inspection of inmate case files (treatment files and DC-14 institutional files) raised concerns about high levels of unsuccessful discharges. Although no official records exist (see Recommendation #9 in this report), informal queries of staff indicated that the unsuccessful discharge rate may be as high as 50-70%. A high rate of unsuccessful discharges is of course subject to several interpretations.

On one hand, a high dropout rate may imply that the program employs stringent criteria for participation and strongly enforces program rules. Our data (e.g., interviews with inmates and staff, and inspection of program documents) suggest that such policing and enforcement occasionally occurs, but more so for extreme cases of inmate misbehavior and nonparticipation rather than as a general rule. On the other hand, a high dropout rate may suggest that programs are (at least partially) wasting scarce resources by admitting large numbers of candidates who are unsuitable or unwilling to benefit from TC. In this sense, there is a considerable "filtering" out of inmates initially admitted into the TC. Unsuitable candidates should certainly be filtered out, but better decisions could perhaps be made prior to program admission if more objective procedures for assessing the inmate's level of need for treatment and suitability for treatment were employed.[7] The earlier the decision to discharge unsuitable candidates the less disruptive it is for other inmates in the program. Staff interviews indicated that some inmates have been unsuccessfully discharged after completing six months or more of the program, although the longest period of TC

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[7] For further discussion and recommendations on matching inmate needs with appropriate treatment, see also *Implications for Program Planning and Evaluation*, esp. pp. 36, 42-43; and *Recommendation #1*, pp. 45-46.

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participation (prior to unsuccessful discharge) detected by our limited review of inmate case files was two months [see Hun-06-3-4]. Not only is the filtering process potentially inefficient and cost ineffective, but large numbers of unsuitable or unmotivated participants present in the TC at any time dampen the enthusiasm and energy that others may have for treatment. High dropout rates can also potentially weaken outcome evaluations because they weaken our ability to form and maintain valid comparison groups, and they make it more difficult to obtain adequate numbers in treatment and comparison groups. Differential attrition is one of the most serious threats to the internal validity of an experiment.

Some problems with the physical plants of the two facilities were observed. At Houtzdale, the common room was too large and cavernous for morning meetings with 124 inmates. It was impossible to hear well. Meetings should be split into smaller groups. In general, the sense of "community" required for a TC is greatly diminished by the size and anonymity of this unit. At Huntingdon, physical limitations in terms of size, age, and layout of meeting rooms were concerns (see Appendix 6). For example, the main meeting room was a long, narrow, rectangular room that was not very large or conducive to group discussion, although counselors monitored and solicited participation quite well.

At both sites, there was very little communication with parole or other aftercare agencies. This was not surprising given the excessive demands made upon staff to provide education and treatment services, although it is clearly not the responsibility of treatment staff to monitor and supervise inmates upon their release. However, DOC has little information about where inmates go after release, and we don't know what kind of aftercare treatment or support TC graduates receive (if any). DOC thus experiences a considerable information gap in its knowledge about D & A program graduates, and this deficiency contributes to an inadequate knowledge base about important outcomes such as recidivism (e.g., do TC graduates do better than non-TC graduates? Do those who receive TC + Aftercare do better than those who receive TC alone?).

Drug & Alcohol Education. With rare exceptions, inmates in D & A education programs showed little involvement or concern with recovery. We typically observed and heard low levels of enthusiasm and interest by inmates. Inmates interviewed tended to admit that they had little interest in drug education or treatment, but desired a certificate for their parole applications [e.g., Hun-11-1-3, Htz-19-1-3]. Staff expressed and displayed considerable discretion in how they conducted group sessions with inmates. Different staff utilized very different methods and examples, and printed lesson plans describing specific

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content and objectives were not followed closely. Criteria for inmate selection and eligibility was unclear: anyone identified at the point of entry into the prison system as having a drug and alcohol problem is eligible; anyone volunteering is eligible; anyone referred by Parole or by other DOC staff is eligible. No screening for level of need is provided. Intensity of treatment is low. Programs at the two institutions observed last only 4-10 weeks. **Maximum possible attendance is 4-10 sessions (1 hr. each)**, but inmates may attend even fewer sessions. According to program rules, inmates may not miss two sessions in a row, and inmates may be dropped from the program if their attendance and participation is poor. A summary of key issues for Education programs at the two institutions is provided in Figure 12.

Outpatient Treatment. Outpatient treatment is only slightly more intensive than drug and alcohol education, and much less intensive than inpatient therapeutic community programs. Six to ten hours of group meetings, in the absence of more intensive treatment, cannot be expected to produce any observable changes in attitudes or behavior. Evidence from our earlier D & A Program Surveys and our on-site process evaluation research suggests that outpatient programming varies a great deal across different institutions, staff persons, and even weekly sessions. Programs may occasionally run 10-14 weeks (only rarely do they last longer), *but it is not unusual for the "program" to have no definite duration at all* (i.e., at Houtzdale, an inmate may stay in the program until transfer or release; there is no specific start date or end date). As a result, there is little continuity or consistency in topics, content, or group membership from one week to another; there is little sense of progress toward specific treatment goals. A summary of key issues affecting Outpatient programs at the two institutions is provided in Figure 13.

Inmates in outpatient programs occasionally expressed more of an interest in seeking more intensive treatment than inmates in educational programs, but they seemed unable to recount many specific examples of content in their current treatment. Individual counseling is very rarely provided to inmates in these programs. Program observations suggested that group sessions generally followed a 12-step theme, rather than more sophisticated research- or theory-based treatment models. Staff involvement and guidance was quite variable. Printed lesson plans were available at only one of the two institutions examined, and Addictions Treatment staff described and displayed a high level of discretion in their approach to group sessions. Again, little evidence of screening for level of need for treatment or eligibility criteria was found. It is possible that more specific criteria and assessment procedures exist (although no standardized assessment instrument is administered); it is impossible however for researchers to determine criteria where no written program procedures or policies exist (Addictions Treatment).

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	Programming	Staff	Inmates
Huntingdon	• Inmates: Mainly, we talk about impact of using drugs; how to stop. Test at end of program. • Sharing of personal life histories perceived as most helpful by inmates, although some perceived nothing as helpful. One claims: "never heard anything I didn't already know." • Only 6-8 weeks, meet once per week. Must attend all 6 sessions for SAE, 6/8 for AE. • Classroom format: staff presentation w/some discussion, some writing assignments. • Six hr. of education by itself is unlikely to produce any change (inmates, staff, and researchers largely agree on this issue). • One inmate, now in TC, says "Education classes did nothing for me."	• Staff are described as fair, respectful, honest, straight, informative, clear.	• Most inmates report they participate only because D & A program is in their prescriptive plan and/or parole requires it. • Some feel "drug dealer" programs would be more appropriate. • Some feel education programs are offered only to prove that prison is doing something: "They're supposed to be rehabilitating us, so they have to do something to cover their asses." • Inspection of program documents, interviews, and observations indicate little (if any) screening for level of need: any evidence of a "drug problem" is suitable for eligibility.
Houtzdale	• Mainly discuss effects of drugs on individual, family, and psychological functioning, etc. • Mainly a classroom approach (presentation with some group discussion) • Inmates report that group helps raise awareness. • Inmates participate and provide personal examples when prompted to do so.	• Staff perceived by inmates as fair, sincere, caring. • Observations indicated that staff person leading the group had good rapport and constructively engaged inmates about the subject matter.	• Inmates hear about programs at orientation. • Most volunteer because it is part of their prescriptive plan. • One inmate sees it as "part of the puzzle," mainly increasing knowledge about drugs and thinking about one's reasons for using drugs.

Figure 12. D & A Educational Programs: Key Issues

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Site	Programming	Staff	Inmates
Huntingdon	• Addictions Treatment was not offered during the summer (physical plant renovations). In our program reports, however (Appendix B), we provide description from program documents.		
Houtzdale	• More interactive than education groups, according to inmates. But: Meetings are still run very much like AA/NA (i.e., inmate-led, 12-step). Why call it "treatment"? • Inmates: many disagreed with religious aspects; argued that it interferes with treatment. • Inmates complain that there are no consequences for misbehavior, poor attendance, or poor participation. Rules not enforced. • What is **most helpful** (according to inmates): positive information and learning. • What is **least helpful** (according to inmates): too much bullshit by inmates, not allowed to challenge./Too many people just stating opinions, not working on treatment issues./Inmate code: don't trust staff./Need smaller groups (too large), more regular meetings (1 per week is not enough)./Lack of individual counseling is a problem (staff don't have time). • Observations: most inmates are sullen; slow to warm up; little enthusiasm or interest. Only a few inmates participate. In one group, 7 of 20 said nothing throughout. • No written program policies, lesson plans, or procedures were available.	• Some staff are perceived by inmates as caring and sincere, some are not. • Inmates say they receive conflicting information from different staff. • Inmates state that some staff are not knowledgeable about life on the street. • Observations: not much talk between staff and inmates; some new group members may account for this, but one hr./wk is insufficient to build trust or rapport.	• One inmate says he manipulates programs to get out. Most admit that the only motivation is parole; most felt coerced into participating. • Many inmates are perceived (by other inmates, staff) as insincere, and this compromises the treatment effort. • No assessment of level of need for treatment; little screening for drug involvement. • Some guys report they are sellers, not users: inappropriate for them to be there. • Inmates: An individual needs to be extremely motivated to benefit from this program.

Figure 13. Outpatient Treatment Programs: Key Issues

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Inmate interviews, staff interviews, and our own observations suggested that many inmates in these programs are neither participating seriously in treatment nor likely to benefit from it [see Htz-22-2-3], although some specific inmates expressed a desire to participate in more structured or intensive levels of treatment with other inmates who were more motivated [e.g., Htz-20-1-3]. Interviews with inmates and program observations indicated a slightly higher level of inmate involvement than found than with education, but inmates who reported that they were making any progress in outpatient treatment tended to attribute it to their own initiative and motivation [see Htz-20-1-3, Htz-22-2-3]. Program policies and procedures state that inmates may not miss two outpatient sessions in a row.

Staffing

Houtzdale. Houtzdale has a young and energetic treatment staff that can potentially provide a solid foundation for the future. However, only two of six staff persons as of August 1999 (aside from the DATS Supervisor) had more than three years experience with DOC. Of the seven DATS (including the Supervisor), five have Master's degrees; all have at least a B.A. degree in criminal justice, psychology, counseling, or related fields. Three are CAC certified; three are currently working toward CAC certification.

In addition to their demanding TC caseloads and group treatment duties, DATS staff provide drug and alcohol education and outpatient treatment services to large numbers of inmates in general population (up to 140 in Outpatient treatment, and another 120 - 140 in D & A Education at any one time). Insufficient staffing is a concern, although the staff are to be commended for the breadth and quality of services they provide. Staff were generally described by observers as respectful, trusting, calm, and having good rapport with inmates. There were occasional exceptions, although such incidents were rare [see Htz-60-1-1].

Some concern was noted, however, that many group treatment sessions observed at Houtzdale (e.g., phase class, small group) revolved almost exclusively around the standard 12-step approach rather than more sophisticated treatment models (e.g., cognitive-behavioral approach). One staff member described the treatment approach used in small group as "group psychotherapy," although researchers found no evidence of psychodynamic theory in lesson plans, interviews, or observations. One staff person stated that "cognitive restructuring" was a major treatment approach in the TC, but wasn't sure about what

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that approach entailed or how it influenced treatment. One researcher noted that although a specific phase class was relevant to the goals of the program, specific information provided by the staff person on the disease concept and a possible genetic predisposition for addiction was either unclear or inaccurate.

All respondents described the relationships between the D & A staff as positive. Responses ranged from "good" to "wonderful" and "excellent." Other descriptors included professional, consistent, helpful, and supportive. One interviewee stated that all staff take the initiative to problem solve and to maintain the integrity of the treatment programs. Relationships between D & A staff and security were more varied, ranging from "fairly good," "okay," or "not much interaction", to "they won't even return a hello or good morning." Most D & A staff were very respectful of security, though, and they felt that security was extremely important and that security staff did their jobs well. DATS staff mentioned that they receive training in security issues and are sensitive to security concerns in their institution.

Huntingdon D & A Staff. Only three full time DATS staff (plus the DATS Supervisor) were employed during July and August when we conducted on-site research; the same staff are also responsible for providing a wide range of general population programming. At Huntingdon, all staff persons have considerable treatment experience, and that factor seems to strengthen and enhance the overall mission of the TC. Staff were very well regarded by inmates; researchers agreed that a high level of professionalism and expertise was characteristic of staff. Staff were consistently described by observers as knowledgeable, respectful, trusting, calm, and having good rapport with inmates. All three full-time DATS staff have Master's degrees. DATS staff have a good deal of flexibility in how they run and manage their groups, and they feel that this is appropriate (i.e., "you can't just do a standard paradigm").

Although the staff are to be commended for the breadth and quality of services they provide, staffing levels one again caused some concern. At the time of our visits during July and August of 1999, the Drug and Alcohol Department at Huntingdon had been shorthanded for at least several months, and TC programming (e.g., phase advancement, individual counseling) had suffered somewhat as a result. Several inmates were behind in their treatment plans because required phase classes had not yet been offered. TC staff have significant General Population responsibilities as well. A huge time lag in hiring a new DATS may have been at least partially related to restrictive state and/or agency requirements for recruiting, interviewing and hiring a new DATS staff person. The potential for recruiting and retaining well-qualified, professional DATS staff is somewhat unclear due to limited opportunities for advancement. For example,

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several former DATS Supervisors within DOC (e.g., Cresson, Huntingdon) have accepted higher paid jobs elsewhere in their institutions (e.g., Inmate Program Manager). In each case, these were very well-respected and experienced DATS. Two recent staff additions have alleviated concerns to some extent, although DATS still have a wide range of general population duties and administrative responsibilities in addition to TC. One new DATS position was approved as of August 1999, and another DATS was added early in 2000.

Budget isn't everything, one DATS stated, but a few wisely spent dollars "would make a difference" to treatment quality. For example, staff feel that a unit secretary could help with paperwork and administrative duties considerably. The physical plant creates certain treatment obstacles (e.g., both of the two main meeting rooms experience recurrent plumbing leaks; there is a lack of segregation of TC inmates from the general population). More attention needs to be devoted to aftercare planning and follow-up as well. During our interviews with staff, some DATS raised important questions about DOC's overall approach to drug and alcohol treatment **[e.g., Hun-95-3-2]**. For example, it was suggested, DOC policy seems to favor getting more and more inmates into drug and alcohol education programs, rather than intensive treatment programs such as TC.

DATS personnel form a cohesive, supportive, well-knit group with a great deal of respect for each other. They report working together very well. Relationships are described as collegial, and staff report that they try for "triangulation" on the different inmates they work with. Relations with security are generally positive; staff acknowledge that Huntingdon is a tightly run, maximum security prison and that they must respect security issues. DATS have good relations with most departments; they work well with the education department in particular. For reasons we are unable to fully determine, relationships with the Psychology Department are tenuous. Except for occasional psychological assessments requested for some inmates, DATS staff report that there is little communication between the two departments.

Inmates

Inmates in TC programs usually (but not always) displayed good levels of attentiveness, interest, and enthusiasm. There were no disciplinary problems to speak of, although inmates participating in groups in both programs tended at times to wander off the topic, evade questions or issues, or hold sidebar conversations. Staff were not always directive or challenging with inmates in group sessions **[e.g., Hun-48-2-1, Htz-60-1-1, Htz-66-1-1]**. As noted earlier, researchers expressed concerns that some inmates in TC

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may be unsuited for treatment, and further review by DOC of assessment procedures for all drug and alcohol programs is warranted to improve program placement and selection decisions.

When asked what they found **most helpful** about the TC, common inmate responses included the following:

- Listening to other people's stories and learning from others;
- Learning how to work the 12 steps;
- NA groups, particularly when someone is sharing a life story;
- Cognitive restructuring, including learning about criminal thinking patterns (received high praise from inmates at both institutions); and
- Learning about individual lifestyles and drug problems. Several inmates reported that their greatest insights obtained from treatment were that drug use wasn't just about seeking pleasure; it was a way of life. Thus, they reported, their entire lifestyle and patterns of thinking need to be addressed, not just drug use.

When asked what they found **least helpful** about the TC, common inmate responses included the following:

- Not having meetings on the weekend;
- Seminars can become humdrum because the themes are the same;
- Basic Concepts and AA/NA are repetitive because we already know this stuff; and
- Pull-ups: some (not all) inmates reported that the pull-up system was unhelpful or potentially harmful **[Htz-16-1-3, Htz-24-2-3, Htz-26-2-3, Htz-27-2-3]**. Several TC inmates questioned why inmates weren't required to informally address a perceived problem with an individual prior to formally writing someone up for a pull up. Too many trivial behaviors were emphasized, they felt, and pull-ups were too often "vindictive" rather than helpful.

Inmates generally reported that they were treated with fairness and respect by staff. Most stated clearly that they felt it was up to the individual inmate to work towards recovery; staff are there to help. However, many TC inmates reported that the counselors just don't have enough time for individual

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treatment sessions [see **Hun-13-1-3, Hun-15-1-3, Hun-30-2-3, Hun-31-2-3, Htz-16-1-3, Htz-17-1-3, Htz-37-3-3**]. For example, "Main problem is that counselors just don't have enough time in the day. After group, guys just flock to them with individual issues and questions, but there is not enough time" [**Htz-37-3-3**].

When asked about perceived **rewards and punishments** used in the TC (e.g., consequences for good or poor participation), inmates reported the following rewards:

- Positive pull-ups;
- Being named "newcomer of the month" or "inmate of the month";
- Obtaining program completion certificates;
- Obtaining recommendations for parole;
- Learning all you can about yourself;
- Self-discovery; and
- Advancing through program phases by meeting required criteria.

Several inmates interviewed [**Hun-13-1-3, Htz-16-1-3, Htz-26-2-3, Htz-27-2-3**] reported that parole was their desired reward for the program. Several inmates stated that the program rewards weren't as visible as the punishments. Inmates frequently reported that pull-ups were punishment (see above), and often they included sanctions. Several inmates stated that the biggest punishment is not getting out on time because you're not doing what you're supposed to be doing, and that participation in the TC can affect one's chances of parole and release [**Htz-17-1-3. Htz-24-2-3, Htz-25-2-3, Htz-27-3-3, Hun-29-2-3**].

V. IMPLICATIONS FOR PROGRAM PLANNING AND PROGRAM EVALUATION

Implications for Program Planning

In general, our review of program documents demonstrated that drug and alcohol programs have clearly defined program structure, content, and goals. Our on-site research indicated that a qualified, professional staff provides extensive drug and alcohol programming to a very diverse inmate population. However, our research suggests that program intensity and inmate engagement vary tremendously across

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program types: educational and outpatient treatment programs pale in comparison to residential programs such as TC.

Any inmate seriously in need of treatment and sincerely interested in treatment (i.e., *readiness* and *motivation*), is most likely to benefit from daily participation in a highly-structured, intensive, closely-monitored therapeutic community treatment environment over a one-year period. Potential improvements resulting from TC participation are substantially larger than for any other form of treatment (see reviews by Inciardi, 1995; Lipton et al., 1992, Lipton, 1995, and Pearson and Lipton, 1999).

Any significant change in inmate attitudes and behaviors is unlikely to result from participation in educational or outpatient treatment programs alone.[8] There is simply nothing in the literature on prison-based drug treatment or rehabilitation to support the hypothesis that six to ten hours of ***any*** programming can effect significant attitudinal or behavioral change (Andrews et al., 1990; Pearson and Lipton, 1999). As Pearson and Lipton (1999:402-3) emphasize, ".... it does not seem plausible to us that substance abuse education would be very effective as a stand-alone treatment (or even as the most important treatment component administered) when the clients are identified substance abusers in prisons. Research suggests that they would need much more than education about substance abuse." Similarly, Outpatient Treatment by itself seems to provide a very low-intensity form of treatment for those who are unable or unwilling to get into a more intensive residential (TC) program. D & A Education seems to provide inmates with a certificate that may or may not satisfy the minimal requirements of the Parole Board when they come up for their hearings. It may, for some inmates, spark interest in seeking further treatment. Data from our Drug And Alcohol Program Census indicate that these programs also varied tremendously across different institutions in terms of intensity, approach, and content, rendering invalid many potential program comparisons in an outcome evaluation design. It is not entirely clear what other possible objectives the provision of educational and outpatient programs may serve, but the mission of these programs and their place within the full spectrum of D & A programming offered by DOC deserves careful consideration and review.

Resource allocation to specific program types is a primary issue. Correctional agencies should consider whether appropriate resources are being applied to their strongest forms of treatment (primarily TC), and whether the efforts required to offer low intensity D & A intervention (education and outpatient

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treatment) to an extremely large inmate population is cost effective, much less sufficient to effect any significant change in entrenched criminal behaviors and lifestyles. Even at two institutions with a high level of staff professionalism and commitment, the quality of D & A programming may be compromised to some extent by inadequate levels of staffing and other resources.

Our results also suggested that **careful review of current inmate drug screening procedures and assessment of need for treatment is in order**. Eligibility criteria for different programs were often unclear, overly broad, or both. Screening for level of drug involvement and need for treatment is sometimes subjective and/or cursory; no standardized assessment instrument was used at the institutional level. A barrage of clinical assessment instruments were administered *after* an inmate was admitted to TC, but for the most part, these yielded no standard score that reflected level of need for drug treatment. Substantial data (including staff and inmate interviews, case file reviews) indicated that these instruments had little bearing upon either program placement or treatment planning decisions (once admitted). One detailed example illustrates these findings [see **Hun-08-1-4**].

In our reviews of case files, researchers posed several questions. For example, question #3 from the form, *"Inmate Case Files: Observation Guide"* **(see Appendix 4)**, asked, "How was the inmate's **eligibility** for this program assessed (e.g., type and seriousness of D & A problem, time remaining in sentence)? What specific form(s) or assessment instruments were used?" Researchers noted that four instruments, found in the treatment file, appeared to be concerned with the assessment of an inmate's need for treatment: **Medical History, Psychosocial Evaluation, Global Goal Treatment Sheet, and Multi-Modal Life Questionnaire.** Numerous pieces of information were collected (e.g., "No father was identified for this inmate;" "A step-father was identified - he was described as physically abusive, with his own drug and alcohol problems and he, too, had a criminal history;" "Inmate was identified as having chest pains, heart problems and hearing problems;" "Child life was described by the interviewer as "very sad;" "A history of sexual abuse was noted" (Unclear as to whether the inmate was the offender or victim).

Question #6 from the form, *"Inmate Case Files: Observation Guide"* (see Appendix 4), asked about **treatment planning:** "Is a specific form used? Briefly describe the inmate's **treatment goals or objectives** in this program, specific **treatment strategies and activities prescribed**, and inmate **progress** on specific goals." Different treatment goals, sometimes overlapping, sometimes inconsistent, and

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[8] See also *Systemic Recommendation #1.*

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sometimes later ignored, were found. Weaknesses in individualized treatment planning are illustrated by an example taken from one inmate case file.

A Case Example of Individualized Treatment Planning [excerpted from **Hun-08-1-4**].

In the **Psychosocial Evaluation** dated **10-20-98,** the *inmate* identified the following issues: "Adjustment to the therapeutic community;" "Deal with anxiety;" "Deal with his sister;" "Develop spirituality." In the same form, the *interviewer* identified the following issues: "Passive-aggressive from an abusive family;" "Shy and retiring, does not readily divulge;" "Afraid of anger because of history of violent relationship with step-father." Documented in the same form but not addressed in any evaluative manner were the following issues: "Inmate left family at the age of 12;" "Reports drinking history began at the age of 12;" "Descriptions of ongoing history of rescuing and people-pleasing behavior;" "lack of knowledge about the disease concept;" he believes he "feels less depressed."

In the **Global Goal Treatment Sheet,** the following issues were noted for the same inmate: "Drug and Alcohol abuse;" "feeling less depressed;" "desire to reduce anxiety;" "desire to avoid old friends;" "desire to learn how to change behavior to avoid problems with the police;" "desire to become more open;" "desire to increase self-awareness;" "know how to distinguish wants and needs;" "attend AA meetings;" "deal with resentment."

In the first treatment plan for this inmate, **Phase I Treatment Plan**, a goal is identified that in three months, ending **1-20-99,** the inmate should "define treatment issues." **Evidently, treatment planning ignored issues extracted from documentation available prior to the date the Phase I treatment plan was signed, 10-20-98.** Researchers found treatment plans for all Phases to be standardized, pre-printed forms. Some effort was made by treatment staff to individualize one or two goals in the Phase treatment plans, but these attempts at individualizing and operationalizing treatment goals were few, ambiguous, and lacking clear performance criteria. **Phase Advancement Sheets**, ntended to document the transition of an inmate from one Phase to the next, made no reference to this inmate's progress on treatment goals.

Information available in the treatment files on the inmate's level of drug involvement and need for treatment *prior to program placement* was often scanty or missing [e.g., **Hun-07-3-4**]. The PACSI score, generally obtained at the initial point of entry into DOC during inmate classification months or years

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earlier, was often unavailable to treatment staff at the time of referral, and it was rarely used by staff to make critical program placement or selection decisions. The assessment of inmate readiness and motivation for treatment, another important variable, was subjective and cursory. Standardized instruments yielding objective scores (PACSI or other) were rarely used to inform actual program placement decisions. **Several reliable, valid, standardized instruments for assessing level of need for treatment and readiness for treatment are available, and such assessment instruments could profitably be used for (a) improving program selection and placement decisions, (b) improving individual treatment planning, and (c) constructing matched comparison groups in a valid outcome evaluation.**

Implications for Program Evaluation

A major product intended as a result of the partnership was the development of a valid research design to evaluate outcomes of prison-based drug treatment. In regular monthly meetings with DOC staff and officials, researchers continuously presented results as they came in, discussed how results could be most efficiently communicated, and discussed how results could be used. Once the program and policy environment of AOD treatment was carefully described, and specific strengths and weaknesses in service delivery were identified and discussed, an outcome evaluation design was developed and implemented.

First, we discussed potential sampling strategies. We reviewed major descriptors of drug and alcohol programming at all DOC institutions, including the number of treatment slots available at each institution for inmates with varying levels of need. For example, Therapeutic Community programming statewide offered 360 beds, but Huntingdon had only 36 beds, while Houtzdale had 128 beds. Because considerable variability existed in the quantity and type of other AOD treatment services provided across institutions, the most sensible approach while working toward treatment standardization was to focus on five institutions (identified in collaboration with DOC) that carried a full range of drug and alcohol programming, including TC: Cresson (Security Level 3, pop. = 1,302), Graterford (Security Level 4, pop. = 3,638), Houtzdale (Security Level 3, pop. = 1,500), Huntingdon (Security Level 4, pop. = 1,888) and Waymart (Security Level 2, pop. = 1,218)[1]. In this way, we could account for differences in programming across institutions (e.g., treatment exposure) and use this information to help design valid comparison groups.

If TC clients were all "high need" clients, for example, then valid comparison groups would need to consist of high need clients also. We decided to use a quasi-experimental design with matched

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comparison groups. While the advantages of randomized research designs are well known, many programs (including mandated drug treatment programs) are obligated by concerns of legality and ethicality to select clients on the basis of their need and suitability for treatment. In addition, inmates with a documented drug and alcohol problem are either required or "strongly encouraged" to volunteer for AOD programs in the interest of strengthening future applications (or re-applications) for parole. In such cases, randomization is not feasible. Treatment cannot be withheld from those who need and want it. While a true randomized experiment is not possible, a strong research design is afforded by the opportunity to use matched controls to form comparison groups (Rossi and Freeman, 1989). Critical to the matching process is the use of matching criteria closely related to the outcome criteria (recidivism and drug use).

The experimental group consisted of all inmates entering therapeutic community (TC) programs at the five institutions. Comparison groups were formed from similar inmates participating in much lower-intensity D & A programs at the 5 institutions, using a matching design to control for differences in drug involvement (i.e., assessed need for treatment) and overall risk (e.g., current offense and criminal history). Because we closely track admissions and discharges from each program, we are able to control for other important process variables potentially related to outcome, including level of exposure to drug treatment (e.g., 1 month v. 1 year) and whether or not an inmate successfully graduates a specific program. Through the drug treatment program database established through our initial research partnership grant, we are also able to control for differences in program structure and content (e.g., number of hours, primary treatment approach, etc.).[2]

Initially, all inmates in TC, Education, or Outpatient treatment programs as of January 1, 2000 were approached and asked to participate in the study. Those who agreed to participate signed our Subject Consent Form and completed the TCU Drug Screen. TC inmates were asked to complete the TCU Resident Evaluation of Self and Treatment (REST) form, and TC staff were asked to complete the TCU Counselor Rating of Client (CRC) form for each current TC inmate.[3]

The TCU (Texas Christian University) Drug Screen has been in use since 1993 and has been specifically adapted for self-administration to a prison population. It serves as tool for quickly identifying inmates who might be eligible for different treatment options. Items in this screening tool represent key clinical and diagnostic criteria for substance dependency as they appear in the DSM and the NIMH Diagnostic Interview Schedule. A scoring guide based on DSM standards is available. The instrument has

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shown good reliability and validity, and is widely used with prisoner populations (Broome, Knight, Joe, and Simpson, 1996; Carter and Ortiz, 1998; Peters et al., in press; Shearer and Carter, 1999; Simpson, Knight and Broome, 1997).

The TCU ***Resident Evaluation of Self and Treatment*** (REST) form records inmate ratings of counselors, therapeutic groups, and the program in general. It also contains scales that assess psychological adjustment, social functioning, and motivation and readiness for treatment. All scales are based on or adapted from instruments with well-established reliability and validity (Knight et al., 1997; Simpson, 1994). The form includes inmate ratings of perceptions of drug-related problems and psychological functioning, treatment program features, participation in therapeutic groups, counselor attitudes and behavior, resident attitudes and behavior, and counseling sessions (both group and individual). The ***Psychosocial Functioning*** scales include standardized measures of psychological adjustment (e.g., self-esteem, depression, anxiety, decision-making) and social functioning (e.g. childhood problems, hostility, risk-taking, and social conformity). The Self Rating forms also include measures of ***Motivation for Treatment***, another variable that has been found to influence treatment outcome (Broome, Knight, Knight, Hiller and Simpson, 1997; Czuchry, Dansereau, Sia, and Simpson, 1998). All scales have evidenced good reliability and have been validated upon inmate treatment populations (Simpson and Knight, 1998). [9] These instruments allowed us to assess various aspects of inmate psychosocial functioning, participation in treatment, perceptions of treatment, and staff ratings of inmate engagement in treatment.

Overall, 2,895 inmates were admitted to drug and alcohol programs at the five institutions during the sampling period (January 1, 2000 - November 30, 2000). So far, 2,684 inmates have been discharged from programs. Of these, 1,068 inmates have been released from custody so far. Post-release data collection for this subsample is currently underway, and cases will be added as inmates are released back into the community. With the cooperation of three agencies, three types of post-release data are being collected: (1) reincarceration data, (2) rearrest data, and (3) parole data.

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[9] Other standardized psychological measures used by the TCU research group to evaluate prison-based TC in Texas include the Michigan Alcoholism Screening Test (MAST) (Seltzer, 1971), the Beck Depression Inventory (Beck and Steer, 1987), the Self Efficacy Scale (Pearlin and Schooler, 1978), and the SCL-90 checklist for clinical symptoms (Derogatis, Yevzeroff, and Wittelsberger, 1975). Inmate changes in psychological functioning due to treatment and relationships between psychological functioning and other treatment outcomes (i.e., relapse and recidivism) have been somewhat neglected in research on prison-based TC to date (Knight et al., 1997).

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Reincarceration data is collected from the Department of Corrections, including the inmates' most recent date of release from custody, type of release (e.g., parole v. full sentence served) and any new incarcerations thereafter (including type of offense and sentence). Rearrest data, collected by the Pennsylvania State Police, is available through the Pennsylvania Commission on Crime and Delinquency (PCCD). As with DOC, we submit a list of all inmates released from custody within a specified time period. For each inmate, we code date, type and disposition of any new arrest. Parole data provide another important source of post-release data[4]. Officials from the Pennsylvania Board of Probation and Parole have granted access to several specific types of data. First, we can determine whether an inmate successfully completes his term of parole or not, and whether the inmate tests positive for any type of drug use while on parole. If an inmate is resentenced into DOC custody for a parole violation, we would identify such activity through the DOC data system. Examination of parole data, however, also allow us to detect cases where an inmate may or may not be found guilty of a parole violation, and may or may not be recommitted to DOC. Parole also provides several other important measures that may significantly influence recidivism, including employment and participation in aftercare treatment.

The use of standardized instruments in the DOC-Temple project will greatly facilitate comparisons of our results with recent and ongoing research evaluating the effects of prison-based TC. Prior process evaluation strongly aided outcome evaluation not only by ensuring strong implementation of treatment services, but by documenting variations in intensity (e.g., hours attended, length of treatment) and type of services (e.g., individual v. group counseling; self-help v. therapist-guided groups) provided in each program. Such controls can be carefully applied in the construction of comparison groups.

VI. RECOMMENDATIONS

A number of specific recommendations for correctional agencies were supported by our findings. Below, we summarize our major recommendations in two categories: (1) short-term, feasible strategies, and (2) longer-term, systemic issues and policies that warrant review.

We emphasize the necessity of involving field staff in the review and revision of drug and alcohol policies: "Having the relevant stakeholders involved in setting program goals is crucial to gaining the support and cooperation necessary to make the intervention work (Welsh and Harris, 1999:85)." Very real dangers are involved if the views of program staff (and clients) are ignored: "The danger is that the goals handed down from above may be unrealistic to program staff or irrelevant to the clients. In either case, the impact of the intervention could be severely compromised . . . (Welsh and Harris, 1999:86)."

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In this section, we refer to two recent, useful documents that articulate specific standards for drug treatment. The first and most relevant is a recent report issued by the Office of National Drug Control Policy (ONDCP) (1999), called *Therapeutic Communities in Correctional Settings: The Prison Based TC Standards Development Project.* The standards articulated in that report will soon be incorporated into a formal accreditation process for prison based TC, to be conducted by the American Correctional Association (ACA). The second is a recent report by the National Institute on Drug Abuse (NIDA) (1999), called *Principles of Drug Addiction Treatment: A Research-Based Guide.* This report describes several relevant, well-established principles for different types of drug treatment programs.

Short-Term, Feasible Recommendations

Recommendation #1: Standardized instruments for assessing inmates' level of need for treatment, readiness for treatment, and psychological functioning should be used to (a) improve program selection and placement decisions, (b) inform treatment planning, and (c) construct comparison groups in valid evaluation research designs.

As articulated earlier in this report and supported by extensive data (review of program documents, inspection of inmate case files, interviews with staff and inmates, and program observations), current procedures for assessing an inmate's level of need for drug treatment (and matching treatment needs with appropriate program placement decisions) were often subjective and inconsistent across institutions. Other than the PACSI (drug abuse severity score) administered at the time of the inmate's initial classification (months or years before an institutional D & A assessment or program placement decision is made)[10], no standardized, objective D & A assessments guided screening and program placement decisions. Measures recommended (see Section III) for consideration included the **TCU Drug Screen.**

As a recent NIDA (1999:3) report confirms, the number one principle of effective drug treatment is that "No single treatment is appropriate for all individuals. Matching treatment settings, interventions, and services to each individual's particular problems and needs is critical to his or her ultimate success in returning to productive functioning in the family, workplace, and society." Further, a sizable body of research has convincingly demonstrated three principles of effective correctional treatment. First, effective

[10] As noted earlier, even the earlier PACSI scores are frequently unavailable for inmates at the time of their institutional D & A assessment and the program placement decision.

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programs must clearly differentiate between **low-risk** and **high-risk** clients (Andrews et al., 1990; Bonta, 1996; Gendreau, 1996; Jones, 1996). High-risk cases should receive high levels of intervention and services; low-risk cases should receive minimal intervention. Second, programs that effectively target and reduce individual, criminogenic needs accomplish larger decreases in re-offending (Andrews et al., 1990; Lipton and Pearson, 1998; Pearson and Lipton, 1999). Third, programs that ***appropriately*** target the specific needs and learning styles of their clients (i.e., ***responsivity***) tend to be more effective (Andrews et al., 1990).

According to *The Prison Based TC Standards Development Project* (ONDCP, 1999, Revised Prison Standards, p. 13), the following (minimal) standards should apply to intake screening and assessment:

> SA1. The program has written eligibility criteria agreed upon by the sponsoring agency and corrections officials to identify participants most likely to benefit from the program.
>
> SA2. Residents conduct outreach activities within the general prison population.
>
> SA3. There is a standardized admission screening and assessment format, which may include interviews with senior program participants.
>
> SA4. Mental health screening is conducted by qualified staff.

These four standards (especially SA1) were implemented to a greater degree for TC than for other types of D & A programs, although criteria varied somewhat from one institution to another. In contrast, D & A education and outpatient treatment programs often lacked written policies that clearly specified inmate eligibility criteria, target selection procedures, and program content/structure.

Recommendation #2: Delegate a subcommittee to make recommendations about the use of specific clinical assessment tools to be used for prison-based drug treatment programs.

A variegated battery of clinical instruments was administered at different institutions[11] (e.g., **Medical History, Psychosocial Evaluation, Global Goal Treatment Sheet, and Multi-Modal Life**

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[11] Although these clinical instruments were used at both Houtzdale and Huntingdon, note that there was considerable variability in assessment procedures across DOC institutions (as indicated by previous drug

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Questionnaire). Although these take some time to administer, they had little observable influence on ***either*** (a) program admission decisions [see **Htz-01-3-4, Htz-05-3-4, Hun-06-3-4, Hun-07-3-4**] or (b) individualized treatment planning [e.g., see **Hun-08-1-4**]. To what degree is each of these useful for program placement or treatment planning decisions? What are the appropriate criteria for making program admission and treatment planning decisions? How can assessment procedures be rendered more consistent, efficient and useful?

As NIDA (1999:3) suggests, "Effective treatment attends to multiple needs of the individual, not just his or her drug use. To be effective, treatment must address the individual's drug use and any associated medical, psychological, social, vocational, and legal problems." Further, "An individual's treatment and services plan must be assessed continually and modified as necessary to ensure that the plan meets the person's changing needs (NIDA, 1999:3)." As noted earlier, our data indicated that this standard was not regularly followed.

According to *The Prison Based TC Standards Development Project* (ONDCP, 1999, Revised Prison Standards, p. 13), the following standards apply to post-admission (intake) assessment:

> SA5. The program has the authority to reject inappropriate and unmotivated applicants.
>
> SA6. Staff conduct a thorough biopsychosocial assessment within 10 days of admission, which includes identification of the program participant's strengths and weaknesses.

As noted earlier, such assessments were completed for TC inmates at both institutions examined, but it was unclear from case file reviews that such assessments had any observable impact upon treatment planning or services rendered. Because such assessments were conducted only after an inmate's admission to TC, they had no influence on admission decisions whatsoever.

Recommendation #3: Carefully examine staffing of prison-based drug and alcohol programs.

In both of the TC programs that we observed, the same counselors that provided intensive residential treatment to TC inmates were also expected to provide education and outpatient programming to

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and alcohol program surveys). No standardized assessment procedures currently exist, and even more different assessment instruments or techniques are used at other institutions.

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large numbers of inmates in the general population (at least 100 - 200 at any given time). In addition to the direct provision of drug treatment services, DATS typically have non-treatment related responsibilities, including general inmate case management and counseling, staff training, and participation in special functions, such as emergency response teams. This state of affairs is by design. When the DATS job class was developed in the early 1990's, there was concern on the part of corrections officials that these treatment personnel be seen as integral to the larger institutional workplace. This entailed giving them some duties that allowed them to contribute to institutional missions that were not directly related to drug treatment. Such cross-functionality is seen as desirable in many correctional settings. While these extra duties do afford opportunities for the integration of treatment specialists into other institutional functions, they do compete for their time and attention, and do have implications for the level of treatment services provided.

Even if DATS had no general population duties (and they do), the inmate/staff ratio for TC would be at least 26:1 at Houtzdale and at least 12:1 at Huntingdon[12]. At other TC programs, staff/inmate ratios for TC were 26:1 (Cresson), 25:1 (Graterford), and 20:1 (Waymart)[13]. However, ***even these estimates are underestimates*** (i.e., these figures don't reflect the additional staff time spent on non-TC duties).

While no national studies of staffing in prison-based TC programs have yet been conducted, and no widely accepted standards for inmate/staff ratios have yet been developed, existing staff ratios are likely too high. According to Dr. George De Leon, Director of the Center for Therapeutic Community Research at National Development Research Institute (NDRI) and perhaps the foremost U.S. expert on prison based TC programs, inmate/staff ratios in community based TC programs average about 13:1 nationally (George De Leon, personal communication, January 24, 2000). Staff resources in prison TC programs vary widely. However, if anything, demands upon counselors in prison TC are greater (e.g., prison D & A staff carry additional administrative, treatment, and institutional duties, in addition to greater demands placed upon them by inmates requesting assistance with referrals to education and work programs, issuance of passes for institutional movement, liaison with parole board, assistance with aftercare planning, and other institutional issues). De Leon recommends a ***maximum inmate/staff ratio of 10:1 for prison TC*** (George De Leon, personal communication, January 24, 2000).

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[12] A fourth DATS was added after the process evaluation data were collected, reducing the estimated inmate/staff ratio at Huntingdon to 9:1. Note, however, that this is still an underestimate because TC staff still have significant, additional general population duties.

[13] Staffing estimates were obtained through our Drug and Alcohol Program Surveys, and verified by inmate population data obtained through our outcome evaluation of TC at five institutions.

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This 10:1 staffing ratio represents a standard towards which prison-based TC's can strive. It is unclear at this point how many prison-based TC's nationwide actually achieve this ratio, and there are obstacles to meeting this ratio. In any prison system, staffing is typically driven by security concerns. The first priority when new positions become available is usually for additional security staff. Security concerns are heightened in response to crises such as escapes, inmate disturbances, and assaults, but also by "get tough" legislation (e.g., determinate sentencing, more restrictive criteria for parole eligibility and revocation) that results in increased needs for inmate housing. As a member of our Steering Committee noted, drug and alcohol treatment needs rarely rise to the same level of urgency as institutional security needs. Moreover, a strong national and state economy has made public sector personnel recruitment somewhat more difficult. Drug treatment programs must compete for staff positions with all other sectors of the correctional system. It is thus a challenge to staff prison TC's according to the standards recommended by experts such as De Leon.

While we have not conducted a formal, comprehensive job analysis of DATS staffing across the 24 DOC institutions, we fully agree with De Leon that understaffing can impair the proper implementation of the TC philosophy and weaken expected program impacts (De Leon, 2000). Staffing deficits can compromise the quality of all programming efforts (e.g., little individualized treatment planning or counseling-- **see Hun-13-1-3**), lower staff morale, and potentially increase staff turnover. Understaffing also leads to inadequate monitoring of inmate behavior, particularly after D & A staff go home at the end of the day: "There must be a continuous (i.e., 24-hour) atmosphere of constructive confrontation and feedback to individuals and the community as a whole, in order to raise personal awareness of the individual's behavior and attitudes (ONDCP, 1999, Appendix B:3)." There are two options: (1) Either staffing levels need to rise to the levels required by current D & A program offerings, or (2) current programming priorities (e.g., D & A educational programs) need to be carefully reexamined.

According to *The Prison Based TC Standards Development Project* (ONDCP, 1999, Revised Prison Standards, p. 6), the following additional standards apply to staffing resources:

> AD10. The program has sufficient financial support and resources to maintain the integrity and autonomy of the therapeutic community process while insuring safe integration into the prison population.

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TC7. Staff counselors meet individually with program participants on at least a twice-monthly basis.

Recommendation #4: Ensure that all prison-based drug treatment staff have the opportunity to advance their training and education to remain current with the latest standards in the addictions counseling field.

All DATS exceeded minimum job requirements as specified by the Commonwealth of Pennsylvania, State Civil Service Commission.[14] As noted earlier in this report (see pp. 28-31), researchers were generally impressed with the level of expertise among treatment staff and the quality of therapeutic relationships with inmates. At the same time, prison TC standards clearly specify that programs should be staffed by highly trained and experienced clinical staff (De Leon, 2000). Only minor concerns about these particular issues surfaced at one of the two institutions examined via process evaluation, but similar issues may exist to an unknown degree across different program types and across DOC institutions. For example, some inmates claimed that staff "hadn't been where they [inmates] have been," that "they don't know what life on the street is like," and so forth [see **Htz-19-1-3, Htz-20-1-3**]. Several (not all) program observations indicated some degree of staff inexperience and discomfort in relating to inmates, and occasional lack of clarity in explaining treatment concepts [e.g., **see Htz-60-1-1, Htz-66-1-1, Htz-72-1-1**].

Professional standards for prison TC also recommend that clinical staff include substance abusers in recovery, preferably with a thorough knowledge of TC theory and method (ONDCP, 1999). In practice, it may be difficult to recruit or hire counselors that are in recovery. The American Disabilities Act prohibits asking prospective employees questions about whether they are in recovery or how long they have been clean.

De Leon (2000) also highly recommends cross-trained TC and correctional officers (De Leon, 2000). It is not sufficient to have a unit CO who *tolerates* the concept of drug treatment; it is essential to have a CO who thoroughly *understands* the TC philosophy and how treatment and security issues may conflict. Where, for example, many TC inmates perceive that they are treated unfairly by the unit CO (e.g., being called "crack heads"), or that they are punished frequently and severely for minor infractions (or punished twice for the same infraction), such events can have a negative impact on treatment outcomes

[14] Available at http://www.scsc.state.pa.us/announcements/74396.htm

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[e.g., see **Htz-25-2-3, Htz-26-2-3**]. The large number of complaints voiced by inmates at one TC suggests that these issues bear scrutiny. The appropriate selection and training of correctional officers who are willing to work within a TC environment can be critical to the success of the program (De Leon, 2000).

According to *The Prison Based TC Standards Development Project* (ONDCP, 1999, Revised Prison Standards, p. 13), minimal standards applicable to staffing include the following nine. Based upon programming gaps indicated by our research, we recommend that correctional agencies examine the degree to which these standards are used within TC programs.

> S1. The clinical staff includes recovering addicts and/or ex-offenders, preferably graduates from a TC, who act as positive recovering role models.
>
> S2. Staff who are not in personal recovery are fully integrated into the TC concept and act as role models.
>
> S4. There is a TC staff orientation program consisting of at least 30 hours of didactic and experiential (e.g., immersion) training required for all employees, and an ongoing schedule of in-service and TC-0specific training activities.
>
> S5. Key administration officials from the contract agency and from the public agency and institution receive a minimum of 15 hours of TC-specific training, including both didactic and experiential.
>
> S6. Clinical staff are appropriately certified as may be required by state regulations, and all staff are encouraged to obtain TCA certification.
>
> S7. TC and security staff receive cross-training, i.e., TC staff receive security training from the public agency and security staff receive TC-specific training through a qualified provider.
>
> S8. All clinical staff receive at least 2 hours of individual and 6 hours of group clinical supervision per month.
>
> CP3. Both TC staff and security staff are seen as members of the community, with different roles and responsibilities.
>
> CP7. The locus of control is shared between staff and program participants. However, the staff maintains ultimate authority, and applies it in a rational manner.

Recommendation #5: Treatment staff in each program should have a clear, shared understanding of the program's goals, objectives, and structure (e.g., treatment approach and content). Correctional agencies should develop a treatment program rating system that adequately reflects variations in the intensity level of drug and alcohol programs offered to inmates at each institution.

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Written policies and procedures for specific programs should in some cases be more clear or complete, and greater staff consensus about a given program's goals, objectives and structure should be fostered. While such weaknesses were certainly more characteristic of education and outpatient programs than TC, some gaps in written policies were noted for all program types. D & A treatment staff would benefit greatly from increased staff development time allocated toward discussing these and other concerns related to their work. It is difficult to undertake reflection or discussion about program goals, design, or planning when staff are overwhelmed with programmatic and administrative duties.

Program intensity, quality, and inmate engagement in treatment varied across program types (as illustrated by findings from the Drug and Alcohol Program Census). Inadequate distinctions about treatment intensity were made between different programs. Some unknown proportion of high need inmates were placed in low intensity programs, and some low need inmates were placed in high intensity programs. Correctional agencies should develop a treatment program rating system that adequately reflects variations in the intensity level of drug and alcohol programs offered to inmates at each institution. Such a system would greatly improve appropriate program placement decisions. Such a system would also facilitate improved communication with Parole personnel, Correctional Counselors, and various correctional personnel (e.g., Inmate Program Managers, Unit Managers) who participate in prescriptive program planning and/or vote sheets on program placement and parole decisions.

According to *The Prison Based TC Standards Development Project* (ONDCP, 1999, Revised Prison Standards, p. 13), "It is essential that programs operating as TC's have a solid grounding in the existing literature which describes the TC (history), theory and treatment model" (ONDCP, 1999, Appendix B:2). Minimal standards applicable to program goals, objectives, and structure include the following:

> AD1. The agency maintains written administrative policies and procedures that are known to the staff, and are updated at least annually.
>
> AD15. The entire staff meets and communicates regularly in order to address clinical issues and to assess the functioning of the TC process.
>
> A2. The agency has a written quality assurance plan that insures that corrective action takes place in a timely fashion.

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T1. The program has a package of written orientation materials that includes a statement of program philosophy that is consistent with the TC perspective.

T3. The program handbook or manual should provide an explicit and comprehensive perspective on the substance abuse disorder. Substance abuse and criminality are seen as symptomatic behavioral problems that are secondary to the disorder of the whole person.

T8. TC prison programs should have a clearly defined, written glossary of program terminology based upon general TC and program-specific sources that is given to participants upon entry, as well as to clinical and security staff at onset of employment.

Recommendation #6: Review and revise procedures for "pull-ups" within prison-based TC programs.

Pull-ups were a considerable source of inmate frustration and resentment [e.g., see **Htz-16-1-3, Htz-24-2-3, Htz-25-2-3, Htz-26-2-3, Htz-27-2-3, Htz-37-3-3, Hun 38-3-3**]. The basic process was intended to foster a sense of community, encourage inmates to take collective responsibility for appropriate behavior on the unit, and to stay focused on recovery. When an inmate violates a rule or behaves poorly, another inmate may write up a "pull-up" or "helping measure" which is submitted to an inmate committee for review. Once or twice a week, the inmate committee (under the supervision of TC staff) reviews all pull-ups submitted, summons the "offender" to appear and discuss the incident, and may choose to issue appropriate warnings or sanctions. Some portion of frustration expressed by inmates in our sample might legitimately be construed as inmate denial and resistance to change; some portion was probably related to the manner in which such activities were conducted (e.g., see **Hun-81-1-1**). There is, without question, considerable variability in how these activities are conducted in different programs at different institutions. Even different staff at the same institution occasionally evidenced different styles in how they supervised this process. Such activities may benefit from (a) better inmate training, (b) better staff supervision, (c) more consistent procedures and sanctions, (d) less attention to trivial behaviors.

According to *The Prison Based TC Standards Development Project* (ONDCP, 1999, Revised Prison Standards, p. 6), the following standards apply to TC rewards and punishments:

CP2. The prevailing moral imperative is "I am my brother's keeper" as opposed to the prevailing prison culture attitude.

CP4. Participants are aware of each other's treatment goals and objectives and help others to achieve personal growth toward their goals.

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CP6. Participants are accountable to each other and the community on a continuous basis, fostering a strong sense of responsibility for staff and others.

CP13. Positive feedback such as encouragement is provided more frequently than negative feedback.

TP1. To strengthen trust in the program, the staff guide program participants to use the community process.

TP5. Much of the actual help received by program participants is through informal interactions between program participants in the course of daily activities.

TP7. The prevailing mode of interaction is positive peer pressure, including confrontation and supportive feedback aimed at changing negative behavior and attitudes.

ST6. The primary treatment stage emphasizes full use of positive reinforcement of positive privilege and status level systems.

CM1. There are written behavioral norms which govern participant behavior.

CM2. Graduated sanctions for violation of rules are well defined, and known by all program participants.

CM3. Participants are involved in handing out behavioral consequences and earned privileges to the extent possible, under staff supervision.

CM4. There are clearly defined privileges, e.g., status advancement, more desirable living space, which are earned based upon clinical progress.

CM6. Negative behaviors and attitudes are confronted immediately and directly by peers. This practice is seen as acceptable to the community, is reinforced by it, and acts to neutralize prison culture attitudes.

CM7. Critical feedback is directed at negative behavior and attitudes, not at the individual's character.

Recommendation #7: Physical plant problems that potentially influence treatment process and outcome of prison-based drug treatment programs should be addressed.

The treatment setting is one of many variables that significantly affect an inmate's perception of correctional treatment and his/her reaction to it (e.g., Andrews et al., 1990). A pleasant, well-maintained treatment setting sends a message that the institution (and perhaps the Department) cares about inmates

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participating in treatment. Successful correctional treatment programs tend to offer facilities that are clean and bright, if not necessarily palatial.

According to *The Prison Based TC Standards Development Project* (ONDCP, 1999, Revised Prison Standards, p. 13), "The environment should support the primary identification of program participants with the TC culture in contrast with the prison culture (ONDCP, 1999, Appendix B:8). Further, "The atmosphere within the TC facility should be one of safety, identification and caring . . . It is important that the physical space reflect the care and concern which program participants in the TC demonstrate toward each other. When something is broken it should be fixed immediately (ONDCP, 1999, Appendix B:8)." Minimal standards applicable to the facility/environment include the following:

> FE1. To the extent possible the program should be a self-contained environment within the larger prison setting. The treatment program is situated in special housing and space and there is minimal mixing of the treatment participants with the population in the recreational yard or at mealtimes.
>
> FE2. The facility meets all applicable fire/safety and building codes, and local, state and federal regulations, including licensing requirements, as may be required.
>
> FE3. The facility is clean, safe and adequate in space to meet the needs of the TC program.
>
> FE4. Throughout the TC space, there are highly visible signs, slogans and symbols indicating a common philosophy, purpose and identification.
>
> FE5. Larger TC programs are subdivided into units no larger than [50 - 75].

Matters such as prominent, chronic, overhead plumbing leaks in group meeting rooms should be addressed. Matters such as inability to see or hear other inmates participating in group activities in the large common area of a living unit (as well as lack of privacy) require smaller groups and perhaps additional group meeting space. Residential TC programs should also be segregated from general population to a greater degree than is currently the case [e.g., see **Hun-29-2-3, Hun-35-3-3, Hun-38-3-3**].

Recommendation #8: Correctional agencies should design, implement and update (on an annual basis) a Drug & Alcohol Program Census, in order to create and maintain a current program database.

We need current, reliable, basic information about program structure to better understand how program process (e.g., program duration, treatment approach) influences outcome. Otherwise, program participation becomes a "black box" that defies easy description (Hiller et al., 1999). How can we ever say

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that a "program" (X) produced a specific outcome such as recidivism (Y), if we have no idea what "X" was in the first place (Welsh, 1998; Welsh and Harris, 1999)? How do we know what was actually delivered, or what significant aspects of treatment (which can vary considerably across different institutions) influenced observed outcomes? While designed as part of the demonstration research project for our research partnership, this accounting of program content and structure should become a regular feature of D & A program monitoring and auditing.

In particular, we found that definitions of what constituted a "program" varied considerably across institutions. A list of programs initially supplied to researchers by the Bureau of Inmate Services was used to create a list of D & A Programs to be surveyed at each institution. When presented to D & A Supervisors at each institution, the program lists were often reported to be incomplete, inaccurate, and/or out of date. Further, programs had often been "self-defined" by institutional staff at some point in the past[15]. Thus, determining which programs were even being offered at each institution turned into a considerable subject of discussion between researchers and DATS Supervisors or Managers at each institution. For example, some institutions displayed the habit of listing every single "group" ever offered as a separate "program," rather than listing just ***the program*** itself (e.g., the TC or DATU). Perhaps this was done partially to convince central office that a specific institution runs a large number of "programs." When we asked DATS to complete surveys asking about the structure of specific "programs," however, it was brought to our attention that many of these self-defined "programs" were not programs at all (reporting a large number of "programs" became a disincentive, because it meant completing additional paperwork).

According to Welsh and Harris (1999:6), ***a program*** is "A set of services aimed at achieving specific goals and objectives within specified individuals, groups, organizations or communities." ***Programs consist of a specific set of services delivered to a specific cohort in a specific place or setting.*** A TC or outpatient program that runs dozens of different "groups," then, is one "program," although clearly such comprehensive programs can and should be distinguished from more simple (e.g., D & A educational) programs. Indeed, our survey was designed to detect and record such programmatic differences. Such accounting is vital for program monitoring and evaluation purposes.

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[15] However, many DATS Supervisors could not recall when, how or by whom such program listings were created.

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Recommendation #9: Correctional agencies should develop and establish a computerized, offender-based treatment database, and develop overall information system capacities regarding offender program participation.

Basic information on offender participation in programs is vital for program monitoring, management and evaluation: "*Monitoring* provides essential, continuous information that can be used to satisfy accountability requirements, improve program services or policy implementation on a regular basis, and move toward desired outcomes" (Welsh and Harris, 1999:171). For example, all programs need to record some basic information for accountability purposes, such as weekly attendance at group counseling sessions in a substance abuse program. Without accessible, reliable records of inmate participation in D & A treatment, evaluation efforts will prove difficult: "Thorough monitoring should precede and accompany any valid evaluation of a program or policy" (Welsh and Harris, 1999: 171). Monitoring requires collecting information.

Information Systems refer to on-going methods of collecting data about clients, staff, and program activities. Information systems may consist of written forms and records, or fully computerized data entry and storage systems. A good information system serves several purposes. First and foremost, a good information system can demonstrate accountability to funding agents, the community, and other stakeholders who may provide either critical support or resistance. A good information system is also useful for planning: it allows program managers or policy makers to see how well current plans are going, identify problems, and make adjustments. A useful information system allows for continuous monitoring over time: it is sensitive to both intended and unintended changes in program or policy design. Sad to say, collecting and reporting such information usually means more work for program and/or agency staff, on top of their existing duties. Such information is indispensable, however, and no program or agency can survive or grow without it (Welsh and Harris, 1999).

From their work with numerous criminal justice agencies, Welsh and Harris (1999) report that agency executives and program supervisors do not always adequately communicate or emphasize the importance of information reporting requirements. Further, staff who have been assigned the responsibility for collecting monitoring data often lack the training, skills, and time needed to fulfill such tasks. These are not excuses, however (Welsh and Harris, 1999:168): "The program manager or director bears full responsibility to make sure that certain information is recorded consistently and accurately. Expect that

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stakeholders will want regular reports on the numbers and characteristics of clients served, their level of need, their progress and participation in the program, and, eventually, their outcomes."

Correctional agencies do not always do a stellar job of collecting core data elements. A recent report by the U.S. Department of Justice (1998) assessed the current status of offender-based information systems in corrections and identified information needs and obstacles. Correctional administrators across the U.S. stated that they often lacked the basic information needed to formulate new policies or to defend existing practices. Researchers highlighted the difficulties of conducting comparative studies in the absence of basic agreement on data concepts and definitions, and diversity in the quality and coverage of data elements in correctional information systems.

In response, the Corrections Program Office, Bureau of Justice Statistics, and the National Institute of Justice sponsored a project to conduct an assessment of more than 200 data elements in State and Federal corrections information systems. Its purpose was to provide a basis for improving the quality of corrections data, enhancing electronic sharing of information, and improving the capacity of corrections departments to provide comparable data for corrections performance measures, and for cross-jurisdictional research. Questions were posed in two structured questionnaires and a telephone interview. During January 1998, questionnaires were mailed to information officers in 50 State departments of corrections, the District of Columbia and the Federal Bureau of Prisons. Fifty-one of the 52 departments responded to all three inquiries.

Assessments of correctional information system capacities were based upon the following concepts (U.S. Department of Justice, 1998). "High Availability" means that an information system has a data element in electronic form for more than 75% of offenders. This high percentage indicates extensive coverage on a given data element. The electronic form indicates the data potentially can be extracted, linked, and easily shared electronically. "Medium Availability" means that an information system has a data element in electronic form but for less than 75% of offenders. The scope of coverage is also less. "Low Availability" means that a data element is available only in paper form. Data elements available in low-availability form cannot be extracted, linked, and shared electronically. For the purposes of using offender-based data elements to generate statistical information, low-availability data elements present large obstacles for departments' capacities. "No Availability" indicates that a department does not collect a given data element in any form.

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The Inventory included questions about 207 offender-based data items organized into 4 stages of corrections processing:

> Stage 1, Profiling And Describing Offenders, contains dimensions that describe offenders' demographic characteristics, socio-economic status, and family characteristics and living arrangements;
>
> Stage 2, Committing Offenders, contains dimensions that describe offenders' commitment offenses, sentencing information, and assessment and confinement decisions;
>
> Stage 3, Managing Offenders, contains dimensions that describe routine offender management, methods of release from prison, and internal order and security; and
>
> Stage 4, Supervising Offenders, contains dimensions that describe offender behavior after release, and details about new crimes committed and the victims of these crimes.

Since the Stage 3 data elements include data on offender program participation, we confine our discussion to those specific findings and recommendations. Eleven data items were assessed: 1) offender eligibility for program, 2) type of program, 3) reason for program participation, 4) authorization for program, 5) whether it is a regular, ongoing prison program, 6) location of program, 7) program intensity, 8) length of program, 9) date offender began program, 10) date offender ended program, and 11) outcome of program.

As indicated in Chapter 3 of the report (U.S. Department of Justice, 1998: 33-44), correctional departments collect very few data elements on programmatic activities at a high-availability level. A maximum of 28 departments collected any of the eleven data items at a high-availability level. Data elements on *types of programs* were collected by 28 of the departments at a high-availability level. Twenty-eight departments collected data on the *date the offender began the program* at a high-availability level, and 26 departments did so on the *date the offender ended the program*. About half of the departments did not collect any data on *reasons for program participation* or on the *authorization* for the program. In general, departments often collected important data items on offender program participation in paper format only (i.e., "Low Availability").

As the U.S. Department of Justice (1998) report indicates, the "Low Availability" assessment for a given data item indicates that departments do not collect the data element in electronic form. Data elements

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are maintained in paper rather than electronic form for many reasons. Some may not lend themselves to easy transcription and entry into computers. Others may be highly confidential. Still others may be used intermittently in decision making about individual offenders. Important data elements may also be stored in paper form because of information system deficiencies. Departments may not consider the data element among those crucial for day-to-day management or for use in regular reports. But this does not imply that a data element is unimportant to these departments, or even that it is less important than a data element maintained in high-availability form. For example, parole decisions are often based on correctional information that is maintained in a low availability form (e.g., correctional staff judgments of the offender's participation in educational, treatment, and work programs).

At least maintaining data elements in paper form indicates that they do exist in a given corrections information system. This means that the system has developed rules and procedures for defining, collecting, and maintaining the data element—putting that system at a distinct advantage over other systems that do not maintain it in any form. In the case of "No Availability" data elements, departments have not even defined the element, let alone established rules and procedures for collecting and maintaining it. The "No Availability" format reflects the judgment that the system in question does not use the data element for making corrections processing or management decisions.

At the time of our study, DOC data on offender program participation fell into either the *Low Availability* or *No Availability* categories. While some *program* data (e.g., type of programs) was available in Low Availability format (see recommendation #8), little data on *offender* program participation was collected in any consistent format across institutions. For example, it was impractical or impossible for D & A staff to discover whether (or when) any given inmate previously participated in any prior D & A education, outpatient, or treatment program within DOC, whether the inmate successfully completed the program or not, and whether the inmate participated actively in treatment. As we also discovered from the early stages of our outcome evaluation of D & A programming, it was difficult for D & A staff to gather and report basic inmate intake and discharge data for D & A programs at their institutions (e.g., date of program admission, date of discharge, reason for discharge, successful or unsuccessful discharge). No standardized record keeping system existed for collecting or reporting this information, and in many cases treatment staff must search through inmate call sheets, security memos, or other diverse paper sources to discover such information. Information reported under these conditions is invariably incomplete and inconsistent, constituting a serious information gap for program evaluation.

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To address this recommendation, DOC is working further to develop an ***Offender-Based Treatment Database*** and improve its existing information system capacities related to offender program participation. At a minimum, a useful treatment database would contain basic information about all inmates admitted into any D & A program within DOC, including an inmate's name and number, date of program admission and discharge and reason for discharge. It must be emphasized that ***such information is a necessity, not a luxury, for any state correctional agency that wishes to effectively monitor and evaluate its offender programs*** (U.S. Department of Justice, 1998). At least three basic steps would be involved in creating an offender-based D & A database:

> Step 1: *Initial identification of Inmates in Drug and Alcohol Programs*. Assigned staff at each institution would need to prepare a list of all D & A program participants as of a given date. For each program, staff would list inmate name and number, name and type of program entered, and date of program admission. This information would be computerized into a DOC database accessible via one or more institutional computer terminals.
>
> Step 2: *Monthly identification of new D & A admissions and discharges*. For each program, assigned staff would need to collect and enter new data on a monthly basis, including inmate name and number, name and type of program, date of program admission or date of discharge, and reason for discharge (e.g., successful or unsuccessful discharge).
>
> Step 3: *With data obtained from steps 1 and 2, additional offender information can be then extracted from other DOC databases and merged with the treatment database*. For each inmate listed, agency staff would extract the following data items from DOC centralized databases: PACSI (drug abuse severity) score, institutional violence history, offense severity (current), offense severity (prior), minimum release date, and age.

A database with these minimal characteristics would provide critical information for program monitoring and evaluation. For example, program admission decisions could be better informed by information about the inmate's previous participation in DOC-provided D & A treatment, as well as the inmate's assessed need for treatment (PACSI) and other program eligibility criteria (e.g., type of offense, minimum release data). The same data are vital for setting up valid comparison groups for outcome evaluation (e.g., matching designs).

Naturally, requisite staff resources must be specifically assigned to accomplish these objectives: "The risk of not taking such "mundane" considerations seriously is the potential death of the program or policy when those funding it or authorizing it lose faith in it (Welsh and Harris, 1999:168)." Where agency

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and institutional capacity to report such information is weak, staff will also feel burdened when asked to produce information required for program monitoring and evaluation.

According to *The Prison Based TC Standards Development Project* (ONDCP, 1999, Appendix B), the following standards apply to ongoing data collection for prison TC programs:

> AD6. The agency is committed to documenting the effectiveness of treatment through the identification of, and collection of data on, relevant outcome indicators.
>
> AD7. The agency maintains clinical records in a manner which meets regulatory requirements, but also facilitates clinical work.

Systemic Issues and Policies In Need of Review

Recommendation #1: The mission of drug and alcohol education and outpatient treatment programs within the full spectrum of D & A programming offered by correctional agencies deserves careful consideration and review.

Little impact is to be expected from education and outpatient programs that offer no more than ten to twelve hours of group programming. According to NIDA (1999:16), "... research has shown unequivocally that good outcomes are contingent on adequate lengths of treatment. Generally, for residential or outpatient treatment, participation for less than 90 days is of limited or no effectiveness, and treatments lasting significantly longer often are indicated." The provision of short-term programs, however, may serve three other purposes: (1) to recruit inmates who may be motivated and capable of benefiting from participation in more intensive treatment, (2) to raise inmate awareness and engagement as the first phase of more intensive treatment, and (3) to occupy inmates in some constructive activity for a limited time. As stand-alone programs, however, short-term education and outpatient programs have little value.

Recommendation #2. Correctional agencies could profitably examine and address sources of treatment staff morale and job satisfaction (e.g., perceived supports v. obstacles; perception of reward structures).

Our interviews with DATS staff, supported by written comments on the ***D & A Program Survey*** and feedback obtained from DATS personnel at the ***1-day D & A Symposium*** held in June, 1999,

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suggested somewhat low levels of D & A staff morale. Several excellent survey instruments are available for assessing staff perceptions of organizational climate, job satisfaction, stress, and so on, including the *Prison Social Climate Survey* (PSCS) developed by William Saylor and his colleagues at the federal Bureau of Prisons (see, for example, Camp, Saylor, and Harer, 1997; Saylor and Wright, 1992; Wright, Saylor, Gilman, and Camp, 1997). The Work Environment section of the survey (one of four sections) contains scales that assess institutional commitment, job satisfaction, and efficacy in dealing with inmates, job-related stress, participation in decision-making, and job autonomy.

Recommendation #3. Correctional agencies should conduct research to learn more about what aftercare treatment options are available to D & A program graduates, what resources are required by released offenders, and the level and quality of participation in aftercare.

A program database of aftercare containing basic information about aftercare treatment options would be invaluable. Research should examine the entire range of aftercare options available to DOC inmates, and gradually build information about aftercare program participation and graduation into program evaluation studies.

According to *The Prison Based TC Standards Development Project* (ONDCP, 1999, Revised Prison Standards, p. 6), the following standards apply to TC aftercare:

ST11. The provider agency maintains qualified service agreements with a network of community-based aftercare resources.

ST12. The program maintains positive relations with community corrections and justice agencies responsible for follow-up treatment and aftercare services in the community.

ST13. The program initiates joint discharge planning with parole and/or other community supervision staff at least 90-120 days prior to a participant's release date.

Recommendation #4. Correctional agencies should consider training and using inmates as peer facilitators to assist in specific aspects of treatment programming.

Such efforts, if properly supported with required staff positions and adequate resources for inmate training, development, and supervision, can provide constructive treatment tasks for inmates as well as

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valuable assistance for treatment programming (De Leon, 2000). For example, one program at Houtzdale makes use of advanced TC participants as guest speakers to inmates in the Youthful Adult Offenders Unit (YAOU). TC programs at both institutions make use of more experienced TC participants acting as "big brothers" to help orientate and mentor newcomers to the TC. Inmate committees supervise "pull-up" procedures in TC at both institutions. At both institutions, 12-step programs (NA, AA) further encourage inmates to develop self-responsibility and leadership skills (e.g., chairing meetings). Indeed, the TC concept as adapted to prison-based D & A treatment assumes that recovering addicts play a significant role in the treatment process (Inciardi, 1995; Inciardi et al., 1992; Lipton, 1995; Lipton, Falkin and Wexler, 1992; National Center on Addiction and Substance Abuse, 1998; National Institute on Drug Abuse; 1981; Office of National Drug Control Policy, 1996; 1999). Given proper attention to legitimate security and training concerns (e.g., screening out inmates with personality disorders), further efforts that utilize experienced TC inmates in specific and focused aspects of treatment delivery could be productively cultivated in the TC as well as other program types.

VII. Impacts of Research on Drug Treatment Policies

DOC has reviewed its tools for screening and assessing the substance abuse problems and needs of inmates, as well as procedures for placing them into programs. The process evaluation pointed out the importance of placing the right inmates into the right program(s) for the right reasons, and recommended a more structured approach to inmate screening and assessment. DOC reviewed the drug and alcohol screening instrument (the PACSI) developed and validated in-house and used within the department during the 1990's. They concluded that the Drug Screen produced by Texas Christian University (TCU), which was used in the subsequent outcome evaluation being conducted by Temple University, would better suit their needs. The department replaced the PACSI with the TCU Drug Screen in January of 2001.[5] The process evaluation also revealed that variegated batteries of clinical instruments were being administered across institutions (mainly to TC inmates), but only *after* an inmate was admitted to a program. Although these assessments take some time to administer, they seemed to have little observable influence on individualized treatment planning. A more comprehensive review of assessment options, including other TCU instruments such as the Initial Assessment Form (Simpson, 1994; Simpson and Knight, 1998) is presently under way. The objective is to ensure that inmates enter programs that best meet their needs, level of risk and readiness for change.

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The findings of variation and fragmentation in the implementation and operation of drug treatment programs reinforced the need for standardized procedures for providing all types of treatment to inmates across all institutions. Researchers recommended that DOC develop a program rating system that adequately reflects variations in the intensity level of drug and alcohol programs offered to inmates at each institution. For example, written policies and procedures for different types of programs needed to be more clear, complete and consistent across institutions. Process evaluation findings contributed significantly to an overall program standardization effort that has been underway in the department for the past several years. The committee overseeing the standardization effort has reviewed the process evaluation report and has utilized its conclusions and recommendations in its own planning efforts (Pennsylvania Department of Corrections, 2001). Standardization will promote more consistent delivery of AOD services across different institutions.

The process evaluation identified gaps in automated treatment information available to the department. While participation and progress in treatment programs is documented in individual inmate files, there is no comprehensive, centralized treatment database for the department. This has hampered evaluation efforts. Basic information on offender participation in programs is vital for program monitoring, management and evaluation. At a minimum, a useful AOD treatment database would include an inmate's name and number; date of each AOD program admission and discharge; name, location and type of program; and reason for discharge (e.g., successful v. unsuccessful). Such information is a necessity for any state correctional agency that wishes to effectively monitor and evaluate its offender programs. The department is presently working with a contractor to build a treatment database into an existing inmate management information system.

Researchers presented recommendations regarding several other issues, such as space resources available to drug treatment programs, staffing patterns, aftercare options and procedures for managing inmate interactions within the TC's. The department is seriously reviewing these recommendations and attempting to use this information to inform future program plans. For example, the treatment setting is one of many variables that significantly affect an inmate's perception of correctional treatment and his/her reaction to it: "The atmosphere within the TC facility should be one of safety, identification and caring . . . It is important that the physical space reflect the care and concern which program participants in the TC demonstrate toward each other. When something is broken it should be fixed immediately (ONDCP, 1999, Appendix B:8)." Equally important, understaffing may compromise the quality of AOD programming

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efforts (e.g., little individualized treatment planning or counseling), lower staff morale, and potentially increase staff turnover. Either staffing levels need to rise to the levels required by current AOD program offerings, or current programming priorities (e.g., educational programs) need to be reexamined.

Aside from several Community Corrections Centers (CCCs) operated by the state, aftercare treatment for released inmates in Pennsylvania is supplied by many diverse private providers. Little information about the structure and content of such programs is available. A program database containing basic information about aftercare treatment options would be invaluable. Research should examine the entire range of aftercare options available to DOC inmates, and gradually build information about aftercare program participation and graduation into program evaluation studies. Recommendations regarding aftercare for inmates completing treatment programs are under review, and new program offerings are being developed.

Research results and products were also intended to provide DOC with useful information for program management and monitoring. As a result of the drug treatment program survey conducted across 24 institutions, this partnership has produced a comprehensive database of AOD treatment programs within the department. Such information has already proven vital for informing the research design of outcome evaluation efforts (e.g., designing appropriate treatment and comparison groups). We need current, reliable, basic information about program structure to better understand how program process (e.g., program duration, treatment approach) influences outcome. Otherwise, programming is a "black box" that defies easy description. In order to demonstrate that a "program" (X) produces any specific outcome (Y), we must be able to specify what "X" was in the first place.

The partnership and evaluation has enhanced the capacity of the department to identify evaluation needs and to develop plans for meeting those needs. This approach has subsequently been extended to examine a wide range of programming, including educational and vocational training, parenting programs, reentry programs and programs for special populations (e.g. Young Adult Offenders). The department has been able to undertake these projects in cooperation with outside experts and utilizing third party funding, while maintaining control over the direction and utilization of the research. Thus, the capacity of the department to initiate and manage evaluation activities has been enhanced as a result of this partnership. DOC and Temple have now collaborated on four grant proposals, including an outcome evaluation of drug treatment programs at five institutions, a follow-up study tracking post-release outcomes for drug treatment

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participants, and an evaluation of treatment programming at the department's specialized substance abuse facility, SCI-Chester.[6]

VIII. DISCUSSION AND CONCLUSIONS

In the first part of our study, we focused on the development of the research partnership and results from a census of prison-based drug and alcohol programs (e.g., describing similarities and differences in D & A programming provided at different institutions). Four types of D & A programs were examined: education, outpatient treatment, DATU (Drug and Alcohol Treatment Unit), and Therapeutic Community (TC). In several areas (e.g., primary treatment approach), we found high levels of consistency. In other areas (e.g., program duration, intensity, and staffing), there were huge variations across institutions and programs, and some procedures (e.g., criteria driving target selection and program placement decisions) were vague. Specific findings and recommendations were discussed.

In the second part of our study, we focused on providing detailed descriptive assessments of the four types of programming, assessing strengths and weaknesses, and making recommendations for strengthening D & A treatment programming. In addition to the large body of data that informed our process evaluation (nearly 100 staff and inmate interviews, program observations, and case file reviews), our conclusions were informed by the Drug and Alcohol Program Census (N = 118) obtained from 24 DOC institutions, D & A program and policy documents submitted by each institution, and feedback provided by 48 DATS who attended a special 1-day symposium on Drug and Alcohol Programming held in June, 1999. The Bureau of Inmate Services provided further documentation and information on D & A programming and policies.

One major conclusion was that TC programming alone was of sufficient clarity, intensity and duration to warrant full-scale outcome evaluation at this time. Procedures and policies regarding other types of D & A programming (esp. education and outpatient) received careful review. Following summary and discussion of major findings from process evaluation, ten short-term recommendations and four long-term recommendations for review of D & A programming and policies were presented. Impacts of the research on drug treatment policies within DOC were discussed, including implementation of a drug treatment program standardization initiative fueled by the research findings.

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It is unlikely that the strengths and weaknesses in prison-based drug and alcohol programming reported in this paper are unique to Pennsylvania. Process evaluations of prison-based drug and alcohol treatment in other states have reported numerous implementation problems including inadequate numbers of trained and experienced counseling staff and lack of standardized screening, assessment, and selection processes (e.g., Inciardi, Martin, Lockwood, Hooper and Wald, 1992; Martin, Butzin and Inciardi, 1995). While the present study is to some degree a modified replication of previous studies, few studies have attempted the scope and detail described here. In spite of recommendations that evaluators of correctional treatment effects need to more precisely measure and enter programmatic variations as predictors in outcome evaluations (Palmer, 1992, 1995), evaluators rarely do so. Toward this end, we hope that that other states and localities may learn from the research methods, data and conclusions presented here. Through program surveys and process evaluations, we focused on providing detailed descriptive assessments of treatment programming, assessing strengths and weaknesses, and making recommendations for program planning, implementation and evaluation.

In particular, detailed process evaluations (including assessment of programmatic characteristics such as intensity, duration, and treatment approach) should precede and inform any meaningful outcome evaluation of drug treatment effects (Welsh and Harris, 1999). Despite the widespread proliferation of prison-based drug treatment, little research has considered how critical variations in programming may influence treatment outcomes. Results of our program census indicated considerable variability in programming across institutions and program types. We discussed the implications of these findings for program development and evaluation, focusing on how the research has impacted on drug treatment policies within the Department of Corrections. It is equally true, however, that efforts to design, monitor and evaluate prison-based drug treatment programs nationwide must pay more careful attention to mapping critical dimensions of program structure, content and process than has previously been the case (Welsh and Zajac, 2001).

Most prison-based drug treatment programs remain unevaluated and relationships between inmate characteristics, treatment process and outcomes remain only poorly understood (Lipton and Pearson, 1998; NIDA, 1981, 1999). Surprisingly little information is available about variation in the content, structure and process of such programs (e.g., intensity, duration, treatment approaches). As a result, research to date has been somewhat limited, confined mainly to evaluations of prison-based therapeutic community (TC) drug

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treatment programs in a few states (e.g., Knight, Simpson and Hiller, 1999; Martin et al., 1999, Wexler et al., 1999).

Nearly 2 million inmates were incarcerated in U.S. jails and prisons at year-end 2000, a rate of 699 per 100,000 adults (up from 458 in 1990) (Beck and Harrison, 2001). Although estimates of alcohol or other drug dependence among inmate populations vary widely depending upon the type of assessment procedure used, most professionals accept estimates based upon the DSM-IV Structured Clinical Interview (SCID-IV) as among the most reliable (Peters, Greenbaum and Edens, 1998). Administering this instrument to a sample of 400 state prison inmates, Peters and his colleagues estimated lifetime prevalence rates of substance abuse or dependence disorders among 74% of the inmate population. Over half were diagnosed as exhibiting substance abuse or dependence disorders for the 30 days prior to their current incarceration.

About 2 out of 3 inmates admit drug histories, but less than 15% receive any systematic treatment while in prison (Mumola, 1999). In 1997, 9.7% of State prison inmates (101,729) and 9.2% of Federal prison inmates (8,070) reported participation in drug treatment (i.e., residential treatment, professional counseling, detoxification, or use of a maintenance drug) since their admission (Mumola, 1999). Participation in much less intensive drug abuse programs (e.g., self-help, peer group or drug education classes) was more common: 20% of State and 9% of Federal prison inmates reported participation in such programs. According to a recent report by the Substance Abuse and Mental Health Services Administration (SAMHSA) (2000), 40% of all correctional facilities nationwide (federal and state prisons, local jails, and juvenile facilities) provided some sort of on-site substance abuse treatment (i.e., detoxification, group or individual counseling, rehabilitation, and methadone or other pharmaceutical treatment) to inmates in 1997. However, only about 11% of inmates in these institutions received any treatment, most frequently in a general facility population program. Few of these inmates were treated in specialized treatment units (28%) or hospital or psychiatric inpatient units (2%). Given available estimates of treatment need and availability, it is unlikely that even a majority of inmates with serious substance abuse problems receive intensive treatment (Lipton, 1995).

While estimates of inmate need for treatment, program availability and participation in treatment are useful, surprisingly little information is available about the ***variety*** (e.g., intensity, duration and quality) of prison-based drug treatment programs. For example, say that Inmate A receives 6 weeks of group

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counseling consisting of two one-hour sessions per week for a total treatment exposure of 12 hours, while Inmate B completes a one-year, residential drug treatment program consisting of 30 hours of individual and group counseling per week for a total treatment exposure of 1,560 hours. Estimates of inmate participation in treatment and program availability do not adequately distinguish between different programs (and inmates), and program evaluations only rarely account for such critical variations in programming.

Conclusion

A successful research partnership requires investment of time and resources on the part of both a public agency and a university. Active participation by agency personnel with focused expertise and decision-making authority is a necessary but not sufficient condition for success. Strong leadership by key DOC personnel and the formation of mutually rewarding work relationships have likely made the biggest differences to the success of this partnership so far.

The DOC Steering Committee established to oversee this project is committed to using the evaluation findings to inform the design and refinement of drug and alcohol treatment programs throughout the department. The context in which this evaluation has taken place is that of organizational learning (Argyris, 1982). The department, in cooperation with researchers, actively and openly seeks out information about the operations of its programs. This information feeds inquiry and analysis of the strengths, weaknesses and overall effectiveness of these programs. This inquiry and analysis informs plans to address program deficits and build upon program successes. Evaluation of these changes will continue, producing an ongoing cycle of organizational inquiry, learning and change. The ultimate utility of the evaluation exercise will itself be evaluated by the extent to which it has empowered the department to become its own agent of positive change (Zajac and Comfort, 1997).

Research has taken place within an atmosphere of participation and ownership. The Steering Committee includes stakeholders directly involved in providing and managing drug treatment services to inmates, most critically drug treatment staff from the field. Extensive efforts have been made to communicate evaluation findings widely throughout the department, and to solicit feedback from interested parties. All evaluation activities have been reviewed and approved by the committee, with all members invited to critique research plans. During the data collection phase at the institutions, concerns of field staff have been attended to by the committee and by the researchers on-site. To the extent possible, evaluation activities have been integrated into the daily operations of treatment programs. The goal was to have

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evaluation seen not as something foreign, arcane or threatening, but rather as an open and participatory process.

The Pennsylvania Department of Corrections is to be commended for its active participation as partners in this research enterprise and for its willingness to constructively examine its programming for substance-abusing offenders. It is in the spirit of continued cooperation between researchers and correctional professionals, constructive feedback and discussion, and ongoing development of effective programs that we present our experience to others.

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NOTES

[1] Institutional security levels range from community (1) to maximum (5) .
[2] For each inmate in our sample we have coded the exact treatment program start and end dates, the reason for program discharge (e.g., successful v. unsuccessful), date of release from DOC custody, and date of the data run by each of the three participating agencies. We are thus able to calculate not only total exposure to treatment, but the exact amount of "time at risk" for each inmate following release. It will thus be a straightforward task to collapse the reporting of post-release "at-risk" periods into 6-month, 12-month, or 18-month intervals. It will also be possible to examine hazard and survival rates for recidivism.
[3] Description of these instruments is provided by Simpson (1994) and Simpson and Knight (1998). Further documentation and information is available at http://www.ibr.tcu.edu.
[4] Of 1,068 inmates released, 922 (86%) were actually paroled or reparoled.
[5] Up until the end of December 2000, DOC used the *Pennsylvania Department of Corrections Screening Instrument* (PACSI) to determine if an inmate had a problem with substance abuse. The PACSI results in a need for treatment score that ranges from 0 - 10. This screening process was designed to determine who can benefit from treatment and which general category of substance abuse treatment is most suited for each inmate. As of January 1, 2001, DOC is using the well-validated TCU Drug Screen (the same instrument used in the outcome evaluation study) to screen all inmates for D & A treatment needs. Based on DSM-IV diagnostic criteria, the TCU Drug Screen results in a need for treatment score that ranges from 0 - 9.
[6] Prior to submission, each proposal was circulated to Steering Committee Members for review. The TC outcome evaluation proposal was submitted to NIJ and subsequently funded beginning in January of 2000 (Grant #99-CE-VX-0009). The post-release follow-up study, submitted to Pennsylvania Commission on Crime and Delinquency, was funded beginning in October 2001 (subgrant #00-DS-19-11188). The third proposal, an outcome evaluation of drug treatment programs at SCI-Chester, a specialized drug treatment facility, was in preparation at the time this article was written. Gaudenzia, a private provider, provides treatment services while DOC operates all other facets of the correctional facility. SCI-Chester was not included in our original assessment for three reasons: (1) its programs were not provided by DOC staff, (2) its programs' content and structure are different from DOC-provided programs, and (3) a valid evaluation requires a separate research design and sample.

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APPENDICES

Appendix 1. DOC Data Bases and Elements
Appendix 2. Survey of Drug and Alcohol Programs
Appendix 3. D & A Program Survey Results: Tables 1-78
Appendix 4: Process Evaluation Research Instruments
- Observation Checklist Form
- Inmate (Program Participant) Interview Form
- Staff Interview Form
- Inmate Case Files: Observation Guide

Appendix 5: Individual Program Reports: SCI - Houtzdale
- Courage to Change Therapeutic Community (CCTC)
- Substance Abuse Education
- Addictions Education
- Addictions Treatment (Outpatient)
- Relapse Prevention
- Youthful Adult Offenders Unit (YAOU): Substance Abuse Education

Appendix 6: Individual Program Reports: SCI - Huntingdon
- Living Sober Therapeutic Community (LSTC)
- Addictions Treatment (Outpatient)
- Substance Abuse Education
- Addictions Education

Appendix 7: Transcripts Of Inmate And Staff Interviews, Program Observations, And Case File Reviews **(bound separately)**

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Appendix 1. Overview of DOC Databases and Fields Relevant to D&A Evaluation[1]

The following is a summary of key automated databases and elements that are relevant to attempts to evaluate D&A programs. This is not necessarily a comprehensive list of all data available to the DOC. For example, there are other databases that keep track of inmate bed assignments and inmate commissary accounts. Also, some are currently undergoing refinement or redevelopment. Finally, data may not be complete in all cases.

RISP

RISP refers to the DOC ***random inmate selection process*** for drug testing. Such random testing was recently mandated by the federal government. The drug testing data available now are preliminary. The drug testing results database presently contains the following fields.

Inmate number	Name
Race	Counselor (initials)
Custody	Population status
Cell block	Cell number
Date of birth	Date received (in the institution)
Effective date (of the sentence)	Maximum sentence date
Minimum sentence date	Offense
Job description	Test person (initials)
Date picked for test	Date test is scheduled
Time of test	Result date of test
No show (inmate did not show up)	No test
Overall summary	Misconduct (given)
Who recorded results (initials)	Retest date
Retest result	Comment
Test type[2]	

MISCONDUCT DATABASE

The department is developing a master database for all misconduct data. A *misconduct* is an internal sanction applied to an inmate when that inmate violates an institutional rule of some sort. This may result in *disciplinary custody time* for the inmate, which may involve assignment to a *restricted housing unit* for a specified period of time. DOC is currently working to further develop and refine this database.

Active Sanctions Table

Status	Date Served
Inmate Control Number	Sanction Code
Misconduct Number	Signature Date
Signature Time	User ID
Consecutive or Concurrent Sentence	Effective Date
Number of Days	Completion Date (Scheduled)
Actual Completion Date	Sanction Code Description
Sanction was amended	

---

[1] We are grateful to Department of Corrections staff for assembling this information.

[2] A field for the test result for each of the following drug types – Alcohol; amphetamines; barb, benzo, phenal, cann, cocaine, opiate, meth, fenta

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Charges Table

Inmate Control Number
Misconduct Number
Reference Code
Signature Time
Counts
Inmate Pleads Guilty
Verdict Guilty
Verdict Dismissed With Prejudice
Verdict Reduced
Flag

Misconduct Date
Category Charge
Signature Date
User ID
Charge Description
Inmate Pleads Not Guilty
Verdict Not Guilty
Verdict Dismissed Without Prejudice
Was Amended

Misconduct Table

Institution
141 Form
Inmate Control Number
Signature Date
User ID
Report Date
Place Code
Misconduct Hour
Others Involved
Category of Charge 2
Category of Charge 4
Confinement
Confinement Hour
Hearings Held
Inmate Version
Recording Staff List (Name)
Reviewing Staff List (Name)
Inmate Notice Date
Inmate Notice Minute
Hearing After Hour
141 Status
802 Reason
Comments

Misconduct Date
Date Follow-up
Misconduct Number
Signature Time
Institution Description
Place of Misconduct
Place Extended
Misconduct Minute
Category of Charge 1
Category of Charge 3
Category of Charge 5
Confinement Date
Confinement Minute
Witnesses
Recording Staff (Number)
Reviewing Staff (Number)
Date Reviewed
Inmate Notice Hour
Hearing After Date
Hearing After Minute
141 Status Description
802 Reason Description

Hearing Table[3]

Inmate Control Number
Misconduct Number
Sequence Number
Signature Time
Hearing Hour
Examiner Number
Inmate Waivers
Witnesses

Continuance Requested
Hearing Date
Signature Date
User ID
Hearing Minute
Examiner Name
Inmate Waivers Description

[3] There are also tables for the PRC review, event scheduling, appeals and history tables for appeal and misconduct charges.

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INMATE RECORDS SYSTEM

This database provides a general summary of information about all inmates. It contains the following primary elements.

Inmate ID Number
Photo Number
Parole Number
Indictment Number
FBI Number
Social Security Number
State ID Number
Race
Sex
Date of Birth
Place of Birth
Citizenship
Marital Status
Ethnic Group
Sentencing Judge

Legal Address (at arrest or of family)
Next of Kin
Aliases
Sentence Status
Minimum Sentence/Date
Maximum Sentence/Date
Minimum Offense
Maximum Offense
Parole Status
Parole Violator Data
Detainer Data
Escape Time
Commitment Date
Committing County
Current Location

CLASSIFICATION DATA BASE

This database provides information on the results of the classification process that is applied to all inmates upon reception to the system, and again on a periodic basis while in the system (reclassification). Reclassification may also occur after unusual incidents (e.g. a serious misconduct). The classification data base contains the following primary elements.

Classification Date
Reclassify in .....
Severity of Offense
Severity of Criminal History
Escape History
Institutional Adjustment
Number of Prior Commitments
Time to Expected Release
Employed When Committed
Medical Needs
Emotional Needs – How Found
D&A Needs – How Found
D&A Score
Type of Problem
Vocational Needs – How Found
Sexual Problems
Alcohol Problem
Escape Problem
Psychiatric Problem
Drug Problem
Suicide Problem
Assault Problem

Custody Level
Educational Needs – How Found
IQ
Grade Completed
Reading Score
Spelling Score
Arithmetic Score
Institutional Violence
Discipline Report
Work Performance
Housing Performance
Prescriptive Programs

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Appendix 2.

Survey of Drug and Alcohol Programs

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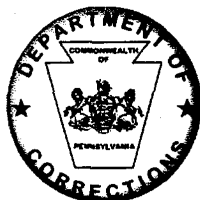
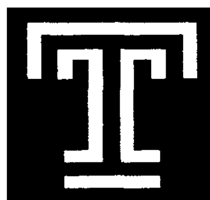
A Survey of Prison-Based Drug and Alcohol Treatment Programs in the Commonwealth of Pennsylvania

Sponsored By: The Research Collaboration Between The Pennsylvania Department of Corrections and The Center for Public Policy At Temple University





This is a survey of D & A treatment programming in Pennsylvania prisons. The purpose is to collect detailed descriptive information about treatment programming in three areas: 1) program content, 2) program staff, and 3) program clients (e.g., eligibility criteria). Survey respondents, like yourself, are Department of Corrections personnel who provide D & A programming at each state institution (excluding privately contracted facilities). Because the survey is *program* specific, it is necessary to complete several surveys at each institution. Programs were identified by the Bureau of Inmate Services, Treatment Division, in consultation with researchers from Temple University.

The information you provide will greatly assist correctional managers and researchers in designing, implementing and tracking the effects of prison-based drug and alcohol treatment. Treatment staff from each institution will also be invited to attend a 1-day meeting, to be held in mid-May, where we will present survey results and discuss elements of effective treatment programming.

Thank you very much for your help.

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Please answer each question. The first few questions identify the program and the person completing this survey.

1. Name of Institution: ________________________________

2. Name of Program: ________________________________

3. Type of Program Setting. Check *one* category that *best* describes this program:

   a. Drug and Alcohol Education Program: _____
   b. Outpatient (Non-Residential) Treatment Program: _____
   c. Drug and Alcohol Treatment Unit (DATU): _____
   d. Therapeutic Community (TC): _____

4. Name of Staff Person Completing This Survey: ________________________

   Phone Number (with area code): ________________________

   Job Title: ________________________________

Now, we'd like to ask you a few questions about the program.

5. How many years has this program has been in operation?

   Please enter number of years: _____

6. Program Duration: what is the normal length of participation in this program?

   Total Number of Weeks: _____

7. How many total hours of programming are provided each week?

   Total number of hours of programming per week: _____

8. *Criteria for program completion*: are participants required to complete a specific number of hours in this program? Circle one:

   a. Yes (go to question #9)
   b. No (go to question #10)

9. If *yes* to Q #8, what is the minimum number of hours required for completion? ____

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If this program is a DATU or a TC, please answer questions #10 and #11. Otherwise, please skip to question #12.

10. Are drug and alcohol program participants completely separated from non-participants 24 hr. per day? (Circle one):

    a. yes (go to question #12)
    b. no (answer question #11)

11. Please estimate the *total number of hours weekly* that program participants spend with non-participants in each activity:

Activity	Hours spent weekly with non-participants
a. housing	
b. meals	
c. yard	
d. school	
e. chapel	
f. work assignments	
g. special events	
h. other (please specify): ____________	

12. *Treatment Approach*: In this program, please rate how much emphasis is placed on each approach (you may assume that commonly accepted definitions apply):

    1 = a primary treatment approach that is used in this program
    2 = a secondary treatment approach that is used in this program
    3 = an approach that is not used at all in this program

	(Circle your answer for each): Primary approach	Secondary approach	Not used at all
a. cognitive therapy..	1	2	3
b. traditional behavior modification	1	2	3
c. cognitive-behavioral approach	1	2	3
d. psychotherapy..	1	2	3
e. rational emotive therapy..................................	1	2	3
f. transactional analysis......................................	1	2	3
g. reality therapy...	1	2	3
h. milieu therapy	1	2	3
i. "dual diagnosis"...	1	2	3

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13. In this program, how *important* are each of the following criteria to determine whether a client has completed the program or not? Please rate each using the following scale:

1 = very important
2 = somewhat important
3 = not very important

	(Circle your answer for each):		
	very important	somewhat important	not very important
a. Drug and Alcohol Knowledge Test	1	2	3
b. Measures of Attitudinal or Behavioral Change.............	1	2	3
c. Case Progress Review by Treatment Staff....................	1	2	3
d. Other (please specify): ______________________	1	2	3

14. How important are each of these criteria to determine an ***unsuccessful discharge from this** program*? Please rate each item using the following scale:

1 = very important
2 = somewhat important
3 = not very important

	(Circle your answer for each):		
	very important	somewhat important	not very important
a. Violation of Program Rules...	1	2	3
b. Violation of Institutional Rules....................................	1	2	3
c. Security Concerns...	1	2	3
d. Failure to Pass a D & A Knowledge Test....................	1	2	3
e. Inadequate Attitudinal or Behavioral Change.............	1	2	3
f. Not Attending Required Number of Sessions	1	2	3
g. Failure to Complete Required Assignments	1	2	3
h. Inappropriate Classroom or Session Behavior	1	2	3
i. Case Progress Review by Treatment Staff...................	1	2	3
j. Other (please specify): ______________________	1	2	3

15. How are policies *for this program* communicated to *staff*? (Check all that apply):

a. a written policy manual for staff (please attach) : _____
b. structured lesson plans: _____
c. verbal orientation: _____
d. other (please specify): ______________________________

16. How are policies *for this program* communicated to *inmates?* (Check all that apply):

a. a written policy manual for inmates (please attach) : _____
b. instructions in consent to treatment form: _____
c. verbal orientation: _____
d. other (please specify): ______________________________

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17. *Program Records*: Which of the following types of client records are kept for this program? Please rate each item below using the following scale:

1 = written records
2 = computer records
3 = no formal records kept

	(Circle your answer for each):		
	written records	**computer records**	**no formal records kept**
a. Inmate Attendance at Sessions	1	2	3
b. Quality of Participation at Treatment Sessions ...	1	2	3
c Case Notes on Individual Clients	1	2	3
d. Reason for Early Termination	1	2	3
e. Discharge Summary	1	2	3
f. Treatment Consent Form	1	2	3
g. Records of Previous Treatment in PA-DOC	1	2	3
h. Records of Previous Treatment Elsewhere	1	2	3
i. Drug and Alcohol Individualized Treatment Plans	1	2	3
j. Inmate Correspondence Related to Treatment	1	2	3
k. Aftercare Plan	1	2	3
l. Follow-up Information (if applicable)	1	2	3
m. Other (please specify): ____________	1	2	3
n. Other (please specify): ____________	1	2	3

18. *Treatment Format*: Please estimate the ***percentage of time (0 - 100%)*** that each of the following treatment formats are used during the entire course of this program:

Treatment Format	**Percentage of Time (overall):**
a. lecture by DATS or other professional	
b. film or video	
c. workbook or written assignments	
d. instructor-led group discussion	
e. peer-led group discussion	
f. individual counseling sessions	
g. group counseling sessions	
h. other (please specify) ____________	

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19. *Program Content* (topics): ***How much time*** in this program is spent addressing each of the following topics? Please rate each item (1, 2, 3, or 4) using the following scale:

1 = a great deal of time
2 = moderate amount of time
3 = very little time
4 = no time

	(Circle your answer for each):			
	A Great Deal Of Time	**Moderate Amount Of Time**	**Very Little Time**	**No Time**
a. AIDS/Infectious Diseases	1	2	3	4
b. Models Of Addiction	1	2	3	4
c. Working Steps to Recovery	1	2	3	4
d. Impacts Of Drug Use	1	2	3	4
e. Family Issues	1	2	3	4
f. Job Issues	1	2	3	4
g. Lifeskills	1	2	3	4
h. Problem Solving Skills	1	2	3	4
i. Obstacles to Treatment	1	2	3	4
j. Thinking Errors	1	2	3	4
k. Problem Solving Skills	1	2	3	4
l. Social Skills/Communication Skills	1	2	3	4
m. Interpersonal Relationships	1	2	3	4
n. Self Esteem	1	2	3	4
o. Anger/Temper Control	1	2	3	4
p. Assertiveness Training	1	2	3	4
q. Stress Management	1	2	3	4
r. Criminality/Antisocial Attitudes	1	2	3	4
s. Antisocial Peer Associations	1	2	3	4
t. Focus On Harm Done To Victim	1	2	3	4
u. Relapse Prevention	1	2	3	4
v. Addiction and Spirituality	1	2	3	4
w. Pharmacology	1	2	3	4
x. Other (please specify) ____________	1	2	3	4

20. Which q*uality assurance methods* are used *for this program*? (Check all that apply):

a. case file review: _____
b. clinical supervision during live or taped sessions: _____
c. client feedback: _____
d. client satisfaction survey: _____
e. central office audit: _____
f. other (describe briefly): ____________________________

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Next, we'd like to ask a few general questions about the *clients* in this program.

21. *Numbers:* what is the maximum number of clients this program can program serve at one time? (Please enter below):

    Maximum number program can serve: _____

22. *Recruitment:* how do clients become aware of this program? (Check all that apply):

    a. Formal referral: ____
    b. Word of mouth: _____
    c. Staff presentation: _____
    d. Brochures or pamphlets: _____
    e. Other (please specify): _________________________

23. Is there an institutional orientation procedure that provides specific information about the institution's drug and alcohol programs and how to access them? (Circle one):

    a. Yes
    b. No

24. *Intake:* Is an intake interview conducted *for this program*? (Circle one):

    a. Yes
    b. No

25. *Orientation*: During program intake, do inmates receive a program orientation where rules and goals of this program are explained? (Circle one):

    a. Yes
    b. No

26. Does the inmate sign a "consent to treatment" form for this program? (Circle one):

    a. Yes
    b. No

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27. *Screening*: How important are each of the following criteria in making decisions about the client's admission in this program? Please rate each item using the following scale:

1 = very important
2 = somewhat important
3 = not very important

	(Circle your answer for each):		
	very important	somewhat important	not very important
a. inmate's level of motivation	1	2	3
b. level of drug involvement	1	2	3
c. type of offense	1	2	3
d. criminal history	1	2	3
e. amount of time served in current sentence ..	1	2	3
f. absence of medical problems	1	2	3
g. institutional record of drug use	1	2	3
h. institutional record of violence	1	2	3
i. institutional record of other misconducts	1	2	3
j. other (please specify): ________________	1	2	3

28. Are Drug and Alcohol Individualized Treatment Plans developed for each client in this program? (Circle one):

a. Yes
b. No

29. Does this program have general goals for all participants? (Circle one):

a. Yes (If "yes," please attach written program goals)
b. No

30. Case Progress Review: How often do staff conduct a formal case progress review of each participant in this program? (Circle one):

1 = never
2 = weekly
3 = monthly
4 = at discharge only

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31. How often are other disciplines involved in case progress reviews of participants in this program? Please rank the involvement of each using the following scale:

1 = always
2 = usually
3 = occasionally
4 = rarely
5 = never

	(Circle your answer for each):				
	always	**usually**	**occasionally**	**rarely**	**never**
a. psychologist	1	2	3	4	5
b. psychiatrist	1	2	3	4	5
c. clergy	1	2	3	4	5
d. school staff	1	2	3	4	5
e. vocational staff	1	2	3	4	5
f. security	1	2	3	4	5

32. *Client Input (program)*: Do clients in this program have any input into programmatic structure or activities? (Circle one):

a. Yes
b. No

If "yes," please describe briefly:

____

____

33. *Client Input (sanctions)*: Do clients in this program have any input into determining rewards and sanctions (e.g., peer feedback)? (Circle one):

a. Yes
b. No

If "yes," please describe briefly:

____

____

34. What assessment tool, if any, is used to identify client needs/risk in ***this program***? (Describe briefly):

____

____

____

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35. What other methods, if any, are used to assess client needs/risk in this program? (Describe briefly):

____

____

36. Is any re-assessment of client needs/risk done prior to discharge from this program?

a. Yes
b. No

If "yes," please describe briefly:

____

____

37. *Readmission:* are readmissions into this program permitted?

a. Yes (please attach any written rules for readmission)
b. No

Finally, we'd like to ask a few general questions about the *staff* of this program.

38. *Staff Numbers*:

How many **full time agency staff** are assigned to this program? ____
How many **full time contract staff** are assigned to this program? ____
How many **part time agency staff** provide treatment services? ____
How many **part time contract staff** provide treatment services? ____
How many **volunteers** provide treatment services? _____
How many **interns** provide treatment services? _____

39. *Staff/Inmate Ratio for this program*:

a. What is the ***current*** inmate/staff ratio? # of inmates _____: _____ # of staff
b. what is the ***maximum*** inmate/staff ratio? # of inmates _____: _____ # of staff

40. How frequently is the DATS Manager/Supervisor involved in service delivery in this program? (Circle one):

1 = always
2 = usually
3 = occasionally
4 = rarely
5 = never

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41. How frequently is the DATS Manager/Supervisor involved in direct staff supervision in this program? (Circle one):

1 = always
2 = usually
3 = occasionally
4 = rarely
5 = never

42. Please estimate the percentage of time that treatment staff spend on each activity in this program:

	% of staff time (0 - 100%)
a. Direct Treatment or Service	______
b. Clinical Supervision	______
c. Clinical Case Reviews	______
d. Program Planning Activities	______
e. Administrative and Managerial Functions	______
f. DC-14 Maintenance	______
g. Special Duties[1]	______
h. Other (specify): ___________________________	______

43. *Staff Assessment*: are any formal procedures in place to evaluate staff performance in this program? (Circle one):

a. Yes
b. No

If "yes," please describe briefly:

____

____

44. *Staff and Clients*: Is this program, are counselors assigned to work with certain inmates on an individual, one-to-one basis? (Circle one):

a. Yes
b. No

If "yes", on what basis are staff assigned to work with clients? Please describe briefly:

____

____

[1] May include Hostage Negotiation Team, Cultural Programs, Volunteer Committee, etc.)

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45. Is any specialized In-House Drug and Alcohol Training provided for treatment staff in this program? (Circle one):

a. Yes
b. No

If "yes," please describe briefly:

____
____
____

46. *Staff Input*: Do staff in this program have any input into modifying program structure or activities?

a. Yes
b. No

If "yes," please describe briefly:

____
____
____

47. *Job Titles and Qualifications*

For each full time agency position *in this program*, please list experience and training:

Name of Staff Member:	**Job Title:**	**Highest Degree Awarded:**	**Academic Discipline or Major:**	**Specialized Certification, if any:**	**Length Of Employment With DOC:**	**Number Of Years Experience Providing Direct D/A Treatment To Clients:**
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						

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48. *Staff Demographics* (full time agency staff only):

	Number of staff
Number of male staff	______
Number of females	______
Number of Caucasian staff	______
Number of African American staff	______
Number of Native American staff	______
Number of Hispanic staff	______
Number of Asian staff	______
Number of Other staff	______

49. How many treatment staff in this program consider themselves in recovery from their own D & A problem?

Number of staff who consider themselves in recovery: _____

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Is there anything else you would like to tell us about this program? If so, please use this space for that purpose. Also, any comments that you think would help us better understand the issues involved in providing drug and alcohol treatment services to inmates in Pennsylvania prisons would be appreciated.

Your contribution to this effort is greatly appreciated. If you would like a summary of results mailed to you, please indicate by placing a check in the box to the right: ☐

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Appendix 3.

D & A Program Survey Results: Tables 1-78

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Part I. Programming Structure and Content

Table 1. Program Type

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1.00 D & A Education Program	44	37.3	37.3	37.3
	2.00 Outpatient Treatment Program	58	49.2	49.2	86.4
	3.00 DATU (D & A Treatment Unit)	10	8.5	8.5	94.9
	4.00 TC (Therapeutic Community)	6	5.1	5.1	100.0
	Total	118	100.0	100.0	

Table 2. Program Duration and Weekly Hours

PROGTYPE program type		Q6 program duration (total # of weeks)	Q7 hrs. of program each week
1.00 D & A Education Program	Mean	12.3500	2.6512
	N	40	43
	Std. Deviation	5.3997	2.9430
	Minimum	4.00	1.00
	Maximum	32.00	14.00
2.00 Outpatient Treatment Program	Mean	13.3208	3.1754
	N	53	57
	Std. Deviation	7.4415	5.1794
	Minimum	4.00	.00
	Maximum	36.00	28.00
3.00 DATU (D & A Treatment Unit)	Mean	22.2222	8.1000
	N	9	10
	Std. Deviation	13.8363	6.8060
	Minimum	8.00	2.00
	Maximum	52.00	20.00
4.00 TC (Therapeutic Community)	Mean	46.3333	29.5000
	N	6	6
	Std. Deviation	10.1522	11.0045
	Minimum	26.00	15.00
	Maximum	52.00	40.00
Total	Mean	15.5370	4.7672
	N	108	116
	Std. Deviation	10.9471	7.8056
	Minimum	4.00	.00
	Maximum	52.00	40.00

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Table 3. Q8 Are participants required to complete specific # of hrs?

			Q8 are participants required to complete specific # of hrs?		
			.00 no	1.00 yes	Total
PROGTYPE program type	1.00 D & A Education Program	Count	3	41	44
		% within PROGTYPE program type	6.8%	93.2%	100.0%
	2.00 Outpatient Treatment Program	Count	4	51	55
		% within PROGTYPE program type	7.3%	92.7%	100.0%
	3.00 DATU (D & A Treatment Unit)	Count	3	7	10
		% within PROGTYPE program type	30.0%	70.0%	100.0%
	4.00 TC (Therapeutic Community)	Count	6		6
		% within PROGTYPE program type	100.0%		100.0%
Total		Count	16	99	115
		% within PROGTYPE program type	13.9%	86.1%	100.0%

Table 4. Q9 Minimum # of hours required for program completion

PROGTYPE program type	Mean	N	Std. Deviation	Minimum	Maximum
1.00 D & A Education Program	13.9744	39	10.7373	4.00	70.00
2.00 Outpatient Treatment Program	18.4468	47	14.1480	4.00	67.00
3.00 DATU (D & A Treatment Unit)	38.3333	6	39.1850	8.00	109.00
Total	17.8478	92	16.3700	4.00	109.00

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Table 5. Q12A How much emphasis on cognitive therapy?

			Q12A how much emphasis on cognitive therapy			
			1.00 primary treatment	2.00 secondary approach	3.00 not used at all	Total
PROGTYPE program type	1.00 D & A Education Program	Count	16	15	11	42
		% within PROGTYPE program type	38.1%	35.7%	26.2%	100.0%
	2.00 Outpatient Treatment Program	Count	31	23	3	57
		% within PROGTYPE program type	54.4%	40.4%	5.3%	100.0%
	3.00 DATU (D & A Treatment Unit)	Count	5	4	1	10
		% within PROGTYPE program type	50.0%	40.0%	10.0%	100.0%
	4.00 TC (Therapeutic Community)	Count	4	2		6
		% within PROGTYPE program type	66.7%	33.3%		100.0%
Total		Count	56	44	15	115
		% within PROGTYPE program type	48.7%	38.3%	13.0%	100.0%

Table 6. Q12B How much emphasis on traditional behavior modification?

			Q12B how much emphasis on traditional behavior modification			
			1.00 primary approach	2.00 secondary approach	3.00 not used at all	Total
PROGTYPE program type	1.00 D & A Education Program	Count	13	18	13	44
		% within PROGTYPE program type	29.5%	40.9%	29.5%	100.0%
	2.00 Outpatient Treatment Program	Count	4	23	30	57
		% within PROGTYPE program type	7.0%	40.4%	52.6%	100.0%
	3.00 DATU (D & A Treatment Unit)	Count	3	4	3	10
		% within PROGTYPE program type	30.0%	40.0%	30.0%	100.0%
	4.00 TC (Therapeutic Community)	Count	3	2	1	6
		% within PROGTYPE program type	50.0%	33.3%	16.7%	100.0%
Total		Count	23	47	47	117
		% within PROGTYPE program type	19.7%	40.2%	40.2%	100.0%

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Table 7. Q12C How much emphasis on cognitive-behavioral approach?

			Q12C how much emphasis on cognitive-behavioral approach			
			1.00 primary approach	2.00 secondary approach	3.00 not used at all	Total
PROGTYPE program type	1.00 D & A Education Program	Count	19	15	8	42
		% within PROGTYPE program type	45.2%	35.7%	19.0%	100.0%
	2.00 Outpatient Treatment Program	Count	31	20	7	58
		% within PROGTYPE program type	53.4%	34.5%	12.1%	100.0%
	3.00 DATU (D & A Treatment Unit)	Count	6	3	1	10
		% within PROGTYPE program type	60.0%	30.0%	10.0%	100.0%
	4.00 TC (Therapeutic Community)	Count	5	1		6
		% within PROGTYPE program type	83.3%	16.7%		100.0%
Total		Count	61	39	16	116
		% within PROGTYPE program type	52.6%	33.6%	13.8%	100.0%

Table 8. Q12D How much emphasis on psychotherapy?

			Q12D how much emphasis on psychotherapy			
			1.00 primary approach	2.00 secondary approach	3.00 not used at all	Total
PROGTYPE program type	1.00 D & A Education Program	Count		8	35	43
		% within PROGTYPE program type		18.6%	81.4%	100.0%
	2.00 Outpatient Treatment Program	Count	10	12	36	58
		% within PROGTYPE program type	17.2%	20.7%	62.1%	100.0%
	3.00 DATU (D & A Treatment Unit)	Count	2	5	3	10
		% within PROGTYPE program type	20.0%	50.0%	30.0%	100.0%
	4.00 TC (Therapeutic Community)	Count	3	3		6
		% within PROGTYPE program type	50.0%	50.0%		100.0%
Total		Count	15	28	74	117
		% within PROGTYPE program type	12.8%	23.9%	63.2%	100.0%

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Table 9. Q12E How much emphasis on rational emotive therapy?

			Q12E how much emphasis on rational emotive therapy			
			1.00 primary approach	2.00 secondary approach	3.00 not used at all	Total
PROGTYPE program type	1.00 D & A Education Program	Count	8	21	14	43
		% within PROGTYPE program type	18.6%	48.8%	32.6%	100.0%
	2.00 Outpatient Treatment Program	Count	26	25	7	58
		% within PROGTYPE program type	44.8%	43.1%	12.1%	100.0%
	3.00 DATU (D & A Treatment Unit)	Count	5	5		10
		% within PROGTYPE program type	50.0%	50.0%		100.0%
	4.00 TC (Therapeutic Community)	Count	5	1		6
		% within PROGTYPE program type	83.3%	16.7%		100.0%
Total		Count	44	52	21	117
		% within PROGTYPE program type	37.6%	44.4%	17.9%	100.0%

Table 10. Q12F How much emphasis on transactional analysis ?

			Q12F how much emphasis on transactional analysis			
			1.00 primary approach	2.00 secondary approach	3.00 not used at all	Total
PROGTYPE program type	1.00 D & A Education Program	Count	1	19	24	44
		% within PROGTYPE program type	2.3%	43.2%	54.5%	100.0%
	2.00 Outpatient Treatment Program	Count		22	36	58
		% within PROGTYPE program type		37.9%	62.1%	100.0%
	3.00 DATU (D & A Treatment Unit)	Count		3	7	10
		% within PROGTYPE program type		30.0%	70.0%	100.0%
	4.00 TC (Therapeutic Community)	Count		2	4	6
		% within PROGTYPE program type		33.3%	66.7%	100.0%
Total		Count	1	46	71	118
		% within PROGTYPE program type	.8%	39.0%	60.2%	100.0%

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Table 11. Q12G How much emphasis on reality therapy?

			Q12G how much emphasis on reality therapy			
			1.00 primary approach	2.00 secondary approach	3.00 not used at all	Total
PROGTYPE program type	1.00 D & A Education Program	Count	12	18	14	44
		% within PROGTYPE program type	27.3%	40.9%	31.8%	100.0%
	2.00 Outpatient Treatment Program	Count	30	23	4	57
		% within PROGTYPE program type	52.6%	40.4%	7.0%	100.0%
	3.00 DATU (D & A Treatment Unit)	Count	7	3		10
		% within PROGTYPE program type	70.0%	30.0%		100.0%
	4.00 TC (Therapeutic Community)	Count	3	2	1	6
		% within PROGTYPE program type	50.0%	33.3%	16.7%	100.0%
Total		Count	52	46	19	117
		% within PROGTYPE program type	44.4%	39.3%	16.2%	100.0%

Table 12. Q12H How much emphasis on milieu therapy?

			Q12H how much emphasis on milieu therapy			
			1.00 primary approach	2.00 secondary approach	3.00 not used at all	Total
PROGTYPE program type	1.00 D & A Education Program	Count	5	10	28	43
		% within PROGTYPE program type	11.6%	23.3%	65.1%	100.0%
	2.00 Outpatient Treatment Program	Count	9	19	30	58
		% within PROGTYPE program type	15.5%	32.8%	51.7%	100.0%
	3.00 DATU (D & A Treatment Unit)	Count	2	6	2	10
		% within PROGTYPE program type	20.0%	60.0%	20.0%	100.0%
	4.00 TC (Therapeutic Community)	Count	3	3		6
		% within PROGTYPE program type	50.0%	50.0%		100.0%
Total		Count	19	38	60	117
		% within PROGTYPE program type	16.2%	32.5%	51.3%	100.0%

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Table 13. Q12I How much emphasis on "dual diagnosis" ?

			Q12I how much emphasis on "dual diagnosis"			
			1.00 primary approach	2.00 secondary approach	3.00 not used at all	Total
PROGTYPE program type	1.00 D & A Education Program	Count	4	5	34	43
		% within PROGTYPE program type	9.3%	11.6%	79.1%	100.0%
	2.00 Outpatient Treatment Program	Count	5	12	40	57
		% within PROGTYPE program type	8.8%	21.1%	70.2%	100.0%
	3.00 DATU (D & A Treatment Unit)	Count		3	7	10
		% within PROGTYPE program type		30.0%	70.0%	100.0%
	4.00 TC (Therapeutic Community)	Count	1	3	2	6
		% within PROGTYPE program type	16.7%	50.0%	33.3%	100.0%
Total		Count	10	23	83	116
		% within PROGTYPE program type	8.6%	19.8%	71.6%	100.0%

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Table 14. Q13A how important is d and a knowledge test to determine client complete program or not?

			Q13A how important is d and a knowledge test to determine client complete program or not			
			1.00 very important	2.00 somewhat important	3.00 not very important	Total
PROGTYPE program type	1.00 D & A Education Program	Count	22	11	10	43
		% within PROGTYPE program type	51.2%	25.6%	23.3%	100.0%
	2.00 Outpatient Treatment Program	Count	4	21	31	56
		% within PROGTYPE program type	7.1%	37.5%	55.4%	100.0%
	3.00 DATU (D & A Treatment Unit)	Count	3	4	3	10
		% within PROGTYPE program type	30.0%	40.0%	30.0%	100.0%
	4.00 TC (Therapeutic Community)	Count	2	3		5
		% within PROGTYPE program type	40.0%	60.0%		100.0%
Total		Count	31	39	44	114
		% within PROGTYPE program type	27.2%	34.2%	38.6%	100.0%

Table 15. Q13B how important are measures of attitudinal or behavioral change to determine client completed program or not?

			Q13B how important is measures of attitudinal or behavioral change to determine client completed program or not			
			1.00 very important	2.00 somewhat important	3.00 not very important	Total
PROGTYPE program type	1.00 D & A Education Program	Count	21	7	16	44
		% within PROGTYPE program type	47.7%	15.9%	36.4%	100.0%
	2.00 Outpatient Treatment Program	Count	32	19	6	57
		% within PROGTYPE program type	56.1%	33.3%	10.5%	100.0%
	3.00 DATU (D & A Treatment Unit)	Count	6	3	1	10
		% within PROGTYPE program type	60.0%	30.0%	10.0%	100.0%
	4.00 TC (Therapeutic Community)	Count	5	1		6
		% within PROGTYPE program type	83.3%	16.7%		100.0%
Total		Count	64	30	23	117
		% within PROGTYPE program type	54.7%	25.6%	19.7%	100.0%

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Table 16. Q13C How important is case progress review by treatment staff to determine if client completes program or not?

			Q13C_ how important is case progress reveiw by treatment staff to determine client complete program or not			
			1.00 very important	2.00 somewhat important	3.00 not very important	Total
PROGTYPE program type	1.00 D & A Education Program	Count	6	12	25	43
		% within PROGTYPE program type	14.0%	27.9%	58.1%	100.0%
	2.00 Outpatient Treatment Program	Count	15	32	9	56
		% within PROGTYPE program type	26.8%	57.1%	16.1%	100.0%
	3.00 DATU (D & A Treatment Unit)	Count	7	3		10
		% within PROGTYPE program type	70.0%	30.0%		100.0%
	4.00 TC (Therapeutic Community)	Count	6			6
		% within PROGTYPE program type	100.0%			100.0%
Total		Count	34	47	34	115
		% within PROGTYPE program type	29.6%	40.9%	29.6%	100.0%

Table 17. Q13D2 how important is "other" to determine if client completes program or not?

			Q13D2 how important is "other" to determine if client complete program or not?			
			1.00 very important	2.00 somewhat important	3.00 not very important	Total
PROGTYPE program type	1.00 D & A Education Program	Count	12	2	5	19
		% within PROGTYPE program type	63.2%	10.5%	26.3%	100.0%
	2.00 Outpatient Treatment Program	Count	33	1	1	35
		% within PROGTYPE program type	94.3%	2.9%	2.9%	100.0%
	3.00 DATU (D & A Treatment Unit)	Count	3			3
		% within PROGTYPE program type	100.0%			100.0%
	4.00 TC (Therapeutic Community)	Count	1			1
		% within PROGTYPE program type	100.0%			100.0%
Total		Count	49	3	6	58
		% within PROGTYPE program type	84.5%	5.2%	10.3%	100.0%

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Table 18. Q14A How important is violation of program rules to determine unsuccessful discharge?

			Q14A how important is violation program rules to determine unsuccessful discharge?			Total
			1.00 very important	2.00 somewhat important	3.00 not very important	
PROGTYPE program type	1.00 D & A Education Program	Count	37	4	2	43
		% within PROGTYPE program type	86.0%	9.3%	4.7%	100.0%
	2.00 Outpatient Treatment Program	Count	54	4		58
		% within PROGTYPE program type	93.1%	6.9%		100.0%
	3.00 DATU (D & A Treatment Unit)	Count	7	3		10
		% within PROGTYPE program type	70.0%	30.0%		100.0%
	4.00 TC (Therapeutic Community)	Count	6			6
		% within PROGTYPE program type	100.0%			100.0%
Total		Count	104	11	2	117
		% within PROGTYPE program type	88.9%	9.4%	1.7%	100.0%

Table 19. Q14B How important is violation of institutional rules to determine unsuccessful discharge?

			Q14B_how important is violation of institutional rules to determine unsuccessful discharge?			Total
			1.00 very important	2.00 somewhat important	3.00 not very important	
PROGTYPE program type	1.00 D & A Education Program	Count	42	1	1	44
		% within PROGTYPE program type	95.5%	2.3%	2.3%	100.0%
	2.00 Outpatient Treatment Program	Count	52	6		58
		% within PROGTYPE program type	89.7%	10.3%		100.0%
	3.00 DATU (D & A Treatment Unit)	Count	10			10
		% within PROGTYPE program type	100.0%			100.0%
	4.00 TC (Therapeutic Community)	Count	6			6
		% within PROGTYPE program type	100.0%			100.0%
Total		Count	110	7	1	118
		% within PROGTYPE program type	93.2%	5.9%	.8%	100.0%

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Table 20. Q14C How important are security concerns to determine unsuccessful discharge?

			Q14C How important are security concerns to determine unsuccessful discharge?			Total
			1.00 very important	2.00 somewhat important	3.00 not very important	
PROGTYPE program type	1.00 D & A Education Program	Count	38	5	1	44
		% within PROGTYPE program type	86.4%	11.4%	2.3%	100.0%
	2.00 Outpatient Treatment Program	Count	55	3		58
		% within PROGTYPE program type	94.8%	5.2%		100.0%
	3.00 DATU (D & A Treatment Unit)	Count	10			10
		% within PROGTYPE program type	100.0%			100.0%
	4.00 TC (Therapeutic Community)	Count	6			6
		% within PROGTYPE program type	100.0%			100.0%
Total		Count	109	8	1	118
		% within PROGTYPE program type	92.4%	6.8%	.8%	100.0%

Table 21. Q14D How important is failure to pass a D & A knowledge test?

			Q14D How important is failure to pass a D & A knowledge test?			Total
			1.00 very important	2.00 somewhat important	3.00 not very important	
PROGTYPE program type	1.00 D & A Education Program	Count	10	20	13	43
		% within PROGTYPE program type	23.3%	46.5%	30.2%	100.0%
	2.00 Outpatient Treatment Program	Count	2	17	37	56
		% within PROGTYPE program type	3.6%	30.4%	66.1%	100.0%
	3.00 DATU (D & A Treatment Unit)	Count	2	4	4	10
		% within PROGTYPE program type	20.0%	40.0%	40.0%	100.0%
	4.00 TC (Therapeutic Community)	Count	1	2	2	5
		% within PROGTYPE program type	20.0%	40.0%	40.0%	100.0%
Total		Count	15	43	56	114
		% within PROGTYPE program type	13.2%	37.7%	49.1%	100.0%

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Table 22. Q14E How important is inadequate attitudinal or behavioral change to determine unsuccessful discharge?

			Q14E How important is inadequate attitudinal or behavioral change determine unsuccessful discharge?			
			1.00 very important	2.00 somewhat important	3.00 not very important	Total
PROGTYPE program type	1.00 D & A Education Program	Count	7	25	12	44
		% within PROGTYPE program type	15.9%	56.8%	27.3%	100.0%
	2.00 Outpatient Treatment Program	Count	17	30	11	58
		% within PROGTYPE program type	29.3%	51.7%	19.0%	100.0%
	3.00 DATU (D & A Treatment Unit)	Count	6	3	1	10
		% within PROGTYPE program type	60.0%	30.0%	10.0%	100.0%
	4.00 TC (Therapeutic Community)	Count	4	2		6
		% within PROGTYPE program type	66.7%	33.3%		100.0%
Total		Count	34	60	24	118
		% within PROGTYPE program type	28.8%	50.8%	20.3%	100.0%

Table 23. Q14F How important is not attending required number of sessions to determine unsuccessful discharge?

			Q14F How important is not attending required number of sessions to determine unsuccessful discharge?			
			1.00 very important	2.00 somewhat important	3.00 not very important	Total
PROGTYPE program type	1.00 D & A Education Program	Count	36	5	3	44
		% within PROGTYPE program type	81.8%	11.4%	6.8%	100.0%
	2.00 Outpatient Treatment Program	Count	56	2		58
		% within PROGTYPE program type	96.6%	3.4%		100.0%
	3.00 DATU (D & A Treatment Unit)	Count	8	2		10
		% within PROGTYPE program type	80.0%	20.0%		100.0%
	4.00 TC (Therapeutic Community)	Count	4	2		6
		% within PROGTYPE program type	66.7%	33.3%		100.0%
Total		Count	104	11	3	118
		% within PROGTYPE program type	88.1%	9.3%	2.5%	100.0%

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Table 24. Q14G How important is failure to complete required assignments to determine unsuccessful discharge?

			Q14G How important is failure to complete required assignments to determine unsuccessful discharge?			
			1.00 very important	2.00 somewhat important	3.00 not very important	Total
PROGTYPE program type	1.00 D & A Education Program	Count	20	17	7	44
		% within PROGTYPE program type	45.5%	38.6%	15.9%	100.0%
	2.00 Outpatient Treatment Program	Count	36	17	4	57
		% within PROGTYPE program type	63.2%	29.8%	7.0%	100.0%
	3.00 DATU (D & A Treatment Unit)	Count	7	3		10
		% within PROGTYPE program type	70.0%	30.0%		100.0%
	4.00 TC (Therapeutic Community)	Count	4	2		6
		% within PROGTYPE program type	66.7%	33.3%		100.0%
Total		Count	67	39	11	117
		% within PROGTYPE program type	57.3%	33.3%	9.4%	100.0%

Table 25. Q14H How important is inappropriate classroom or session behavior to determine unsuccessful discharge?

			Q14H How important is inappropriate classroom or session behavior to determine unsuccessful discharge?			
			1.00 very important	2.00 somewhat important	3.00 not very important	Total
PROGTYPE program type	1.00 D & A Education Program	Count	34	9	1	44
		% within PROGTYPE program type	77.3%	20.5%	2.3%	100.0%
	2.00 Outpatient Treatment Program	Count	52	6		58
		% within PROGTYPE program type	89.7%	10.3%		100.0%
	3.00 DATU (D & A Treatment Unit)	Count	4	6		10
		% within PROGTYPE program type	40.0%	60.0%		100.0%
	4.00 TC (Therapeutic Community)	Count	3	3		6
		% within PROGTYPE program type	50.0%	50.0%		100.0%
Total		Count	93	24	1	118
		% within PROGTYPE program type	78.8%	20.3%	.8%	100.0%

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Table 26. Q14l How important is case progress review by treatment staff to determine unsuccessful discharge?

			Q14l How important is case progress review by treatment staff to determine unsuccessful discharge?			
			1.00 very important	2.00 somewhat important	3.00 not very important	Total
PROGTYPE program type	1.00 D & A Education Program	Count	8	8	28	44
		% within PROGTYPE program type	18.2%	18.2%	63.6%	100.0%
	2.00 Outpatient Treatment Program	Count	17	22	19	58
		% within PROGTYPE program type	29.3%	37.9%	32.8%	100.0%
	3.00 DATU (D & A Treatment Unit)	Count	7	2	1	10
		% within PROGTYPE program type	70.0%	20.0%	10.0%	100.0%
	4.00 TC (Therapeutic Community)	Count	6			6
		% within PROGTYPE program type	100.0%			100.0%
Total		Count	38	32	48	118
		% within PROGTYPE program type	32.2%	27.1%	40.7%	100.0%

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Table 27. Q18 Percentage of Time Using Different Treatment or Education Formats

		Mean	N	Std. Deviation	Minimum	Maximum
Q18A percentage of time lecture by DATS or other professional is used	1.00 D & A Education Program	31.4091	44	21.4566	.00	85.00
	2.00 Outpatient Treatment Program	18.5088	57	14.9882	.00	65.00
	3.00 DATU (D & A Treatment Unit)	13.8889	9	12.6930	.00	40.00
	4.00 TC (Therapeutic Community)	9.3333	6	4.0825	5.00	16.00
	Total	22.5690	116	18.6166	.00	85.00
Q18B percentage of time film or video is used	1.00 D & A Education Program	17.0682	44	14.6135	.00	70.00
	2.00 Outpatient Treatment Program	9.6842	57	10.3288	.00	60.00
	3.00 DATU (D & A Treatment Unit)	6.6667	9	4.3301	.00	10.00
	4.00 TC (Therapeutic Community)	6.1667	6	3.7639	.00	10.00
	Total	12.0690	116	12.2558	.00	70.00
Q18C percentage of time workbook or written assignments is used	1.00 D & A Education Program	8.7500	44	8.6350	.00	50.00
	2.00 Outpatient Treatment Program	15.2759	58	16.0567	.00	100.00
	3.00 DATU (D & A Treatment Unit)	14.4444	9	5.8333	5.00	20.00
	4.00 TC (Therapeutic Community)	13.0000	6	3.6878	10.00	19.00
	Total	12.6410	117	12.9125	.00	100.00
Q18D percentage of time instructor-led group discussion is used	1.00 D & A Education Program	25.5682	44	16.5380	.00	80.00
	2.00 Outpatient Treatment Program	23.5517	58	16.3398	.00	100.00
	3.00 DATU (D & A Treatment Unit)	13.8889	9	8.2074	.00	25.00
	4.00 TC (Therapeutic Community)	10.8333	6	4.9160	5.00	20.00
	Total	22.9145	117	15.9690	.00	100.00
Q18E percentage of time peer-led group discussion is used	1.00 D & A Education Program	11.0476	42	18.1793	.00	99.00
	2.00 Outpatient Treatment Program	10.2982	57	10.0516	.00	39.00
	3.00 DATU (D & A Treatment Unit)	13.3333	9	13.2288	.00	40.00
	4.00 TC (Therapeutic Community)	10.6667	6	4.1793	5.00	16.00
	Total	10.8333	114	13.5574	.00	99.00
Q18F percentage of time individual counseling sessions is used	1.00 D & A Education Program	1.6512	43	5.6353	.00	30.00
	2.00 Outpatient Treatment Program	4.7857	56	9.8456	.00	50.00
	3.00 DATU (D & A Treatment Unit)	11.7500	8	10.4300	.00	30.00
	4.00 TC (Therapeutic Community)	14.5000	6	6.2849	5.00	22.00
	Total	4.6018	113	8.9628	.00	50.00
Q18G percentage of time group counseling sessions are used	1.00 D & A Education Program	5.6905	42	16.4027	.00	100.00
	2.00 Outpatient Treatment Program	25.1250	56	29.2109	.00	100.00
	3.00 DATU (D & A Treatment Unit)	32.0000	8	23.1578	15.00	86.00
	4.00 TC (Therapeutic Community)	28.0000	6	9.0111	15.00	40.00
	Total	18.4821	112	25.7273	.00	100.00
Q18H2 percentage of time "other" is used	1.00 D & A Education Program	4.8649	37	18.6520	.00	100.00
	2.00 Outpatient Treatment Program	1.5909	44	5.6828	.00	30.00
	3.00 DATU (D & A Treatment Unit)	1.6667	6	4.0825	.00	10.00
	4.00 TC (Therapeutic Community)	5.8333	6	9.1742	.00	20.00
	Total	3.1720	93	12.6359	.00	100.00

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Table 28. Q19A How much time is spent on AIDS/infectious diseases?

			Q19A How much time is spent on AIDS/infectious diseases?				Total
			1.00 a great deal of time	2.00 moderate amount of time	3.00 very little time	4.00 no time	
PROGTYPE program type	1.00 D & A Education Program	Count	4	13	21	6	44
		% within PROGTYPE program type	9.1%	29.5%	47.7%	13.6%	100.0%
	2.00 Outpatient Treatment Program	Count	3	14	31	10	58
		% within PROGTYPE program type	5.2%	24.1%	53.4%	17.2%	100.0%
	3.00 DATU (D & A Treatment Unit)	Count	1	5	3		9
		% within PROGTYPE program type	11.1%	55.6%	33.3%		100.0%
	4.00 TC (Therapeutic Community)	Count	1	4	1		6
		% within PROGTYPE program type	16.7%	66.7%	16.7%		100.0%
Total		Count	9	36	56	16	117
		% within PROGTYPE program type	7.7%	30.8%	47.9%	13.7%	100.0%

Table 29. Q19B How much time is spent on models of addiction?

			Q19B how much time is spent on models of addiction				Total
			1.00 a great deal of time	2.00 moderate amount of time	3.00 very little time	4.00 no time	
PROGTYPE program type	1.00 D & A Education Program	Count	9	25	6	3	43
		% within PROGTYPE program type	20.9%	58.1%	14.0%	7.0%	100.0%
	2.00 Outpatient Treatment Program	Count	5	24	26	3	58
		% within PROGTYPE program type	8.6%	41.4%	44.8%	5.2%	100.0%
	3.00 DATU (D & A Treatment Unit)	Count	4	5	1		10
		% within PROGTYPE program type	40.0%	50.0%	10.0%		100.0%
	4.00 TC (Therapeutic Community)	Count	3	2	1		6
		% within PROGTYPE program type	50.0%	33.3%	16.7%		100.0%
Total		Count	21	56	34	6	117
		% within PROGTYPE program type	17.9%	47.9%	29.1%	5.1%	100.0%

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Table 30. Q19C How much time is spent on working steps to recovery?

			Q19C How much time is spent on working steps to recovery?				
			1.00 a great deal of time	2.00 moderate amount of time	3.00 very little time	4.00 no time	Total
PROGTYPE program type	1.00 D & A Education Program	Count	21	15	4	4	44
		% within PROGTYPE program type	47.7%	34.1%	9.1%	9.1%	100.0%
	2.00 Outpatient Treatment Program	Count	33	17	7	1	58
		% within PROGTYPE program type	56.9%	29.3%	12.1%	1.7%	100.0%
	3.00 DATU (D & A Treatment Unit)	Count	8	1	1		10
		% within PROGTYPE program type	80.0%	10.0%	10.0%		100.0%
	4.00 TC (Therapeutic Community)	Count	6				6
		% within PROGTYPE program type	100.0%				100.0%
Total		Count	68	33	12	5	118
		% within PROGTYPE program type	57.6%	28.0%	10.2%	4.2%	100.0%

Table 31. Q19D How much time is spent impacts of drug use?

			Q19D How much time is spent impacts of drug use				
			1.00 a great deal of time	2.00 moderate amount of time	3.00 very little time	4.00 no time	Total
PROGTYPE program type	1.00 D & A Education Program	Count	31	12		1	44
		% within PROGTYPE program type	70.5%	27.3%		2.3%	100.0%
	2.00 Outpatient Treatment Program	Count	31	23	4		58
		% within PROGTYPE program type	53.4%	39.7%	6.9%		100.0%
	3.00 DATU (D & A Treatment Unit)	Count	8	2			10
		% within PROGTYPE program type	80.0%	20.0%			100.0%
	4.00 TC (Therapeutic Community)	Count	4	2			6
		% within PROGTYPE program type	66.7%	33.3%			100.0%
Total		Count	74	39	4	1	118
		% within PROGTYPE program type	62.7%	33.1%	3.4%	.8%	100.0%

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Table 32. Q19E How much time is spent on family issues?

			Q19E How much time is spent on family issues				
			1.00 a great deal of time	2.00 moderate amount of time	3.00 very little time	4.00 no time	Total
PROGTYPE program type	1.00 D & A Education Program	Count	10	25	8	1	44
		% within PROGTYPE program type	22.7%	56.8%	18.2%	2.3%	100.0%
	2.00 Outpatient Treatment Program	Count	24	31	3		58
		% within PROGTYPE program type	41.4%	53.4%	5.2%		100.0%
	3.00 DATU (D & A Treatment Unit)	Count	4	5	1		10
		% within PROGTYPE program type	40.0%	50.0%	10.0%		100.0%
	4.00 TC (Therapeutic Community)	Count	3	3			6
		% within PROGTYPE program type	50.0%	50.0%			100.0%
Total		Count	41	64	12	1	118
		% within PROGTYPE program type	34.7%	54.2%	10.2%	.8%	100.0%

Table 33. Q19F How much time is spent on job issues?

			Q19F How much time is spent on job issues				
			1.00 a great deal of time	2.00 moderate amount of time	3.00 very little time	4.00 no time	Total
PROGTYPE program type	1.00 D & A Education Program	Count	4	15	21	4	44
		% within PROGTYPE program type	9.1%	34.1%	47.7%	9.1%	100.0%
	2.00 Outpatient Treatment Program	Count	16	29	11	1	57
		% within PROGTYPE program type	28.1%	50.9%	19.3%	1.8%	100.0%
	3.00 DATU (D & A Treatment Unit)	Count	2	4	4		10
		% within PROGTYPE program type	20.0%	40.0%	40.0%		100.0%
	4.00 TC (Therapeutic Community)	Count	1	5			6
		% within PROGTYPE program type	16.7%	83.3%			100.0%
Total		Count	23	53	36	5	117
		% within PROGTYPE program type	19.7%	45.3%	30.8%	4.3%	100.0%

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Table 34. Q19G How much time is spent on lifeskills?

			Q19G How much time is spent on lifeskills?				
			1.00 a great deal of time	2.00 moderate amount of time	3.00 very little time	4.00 no time	Total
PROGTYPE program type	1.00 D & A Education Program	Count	11	17	14	2	44
		% within PROGTYPE program type	25.0%	38.6%	31.8%	4.5%	100.0%
	2.00 Outpatient Treatment Program	Count	27	24	6	1	58
		% within PROGTYPE program type	46.6%	41.4%	10.3%	1.7%	100.0%
	3.00 DATU (D & A Treatment Unit)	Count	4	4	2		10
		% within PROGTYPE program type	40.0%	40.0%	20.0%		100.0%
	4.00 TC (Therapeutic Community)	Count	2	3	1		6
		% within PROGTYPE program type	33.3%	50.0%	16.7%		100.0%
Total		Count	44	48	23	3	118
		% within PROGTYPE program type	37.3%	40.7%	19.5%	2.5%	100.0%

Table 35. Q19H How much time is spent on problem solving skills?

			Q19H how much time is spent on problem skills				
			1.00 a great deal of time	2.00 moderate amount of time	3.00 very little time	4.00 no time	Total
PROGTYPE program type	1.00 D & A Education Program	Count	12	16	15	1	44
		% within PROGTYPE program type	27.3%	36.4%	34.1%	2.3%	100.0%
	2.00 Outpatient Treatment Program	Count	39	17	2		58
		% within PROGTYPE program type	67.2%	29.3%	3.4%		100.0%
	3.00 DATU (D & A Treatment Unit)	Count	6	3	1		10
		% within PROGTYPE program type	60.0%	30.0%	10.0%		100.0%
	4.00 TC (Therapeutic Community)	Count	5	1			6
		% within PROGTYPE program type	83.3%	16.7%			100.0%
Total		Count	62	37	18	1	118
		% within PROGTYPE program type	52.5%	31.4%	15.3%	.8%	100.0%

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Table 36. Q19I How much time is spent on obstacles to treatment?

			Q19I how much time is spent on obstacles to treatment				
			1.00 a great deal of time	2.00 moderate amount of time	3.00 very little time	4.00 no time	Total
PROGTYPE program type	1.00 D & A Education Program	Count	21	14	8	1	44
		% within PROGTYPE program type	47.7%	31.8%	18.2%	2.3%	100.0%
	2.00 Outpatient Treatment Program	Count	38	19	1		58
		% within PROGTYPE program type	65.5%	32.8%	1.7%		100.0%
	3.00 DATU (D & A Treatment Unit)	Count	5	4	1		10
		% within PROGTYPE program type	50.0%	40.0%	10.0%		100.0%
	4.00 TC (Therapeutic Community)	Count	3	3			6
		% within PROGTYPE program type	50.0%	50.0%			100.0%
Total		Count	67	40	10	1	118
		% within PROGTYPE program type	56.8%	33.9%	8.5%	.8%	100.0%

Table 37. Q19J How much time is spent on thinking errors?

			Q19J how much time is spent on thinking errors				
			1.00 a great deal of time	2.00 moderate amount of time	3.00 very little time	4.00 no time	Total
PROGTYPE program type	1.00 D & A Education Program	Count	21	18	3	1	43
		% within PROGTYPE program type	48.8%	41.9%	7.0%	2.3%	100.0%
	2.00 Outpatient Treatment Program	Count	41	16	1		58
		% within PROGTYPE program type	70.7%	27.6%	1.7%		100.0%
	3.00 DATU (D & A Treatment Unit)	Count	5	4	1		10
		% within PROGTYPE program type	50.0%	40.0%	10.0%		100.0%
	4.00 TC (Therapeutic Community)	Count	6				6
		% within PROGTYPE program type	100.0%				100.0%
Total		Count	73	38	5	1	117
		% within PROGTYPE program type	62.4%	32.5%	4.3%	.9%	100.0%

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Table 38. Q19K How much time is spent on problem solving skills?

			Q19K how much time is spent on problem solving skills				
			1.00 a great deal of time	2.00 moderate amount of time	3.00 very little time	4.00 no time	Total
PROGTYPE program type	1.00 D & A Education Program	Count	12	17	13	1	43
		% within PROGTYPE program type	27.9%	39.5%	30.2%	2.3%	100.0%
	2.00 Outpatient Treatment Program	Count	37	18	3		58
		% within PROGTYPE program type	63.8%	31.0%	5.2%		100.0%
	3.00 DATU (D & A Treatment Unit)	Count	6	2	1		9
		% within PROGTYPE program type	66.7%	22.2%	11.1%		100.0%
	4.00 TC (Therapeutic Community)	Count	5	1			6
		% within PROGTYPE program type	83.3%	16.7%			100.0%
Total		Count	60	38	17	1	116
		% within PROGTYPE program type	51.7%	32.8%	14.7%	.9%	100.0%

Table 39. Q19L How much time is spent on social skills/communication skills?

			Q19L how much time is spent on social skills/communication skills				
			1.00 a great deal of time	2.00 moderate amount of time	3.00 very little time	4.00 no time	Total
PROGTYPE program type	1.00 D & A Education Program	Count	9	18	13	4	44
		% within PROGTYPE program type	20.5%	40.9%	29.5%	9.1%	100.0%
	2.00 Outpatient Treatment Program	Count	28	22	7		57
		% within PROGTYPE program type	49.1%	38.6%	12.3%		100.0%
	3.00 DATU (D & A Treatment Unit)	Count	4	6			10
		% within PROGTYPE program type	40.0%	60.0%			100.0%
	4.00 TC (Therapeutic Community)	Count	4	2			6
		% within PROGTYPE program type	66.7%	33.3%			100.0%
Total		Count	45	48	20	4	117
		% within PROGTYPE program type	38.5%	41.0%	17.1%	3.4%	100.0%

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Table 40. Q19M How much time is spent on interpersonal relationships?

			Q19M how much time is spent on interpersonal relationships				
			1.00 a great deal of time	2.00 moderate amount of time	3.00 very little time	4.00 no time	Total
PROGTYPE program type	1.00 D & A Education Program	Count	9	18	14	3	44
		% within PROGTYPE program type	20.5%	40.9%	31.8%	6.8%	100.0%
	2.00 Outpatient Treatment Program	Count	28	26	4		58
		% within PROGTYPE program type	48.3%	44.8%	6.9%		100.0%
	3.00 DATU (D & A Treatment Unit)	Count	3	7			10
		% within PROGTYPE program type	30.0%	70.0%			100.0%
	4.00 TC (Therapeutic Community)	Count	5	1			6
		% within PROGTYPE program type	83.3%	16.7%			100.0%
Total		Count	45	52	18	3	118
		% within PROGTYPE program type	38.1%	44.1%	15.3%	2.5%	100.0%

Table 41. Q19N How much time is spent on self esteem?

			Q19N how much time is spent on self esteem				
			1.00 a great deal of time	2.00 moderate amount of time	3.00 very little time	4.00 no time	Total
PROGTYPE program type	1.00 D & A Education Program	Count	13	14	13	4	44
		% within PROGTYPE program type	29.5%	31.8%	29.5%	9.1%	100.0%
	2.00 Outpatient Treatment Program	Count	18	32	7	1	58
		% within PROGTYPE program type	31.0%	55.2%	12.1%	1.7%	100.0%
	3.00 DATU (D & A Treatment Unit)	Count	5	5			10
		% within PROGTYPE program type	50.0%	50.0%			100.0%
	4.00 TC (Therapeutic Community)	Count	2	4			6
		% within PROGTYPE program type	33.3%	66.7%			100.0%
Total		Count	38	55	20	5	118
		% within PROGTYPE program type	32.2%	46.6%	16.9%	4.2%	100.0%

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Table 42. Q19O How much time is spent on anger/temper control?

			Q19O how much time is spent on anger/temper control				Total
			1.00 a great deal of time	2.00 moderate amount of time	3.00 very little time	4.00 no time	
PROGTYPE program type	1.00 D & A Education Program	Count	7	18	14	5	44
		% within PROGTYPE program type	15.9%	40.9%	31.8%	11.4%	100.0%
	2.00 Outpatient Treatment Program	Count	24	25	8	1	58
		% within PROGTYPE program type	41.4%	43.1%	13.8%	1.7%	100.0%
	3.00 DATU (D & A Treatment Unit)	Count	7	2	1		10
		% within PROGTYPE program type	70.0%	20.0%	10.0%		100.0%
	4.00 TC (Therapeutic Community)	Count	5	1			6
		% within PROGTYPE program type	83.3%	16.7%			100.0%
Total		Count	43	46	23	6	118
		% within PROGTYPE program type	36.4%	39.0%	19.5%	5.1%	100.0%

Table 43. Q19P How much time is spent on assertiveness training?

			Q19P how much time is spent on assertiveness training				Total
			1.00 a great deal of time	2.00 moderate amount of time	3.00 very little time	4.00 no time	
PROGTYPE program type	1.00 D & A Education Program	Count	5	13	16	10	44
		% within PROGTYPE program type	11.4%	29.5%	36.4%	22.7%	100.0%
	2.00 Outpatient Treatment Program	Count	15	29	12	2	58
		% within PROGTYPE program type	25.9%	50.0%	20.7%	3.4%	100.0%
	3.00 DATU (D & A Treatment Unit)	Count	6	3	1		10
		% within PROGTYPE program type	60.0%	30.0%	10.0%		100.0%
	4.00 TC (Therapeutic Community)	Count	4	2			6
		% within PROGTYPE program type	66.7%	33.3%			100.0%
Total		Count	30	47	29	12	118
		% within PROGTYPE program type	25.4%	39.8%	24.6%	10.2%	100.0%

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Table 44. Q19Q How much time is spent on stress management?

			Q19Q how much time is spent on stress management				
			1.00 a great deal of time	2.00 moderate amount of time	3.00 very little time	4.00 no time	Total
PROGTYPE program type	1.00 D & A Education Program	Count	12	14	13	5	44
		% within PROGTYPE program type	27.3%	31.8%	29.5%	11.4%	100.0%
	2.00 Outpatient Treatment Program	Count	18	26	14		58
		% within PROGTYPE program type	31.0%	44.8%	24.1%		100.0%
	3.00 DATU (D & A Treatment Unit)	Count	5	4	1		10
		% within PROGTYPE program type	50.0%	40.0%	10.0%		100.0%
	4.00 TC (Therapeutic Community)	Count	3	3			6
		% within PROGTYPE program type	50.0%	50.0%			100.0%
Total		Count	38	47	28	5	118
		% within PROGTYPE program type	32.2%	39.8%	23.7%	4.2%	100.0%

Table 45. Q19R How much time is spent on criminality/antisocial attitudes?

			Q19R how much time is spent on criminality/antisocial attitudes				
			1.00 a great deal of time	2.00 moderate amount of time	3.00 very little time	4.00 no time	Total
PROGTYPE program type	1.00 D & A Education Program	Count	22	13	8	1	44
		% within PROGTYPE program type	50.0%	29.5%	18.2%	2.3%	100.0%
	2.00 Outpatient Treatment Program	Count	35	19	4		58
		% within PROGTYPE program type	60.3%	32.8%	6.9%		100.0%
	3.00 DATU (D & A Treatment Unit)	Count	7	2	1		10
		% within PROGTYPE program type	70.0%	20.0%	10.0%		100.0%
	4.00 TC (Therapeutic Community)	Count	6				6
		% within PROGTYPE program type	100.0%				100.0%
Total		Count	70	34	13	1	118
		% within PROGTYPE program type	59.3%	28.8%	11.0%	.8%	100.0%

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Table 46. Q19S How much time is spent on antisocial peer associations?

			Q19S how much time is spent on antisocial peer associations				Total
			1.00 a great deal of time	2.00 moderate amount of time	3.00 very little time	4.00 no time	
PROGTYPE program type	1.00 D & A Education Program	Count	13	22	7	2	44
		% within PROGTYPE program type	29.5%	50.0%	15.9%	4.5%	100.0%
	2.00 Outpatient Treatment Program	Count	29	27	2		58
		% within PROGTYPE program type	50.0%	46.6%	3.4%		100.0%
	3.00 DATU (D & A Treatment Unit)	Count	5	4	1		10
		% within PROGTYPE program type	50.0%	40.0%	10.0%		100.0%
	4.00 TC (Therapeutic Community)	Count	4	2			6
		% within PROGTYPE program type	66.7%	33.3%			100.0%
Total		Count	51	55	10	2	118
		% within PROGTYPE program type	43.2%	46.6%	8.5%	1.7%	100.0%

Table 47. Q19T How much time is spent on focus on harm done to victim?

			Q19T how much time is spent on focus on harm done to victim				Total
			1.00 a great deal of time	2.00 moderate amount of time	3.00 very little time	4.00 no time	
PROGTYPE program type	1.00 D & A Education Program	Count	10	23	8	3	44
		% within PROGTYPE program type	22.7%	52.3%	18.2%	6.8%	100.0%
	2.00 Outpatient Treatment Program	Count	16	21	19	2	58
		% within PROGTYPE program type	27.6%	36.2%	32.8%	3.4%	100.0%
	3.00 DATU (D & A Treatment Unit)	Count	6	3			9
		% within PROGTYPE program type	66.7%	33.3%			100.0%
	4.00 TC (Therapeutic Community)	Count	2	4			6
		% within PROGTYPE program type	33.3%	66.7%			100.0%
Total		Count	34	51	27	5	117
		% within PROGTYPE program type	29.1%	43.6%	23.1%	4.3%	100.0%

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Table 48. Q19U How much time is spent on relapse prevention?

			Q19U how much time is spent on relapse preventior				
			1.00 a great deal of time	2.00 moderate amount of time	3.00 very little time	4.00 no time	Total
PROGTYPE program type	1.00 D & A Education Program	Count	10	21	6	7	44
		% within PROGTYPE program type	22.7%	47.7%	13.6%	15.9%	100.0%
	2.00 Outpatient Treatment Program	Count	38	17	3		58
		% within PROGTYPE program type	65.5%	29.3%	5.2%		100.0%
	3.00 DATU (D & A Treatment Unit)	Count	6	4			10
		% within PROGTYPE program type	60.0%	40.0%			100.0%
	4.00 TC (Therapeutic Community)	Count	5	1			6
		% within PROGTYPE program type	83.3%	16.7%			100.0%
Total		Count	59	43	9	7	118
		% within PROGTYPE program type	50.0%	36.4%	7.6%	5.9%	100.0%

Table 49. Q19V How much time is spent on addiction and spirituality?

			Q19V how much time is spent on addiction and spirituality				
			1.00 a great deal of time	2.00 moderate amount of time	3.00 very little time	4.00 no time	Total
PROGTYPE program type	1.00 D & A Education Program	Count	13	23	4	4	44
		% within PROGTYPE program type	29.5%	52.3%	9.1%	9.1%	100.0%
	2.00 Outpatient Treatment Program	Count	24	23	10	1	58
		% within PROGTYPE program type	41.4%	39.7%	17.2%	1.7%	100.0%
	3.00 DATU (D & A Treatment Unit)	Count	8	2			10
		% within PROGTYPE program type	80.0%	20.0%			100.0%
	4.00 TC (Therapeutic Community)	Count	4	2			6
		% within PROGTYPE program type	66.7%	33.3%			100.0%
Total		Count	49	50	14	5	118
		% within PROGTYPE program type	41.5%	42.4%	11.9%	4.2%	100.0%

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Table 50. Q19W How much time is spent on pharmacology?

			Q19W how much time is spent on pharmacology				
			1.00 a great deal of time	2.00 moderate amount of time	3.00 very little time	4.00 no time	Total
PROGTYPE program type	1.00 D & A Education Program	Count	12	13	12	5	42
		% within PROGTYPE program type	28.6%	31.0%	28.6%	11.9%	100.0%
	2.00 Outpatient Treatment Program	Count	4	18	29	6	57
		% within PROGTYPE program type	7.0%	31.6%	50.9%	10.5%	100.0%
	3.00 DATU (D & A Treatment Unit)	Count	2	5	3		10
		% within PROGTYPE program type	20.0%	50.0%	30.0%		100.0%
	4.00 TC (Therapeutic Community)	Count		5	1		6
		% within PROGTYPE program type		83.3%	16.7%		100.0%
Total		Count	18	41	45	11	115
		% within PROGTYPE program type	15.7%	35.7%	39.1%	9.6%	100.0%

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Table 51. Q21 Maximum # of clients program can serve at one time

PROGTYPE program type	Mean	N	Std. Deviation	Minimum	Maximum
1.00 D & A Education Program	49.7619	42	64.3973	8.00	240.00
2.00 Outpatient Treatment Program	28.0000	58	31.7330	10.00	180.00
3.00 DATU (D & A Treatment Unit)	59.3333	9	65.1575	10.00	180.00
4.00 TC (Therapeutic Community)	69.6667	6	35.9648	36.00	128.00
Total	40.5739	115	50.3338	8.00	240.00

Table 52. Q26 Does the inmate sign a consent to treatment form?

			Q26 does the inmate sign a consent to treatment form		
			.00 no	1.00 yes	Total
PROGTYPE program type	1.00 D & A Education Program	Count	27	16	43
		% within PROGTYPE program type	62.8%	37.2%	100.0%
	2.00 Outpatient Treatment Program	Count	24	34	58
		% within PROGTYPE program type	41.4%	58.6%	100.0%
	3.00 DATU (D & A Treatment Unit)	Count	5	5	10
		% within PROGTYPE program type	50.0%	50.0%	100.0%
	4.00 TC (Therapeutic Community)	Count		6	6
		% within PROGTYPE program type		100.0%	100.0%
Total		Count	56	61	117
		% within PROGTYPE program type	47.9%	52.1%	100.0%

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Table 53. Q27A How important is inmates' level of motivation for admission in program?

			Q27A how important is inmates' level of motivation for admission in program			
			1.00 very important	2.00 somewhat important	3.00 not very important	Total
PROGTYPE program type	1.00 D & A Education Program	Count	10	13	20	43
		% within PROGTYPE program type	23.3%	30.2%	46.5%	100.0%
	2.00 Outpatient Treatment Program	Count	25	22	10	57
		% within PROGTYPE program type	43.9%	38.6%	17.5%	100.0%
	3.00 DATU (D & A Treatment Unit)	Count	3	7		10
		% within PROGTYPE program type	30.0%	70.0%		100.0%
	4.00 TC (Therapeutic Community)	Count	5	1		6
		% within PROGTYPE program type	83.3%	16.7%		100.0%
Total		Count	43	43	30	116
		% within PROGTYPE program type	37.1%	37.1%	25.9%	100.0%

Table 54. Q27B How important is level of drug involvement for admission to program?

			Q27B how important is level of drug involvement for admission to program			
			1.00 very important	2.00 somewhat important	3.00 not very important	Total
PROGTYPE program type	1.00 D & A Education Program	Count	27	9	7	43
		% within PROGTYPE program type	62.8%	20.9%	16.3%	100.0%
	2.00 Outpatient Treatment Program	Count	31	23	3	57
		% within PROGTYPE program type	54.4%	40.4%	5.3%	100.0%
	3.00 DATU (D & A Treatment Unit)	Count	5	5		10
		% within PROGTYPE program type	50.0%	50.0%		100.0%
	4.00 TC (Therapeutic Community)	Count	6			6
		% within PROGTYPE program type	100.0%			100.0%
Total		Count	69	37	10	116
		% within PROGTYPE program type	59.5%	31.9%	8.6%	100.0%

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Table 55. Q27C How important is type of offense for admission for program?

			Q27C how important is type of offense for admission for program			
			1.00 very important	2.00 somewhat important	3.00 not very important	Total
PROGTYPE program type	1.00 D & A Education Program	Count	11	18	14	43
		% within PROGTYPE program type	25.6%	41.9%	32.6%	100.0%
	2.00 Outpatient Treatment Program	Count	15	12	30	57
		% within PROGTYPE program type	26.3%	21.1%	52.6%	100.0%
	3.00 DATU (D & A Treatment Unit)	Count	2	4	4	10
		% within PROGTYPE program type	20.0%	40.0%	40.0%	100.0%
	4.00 TC (Therapeutic Community)	Count		3	3	6
		% within PROGTYPE program type		50.0%	50.0%	100.0%
Total		Count	28	37	51	116
		% within PROGTYPE program type	24.1%	31.9%	44.0%	100.0%

Table 56. Q27D How important is criminal history for admission to program?

			Q27D how important is criminal history for admission to program			
			1.00 very important	2.00 somewhat important	3.00 not very important	Total
PROGTYPE program type	1.00 D & A Education Program	Count	8	20	14	42
		% within PROGTYPE program type	19.0%	47.6%	33.3%	100.0%
	2.00 Outpatient Treatment Program	Count	6	20	31	57
		% within PROGTYPE program type	10.5%	35.1%	54.4%	100.0%
	3.00 DATU (D & A Treatment Unit)	Count	1	4	5	10
		% within PROGTYPE program type	10.0%	40.0%	50.0%	100.0%
	4.00 TC (Therapeutic Community)	Count	1	4	1	6
		% within PROGTYPE program type	16.7%	66.7%	16.7%	100.0%
Total		Count	16	48	51	115
		% within PROGTYPE program type	13.9%	41.7%	44.3%	100.0%

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Table 57. Q27E How important is amount of time served in current sentence for admission to program?

			Q27E how important is amount of time served in current sentence for admission to program			
			1.00 very important	2.00 somewhat important	3.00 not very important	Total
PROGTYPE program type	1.00 D & A Education Program	Count	14	14	14	42
		% within PROGTYPE program type	33.3%	33.3%	33.3%	100.0%
	2.00 Outpatient Treatment Program	Count	12	13	32	57
		% within PROGTYPE program type	21.1%	22.8%	56.1%	100.0%
	3.00 DATU (D & A Treatment Unit)	Count	1	5	4	10
		% within PROGTYPE program type	10.0%	50.0%	40.0%	100.0%
	4.00 TC (Therapeutic Community)	Count	1	3	2	6
		% within PROGTYPE program type	16.7%	50.0%	33.3%	100.0%
Total		Count	28	35	52	115
		% within PROGTYPE program type	24.3%	30.4%	45.2%	100.0%

Table 58. Q27F How important is absense of medical problems for admission to program?

			Q27F how important is absense of medical problems for admission to program			
			1.00 very important	2.00 somewhat important	3.00 not very important	Total
PROGTYPE program type	1.00 D & A Education Program	Count		14	28	42
		% within PROGTYPE program type		33.3%	66.7%	100.0%
	2.00 Outpatient Treatment Program	Count		6	51	57
		% within PROGTYPE program type		10.5%	89.5%	100.0%
	3.00 DATU (D & A Treatment Unit)	Count	1	3	6	10
		% within PROGTYPE program type	10.0%	30.0%	60.0%	100.0%
	4.00 TC (Therapeutic Community)	Count	2	2	2	6
		% within PROGTYPE program type	33.3%	33.3%	33.3%	100.0%
Total		Count	3	25	87	115
		% within PROGTYPE program type	2.6%	21.7%	75.7%	100.0%

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Table 59. Q27G How important is institutional record of drug use for admission to program?

			Q27G how important is institutional record of drug use for admission to program			
			1.00 very important	2.00 somewhat important	3.00 not very important	Total
PROGTYPE program type	1.00 D & A Education Program	Count	21	13	8	42
		% within PROGTYPE program type	50.0%	31.0%	19.0%	100.0%
	2.00 Outpatient Treatment Program	Count	17	14	26	57
		% within PROGTYPE program type	29.8%	24.6%	45.6%	100.0%
	3.00 DATU (D & A Treatment Unit)	Count	2	5	3	10
		% within PROGTYPE program type	20.0%	50.0%	30.0%	100.0%
	4.00 TC (Therapeutic Community)	Count	3	3		6
		% within PROGTYPE program type	50.0%	50.0%		100.0%
Total		Count	43	35	37	115
		% within PROGTYPE program type	37.4%	30.4%	32.2%	100.0%

Table 60. Q27H How important is institutional record of violence for admission to program?

			Q27H how important is institutional record of violence for admission to program			
			1.00 very important	2.00 somewhat important	3.00 not very important	Total
PROGTYPE program type	1.00 D & A Education Program	Count	3	21	17	41
		% within PROGTYPE program type	7.3%	51.2%	41.5%	100.0%
	2.00 Outpatient Treatment Program	Count	7	17	33	57
		% within PROGTYPE program type	12.3%	29.8%	57.9%	100.0%
	3.00 DATU (D & A Treatment Unit)	Count	4	4	2	10
		% within PROGTYPE program type	40.0%	40.0%	20.0%	100.0%
	4.00 TC (Therapeutic Community)	Count	4	1	1	6
		% within PROGTYPE program type	66.7%	16.7%	16.7%	100.0%
Total		Count	18	43	53	114
		% within PROGTYPE program type	15.8%	37.7%	46.5%	100.0%

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Table 61. Q27l How important is institutional record of other misconducts for admisson to program?

			Q27l how important is institutional record of other misconducts for admisson to program			
			1.00 very important	2.00 somewhat important	3.00 not very important	Total
PROGTYPE program type	1.00 D & A Education Program	Count	3	17	22	42
		% within PROGTYPE program type	7.1%	40.5%	52.4%	100.0%
	2.00 Outpatient Treatment Program	Count	5	16	36	57
		% within PROGTYPE program type	8.8%	28.1%	63.2%	100.0%
	3.00 DATU (D & A Treatment Unit)	Count	4	4	2	10
		% within PROGTYPE program type	40.0%	40.0%	20.0%	100.0%
	4.00 TC (Therapeutic Community)	Count	5	1		6
		% within PROGTYPE program type	83.3%	16.7%		100.0%
Total		Count	17	38	60	115
		% within PROGTYPE program type	14.8%	33.0%	52.2%	100.0%

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Table 62. Q28 Are D and A individualized treatment plans developed for each client?

			Q28 Are D and A individualized treatment plans developed for each client?		
			.00 no	1.00 yes	Total
PROGTYPE program type	1.00 D & A Education Program	Count	38	5	43
		% within PROGTYPE program type	88.4%	11.6%	100.0%
	2.00 Outpatient Treatment Program	Count	37	19	56
		% within PROGTYPE program type	66.1%	33.9%	100.0%
	3.00 DATU (D & A Treatment Unit)	Count	5	5	10
		% within PROGTYPE program type	50.0%	50.0%	100.0%
	4.00 TC (Therapeutic Community)	Count		6	6
		% within PROGTYPE program type		100.0%	100.0%
Total		Count	80	35	115
		% within PROGTYPE program type	69.6%	30.4%	100.0%

Table 63. Q29 Does this program have general goals for all participants?

			Q29 does this program have general goals for all participants		
			.00 no	1.00 yes	Total
PROGTYPE program type	1.00 D & A Education Program	Count	11	31	42
		% within PROGTYPE program type	26.2%	73.8%	100.0%
	2.00 Outpatient Treatment Program	Count	5	52	57
		% within PROGTYPE program type	8.8%	91.2%	100.0%
	3.00 DATU (D & A Treatment Unit)	Count	1	9	10
		% within PROGTYPE program type	10.0%	90.0%	100.0%
	4.00 TC (Therapeutic Community)	Count		5	5
		% within PROGTYPE program type		100.0%	100.0%
Total		Count	17	97	114
		% within PROGTYPE program type	14.9%	85.1%	100.0%

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Table 64. Q30 How often do staff conduct a formal case program review of each participant?

			Q30 how often do staff conduct a formal case program review of each participant				Total
			1.00 never	2.00 weekly	3.00 monthly	4.00 at discharge only	
PROGTYPE program type	1.00 D & A Education Program	Count	27	4	2	10	43
		% within PROGTYPE program type	62.8%	9.3%	4.7%	23.3%	100.0%
	2.00 Outpatient Treatment Program	Count	16	6	7	29	58
		% within PROGTYPE program type	27.6%	10.3%	12.1%	50.0%	100.0%
	3.00 DATU (D & A Treatment Unit)	Count	3	1	5	1	10
		% within PROGTYPE program type	30.0%	10.0%	50.0%	10.0%	100.0%
	4.00 TC (Therapeutic Community)	Count		1	5		6
		% within PROGTYPE program type		16.7%	83.3%		100.0%
Total		Count	46	12	19	40	117
		% within PROGTYPE program type	39.3%	10.3%	16.2%	34.2%	100.0%

Table 65. Q32 Do clients in this program have any input into programmatic structure or activites?

			Q32 do clients in this program have any input into programmatic structure or activites		Total
			.00 no	1.00 yes	
PROGTYPE program type	1.00 D & A Education Program	Count	18	25	43
		% within PROGTYPE program type	41.9%	58.1%	100.0%
	2.00 Outpatient Treatment Program	Count	12	44	56
		% within PROGTYPE program type	21.4%	78.6%	100.0%
	3.00 DATU (D & A Treatment Unit)	Count	3	7	10
		% within PROGTYPE program type	30.0%	70.0%	100.0%
	4.00 TC (Therapeutic Community)	Count		6	6
		% within PROGTYPE program type		100.0%	100.0%
Total		Count	33	82	115
		% within PROGTYPE program type	28.7%	71.3%	100.0%

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Table 66. Q33 Do clients in this program have any input into determining rewards and sanctions?

			Q33 do clients in this program have any input in determining rewards and sanctions		
			.00 no	1.00 yes	Total
PROGTYPE program type	1.00 D & A Education Program	Count	37	6	43
		% within PROGTYPE program type	86.0%	14.0%	100.0%
	2.00 Outpatient Treatment Program	Count	40	18	58
		% within PROGTYPE program type	69.0%	31.0%	100.0%
	3.00 DATU (D & A Treatment Unit)	Count	3	7	10
		% within PROGTYPE program type	30.0%	70.0%	100.0%
	4.00 TC (Therapeutic Community)	Count		6	6
		% within PROGTYPE program type		100.0%	100.0%
Total		Count	80	37	117
		% within PROGTYPE program type	68.4%	31.6%	100.0%

Table 67. Q37 Are readmissions into this program permitted?

			Q37 are readmissions into this program permitted?		
			.00 no	1.00 yes	Total
PROGTYPE program type	1.00 D & A Education Program	Count	6	37	43
		% within PROGTYPE program type	14.0%	86.0%	100.0%
	2.00 Outpatient Treatment Program	Count	7	49	56
		% within PROGTYPE program type	12.5%	87.5%	100.0%
	3.00 DATU (D & A Treatment Unit)	Count	1	9	10
		% within PROGTYPE program type	10.0%	90.0%	100.0%
	4.00 TC (Therapeutic Community)	Count		6	6
		% within PROGTYPE program type		100.0%	100.0%
Total		Count	14	101	115
		% within PROGTYPE program type	12.2%	87.8%	100.0%

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Table 68. Q38, Q39 Staff Numbers and Inmate/Staff Ratios

PROGTYPE program type		Q38A # full time agency staff assigned to program	RATIOCUR current inmate/staff ratio	RATIOMAX maximum inmate/staff ratio
1.00 D & A Education Program	Mean	3.1628	20.0427	23.7297
	N	43	39	37
	Std. Deviation	2.5254	14.1979	16.0029
	Minimum	.00	5.00	5.00
	Maximum	16.00	64.67	80.00
2.00 Outpatient Treatment Program	Mean	3.2414	17.2092	20.5449
	N	58	51	52
	Std. Deviation	5.3650	10.7315	14.0331
	Minimum	.00	7.00	10.00
	Maximum	40.00	60.00	77.00
3.00 DATU (D & A Treatment Unit)	Mean	3.0000	29.6481	37.0238
	N	10	9	7
	Std. Deviation	2.0548	25.7712	33.1898
	Minimum	1.00	8.00	12.00
	Maximum	7.00	92.00	105.00
4.00 TC (Therapeutic Community)	Mean	4.1667	17.2222	17.5889
	N	6	6	6
	Std. Deviation	.9832	5.4921	6.0839
	Minimum	3.00	9.00	7.20
	Maximum	5.00	26.00	26.00
Total	Mean	3.2393	19.3286	22.6572
	N	117	105	102
	Std. Deviation	4.1077	13.9078	16.6295
	Minimum	.00	5.00	5.00
	Maximum	40.00	92.00	105.00

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Table 69. Q40 How frequently is the DATS manager/supervisor involved in service delivery?

			Q40 how frequently is the DATS manager/supervisor involved service delivery					
			1.00 always	2.00 usually	3.00 occasion ally	4.00 rarely	5.00 never	Total
PROGTYPE program type	1.00 D & A Education Program	Count	3	7	19	9	5	43
		% within PROGTYPE program type	7.0%	16.3%	44.2%	20.9%	11.6%	100.0%
	2.00 Outpatient Treatment Program	Count	14	9	13	17	4	57
		% within PROGTYPE program type	24.6%	15.8%	22.8%	29.8%	7.0%	100.0%
	3.00 DATU (D & A Treatment Unit)	Count	3	3		1	3	10
		% within PROGTYPE program type	30.0%	30.0%		10.0%	30.0%	100.0%
	4.00 TC (Therapeutic Community)	Count	4			2		6
		% within PROGTYPE program type	66.7%			33.3%		100.0%
Total		Count	24	19	32	29	12	116
		% within PROGTYPE program type	20.7%	16.4%	27.6%	25.0%	10.3%	100.0%

Table 70. Q41 How frequently is the DATS manager/supervisor involved in direct staff supervison ?

			Q41 how frequently is the DATS manager/supervisor involved direct staff supervison					
			1.00 always	2.00 usually	3.00 occasion ally	4.00 rarely	5.00 never	Total
PROGTYPE program type	1.00 D & A Education Program	Count	8	19	8	5	3	43
		% within PROGTYPE program type	18.6%	44.2%	18.6%	11.6%	7.0%	100.0%
	2.00 Outpatient Treatment Program	Count	26	9	17	1	5	58
		% within PROGTYPE program type	44.8%	15.5%	29.3%	1.7%	8.6%	100.0%
	3.00 DATU (D & A Treatment Unit)	Count	6		1	1	2	10
		% within PROGTYPE program type	60.0%		10.0%	10.0%	20.0%	100.0%
	4.00 TC (Therapeutic Community)	Count	4	2				6
		% within PROGTYPE program type	66.7%	33.3%				100.0%
Total		Count	44	30	26	7	10	117
		% within PROGTYPE program type	37.6%	25.6%	22.2%	6.0%	8.5%	100.0%

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Table 71. Q42 Percentage of Time That Staff Spend on Different Activities

PROGTYPE program type		Q42A percentage of time staff spends on direct treatment or service	Q42B percentage of time staff spends on clinical supervision	Q42C percentage of time staff spends on clinical case reviews	Q42D percentage of time staff spends on program planning activities	Q42E percentage of time staff spends on administrative and managerial functions	Q42F percentage of time staff spends on DC-14 maintenance	Q42G percentage of time staff spends on special duties
1.00 D & A Education Program	Mean	65.2619	2.6585	1.8571	10.6905	5.9286	8.2381	5.7073
	N	42	41	42	42	42	42	41
	Std. Deviation	27.0131	6.9700	3.3682	16.0190	13.9902	16.0226	15.9722
	Minimum	.00	.00	.00	.00	.00	.00	.00
	Maximum	100.00	40.00	10.00	100.00	85.00	100.00	100.00
2.00 Outpatient Treatment Program	Mean	58.0175	3.6071	4.0179	11.8214	9.0370	3.8214	4.6250
	N	57	56	56	56	54	56	56
	Std. Deviation	23.6330	4.7623	4.5746	11.4258	19.8266	5.7780	5.6135
	Minimum	1.00	.00	.00	.00	.00	.00	.00
	Maximum	100.00	20.00	20.00	75.00	100.00	26.00	15.00
3.00 DATU (D & A Treatment Unit)	Mean	48.8750	5.1250	2.8750	8.5714	13.0000	18.1250	5.2857
	N	8	8	8	7	8	8	7
	Std. Deviation	27.2839	4.6733	2.5877	8.1416	22.9409	13.9329	4.3861
	Minimum	5.00	.00	.00	.00	.00	.00	.00
	Maximum	100.00	11.00	6.00	20.00	66.00	44.00	11.00
4.00 TC (Therapeutic Community)	Mean	40.0000	8.5000	10.5000	7.5000	22.6667	7.6667	13.2000
	N	6	6	6	6	6	6	5
	Std. Deviation	7.0711	6.9210	5.0498	3.0166	20.3142	7.5011	9.2033
	Minimum	30.00	.00	5.00	3.00	5.00	.00	2.00
	Maximum	50.00	20.00	20.00	10.00	60.00	20.00	25.00
Total	Mean	59.1062	3.6306	3.4732	10.9550	8.8818	6.7054	5.4679
	N	113	111	112	111	110	112	109
	Std. Deviation	25.2386	5.8635	4.4680	12.8985	18.2363	11.8608	10.8582
	Minimum	.00	.00	.00	.00	.00	.00	.00
	Maximum	100.00	40.00	20.00	100.00	100.00	100.00	100.00

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Table 72. Q43 Are any formal procedures in place to evaluate staff performance?

			Q43 are any formal procedures in place to evaluate staff performance		
			.00 no	1.00 yes	Total
PROGTYPE program type	1.00 D & A Education Program	Count	13	30	43
		% within PROGTYPE program type	30.2%	69.8%	100.0%
	2.00 Outpatient Treatment Program	Count	25	33	58
		% within PROGTYPE program type	43.1%	56.9%	100.0%
	3.00 DATU (D & A Treatment Unit)	Count	2	8	10
		% within PROGTYPE program type	20.0%	80.0%	100.0%
	4.00 TC (Therapeutic Community)	Count	1	5	6
		% within PROGTYPE program type	16.7%	83.3%	100.0%
Total		Count	41	76	117
		% within PROGTYPE program type	35.0%	65.0%	100.0%

Table 73. Q44 Are counselors assigned to work with certain inmates on an individual, one-to-one basis?

			Q44 are counselors assigned to work with certain inmates on an individual, one-to-one basis		
			.00 no	1.00 yes	Total
PROGTYPE program type	1.00 D & A Education Program	Count	33	10	43
		% within PROGTYPE program type	76.7%	23.3%	100.0%
	2.00 Outpatient Treatment Program	Count	29	29	58
		% within PROGTYPE program type	50.0%	50.0%	100.0%
	3.00 DATU (D & A Treatment Unit)	Count	3	7	10
		% within PROGTYPE program type	30.0%	70.0%	100.0%
	4.00 TC (Therapeutic Community)	Count	1	5	6
		% within PROGTYPE program type	16.7%	83.3%	100.0%
Total		Count	66	51	117
		% within PROGTYPE program type	56.4%	43.6%	100.0%

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Table 74. Q45 Is any specialized in-house D and A training provided for treatment staff?

			Q45 is any specialized in-house d and a training provided for treatment staff		
			.00 no	1.00 yes	Total
PROGTYPE program type	1.00 D & A Education Program	Count	17	26	43
		% within PROGTYPE program type	39.5%	60.5%	100.0%
	2.00 Outpatient Treatment Program	Count	19	39	58
		% within PROGTYPE program type	32.8%	67.2%	100.0%
	3.00 DATU (D & A Treatment Unit)	Count	5	5	10
		% within PROGTYPE program type	50.0%	50.0%	100.0%
	4.00 TC (Therapeutic Community)	Count		6	6
		% within PROGTYPE program type		100.0%	100.0%
Total		Count	41	76	117
		% within PROGTYPE program type	35.0%	65.0%	100.0%

Table 75. Q46 Does staff have any input into modifying program structure or activities?

			Q46 does staff have any input into modifying program structure or activities		
			.00 no	1.00 yes	Total
PROGTYPE program type	1.00 D & A Education Program	Count	4	39	43
		% within PROGTYPE program type	9.3%	90.7%	100.0%
	2.00 Outpatient Treatment Program	Count		58	58
		% within PROGTYPE program type		100.0%	100.0%
	3.00 DATU (D & A Treatment Unit)	Count		10	10
		% within PROGTYPE program type		100.0%	100.0%
	4.00 TC (Therapeutic Community)	Count		6	6
		% within PROGTYPE program type		100.0%	100.0%
Total		Count	4	113	117
		% within PROGTYPE program type	3.4%	96.6%	100.0%

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Table 76. Q48 Staff Gender By Program Type

PROGTYPE program type		Q48A #of male staff	Q48B # of female staff
1.00 D & A Education Program	Mean	2.2857	1.1429
	N	42	42
	Minimum	.00	.00
	Maximum	14.00	5.00
	Sum	96.00	48.00
2.00 Outpatient Treatment Program	Mean	1.4828	1.2931
	N	58	58
	Minimum	.00	.00
	Maximum	5.00	3.00
	Sum	86.00	75.00
3.00 DATU (D & A Treatment Unit)	Mean	2.5000	.9000
	N	10	10
	Minimum	.00	.00
	Maximum	5.00	3.00
	Sum	25.00	9.00
4.00 TC (Therapeutic Community)	Mean	3.1667	2.1667
	N	6	6
	Minimum	2.00	.00
	Maximum	5.00	5.00
	Sum	19.00	13.00
Total	Mean	1.9483	1.2500
	N	116	116
	Minimum	.00	.00
	Maximum	14.00	5.00
	Sum	226.00	145.00

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Table 77. Q48 Staff Ethnicity By Program Type

PROGTYPE program type		Q48C # of caucasian staff	Q48D # of african american staff	Q48E # of native american staff	Q48F # of hispanic staff	Q48G # of asian staff	Q48H # of other staff
1.00 D & A Education Program	Mean	3.1667	.1667	.0000	4.762E-02	.0000	.0000
	N	42	42	42	42	42	42
	Minimum	.00	.00	.00	.00	.00	.00
	Maximum	14.00	2.00	.00	1.00	.00	.00
	Sum	133.00	7.00	.00	2.00	.00	.00
2.00 Outpatient Treatment Program	Mean	2.4483	.1897	.0000	1.724E-02	.0000	.0000
	N	58	58	58	58	58	58
	Minimum	.00	.00	.00	.00	.00	.00
	Maximum	8.00	1.00	.00	1.00	.00	.00
	Sum	142.00	11.00	.00	1.00	.00	.00
3.00 DATU (D & A Treatment Unit)	Mean	3.0000	.4000	.0000	.0000	.0000	.0000
	N	10	10	10	10	10	10
	Minimum	.00	.00	.00	.00	.00	.00
	Maximum	8.00	3.00	.00	.00	.00	.00
	Sum	30.00	4.00	.00	.00	.00	.00
4.00 TC (Therapeutic Community)	Mean	4.6667	.6667	.0000	.1667	.0000	.0000
	N	6	6	6	6	6	6
	Minimum	2.00	.00	.00	.00	.00	.00
	Maximum	8.00	2.00	.00	1.00	.00	.00
	Sum	28.00	4.00	.00	1.00	.00	.00
Total	Mean	2.8707	.2241	.0000	3.448E-02	.0000	.0000
	N	116	116	116	116	116	116
	Minimum	.00	.00	.00	.00	.00	.00
	Maximum	14.00	3.00	.00	1.00	.00	.00
	Sum	333.00	26.00	.00	4.00	.00	.00

Table 78. Number and Percentage of Staff in Recovery, By Program Type

PROGTYPE program type	N	Mean	Std. Deviation	# in Recovery	Minimum	Maximum	# of Total Staff	% in Recovery
1.00 D & A Education Program	43	.8140	1.1182	35.00	.00	4.00	136	25.7%
2.00 Outpatient Treatment Program	57	1.0175	1.0087	58.00	.00	4.00	188	30.9%
3.00 DATU (D & A Treatment Unit)	10	1.2000	1.3166	12.00	.00	4.00	30	40.0%
4.00 TC (Therapeutic Community)	6	2.3333	1.6330	14.00	.00	4.00	25	56.0%
Total	116	1.0259	1.1456	119.00	.00	4.00	379	31.4%

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Appendix 4:

Process Evaluation Research Instruments

Observation Checklist Form

Inmate (Program Participant) Interview Form

Staff Interview Form

Inmate Case Files: Observation Guide

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Observation Checklist Form: DOC-Temple Research Partnership

Name of Researcher: ____________________ **Date and Time of Visit:** __________

Institution: __________________________________

Name of Program (and Group, if applicable): ______________________________

[Note: This form is program specific]

Researchers: **Thank** the staff and inmates for allowing you to observe. Maintain a low profile. **After** the session, researchers should confer briefly with staff to determine if the nature and extent of inmate participation today was normal or unusual in any way. **Purpose**: In addition to interviews with staff and inmates, we attempt to describe treatment programming by **observing** some groups in action. Observing treatment activities helps us to accurately **describe** D & A programming and plan for future evaluation.

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1. Describe the **physical setting.** Does it appear adequate for educational or treatment needs? Why or why not?

2. Describe **inmate attendance and participation**: Do inmates appear enthusiastic? Interested?

3. How do staff handle any **discipline problems**?

4. How do staff **interact and communicate** with inmates? Give one or two examples. Do different staff members have different **styles of interaction** with inmates?

5. Briefly describe what kind of **content** was covered in the group or session you attended (see survey Q#19). Give one or two examples.

6. What kind of treatment **format** was used? (e.g., lecture, video, peer- or staff-led group: See survey Q#18).

7. From your observations, was it possible to determine what kind of **treatment approach** was used (e.g., cognitive-behavioral, rational emotive therapy, etc.? (See Survey Q#12).

8. Based upon what you know about this program so far, **were the activities you observed relevant to the program's goals**? Why or why not?

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Inmate (Program Participant) Interview Form: DOC-Temple Research Partnership

Name of Researcher: ____________________ **Date of Visit:** ____________________

Institution: ____________________________________

Name of Program Inmate Participates In: ________________________________

[Note: This interview is program specific]

Researchers: Thank the inmate for his/her time. The interview should last about half an hour. **Purpose**: Interviews with participants attempt to describe treatment *programming*. The participation of inmates in the research will allow us to accurately **describe** D & A programming from the inmate's point of view and help us determine which types of programs work best for which types of people under which conditions.

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1. **How long have you been participating** in this program? Are there different "phases"? (If so, **which phase** are you in now?).

2. How did you **first hear about this program**, and what (if anything) did you need to do to **get into** the program (e.g., get a referral? fill out an application? get interviewed by staff or inmates in the program?)

3. How long did you have to **wait** to get into this program?

4. **Why** did you want to participate in this program?

5. Could you describe a **typical day** in this program? For example, what kinds of activities or treatment **methods** are used most often: lecture, video, written assignments, individual counseling, peer-led group discussion, or staff-led group discussion? (**See survey Q#18**).

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6. What kinds of **issues (content)** are addressed in this program? (e.g., impacts of drug use, problem solving skills, relapse prevention, etc.). Could you give one or two examples? **(see survey Q#19)**

7. In this program, what has been:

(a) most helpful to you?

(b) least helpful to you?

8. What do you think about the **staff** in this program? (e.g., How well do staff **interact** with inmates? Are inmates treated with **respect**? Are the staff **fair** with all inmates?)

9. What kinds of **rewards and punishments** are used in this program? (e.g., are there consequences for good participation? Poor participation?) Please explain.

10. Do the inmates in this program have any **input into program structure or activities**? If "yes," please describe briefly:

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11. Have you had any difficulty **accessing** treatment services? If so, please explain.

12. Have you participated in any **other treatment programs** in Pennsylvania state prisons? _____Yes _____ No

If yes:
(a) In what ways is your experience in this program **similar?**

(b) In what ways is your experience in this program **different?**

13. Would you **recommend** this program to someone you know? Why or why not?

14. What, if anything, would you **change** about this program?

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Staff Interview Form: DOC-Temple Research Partnership

Name of Researcher: ________________ **Date of Visit:** ________________

Institution Visited: ________________________________

Name of Staff Person Interviewed ________________ **Job Title:** __________

D & A Program Discussed in Today's Interview: ________________________
[Note: This interview is program specific]

Researchers: Thank the staff person for his/her time. The interview shall not exceed one hour. **Purpose**: Interviews with DATS personnel attempt a detailed description of *program content and structure, inmate participants*, and *staff responsibilities*. **This is not an evaluation**. The participation of DATS staff in the research will allow us to accurately **describe** D & A programming and plan for future evaluation. A summary report of the research will be made available to all D & A staff.

Part I. Questions about Staff

1. Could you tell me just a bit about your **background**? (e.g., educational degree, specialized training, D & A experience)

2. Could you briefly describe your **educational/ treatment duties** in this program (i.e., who does what?)

3. What **other duties and responsibilities (i.e., non-treatment) do you have?** (e.g., see survey Q#42)

4. How would you describe the **relationships** between staff at this institution (e.g., is there a sense of teamwork)?

(a) relationships between D & A staff:

(b) relationships between D & A staff and security:

(c) relationships between D & A staff and other correctional staff or departments:

5. What, if anything, would you **change** about this program?

6. What kind of **input,** if any, do staff in this program have into **modifying program structure or activities?**

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Part II. Questions about Program Content and Structure

7. What are the **general goals** or **mission** of this program? What does it try to do?

8. Could you tell us a bit about the different **program components** (see survey question # 19 for examples of **specific educational or treatment activities).**
[Follow up questions: About how many hours weekly do inmates participate in each activity?]

9. For each **activity or group** listed in Q#8, what is the **intended result or objective?** (i.e., what change in inmate attitudes or behaviors is expected)?

10. What is the main **treatment approach** used in this program? (e.g., see survey Q#12) Could you give one or two examples of *how* this approach is used?

11. How do you structure treatment to address inmate needs (e.g., individual treatment planning, group activities)? [Note: some researchers believe that effective treatment requires matching appropriate treatment services with specific inmate needs]

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Part III. Questions about Inmate Participants

12. What kinds of inmates **do well** in your program? What kinds of inmates present the **most challenges**? Please describe.

13. What is the normal **program enrollment**? (i.e., at one specific time)

14. What is the normal **length of stay** for an inmate in this program?

15. About what percentage of inmates admitted are **discharged early from this program**? Why?

16. Do you ever make **treatment-related referrals to other programs or departments within DOC? To outside agencies**? If so, please describe:

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Inmate Case Files: Observation Guide

Name of Researcher: ____________________ **Date and Time of Visit:** __________
Institution: ________________________________
Name of Program Inmate Participates In: ______________________________
Inmate's Initials: ___________

1. **How long** has the inmate been in this program? Which phase is he/she in?

2. For this inmate, briefly describe what information is recorded about **how the inmate was recruited or referred** for treatment (e.g., How did the inmate hear about this program? Who made the referral? What are the reasons for referral)? Is a specific form used?

3. How was the inmate's **eligibility** for this program assessed (e.g., type and seriousness of D & A problem, time remaining in sentence)? What specific form(s) or assessment instruments were used?

4. **Decision to admit** (or not): Who made the decision? What form(s) was used and what criteria were used? Is a specific form used?

5. Is there an **intake or admission form** in the file? What kind of information was collected? Briefly describe:

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6. **Treatment Plan**: Is a specific form used? Briefly describe the inmate's **treatment goals or objectives** in this program, specific **treatment strategies and activities prescribed**, and inmate **progress** on specific goals.

7. Describe what other types of records are kept about **inmate participation** in treatment (e.g., attendance, **quantity and quality of participation**, etc.). Are specific forms used? Do you find these records adequate to assess inmate participation?

8. What information is recorded on **inmate responses or reactions** to treatment services, and how? Is a specific form used? Describe briefly:

9. What information in the file describes whether the inmate is meeting (or is expected to meet) the criteria for **successful program completion**? For an unsuccessful discharge? Are specific forms used?

10. How is **discharge information** recorded (if applicable)? Is a specific form used? Is there any indication that the inmate was (or might be) **discharged early** from this program? Why?

11. Has this inmate ever been referred (for treatment-related purposes) to **other programs or departments** within DOC? To outside agencies? If so, please describe:

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Appendix 5: Individual Program Reports: SCI - Houtzdale

Courage to Change Therapeutic Community (CCTC)

Substance Abuse Education

Addictions Education

Addictions Treatment (Outpatient)

Relapse Prevention

Youthful Adult Offenders Unit (YAOU): Substance Abuse Education

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INDIVIDUAL PROGRAM REPORTS: DOC-TEMPLE RESEARCH PARTNERSHIP

Institution: Houtzdale

D & A Program: Courage to Change Therapeutic Community

Program Description

General Program Goals and Intervention Philosophy

1. What are the **general goals** or **mission** of this program? What does it try to do? **[Source: program documents, staff interviews].**

The Drug and Alcohol Department Procedures Manual describes the CCTC as follows:
The CCTC addresses the physical, mental spiritual, emotional and social problems associated with drug and alcohol abuse. If you decide to enroll in the CCTC, you will be entering an atmosphere that fosters motivation, self-help and learning. The CCTC is not just a housing area, but a community that strives to help each other and provide constructive feedback.

It further states that the goal of SCI – Houtzdale's Drug and Alcohol Treatment Department is to provide quality drug and alcohol treatment and education to inmates whose lives have been affected by chemical substance abuse.

2. What is the main **treatment approach** or **philosophy** used in this program? Could you give one or two examples of *how* this approach is used? **[Source: staff interviews, program documents].**

The Drug and Alcohol Department Procedures Manual states that a multimodal approach to treatment is used at SCI – Houtzdale. The CCTC is a treatment intensity level III program whose specific treatment approach is non-hospital, residential treatment – total immersion. A variety of levels of treatment and therapeutic approaches are used.

According to Policy Statement 7.4.1HOU2 "General Description of Institutional Drug and Alcohol Treatment Package," the TC programs will adhere to the Bio-Psychosocial model of addiction, and will utilize a total immersion treatment approach.

The TC Proposal states that the specific treatment approach is non-hospital, residential treatment in which the cognitive, spiritual, social, physical and emotional aspects of the person will be addressed.

In response to question # 12 of the Survey of Prison Based Drug and Alcohol Treatment Programs, other treatment approaches used by the CCTC include cognitive therapy, behavior modification, psychotherapy, RET, and reality therapy.

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Target Population and Target Selection

3. **For this program**, describe inmate **recruiting, outreach, or referral procedures** (e.g., How do inmates hear about this program? Who makes referrals? What are the reasons for referral)? **[Source: program documents].**

Both the Drug and Alcohol Department Procedures Manual and Policy Statement 7.4.1 HOU8 "Weekly General Population Inmate Drug and Alcohol Orientation" indicate that new arrivals to SCI – Houtzdale will attend an orientation in which verbal and written information is provided describing drug and alcohol programming. Referrals can be generated by inmates or DOC staff, and each are tracked according to an automated system that lists inmates according to their minimum and referral dates. According to the Inmate Handbook, referrals from DOC staff could include the Corrections Counselor, Unit Manager, or DATS. A vote sheet system is then initiated with the Deputy Superintendent having the final decision. As per Policy Statement 7.4.1 HOU4, inmates self-referring should complete form DC-135A, and staff-generated referrals should use a DC-134 form.

4. What are the specific **eligibility** requirements for this program (e.g., type and seriousness of D & A problem, time remaining in sentence)? Are exceptions made? **[Source: program documents].**

The Procedures Manual for the Drug and Alcohol Department articulates the eligibility for the CCTC. Inmates must be six months misconduct free; must voluntarily enter the program; and must have one or more of the following: a Psychoactive Dependence Scale Score reflecting a need for intensive treatment, a documented drug and alcohol history, drug and alcohol related charges, drug and alcohol related misconducts, admits to a drug and alcohol problem, previous drug and alcohol placements, admit to being under the influence at the time of the offense, or commission of a crime for monetary support for his addiction. Each of these criteria are also listed in Policy Statement 7.4.1 HOU6 "Referral Process for CCTC."

The Inmate Handbook outlines some additional entrance criteria. One criteria is that there be no psychosis or intellectual functioning that precludes comprehension of objectives or participation in activities. Another is that he may not be using illicit drugs, which will be assessed through urinalysis. Also, a "Z" code, according to page 4 of the Inmate Handbook may preclude consideration of a candidate.

5. **Decision to admit (or not):** Who makes the decision? What are the most important criteria? About what percentage of referrals are rejected? **[Source: program documents, D & A Program Survey].**

According to Policy Statement 7.4.1 HOU6, "Referral Process for CCTC," the Corrections Counselor circulates a vote sheet (form DC-46) to the Unit Manager, DATS Supervisor, Inmate Program Manager, and the Deputy of Centralized Services, who makes the final decision.

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In response to question #27 of the Survey of Prison-Based Drug and Alcohol Treatment Programs, the most important screening criteria of all those listed previously are level of drug involvement, and institutional record of drug use and misconducts.

In addition to all of the eligibility requirements outlined above in question #4, the Drug and Alcohol Department Procedures Manual states that other important individual qualities include genuine heart, courage, and determination.

Intake, Exit, and Follow-up Procedures

6. Describe the **intake/admission process** (e.g., What happens to an inmate when they first attend this program? Is there an orientation, intake interview, etc.?) **[Source: program documents].**

Procedure X in the Drug and Alcohol Department Procedures Manual addresses the needs of newly arriving CCTC members. The screening process includes an interview with DATS staff, where rules and expectations are discussed. If the inmate is deemed appropriate for treatment, they will be added to the TC as space becomes available. Once approved and during their orientation, the DATS gives the inmates their Community Resident Handbook, behavior objectives, treatment records packet, and his AA/NA books. The inmate also signs the disclosure, inmate rights, and consent to treatment forms.

In addition, the Inmate Handbook states that each new resident will meet with the Intake Committee the day he arrives on the TC, and will be assigned a big brother to assist him with his transition to the unit. Each new inmate is granted a two-week orientation period in which they become familiar with the schedules and routines. They each complete a "pop sheet" to help them become familiar with their small group members. They must also sign a six-month celling agreement.

7. What is the normal **program enrollment**? (i.e., at one specific time) **[Source: program documents].**

The normal program enrollment in the CCTC is 128 inmates, according to the Drug and Alcohol Department Procedures Manual.

8. What is the normal **length of stay** for an inmate in this program? **[Source: program documents].**

According to the Drug and Alcohol Department Procedures Manual, the length of stay for the inmates in the CCTC is 12 months. However, the Inmate Handbook also indicates that the actual time in the program may be more or less than this because time frames are based on individual considerations.

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9. What are the **criteria for successful program completion? For an unsuccessful discharge**? **[Source: program documents].**

The Inmate Handbook outlines discharge procedures and definitions. A successful discharge occurs when a TC member has completed all the requirements of the three phases of the CCTC. A neutral discharge is granted when a TC member prematurely leaves the program prior to completion due to circumstances beyond his control (parole, pre-release, medical reasons, limited mental capacities). An unsuccessful discharge occurs when a TC member with the ability to complete the program prematurely leaves due to termination or voluntary withdrawal.

The Inmate Handbook also lists reasons for termination, including misconducts, violation of rules, non-adherence to treatment plan, several medical or emotional problems, sentence status change or failure to adjust.

According to the response to question #13 of the Survey of Prison-Based Drug and Alcohol Treatment Programs, the two most important criteria to determine successful completion are Measures of Attitudinal or Behavioral Change, and Case Progress Review by Treatment Staff.

Specific Program Content and Structure

10. **Describe** (a) the different **program components or activities** (see D & A Program Survey question # 19 for examples of specific educational or treatment activities), and (b) the **intended result or objective of each activity [Source: staff interviews, observations, program documents]**. Include the following in the report:

- Provide a **title and brief description** of the activity.
- How many **hours** weekly do inmates participate in each activity? How often do they meet?
- Describe a few **examples of program content** from lesson plans, printed program descriptions, observations, and interviews (i.e., what do they do and how do they do it?)
- For each **activity or group**, what is the **intended result or objective?** (i.e., what change in inmate attitudes or behaviors is expected)?

According to the Proposal for the TC dated 1996, there are four goals of the TC. These include: to increase knowledge and dispel myths by education of chemical dependency; to improve knowledge and practice cognitive and behavioral coping strategies to use throughout recovery and to improve and practice interpersonal skills and the group process; to develop intrapersonal skills and to become aware of social and re-entry issues; and to develop refusal skills and an awareness of relapse warning signs and symptoms necessary to facilitate long-term recovery. Page 19 of the Proposal states that weekly activities designated to achieve these goals include morning meeting; seminars; pull up hearings; Phase I, II, and III classes; small groups; AA/NA meetings; and the confrontation support group.

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According to the Drug and Alcohol Department Procedures Manual, both individual and group therapy are provided to inmates in the CCTC. In addition, numerous classes are offered in a wide range of topics, such as basic concepts, cognitive restructuring, and communication. The TC Proposal also identifies classes in sexuality, inter/intra personal skills, and confrontation support.

According to the Course Outline for the Basic Concepts of Recovery Phase I Class, the sections include: What is AA/NA?, Spirituality vs. Religion, The Disease Concept, the Process of Recovery, and Sponsorship. A final exam completes the section. As per the lesson plans for the Phase II Communications course, topics such as Speaking in Code, Cycles of Communication, Active Listening, and Blocks to Effective Listening are included in this section. The Phase III Cognitive Restructuring Course involves eight sessions of one hour each, such as Emotions as Problems, Thinking and Emotions, Irrational Beliefs, and Rational Emotive Homework.

The Inmate Handbook and the TC Proposal also list and describe each of the committees inmates are required to attend or be assigned to. These included committees for Activities, Education, Intake, Interaction, Maintenance, Programs, and Public Relations.

The Inmate Handbook states that TC members are compensated for a 30-hour work week, and are expected to complete committee assignments and attend groups, meetings, and classes. Inmates with a fifth grade reading level or less will be required to attend school on a half-day basis (in lieu of work assignment, where applicable).

Policy Statement 7.4.1 HOU17 "CCTC Amended Pay Schedule," reflects the following levels of compensation: Phase I inmates receive .18/hr., Phase II .19/hr., Phase III .23/hr., and Phase IV (chairman and secretary positions) receive .24/hr.

According to the Unit Schedule, each day (excluding weekends) includes one hour each of a Phase Class, Small Group, and AA/NA meeting. Each week, Pull-up Hearings and Seminars are held, and each month, Counselor Hours are available to TC inmates.

11. How is treatment structured to address **individual inmate needs** (e.g., **individual treatment planning**)? [Note: The "responsivity" principle of effective treatment requires matching appropriate treatment services with specific inmate needs]. Describe how **D & A needs assessments and treatment planning** are done (if applicable). **[Source: staff interviews, program documents]**.

The inmates are given a treatment plan with specific goals that may include group exercises, written assignments, and oral presentations, according to the Drug and Alcohol Department Procedures Manual. Treatment plans are categorized according to Phase I, II, and III, with action steps, including goals and objectives, specified for each problem areas. DATS staff can add individual action steps for each inmate, if desired.

Examples of Phase I problem areas are lack of investment in TC, lack of knowledge and practice of communication skills, lack of knowledge of the dynamics of addiction, and need to sustain recovery and abstinence.

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Examples of Phase II problem areas are limited ability to practice cognitive and behavioral coping strategies, denial, lack of knowledge and practice of the12 steps of recovery, and need to sustain recovery and abstinence.

Examples of Phase III problem areas are lack of knowledge of inter- and intra-personal skills, lack of knowledge of relapse, and lack of experience in effective and consistent application of recovery tools. For each problem area and for every phase, generalized action steps are suggested, and often include developing a seminar, attending classes, discussing an issue, completing a plan or reading, etc. Additional problem areas and action steps may be added to each treatment plan as needed.

12. What types of **program records** about inmate participants are kept, and how (e.g., client needs, attendance, level of participation, treatment progress, etc.)? Are these records adequate? [**Source: inmate case file reviews**].

Policy Statement 7.4.1 HOU11 "Preparation of Inmate Drug and Alcohol Summaries;" Policy Statement 7.4.1 HOU12 "Organization of Drug and Alcohol Treatment Records;" Policy Statement 7.4.1 HOU13 "Preparation of Individual Group Progress Notes; and

Policy Statement 7.4.1 HOU14 "Discharges, Discharge Summaries, and Notification of Termination Forms" all govern the treatment records for the inmates assigned to the CCTC. Formal summaries should include client history and treatment programming. Progress notes should include the dynamics of the therapy session as well as the client's role in the session, and should stress data, assessment, and plan.

In addition, according to the Drug and Alcohol Department Procedures Manual, Procedure XII dictates the "Procedure for Preparing Individual/Group Progress Notes." Procedure XIV reflects the "Procedure for Discharges, Discharge Summaries, and Notification of Termination Forms." Both highlight the content, format, and time frames for proper completion of the respective treatment forms, and both reflect ODAP standards.

Program Staff

13. Provide a brief description of the primary staff for this program (1 paragraph each). [**Source: staff interviews**]. Include the following for each (or note if all have the same duties):

- **Name and background** (e.g., educational degree, specialized training, D & A experience)
- **educational/ treatment duties** in this program (i.e., who does what?)
- **other duties and responsibilities (i.e., non-treatment)** (e.g., see survey Q#42)

David J. close is the DATS Supervisor at SCI – Houtzdale. He is responsible for the operation of all the drug and alcohol education and treatment programs, including CCTC, Substance Abuse Education, Relapse Prevention, and Addictions Education. He has a MS Degree in Criminal Justice and his CAC. He has worked at the DOC for

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seven years, and has a total of eleven years of experience in providing direct treatment to substance abusing clients. This information is derived from the survey data. According to the staff interview, David was a Juvenile Probation Officer focusing on drug and alcohol offenders. He is also on the board of the Employee's Association at SCI – Houtzdale, and he is on the Transition Team for the new institution due to open in Pine Grove. David serves on the Steering Committee for the Research Partnership between the DOC and Temple University.

Colleen Kawa is a DATS II, and has responsibilities for providing services to the CCTC, Addictions Treatment, Substance Abuse Education, and Addictions Education. She has a M.Ed. in Rehabilitation Education, and has obtained her CRC. According to the staff interview, she is also currently working on her CAC. She has worked at the DOC for three years, and has eleven years of experience in providing direct treatment services to clients.

Randy Zitterbart is also a DATS II. He has responsibilities for the CCTC, Addiction Treatment, Substance Abuse Education, and Addictions Education. Randy has a BS Degree in Administration of Criminal Justice and an AA Degree in Law Enforcement. He has worked for the DOC for 3.5 years. Randy indicated in the staff interview that he began as a correctional officer, and has been involved in specialized training in sex offender treatment, drug and alcohol treatment, and hostage negotiations. Randy is the primary hostage negotiator for SCI – Houtzdale, and he is the Volunteer Coordinator, responsible for securing outside speakers for AA/NA meetings. He has a total of three years of direct treatment service with substance abusing clients.

Heather Hastings is a DATS II, and provides services to the Young Adult Offenders Unit, the CCTC, Addiction Treatment, Substance Abuse Education, and Addictions Education. She has a MA Degree in Counseling as well as her CAC. She has four years of experience in providing direct services in the drug and alcohol field, and she has worked for the DOC for approximately one year. Heather's background includes working with drug and alcohol placements for juveniles as well as a community service program serving youth.

Cherie Williams is a DATS II. Cherie has responsibilities for the CCTC, Addiction Treatment, Substance Abuse Education, and Addictions Education. She has a MA Degree in Counseling, and a BA Degree in Psychology. She has worked for the DOC for one year, and has one year of experience in providing direct services to substance abusing clients. Cherie is also the coordinator for the SEAP Program, an employee assistance program at the institution. According to the staff interview, Cherie served in the military as a radio operator prior to her employment at DOC.

Jennifer Rossman is a DATS I at SCI – Houtzdale. She has responsibilities for services to the CCTC, Substance Abuse Education, and Addictions Education. She has a BS Degree in Administration of Justice as well as her CDT. According to the staff interview, she has worked for the DOC for ten months, and has ten months of

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experience in providing direct services in the drug and alcohol treatment field. Jennifer previously worked as a DATS at the county level.

Marilee Spears is a DATS I and is the most recently hired of the treatment staff. According to the staff interview, she has been employed for approximately two months with the DOC, and has just graduated with a MA Degree in Counseling Education. She also has her CAC. As of this date, Marilee has not yet been given her assignments or responsibilities.

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Results of Process Evaluation

I. Program Observations

[Provide representative answers to questions and examples from **observation forms.** Give examples that illustrate what the program actually provides in terms of treatment or education, using the program model as a guide]

1. Describe the physical setting. Does it appear adequate for educational or treatment needs? Why or why not?

The physical settings varied from one activity to another in the TC. The small groups, phase groups, some of the AA/NA groups, and the pull ups were held in one of two small rooms right on the housing unit. The morning meeting and the rest of the AA/NA meetings were held in the large space that comprises the center of the housing unit. Consistent comments were made on the observation forms about how difficult it was to hear during morning meeting since this room is large and cavernous. The room was comfortable, well lit, and clean, but because of the acoustics, it was difficult to hear when the entire group was meeting together. The large space and the small rooms were both adequate for treatment and education purposes. In the small groups and phase groups, staff were described as respectful, trusting, calm, and having a good rapport.

2. Describe inmate attendance and participation: Do inmates appear enthusiastic? Interested?

Most of the inmates participated in most of the activities that were observed, including morning meeting, small groups, phase classes, 12-step meetings, an orientation, and a talent show. Participation at the morning meeting characterized inmates as being orderly, disciplined, prepared, ritualistic, choreographed, and militaristic. Inmates in the small group and phase classes were described as being supportive, animated, offering praise, and acting emotional at times. There were about 20-25 inmates in the small groups, phase classes, and 12-step meetings, and 126 inmates in the morning meeting, which was described as a "large AA/NA meeting. All inmates were very engaged with the talent show, and two researchers noted the comment stated by one of the DATS staff, "Recovery should be fun, too."

3. How do staff handle any discipline problems?

There were no disciplinary problems to speak of. The inmates tended, in some programs, to wander off topic, evade questions or issues, or hold sidebar conversations, but there were no instances of any major disciplinary problems. Each of the issues mentioned above were addressed appropriately by staff, and the behaviors ceased, at least for a

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while. One inmate received a pull up for falling asleep in an NA meeting the occurred the day before and one that was being visited by the research team.

4. How do staff interact and communicate with inmates? Give one or two examples. Do different staff members have different styles of interaction with inmates?

Many of the observation forms indicated that staff were either not directly present during the activity, or they had a very minimal involvement because the activities were inmate-led. This was true of the morning meeting, the 12-step meetings, the inmate orientation, and the talent show. Staff, treatment and/or security, were always within earshot and visibility, but were not always present or necessarily of the content of the meeting. Some staff interactions included adding structure to the activity, guiding the discussion, and using humor as a means to communicate. Observations from the pull up sessions indicated that the staff had somewhat more involvement in that activity. Staff were described as being direct, and as using gentle persuasion

5. Briefly describe what kind of content was covered in the group or session you attended (see survey Q#19). Give one or two examples.

In the morning meeting, the word, thought, and goal for the day (which vary daily) provide themes for sharing. One researcher noted that opinions offered through this process provide no opportunity for feedback or challenge in this structure. At the TC orientation session, many topics were covered, including information on the operation and functioning of the unit, expectations, schedules, committees, etc. "Burning desires" were mentioned as a focus, or at least an opening, to several of the activities, primarily the small groups. Issues surrounding the system for pull-ups were addressed with fair frequency. These concerns included questioning why the pull up would be the first line of defense before trying to address a problem with someone to his face directly. The importance of accountability was emphasized in the observations, as was phase advancement. The content of the 12-step meetings involved sharing step work and personal stories.

6. What kind of treatment format was used? (e.g., lecture, video, peer- or staff-led group: See survey Q#18).

The observation forms indicated a fairly even split between activities that were inmate-led, such as 12-step meetings, morning meetings, orientation and the talent show, and the staff-led activities. These included the small groups and the phase classes, which were staff-led, but inmates did 95% of the talking.

7. From your observations, was it possible to determine what kind of treatment approach was used (e.g., cognitive-behavioral, rational emotive therapy, etc.? (See Survey Q#12).

Seven of the activities were identified as a peer-led, 12-step approach to treatment. Even the talent show was described as having a 12-step theme through the songs, poetry,

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and readings. The TC milieu approach was observed in two groups, and cognitive behavioral was identified as the approach in another group. Other approaches, identified in three activities as non-treatment approaches, were lecture and non-directed open discussions.

8. Based upon what you know about this program so far, were the activities you observed relevant to the program's goals? Why or why not?

All the activities observed were described as being relevant to the program's goals, although some were identified as more relevant than others. There was some concern that too many of the programs revolved around the 12-step approach rather than more sophisticated treatment models. A staff member described the treatment approach in the small group as "group psychotherapy," however, the researcher noted that what he observed was very different than Freudian psychodynamic theory. Another researcher noted that although the phase class was relevant to the goals of the program, he questioned the degree of accuracy of the information provided by staff on the disease concept as well as the clarity of understanding of complex concepts such as genetic predisposition.

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II. Staff Interviews

[Provide representative answers to questions from staff interview forms]

1. How would you describe the **relationships** between staff at this institution (e.g., is there a sense of teamwork)?

Six staff representing the TC were interviewed for this study, including the DATS Supervisor, the TC Correctional Officer, two DATS II's and two DATS I's. They range in tenure from seven years with the DOC (DATS Supervisor) to 2 months (DATS I), with the other staff being with the DOC for 3.5 years, 3 years, 1.5 years, and 10 months.

(a) Relationships between D & A staff:

All respondents report the relationships between the D & A staff as being positive. Responses range from "good" to "wonderful" and "excellent." Other descriptors include professional, consistent, helpful, and supportive. One interview revealed that all staff take the initiative to problem solve and to maintain the integrity of the treatment programs. The most recently hired staff member stated she never feels alienated, and that she feels the staff are all open, and are equal in terms of their focus on being treatment oriented and security conscious.

(b) Relationships between D & A staff and security:

Comments include "fairly good," "very good," and "not much interaction so far", as in the case of the newer staff. The CO on the unit indicated that some security staff refer to the treatment staff as "treatment weenies," or "inmate lovers," acknowledging that some officers can get that perception. He was quick to add, however, that the treatment staff are very security minded. One DATS staff mentioned that there is a great deal of training in security issues provided to all staff, including treatment staff.

(c) Relationships between D & A staff and other correctional staff or departments:

One respondent reported that she doesn't differentiate between the D&A Department and other staff, commenting that they are all in this together as one staff. The DATS Supervisor reported that when a new treatment staff is hired, they spend a great deal of time touring the entire institution and meeting a wide range of individuals. Departments that were mentioned as important to the treatment department include Psychology, Parole, and the Chaplain.

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2. What, if anything, would you **change** about this program?

All respondents had ideas about how to change the program. One DATS said she would like to see all the activities be "phase-pure," rather than mixing the phases for groups and meetings as is currently done. Another DATS indicated he would add more staff, including a D&A manager and a couple of supervisors, as well as add more space for groups and meetings to occur. Three staff said they would like to have more time with the inmates to focus on treatment and group work. One DATS suggested that general population inmates become more involved with 12-step meetings earlier in order to prepare them for the TC. Finally, one DATS said she would make the program more culturally sensitive, stating they need more Spanish AA/NA books as well as staff who speak Spanish.

3. What kind of **input,** if any, do staff in this program have into **modifying program structure or activities?**

All staff interviewed indicated that they do have input into modifying program structure or activities. Two staff mentioned that there are lesson plans for phase classes, but that they are just a general guideline, and that staff can revise material as long as they cover the required material. They often use their own assignments, movies, exercises, and discussion questions. Another staff mentioned that the supervisor is open to changes, but he needs to know bout and approve the suggestion before it is implemented. One staff felt that she was free to make her opinion or suggestions known to the supervisor, but she was unsure about what happens to this type of input. Even the CO stated he is able to share his perspectives with staff and even make suggestions to them for seminars he thinks would be helpful to have specific inmates present.

4. What kinds of inmates **do well** in your program? What kinds of inmates present the **most challenges**? Please describe.

Inmates that do well in the TC were characterized in several ways. Those that do well are those that are motivated and truly want to stop using drugs, those that are open-minded to challenge their belief systems, or those that have hit rock bottom. Another staff stated that those inmates that do well are those that have a higher reading and writing level, since this helps with all the homework assignments. Yet another staff stated that inmates that do well are those who are in their late 30s, or older, who have lost their families and have no where to go. One staff member said she could not, in any way, report or describe a "kind of inmate" who does well. Finally, one staff member said that inmates with a very criminal background and gang history tend to do well because they have leadership abilities, are individualistic, stand alone, resist peer pressure, and expect and even welcome challenges. However, one staff member indicated that those inmates with a prevalent criminal attitude in addition to a drug or alcohol problem are the most challenging. Others reported that those who present the greatest challenge are the 18-20 year-old inmates who are here only because it is on their prescriptive plan to do so. Another staff stated that the most challenging inmates

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are the ones who are more highly educated because they think they know it all. More than one staff member indicated that drug dealers are a challenge, because they are often in extreme denial about their addiction. Another staff stated that if one were to examine the "pull ups," they would find that those who "fill the page" do not do well in the program. Finally, one staff reported that those inmates who are highly religious and are determined to remain religious often do poorly in the TC.

5. About what percentage of inmates admitted are **discharged early from this program**? Why?

Two staff indicated 60% of the inmates are discharged early, mostly for disciplinary problems or poor behavior. One of these two staff members referred to an unscientific study done recently that revealed that about 60% of the inmates were discharged early. Another staff stated that other than those removed for disciplinary reasons, relatively few inmates are discharged early, highlighting the fact that this program is often a condition for parole.

6. Do you ever make **treatment-related referrals to other programs or departments within DOC? To outside agencies**? If so, please describe:

Staff reported making treatment related referrals to psychology, education, parole, chaplain, shift commander, Special Needs Unit (for those demonstrating mental instability), the Domestic Violence Program, religious programs, and TASC (Treatment Alternatives for Safer Communities), where assistance is provided for aftercare plans. The psychology department and the Special Needs Unit were cited most often, according to the staff interviews.

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III. Inmate Interviews

[Provide representative answers to questions from inmate interview forms]

Seven inmates from the TC were interviewed, including three from Phase I, one from Phase II, and three from Phase III.

1. How did you **first hear about this program**, and what (if anything) did you need to do to **get into** the program (e.g., get a referral? fill out an application? get interviewed by staff or inmates in the program?)

Two inmates report hearing about the TC in the orientation as a newly arriving inmate. Two inmates stated they heard about the program from their counselor, who helped them apply to the program. One inmate said he had been in the prison since it first opened and was among those approached to "volunteer" for admission. Another reported he heard inmates in Camp Hill and Waymart talking about the program. Another inmate said that when he was sentenced in county, he asked for the program, because he needed serious help with a drug problem. He also reported his sentence could have enabled him to do his time at the county level, but that they didn't have programs to help his addiction, so he asked for state time to get into a drug treatment program. All but one stated that they filled out an application for the program and most mentioned that they were interviewed. One inmate claimed that his counselor filled out an application for him and that he did not know why he was recommended. He stated that there was nothing on his record other than an under-age drinking episode and usage of acid, which he assumes gave him a high score on the admission test.

2. How long did you have to **wait** to get into this program?

Five months, five months, seven months on the first admission and a year on the second one, three months, four months, and five months. The inmate that stated he volunteered for the program when the institution opened stated that the first time he was admitted the day after he volunteered, the second time, he waited several months, and the most recent time he waited a "long time" before admission.

3. Why did you want to participate in this program?

Four inmates reported that their first motivation for wanting to participate was to make parole. All four also indicated that they saw the benefit in the program, have learned something, needed help with a drug problem, and came to like the program. Another inmate wanted to participate because he wanted to change his character defects. Another wanted help with his drug problem and didn't mention parole as a motivator at all. One inmate stated he was participating because he wanted to see why people thought acid was a problem.

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4. Could you describe a **typical day** in this program? For example, what kinds of activities or treatment **methods** are used most often: lecture, video, written assignments, individual counseling, peer-led group discussion, or staff-led group discussion? (**See survey Q#18**).

Each of the inmates went into detail about their schedules and their daily activities, collectively mentioning morning meeting, small groups, phase groups, NA/AA meetings, exercise, noise patrol, treatment assignments, seminars, pull ups, yard, and recreation. Other inmates cited activities such as meditation, lifting weights, watching TV, and walking. Three inmates reported treatment assignments or treatment plans as part of their activities. One inmate mentioned individual sessions as part of the TC activities. One inmate stated that on the weekends there are not structured meetings, and that he has time to be quiet and think.

5. What kinds of **issues (content)** are addressed in this program? (e.g., impacts of drug use, problem-solving skills, relapse prevention, etc.). Could you give one or two examples? **(see survey Q#19)**

Inmate responses include the following issues: behavioral issues like manipulation, denial, and minimizing and other things that would make you drink; relapse prevention; character defects; burning desires; 12-steps; resentment; anger; pain; psychological disturbances like sexual abuse, love addiction, and in one case the death of his baby; learning to control; looking at the part you plan to create problems; and issues that you didn't even know you had.

6. In this program, what has been:

(a) most helpful to you?

Inmate responses include the following: listening to other people's stories and learning from others; learning how to work the 12 steps; NA groups, particularly when someone is sharing a life story; learning about LSD; cognitive restructuring; and learning about my drug problem, which wasn't just about seeking pleasure, it was a way of life.

(b) least helpful to you?

Inmate responses include the following: not having meetings on the weekend; the seminars can become humdrum because the themes are the same; and Basic Concepts and What is AA/NA? because we already know this stuff. Four inmates reported that the pull ups system was the least helpful activity for them for a variety of reasons. Three of them stated that they are used in a vindictive way and another stated they are abused. Several questioned why you weren't required to address the problem with the individual first before you resort to pulling someone up.

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7. What do you think about the **staff** in this program? (e.g., How well do staff **interact** with inmates? Are inmates treated with **respect**? Are the staff **fair** with all inmates?)

Inmates generally reported that they were treated with fairness and respect by staff. Some reported the counselors just don't enough time for individual sessions, and one reported that because of his counselor's pregnancy, he hasn't received the attention he requires. One inmate thought the staff were understandably more favorable towards Phase III inmates. Another inmate thought the staff could do a better job of getting them admitted into the program before their minimum. Another inmate discussed an incident in which a fight erupted between two inmates, a situation he felt could have been prevented if staff had taken action when this hostility was brewing in public over a two-month period. Two inmates reported that staff do their jobs and they do their work, and that staff have been helpful along the way for them to learn.

8. What kinds of **rewards and punishments** are used in this program? (e.g., are there consequences for good participation? Poor participation?) Please explain.

Inmates reported the following rewards: positive pull-ups; newcomer of the month; resident of the month; certificates; recommendations; learning all you can about yourself; self-discovery; and advancing through the phases. Two inmates reported that parole was their reward for the program, and one inmate stated that the rewards weren't as visible as the punishments, because they were expected to do these things. Six inmates reported that pull-ups were punishment, and often they included sanctions. Once you receive five pull-ups, you receive a sanction, which can be a writing a seminar, facilitating a meeting, or a cleaning detail. One inmate felt it was very unfair that the block C/O had the right to instill his own sanctions in addition to the formal sanctions he may have received in his pull up session. One inmate also stated that a punishment is not getting out on time because you're not doing what you're supposed to be doing, and that the program can affect one's parole or release.

9. Do the inmates in this program have any **input into program structure or activities**? If "yes," please describe briefly:

One inmate reported that he is new, but that he sees inmates on the committees making decisions that affect the TC. Another reported that by being a chairman on a committee, you get a lot of responsibility. One inmate stated that the staff are open to suggestions, and that they implement them if they can be accommodated. Another inmate cited the talent show as an example of inmate input as well as the word, thought, and goal for the day and the topics for the NA/AA meetings. Two inmates reported that inmates have no input into the program, stating, "you're told what to do."

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10. Have you had any difficulty **accessing** treatment services? If so, please explain.

Two inmates reported they had no difficulty accessing treatment services. One inmate reported it is difficult to see counselors for one-on-one sessions. Another inmate reported that sometimes the treatment staff don't have answers to your questions, and that you have to go to another counselor who usually has the answer. Another inmate stated that he was waiting to get into the Addictions Treatment program, however, the waiting list was so long, that his name came up for the TC before he was able to get into the Addictions Treatment program.

11. Have you participated in any **other treatment programs** in Pennsylvania state prisons?

None of the respondents has ever participated in any other treatment program in Pennsylvania prisons.

If yes:
(a) In what ways is your experience in this program **similar?**

(b) In what ways is your experience in this program **different?**

12. Would you **recommend** this program to someone you know? Why or why not?

All of the inmates responded that they would, indeed, recommend this program to someone he knew, as long as the person really wanted the help. One inmate also indicated that he would suggest that the person keep an open mind. Another stated that the program teaches you the right tools, but it's up to you to pick them up and use them. Another said he wouldn't recommend it to someone unless they had the full length of time left to spend in the program.

13. What, if anything, would you **change** about this program?

Responses to this question include: changing the ability of the C/O to sanction you immediately if he pulls you up; have counselors and not inmates review the pull-ups and eliminate the petty ones; sticking to the topics in AA/NA meetings and not going all over the place with sharing; changing the cell contract arrangement; and making the program nine months long instead of a year. Three inmates reported that the thing they would change is the pull up system by making it mandatory to talk to someone first before you pull them up. One inmate reported he wouldn't change anything at all about the program.

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IV. Gaps Between Program Model and Implementation

[Note any discrepancies observed between the program model (i.e., the "program on paper" and observations of program activities (i.e., "the program in action"). Note any other concerns or questions here.]

From the staff interviews, there was inconsistency in responses to the question regarding the mission and goals of the TC (Question # 7). Generally, an organizational mission is provided in the form of a statement, with all program activities revolving around and supporting this statement. No two staff members gave the same response to this question, although some of the responses were similar. One staff member indicated the mission of the TC was to provide an environment conducive to recovery and to provide tools for recovery. Another staff member stated the mission was to provide tools for recovery and to give the men an opportunity to examine themselves and change. Another staff indicated the mission was to provide the inmates with an environment of respect and to help them learn about drug and alcohol issues. Yet another stated that the mission was to rehabilitate the inmates and help them become productive members of society. Another staff person stated that she believed there was a distinction between what she believes the mission to be and what the program believes the mission of the program to be. Her mission was to provide the men with what they need to embrace the recovery program and its lifestyle, whereas the program's mission would include the above as well as to reduce recidivism.

The TC Proposal indicated several activities that weren't mentioned in any of the staff or inmate interviews, nor were they part of any of the activities the research team observed. For example, page 4 of the Proposal states that inmates must demonstrate a mastery of at least three relaxation techniques as well as maintain a written daily diary. Researchers neither saw nor heard evidence of these practices.

Page 21 of the Proposal states that the capacity of the TC is 115. However, the Drug and Alcohol Treatment Department Procedures Manual indicates the capacity is 128.

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V. Conclusions and Recommendations

1. Program Strengths (note briefly)

- The unit is very clean, orderly, and professionally operated, and the TC Program is well-managed. Treatment activities are well-planned and structured. Treatment staff are motivated and committed to treatment, although a few are relatively inexperienced.
- Exemplifying the TC philosophy, inmates assume a good deal of responsibility in running daily activities, as well as supporting and sanctioning one another.

2. Program Weaknesses (note briefly)

- Caseloads are too high (26:1)[1], and staff have little time for individual counseling.
- Stated selection criteria for assessing inmate suitability for TC are clear, but evidence of how criteria are assessed or used is not clear. It would appear that detailed assessments of drug histories and treatment needs are done only after the inmate is admitted, rather than before. These assessments are somewhat lengthy and subjective, and appear to have little influence on treatment planning.

3. Recommendations for Program Improvement

- Address staffing issues.
- Address physical space needed for meetings and small groups.
- Review the assessment procedures used to make program placement decisions. Consider use of objective instruments such as TCU Drug Screen.
- The inmate attrition rate (60% or more) is somewhat of a concern. Although many inmates are appropriately discharged for rule violations and/or failing to participate in treatment, better screening and assessment procedures could improve earlier admission decisions.
- Review pull up procedures. Consider increasing staff supervision and inmate training in giving and receiving pull ups.

[1] While these caseloads are high, these are still serious underestimates. All TC staff also have additional duties to provide education and outpatient treatment to the inmate general population.

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INDIVIDUAL PROGRAM REPORTS: DOC-TEMPLE RESEARCH PARTNERSHIP

Institution: Houtzdale

D & A Program: Substance Abuse Education

Program Description

General Program Goals and Intervention Philosophy

1. What are the **general goals** or **mission** of this program? What does it try to do? **[Source: program documents, staff interviews].**

The Substance Abuse Education Group Guidelines and Summary describes the main goal of this program as increasing the participants' awareness of drug and alcohol abuse. It is intended for the individual to realize that a problem exists and accept the problem as something to be dealt with on a long – term, continuing basis. Fellow participants constitute a support group based on the common problem they share. Strength is drawn from the group as a whole, but change should occur on an individual basis. Participation in the group helps the participant realize that there are others who are also beginning recovery and also helps participants understand that there is help available if they are willing to change. The program will also help participants come to a clear understanding of what addiction is and how it can be dealt with.

2. What is the main **treatment approach** or **philosophy** used in this program? (e.g., see survey Q#12). Could you give one or two examples of *how* this approach is used? **[Source: staff interviews, program documents].**

The Substance Abuse Summary states that the Substance Abuse Education program is a treatment intensity level II group with a specific treatment approach of information/education. The general way of transmitting information is through lecture, guided discussions, and visual aids.

Target Population and Target Selection

3. **For this program**, describe inmate **recruiting, outreach, or referral procedures** (e.g., How do inmates hear about this program? Who makes referrals? What are the reasons for referral)? **[Source: program documents].**

Both the Drug and Alcohol Department Procedures Manual and Policy Statement 7.4.1 HOU8 "Weekly General Population Inmate Drug and Alcohol Orientation" indicate that new arrivals to SCI – Houtzdale will attend an orientation in which verbal and

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written information is provided describing drug and alcohol programming. Referrals can be generated by inmates or DOC staff, and each are tracked according to an automated system that lists inmates according to their minimum and referral dates. According to the Inmate Handbook, referrals from DOC staff could include the Corrections Counselor, Unit Manager, or DATS. A vote sheet system is then initiated with the Deputy Superintendent having the final decision. As per Policy Statement 7.4.1 HOU4, inmates self-referring should complete form DC-135A, and staff-generated referrals should use a DC-134 form.

4. What are the specific **eligibility** requirements for this program (e.g., type and seriousness of D & A problem, time remaining in sentence)? Are exceptions made? **[Source: program documents].**

The Guidelines state that inmates eligible to participate in this program are those who have used, abused, or experimented with various substances.

5. **Decision to admit (or not):** Who makes the decision? What are the most important criteria? About what percentage of referrals are rejected? **[Source: program documents].**

N/A

Intake, Exit, and Follow-up Procedures

6. Describe the **intake/admission process** (e.g., What happens to an inmate when they first attend this program? Is there an orientation, intake interview, etc.?) **[Source: program documents].**

The inmates are orientated to the expectations of the course through the group guidelines and they are informed of the course content. The inmate's knowledge and understanding of general substance abuse issues are also assessed.

7. What is the normal **program enrollment**? (i.e., at one specific time) **[Source: program documents].**

Program enrollment, according to the Summary, is limited to 60 - 65 individuals.

8. What is the normal **length of stay** for an inmate in this program? **[Source: program documents].**

According to the Guidelines, the inmates enrolled in this program are expected to meet once a week for eight weeks.

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9. What are the **criteria for successful program completion**? **For an unsuccessful discharge**? **[Source: program documents].**

The Guidelines state that for successful completion of the program the participant must attend the first session, the last session, attend at least six out of eight sessions, and pass the final exam.

Specific Program Content and Structure

10. **Describe** (a) the different **program components or activities** (see survey question # 19 for examples of specific educational or treatment activities), and (b) the **intended result or objective of each activity [Source: staff interviews, observations, program documents]**. Include the following in the report:

- Provide a **title and brief description** of the activity.
- How many **hours** weekly do inmates participate in each activity? How often do they meet?
- Describe a few **examples of program content** from lesson plans, printed program descriptions, observations, and interviews (i.e., what do they do and how do they do it?)
- For each **activity or group**, what is the **intended result or objective?** (i.e., what change in inmate attitudes or behaviors is expected)?

According to the Substance Abuse Education Lesson Plan, the group is expected to meet quite a few objectives each time they meet. They are to be taught the chemical nature, source, and characteristics of 10 abusive drugs (cocaine, marijuana, heroin, etc.), and the short-term and long-term effects of these drugs on the body and central nervous system. They are also taught the hazards and risks and the distinction between the effects on the central nervous system of stimulants and depressants.

The program provides drug users and their friends and family with a recognition guide to symptoms of possible drug abuse. Participants are to be taught that the symptoms of drug abuse are reversible when help is sought in time and they are provided a source of such help.

The participants are also presented an authentic account of a person's (Thomas Henderson) drug addiction and road to recovery. They are shown that although drug use first appears to take a person's problems away, it soon causes guilt, shame, anger, fear, and creates problems. It is also shown that drug use traditionally begins as social drinking and casual marijuana use, but can soon progress to a more serious problem. Drug problems among famous people and the illusion that drugs cause fame, fortune, and wealth are also discussed.

The harmful physiological aspects of drug use are discussed. Also the effects cocaine has on the mind and the misconceptions of cocaine use and its dangers.

AIDS and the HIV virus are discussed at length, pertaining to facts and myths of how one receives the disease. Information is also presented on both AIDS and HIV.

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An emphasis is placed on the fact that alcohol is actually a toxic, mind-altering drug. Physiological effects on the body from alcohol are discussed and also the effect alcohol can have to an unborn child. Testimonies of recovering alcoholics who have suffered various physiological ill-effects of alcohol abuse are also presented. These are intended to help the participant realize that excessive use of alcohol should be avoided.

The topic of marijuana is also emphasized. The fact that marijuana is a mind-altering drug that can cause serious medical problems, accidents, and psychological effects.

11. How is treatment structured to address **individual inmate needs** (e.g., **individual treatment planning**)? [Note: some researchers believe that effective treatment requires matching appropriate treatment services with specific inmate needs]. Describe how **D & A needs assessments and treatment planning** are done (if applicable). **[Source: staff interviews, program documents]**.

N/A

12. What types of **program records** about inmate participants are kept, and how (e.g., client needs, attendance, level of participation, treatment progress, etc.)? Are these records adequate? **[Source: inmate case file reviews]**.

N/A

Program Staff

13. Provide a brief description of the primary staff for this program (1 paragraph each). **[Source: staff interviews]**. Include the following for each (or note if all have the same duties):

- **Name and background** (e.g., educational degree, specialized training, D & A experience)
- **educational/ treatment duties** in this program (i.e., who does what?)
- **other duties and responsibilities (i.e., non-treatment)** (e.g., see survey Q#42)

*See Individual Program Report for Houtzdale, Courage to Change Therapeutic Community (CCTC). All TC staff share additional responsibilities for education and outpatient programming with general population inmates.

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Conclusions and Recommendations

1. Program Strengths (note briefly)

- Very ambitious objectives for an 8-week program (8 hours of total programming).

2. Program Weaknesses (note briefly)

- Eligibility criteria are extremely broad, and assessment of inmate needs and/or suitability for this program is weak. Very little information available about how decisions are made to admit inmates into this program. It appears that few are turned away if they volunteer for the program.
- It is not clear that program objectives can be achieved in such a short period of time.
- Staff have little time to prepare for sessions or counsel inmates on an individual basis.
- Very low intensity intervention.

3. Recommendations for Program Evaluation

- Review the proper role of D & A Education within DOC. Consider how scarce staffing and programming resources should be best allocated to different programs.

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INDIVIDUAL PROGRAM REPORTS: DOC-TEMPLE RESEARCH PARTNERSHIP

Institution: Houtzdale

D & A Program: Addictions Education

Program Description

General Program Goals and Intervention Philosophy

1. What are the **general goals** or **mission** of this program? What does it try to do? **[Source: program documents, staff interviews].**

The Addictions Education Group Guidelines describes the main goal of this program as increasing the participant's awareness of the dynamics of addiction. Participation in this group helps the participant realize that there are others who are in the beginning stages of recovery and helps participants understand that there is help available if they are motivated to change. The program helps participants come to a better understanding of what addiction is and how it can be dealt with. It looks into the disease concept, the nature of addiction, and the thinking process involved in addiction. The history and beliefs surrounding drug and alcohol abuse are also discussed, as are the consequences of drug abuse for personal life, family, and society.

2. What is the main **treatment approach** or **philosophy** used in this program? (e.g., see survey Q#12). Could you give one or two examples of *how* this approach is used? **[Source: staff interviews, program documents].**

According to the Summary, Addictions Education is a treatment intensity level II group with a specific treatment approach of information, education, and interaction. Different treatment approaches and alternatives are discussed with an emphasis on the 12 - step philosophy to recovery.

Target Population and Target Selection

3. **For this program**, describe inmate **recruiting, outreach, or referral procedures** (e.g., How do inmates hear about this program? Who makes referrals? What are the reasons for referral)? **[Source: program documents].**

Both the Drug and Alcohol Department Procedures Manual and Policy Statement 7.4.1 HOU8 "Weekly General Population Inmate Drug and Alcohol Orientation" indicate that new arrivals to SCI – Houtzdale will attend an orientation in which verbal and written information is provided describing drug and alcohol programming. Referrals can be generated by inmates or DOC staff, and each are tracked according to an

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automated system that lists inmates according to their minimum and referral dates. According to the Inmate Handbook, referrals from DOC staff could include the Corrections Counselor, Unit Manager, or DATS. A vote sheet system is then initiated with the Deputy Superintendent having the final decision. As per Policy Statement 7.4.1 HOU4, inmates self-referring should complete form DC-135A, and staff-generated referrals should use a DC-134 form.

4. What are the specific **eligibility** requirements for this program (e.g., type and seriousness of D & A problem, time remaining in sentence)? Are exceptions made? **[Source: program documents].**

According to the Summary, in the majority of cases, the participants are required to have completed the Substance Abuse Education program.

5. **Decision to admit (or not):** Who makes the decision? What are the most important criteria? About what percentage of referrals are rejected? **[Source: program documents].**

N/A

Intake, Exit, and Follow-up Procedures

6. Describe the **intake/admission process** (e.g., What happens to an inmate when they first attend this program? Is there an orientation, intake interview, etc.?) **[Source: program documents].**

The Lesson Plan demonstrates that the inmates are orientated to the expectations of the course through the group guidelines and they are informed of the course content.

7. What is the normal **program enrollment**? (i.e., at one specific time) **[Source: program documents].**

The Summary states that enrollment in the group is limited to 60 – 65 individuals.

8. What is the normal **length of stay** for an inmate in this program? **[Source: program documents].**

The Lesson Plan and the Guidelines show that the inmates enrolled in this program are expected to meet once a week for ten weeks.

9. What are the **criteria for successful program completion**? **For an unsuccessful discharge**? **[Source: program documents].**

The Guidelines state that for successful completion the participant must attend the first session, the last session, attend eight out of ten sessions, and pass the final exam.

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Specific Program Content and Structure

10. **Describe** (a) the different **program components or activities** (see survey question # 19 for examples of specific educational or treatment activities), and (b) the **intended result or objective of each activity [Source: staff interviews, observations, program documents]**. Include the following in the report:

- Provide a **title and brief description** of the activity.
- How many **hours** weekly do inmates participate in each activity? How often do they meet?
- Describe a few **examples of program content** from lesson plans, printed program descriptions, observations, and interviews (i.e., what do they do and how do they do it?)
- For each **activity or group**, what is the **intended result or objective?** (i.e., what change in inmate attitudes or behaviors is expected)?

According to the Addictions Education Lesson Plan for Session I, the group is expected to perform quite a few objectives each time they meet. The participants are expected to gain a better understanding of the evolution of Alcoholics Anonymous and Narcotics Anonymous and to understand contemporary beliefs in the AA and NA programs.

In Session II, the inmates are expected to evaluate themselves. They are also expected to become familiar with various self-help groups and different types of AA and NA meetings.

Session IV of the Lesson Plan explains that chemical dependency is an illness similar to diabetes or heart disease and they are taught what things make chemical dependency a disease. The participants also learn the factors associated with chemical dependency and how to fight this disease.

Session V shows that the inmates are taught to identify and relate to criminal thinking errors and to be aware of alternatives to criminal thinking.

Session VI illustrates the concept of powerlessness over chemicals and teaches participants to be able to identify and understand degrees of powerlessness and unmanageability in their lives. They also explore their own personal examples of powerlessness and they are taught to understand and utilize step#1 of the 12-step program.

Session VII states that the inmates are taught the concept of sponsorship and a better understanding of the 12-step program.

11. How is treatment structured to address **individual inmate needs** (e.g., **individual treatment planning**)? [Note: some researchers believe that effective treatment requires matching appropriate treatment services with specific inmate needs]. Describe how **D & A needs assessments and treatment planning** are done (if applicable). **[Source: staff interviews, program documents]**.

N/A

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12. What types of **program records** about inmate participants are kept, and how (e.g., client needs, attendance, level of participation, treatment progress, etc.)? Are these records adequate? **[Source: inmate case file reviews].**

N/A

Program Staff

13. Provide a brief description of the primary staff for this program (1 paragraph each). **[Source: staff interviews]**. Include the following for each (or note if all have the same duties):

- **Name and background** (e.g., educational degree, specialized training, D & A experience)
- **educational/ treatment duties** in this program (i.e., who does what?)
- **other duties and responsibilities (i.e., non-treatment)** (e.g., see survey Q#42)

*See Individual Program Report for Houtzdale, Courage to Change Therapeutic Community (CCTC). All TC staff share additional responsibilities for education and outpatient programming with general population inmates.

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II. Staff Interviews

[Provide representative answers to questions from staff interview forms]

1. How would you describe the **relationships** between staff at this institution (e.g., is there a sense of teamwork)?

(a) Relationships between D & A staff:

D & A staff all share the same vision about the programs. They are very professional and consistent, and there is also a mutual respect between staff. Good communication and they all take the initiative to problem solve and to maintain the integrity of the programs.

(b) Relationships between D & A staff and security:

Most get along well together although there are a few differences between treatment staff and security.

(c) Relationships between D & A staff and other correctional staff or departments:

One staff member stated that they don't have to like each other but they do have to get along, and they get along well.

2. What, if anything, would you **change** about this program?

More staff, a 32:1 staff/inmate ratio is too high. More space for rooms for groups and classes. Also would like to have a D & A Manager and a couple of Supervisors.

3. What kind of **input,** if any, do staff in this program have into **modifying program structure or activities?**

N/A

4. What kinds of inmates **do well** in your program? What kinds of inmates present the **most challenges**? Please describe.

Those that do well are those who are open-minded to challenge their belief systems. Especially those who think they are bad. They have pull and respect from others, and therefore have the greatest ability to thrive in a positive peer environment. Those with a prevalent criminal attitude in addition to drug and/or alcohol problem are the most difficult, and they are not influenced by others to do well.

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5. About what percentage of inmates admitted are **discharged early from this program**? Why?

N/A

6. Do you ever make **treatment-related referrals to other programs or departments within DOC? To outside agencies**? If so, please describe:

They make referrals to Psychology, and the Special Needs Unit, for those who are mentally unstable. They also make referrals to the sex offender unit. Parole handles referrals to outside agencies.

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III. Inmate Interviews

[Provide representative answers to questions from inmate interview forms]

1. How did you **first hear about this program**, and what (if anything) did you need to do to **get into** the program (e.g., get a referral? fill out an application? get interviewed by staff or inmates in the program?)

This inmate heard about the program from pamphlets he received during his orientation to the institution.

2. How long did you have to **wait** to get into this program?

He applied to the program about nine months after being admitted to the institution on a sentence of 18 months to 5 years. He waited about one month for admission.

3. Why did you want to participate in this program?

He claimed that he thought, "it would be helpful."

4. Could you describe a **typical day** in this program? For example, what kinds of activities or treatment **methods** are used most often: lecture, video, written assignments, individual counseling, peer-led group discussion, or staff-led group discussion? (**See survey Q#18**).

Said they use videotapes and group discussion. They seek to determine how people get into their behavior patterns, such as friends you hang around with.

5. What kinds of **issues (content)** are addressed in this program? (e.g., impacts of drug use, problem solving skills, relapse prevention, etc.). Could you give one or two examples? **(see survey Q#19)**

Issues that are addressed are informing the inmates about the effects that drugs have on them physically, psychologically, and on their families. Also that if they use drugs they will go to jail, will die, become insane, or suffer bankruptcy.

6. In this program, what has been:

(a) most helpful to you?

Most helpful has been raising his awareness of the consequences of addiction, such as jail or never having success in life.

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(b) least helpful to you?

Least helpful for him was telling him that he would be broke by using drugs. He claimed there was no way he would ever be broke.

7. What do you think about the **staff** in this program? (e.g., How well do staff **interact** with inmates? Are inmates treated with **respect**? Are the staff **fair** with all inmates?)

Felt that there should be more staff that are also recovering addicts. However, he also said that he felt staff were "alright". Their counselor worked hard to make them understand, was flexible, respectful, fair, and attentive. She always worked to make the information clear.

8. What kinds of **rewards and punishments** are used in this program? (e.g., are there consequences for good participation? Poor participation?) Please explain.

Said that if you miss 2 classes, you get kicked out and if your disruptive you get kicked out.

9. Do the inmates in this program have any **input into program structure or activities**? If "yes," please describe briefly:

Inmate said that inmates do not have any input.

10. Have you had any difficulty **accessing** treatment services? If so, please explain.

Reply was "no."

11. Have you participated in any **other treatment programs** in Pennsylvania state prisons?

No.

If yes:
(a) In what ways is your experience in this program **similar?**
(b) In what ways is your experience in this program **different?**

12. Would you **recommend** this program to someone you know? Why or why not?

Yes, because it helps with parole.

13. What, if anything, would you **change** about this program?

They need to give more job training, because they need something to fall back on.

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Conclusions and Recommendations

1. Program Strengths (note briefly)

- Very ambitious objectives for a 10-week program (10 hours of total programming).
- Staff are perceived by inmates as hard working, fair, and respectful.
- If inmates complete both the Substance Abuse Education and the Addictions Education programs (18 hours total), they may build a good foundation for further (more intensive) treatment.

2. Program Weaknesses (note briefly)

- Eligibility criteria are extremely broad, and assessment of inmate needs and/or suitability for this program is weak. Very little information available about how decisions are made to admit inmates into this program.
- It is not clear that program objectives can be achieved in such a short period of time.
- Staff have little time to prepare for sessions or counsel inmates on an individual basis.
- Very low intensity intervention.

3. Recommendations for Program Evaluation

- Review the proper role of D & A Education within DOC. Consider how scarce staffing and programming resources should be best allocated to different programs.

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INDIVIDUAL PROGRAM REPORTS: DOC-TEMPLE RESEARCH PARTNERSHIP

Institution: Houtzdale

D & A Program: Addictions Treatment

Program Description

General Program Goals and Intervention Philosophy

1. What are the **general goals** or **mission** of this program? What does it try to do? **[Source: program documents, staff interviews].**

According to the Summary, the main goal of this program is to provide both an introduction and general exposure to group process. It is anticipated that this will enable both staff and participants to better identify issues that need to be further addressed.

2. What is the main **treatment approach** or **philosophy** used in this program? (e.g., see survey Q#12). Could you give one or two examples of *how* this approach is used? **[Source: staff interviews, program documents].**

The Summary states that the Addictions Treatment group is a treatment intensity level II group with a specific treatment approach of group psychotherapy. The general way of transmitting information is through group discussions. Members are expected to participate in the discussion to the extent that they do not feel any group pressures concerning participation in exercises, decision making, disclosure of private matters or acceptance of suggestions from others in their group.

Target Population and Target Selection

3. **For this program**, describe inmate **recruiting, outreach, or referral procedures** (e.g., How do inmates hear about this program? Who makes referrals? What are the reasons for referral)? **[Source: program documents].**

Both the Drug and Alcohol Department Procedures Manual and Policy Statement 7.4.1 HOU8 "Weekly General Population Inmate Drug and Alcohol Orientation" indicate that new arrivals to SCI – Houtzdale will attend an orientation in which verbal and written information is provided describing drug and alcohol programming. Referrals can be generated by inmates or DOC staff, and each are tracked according to an automated system that lists inmates according to their minimum and referral dates. According to the Inmate Handbook, referrals from DOC staff could include the

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Corrections Counselor, Unit Manager, or DATS. A vote sheet system is then initiated with the Deputy Superintendent having the final decision. As per Policy Statement 7.4.1 HOU4, inmates self-referring should complete form DC-135A, and staff-generated referrals should use a DC-134 form.

4. What are the specific **eligibility** requirements for this program (e.g., type and seriousness of D & A problem, time remaining in sentence)? Are exceptions made? **[Source: program documents].**

The Summary states that the only requirement for membership in this group are that members must be advanced enough in their recovery so as to be able to identify their need for continued therapy.

5. **Decision to admit (or not):** Who makes the decision? What are the most important criteria? About what percentage of referrals are rejected? **[Source: program documents].**

N/A

Intake, Exit, and Follow-up Procedures

6. Describe the **intake/admission process** (e.g., What happens to an inmate when they first attend this program? Is there an orientation, intake interview, etc.?) **[Source: program documents].**

N/A

7. What is the normal **program enrollment**? (i.e., at one specific time) **[Source: program documents].**

According to the Summary, program enrollment is limited to 20 – 25 members.

8. What is the normal **length of stay** for an inmate in this program? **[Source: program documents].**

The Summary says that the group will last approximately one hour once a week. It is an ongoing group and participants may exit the group at the urging of a counselor or at their own desire/need.

9. What are the **criteria for successful program completion? For an unsuccessful discharge**? **[Source: program documents].**

*N/A

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Specific Program Content and Structure

10. **Describe** (a) the different **program components or activities** (see D & A Program Survey question # 19 for examples of specific educational or treatment activities), and (b) the **intended result or objective of each activity [Source: staff interviews, observations, program documents]**. Include the following in the report:

- Provide a **title and brief description** of the activity.
- How many **hours** weekly do inmates participate in each activity? How often do they meet?
- Describe a few **examples of program content** from lesson plans, printed program descriptions, observations, and interviews (i.e., what do they do and how?)
- For each **activity or group**, what is the **intended result or objective?** (i.e., what change in inmate attitudes or behaviors is expected)?

No written procedures, policies, or lesson plans are available. Staff state that they structure group sessions entirely at their own discretion.

11. How is treatment structured to address **individual inmate needs** (e.g., **individual treatment planning**)? [Note: some researchers believe that effective treatment requires matching appropriate treatment services with specific inmate needs]. Describe how **D & A needs assessments and treatment planning** are done (if applicable). **[Source: staff interviews, program documents]**.

There is no individual counseling, according to inmates and staff.

12. What types of **program records** about inmate participants are kept, and how (e.g., client needs, attendance, level of participation, treatment progress, etc.)? Are these records adequate? **[Source: inmate case file reviews]**.

*N/A

Program Staff

13. Provide a brief description of the primary staff for this program (1 paragraph each). **[Source: staff interviews]**. Include the following for each (or note if all have the same duties):

- **Name and background** (e.g., educational degree, specialized training, D & A experience)
- **educational/ treatment duties** in this program (i.e., who does what?)
- **other duties and responsibilities (i.e., non-treatment)** (e.g., see survey Q#42)

*See Individual Program Report for Houtzdale, Courage to Change Therapeutic Community (CCTC). All TC staff share additional responsibilities for education and outpatient programming with general population inmates.

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Results of Process Evaluation

I. Program Observations

[provide representative answers to questions and examples from **observation forms**. Give examples that illustrate what the program actually provides in terms of treatment or education, using the program model as a guide]

1. Describe the physical setting. Does it appear adequate for educational or treatment needs? Why or why not?

For Addictions Treatment with Mr. Zitterbart and Ms. Kawa, it is a large classroom that is well-lit and roomy, with a lot of windows facing the courtyard. The P.A. system continues to be an annoyance, although it does not seem to bother staff and inmates. For two other programs that were observed, the observer noted that the room was bright and clean and inmates sat in plastic chairs in a large square around the perimeter of the room.

2. Describe inmate attendance and participation: Do inmates appear enthusiastic? Interested?

In one class, inmates were described as being sullen, disinterested, and isolated from one another. Interest was piqued with a handout and a description of the task at hand. Interest increased gradually but inconsistently over the course of the hour.

In another class, the inmates were very attentive and solicitous of the staff member, who was a young, attractive, and visibly pregnant woman. The majority of the group was well engaged throughout the session.

In the third group observed, some inmates were more engaged than others. They were broken into 2 small groups for an activity and some did not participate right away, although they all participated to some extent after awhile.

In the fourth group, several inmates asked questions, primarily to one participant and used gentle confrontation to get this inmate to share since he was reluctant.

3. How do staff handle any discipline problems?
N/A

4. How do staff interact and communicate with inmates? Give one or two examples. Do different staff members have different styles of interaction with inmates?

In one group there did not appear to be any casual banter between the counselor and any of the inmates. The observer felt that the staffperson initially had a very nondirective and non-involved manner. Over time, his manner changed gradually and became more directive, and he eventually related (quite successfully) the lesson to the lives of the inmates.

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In another group, the staffperson was very passive throughout much of the discussion and took little active part in the discussion that occurred. She kept a "student-like" role and seemed to struggle to accept the behavior that one inmate described. Toward the end of the meeting she again assumed the role of leader and pointed out to several members that their behavior during the group had been less than helpful.
In the third group, the staffperson had a professional and respectful attitude toward the inmates. He read the exercise aloud for those who could not read English and kept the activities and discussion moving, but did not intervene.
In the fourth group, the staffperson was described as being friendly, cheerful, and positive. She asked questions and tried to keep things organized.

5. Briefly describe what kind of content was covered in the group or session you attended (see survey Q#19). Give one or two examples.

In the first group, the group did the "Amazon River" exercise and very nice transitions were made to the problems of the inmates with regard to "treatment coercion" and the difficulty of dealing with the inconsistencies of the security staff.
In the second group, the focus was on one new member. The other major issue discussed was the level of participation in this group.
In the third group, the group did the "Amazon River" exercise and Victimology was briefly touched upon.
In the fourth group, there was no prearranged lesson plan. The group was asked what they wanted to discuss. They dealt with issues of trust, power, control, death, guns, fear, choices they made, and assuming responsibility for their actions.

6. What kind of treatment format was used? (e.g., lecture, video, peer- or staff-led group: See survey Q#18).

In one group, the assignment was given by staff to be solved in 2 small peer-led groups and brought back later for discussion.
The rest of the groups observed were staff-led groups.

7. From your observations, was it possible to determine what kind of treatment approach was used (e.g., cognitive-behavioral, rational emotive therapy, etc.? (See Survey Q#12).

In one group, the treatment approach appeared to focus effectively on accessing general attitudes of the inmates towards their treatment (psychodynamic?).
In a second group, the treatment approach was described as "reciprocal teaching" (self-help?)
In the third group and fourth group, it was unclear what treatment approach, if any, guided the sessions.

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8. Based upon what you know about this program so far, were the activities you observed relevant to the program's goals? Why or why not?

In one group, the observer felt that treatment activities were very relevant. The counselor successfully achieved her goal of having the inmate discuss his behaviors, motivations, and what he thinks needs to be changed in his lifestyle. She engaged other group members in a productive manner.

In the third group, at first the activity did not seem directly relevant but the staff member posed questions that brought the activity back to treatment and recovery.

In the fourth group, the activities seemed relevant to the programs goals. Inmates dealt with accountability and the question of when you know you've crossed over into addiction.

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II. Staff Interviews

[Provide representative answers to questions from staff interview forms]

1. How would you describe the **relationships** between staff at this institution (e.g., is there a sense of teamwork)?

(a) Relationships between D & A staff:

Staff felt that relations were good, particularly regarding communication on subject matter for small groups and on problematic inmates. That they all share ideas and experiences and they all get along real well together, that they are respectful towards each other and look out for one another.

(b) Relationships between D & A staff and security:

Communication is good between the security officers and the treatment staff on the TC. Never had a problem working together. Treatment staff are asked to abide by security measure on the unit and they comply.

(c) Relationships between D & A staff and other correctional staff or departments:

Staff felt that it was difficult to say, since this treatment group meets so seldom. Mentioned that the laundry and the maintenance departments work well with them.

2. What, if anything, would you **change** about this program?

Staff said that they could get more people in the program if they had cycles instead of an ongoing group. Might be helpful to have certain levels, that once finished, people are completed from the program. Might also be helpful to have some way to track former participants once they parole out.

3. What kind of **input,** if any, do staff in this program have into **modifying program structure or activities?**

Felt that they had good input; the DATS Supervisor is open to ideas, but realistic about the feasibility of putting into practice some of the ideas presented to him. Many changes have taken place based upon staff input.

4. What kinds of inmates **do well** in your program? What kinds of inmates present the **most challenges**? Please describe.

The inmates that do well are those who are honest and open and interactive with each other and staff. Those that are not afraid to try new behaviors, tools, and exercises.

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Those that present the most challenges are the know-it-alls and those who are there only for parole. Some of these guys know just how far to go before being kicked out of the program and they go that far, but no farther, so they never get kicked out as a result.

5. About what percentage of inmates admitted are **discharged early from this program**? Why?

Discharges occur from behavior problems or are parole generated. Inmates complete the program upon release. Probably around 25% are discharged and 75% are successfully completed or are still enrolled.

6. Do you ever make **treatment-related referrals to other programs or departments within DOC? To outside agencies**? If so, please describe:

Said that they refer to the Psychology department, the sex offender group, and the chaplain for relevant reasons. The parole board is responsible for making outside recommendations.

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III. Inmate Interviews

[Provide representative answers to questions from inmate interview forms]

1. How did you **first hear about this program**, and what (if anything) did you need to do to **get into** the program (e.g., get a referral? fill out an application? get interviewed by staff or inmates in the program?)

There were four inmates interviewed for this program. The first inmate said that he heard about the program through his orientation to the institution and discussing the requirements of his prescriptive plan.
There was no clear answer for the second inmate (Anthony) and the third inmate (Kevin).
The fourth inmate (Dan) said that he first heard about the program in orientation, then from his Corrections Counselor, then when discussing his prescriptive plan. He put in a request to the DATS Supervisor, got screened by one of the DATS, and took 15 months to get in.

2. How long did you have to wait to get into this program?

The first inmate said he waited 2 years, the second inmate (Anthony) said that once he met the eligibility requirements it took 1 1/2 months. Kevin said he had to wait 5 months, and Dan said he waited 15 months.

3. **Why** did you want to participate in this program?

Inmate #1 said he only joined so he could manipulate the program so that he could get released. Anthony said he joined because it was court ordered. Kevin stated that he wanted to participate because he wanted to keep recovery at the center of his program and also for his aftercare plan. Dan said he joined because parole made him; he states that he is a seller, not a user.

4. Could you describe a **typical day** in this program? For example, what kinds of activities or treatment **methods** are used most often: lecture, video, written assignments, individual counseling, peer-led group discussion, or staff-led group discussion? (**See survey Q#18**).

Inmate #1 reported that he works 8 hours a day, 5 days a week as a cook; attends school from 9-10 am; works from 11 - 6pm; and he attends Addictions treatment group once a week and NA once a week.
Anthony reported they talk about their lives and problems, and once in awhile they watch movies and take tests.
Kevin reported they meet once a week and deal with feelings, talk about addiction, watch movies, and have discussion.

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Dan said they have group; sometimes they can pick the topic or sometimes staff does. They watch videos and get feedback from each other.

5. What kinds of **issues (content)** are addressed in this program? (e.g., impacts of drug use, problem solving skills, relapse prevention, etc.). Could you give one or two examples? **(see survey Q#19)**

The first inmate claimed there are discrepancies between what is talked about in group and the knowledge of the staff. He said staff aren't really knowledgeable about what goes on in the streets.
Anthony stated they talk about their problems, strategies, stress management, establishing contacts for aftercare, and recognizing relapse.
Dan said that they talk about physical addiction, attitudes, behaviors, and prison life.

6. In this program, what has been:

(a) most helpful to you?

Most helpful to inmate #1 has been regular attendance, for Anthony and Kevin it has been the influence of the staff, and for Dan it has been listening to others.

(b) least helpful to you?

Least helpful for inmate #1 is that he can't speak out when the counselors aren't saying things that are appropriate and real about what they are discussing.
For Anthony, it is not enough time to talk about issues in group and the fact that he is on the sex offender block and does not belong there.
For Kevin, it's the fact that the guard is right there and it's hard to be honest.
For Dan, it's the fact that they make him feel like he has a drug problem when he does not.

7. What do you think about the **staff** in this program? (e.g., How well do staff **interact** with inmates? Are inmates treated with **respect**? Are the staff **fair** with all inmates?)

Inmate #1 felt that staff has never really "been there" although they do treat him with respect and fairness.
Anthony felt staff was supportive and act appropriately. Kevin felt staff were Okay, and Dan felt that staff treat him with respect and fairness.

8. What kinds of **rewards and punishments** are used in this program? (e.g., are there consequences for good participation? Poor participation?) Please explain.

You have to come to the first and last group and cannot miss 2 groups in a row. If you complete the program you get a certificate. Also, self-gains from participating in the program is a reward.

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9. Do the inmates in this program have any **input into program structure or activities**? If "yes," please describe briefly:

They felt that they have an adequate amount of input in the group.

10. Have you had any difficulty **accessing** treatment services? If so, please explain.

Only Dan expressed difficulty because he waited 15 months to get in. Others commented on the lack of counselor availability for individual counseling.

11. Have you participated in any **other treatment programs** in Pennsylvania state prisons?

No.

If yes:
(a) In what ways is your experience in this program **similar?**
(b) In what ways is your experience in this program **different?**

12. Would you **recommend** this program to someone you know? Why or why not?

All inmates would recommend the program except Dan, who said that he is "not going to tell someone how to run their lives."

13. What, if anything, would you **change** about this program?

Inmate #1 said that he would change admission procedures, that it should be "in order" on the list of requests - first come, first served basis.
Anthony said that he would make the program available to every block and have a D & A counselor on every block.
Kevin said he would make the meetings longer, maybe 2 hour sessions and have more 1-on -1 counseling.
Dan said he would like to have smaller groups, hold them twice a week and have more counselors.

IV. Gaps Between Program Model and Implementation

[Note any discrepancies observed between the program model (i.e., the "program on paper" and observations of program activities (i.e., "the program in action"). Note any other concerns or questions here.][2]

[2] ***Note: Researchers were unable to address this question due to lack of written procedures, policies, or lesson plans. Only a 1-page program summary was available.***

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V. Conclusions and Recommendations

1. Program Strengths (note briefly)

- Staff are generally perceived by inmates as knowledgeable, fair, and respectful. There appear to be one or more exceptions, though, based upon inmate perceptions (and observer comments) that certain staff persons lack adequate knowledge about addiction and/or counseling experience.

2. Program Weaknesses (note briefly)

- There is no definite program duration. No specific start date or end date. Inmates can enter anytime and they can stay indefinitely. Criteria for successfully completing the program are unknown. There should be a more definite cycle of treatment, including clearly specified activities, objectives, and target dates for achieving objectives.
- No written policies, procedures, or lesson plans for treatment. Treatment activities are completely at the discretion of individual DATS. Lack of treatment structure.
- Eligibility criteria are extremely broad, and assessment of inmate needs and/or suitability for the program is weak. Very little information is available about how decisions are made to admit inmates into this program.
- Program objectives are unclear.
- Staff have little time to prepare for sessions or counsel inmates on an individual basis.

3. Recommendations for Program Evaluation

- Program structure and activities should be carefully reviewed. Written objectives, activities, policies, and procedures for treatment are needed. This program is not ready to be evaluated at this time.

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INDIVIDUAL PROGRAM REPORTS: DOC-TEMPLE RESEARCH PARTNERSHIP

Institution: Houtzdale

D & A Program: Relapse Prevention

Program Description

General Program Goals and Intervention Philosophy

1. What are the **general goals** or **mission** of this program? What does it try to do? **[Source: program documents, staff interviews].**

According to the Relapse Prevention Guidelines and Summary, the goal of this program is for the group to learn some principles and techniques that may be useful in dealing with the temptations of relapse. Participation in this group will help participants realize that Relapse Prevention is a difficult and involved process. This class will better prepare individuals to deal with the dynamics of relapse and will help them come to a better understanding of the entire relapse process. It is intended that the individual realizes the dynamics associated with relapse and potential relapse warning signs and symptoms. The client will also develop a meeting list and an aftercare plan in preparation for his release.

2. What is the main **treatment approach** or **philosophy** used in this program? (e.g., see survey Q#12). Could you give one or two examples of *how* this approach is used? **[Source: staff interviews, program documents].**

According to the Guidelines and the Summary, Relapse Prevention is a treatment intensity level II group with a specific approach of information, education, and attitude change. The general way of transmitting the information is through lecture, guided discussion, visual aids, and aftercare planning. The treatment approach for this program is based upon reviewing class material, addressing any problems or concerns related to subject matter, and having participants complete both in-class and homework assignments.

Target Population and Target Selection

3. **For this program**, describe inmate **recruiting, outreach, or referral procedures** (e.g., How do inmates hear about this program? Who makes referrals? What are the reasons for referral)? **[Source: program documents].**

Both the Drug and Alcohol Department Procedures Manual and Policy Statement 7.4.1 HOU8 "Weekly General Population Inmate Drug and Alcohol Orientation" indicate

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that new arrivals to SCI – Houtzdale will attend an orientation in which verbal and written information is provided describing drug and alcohol programming. Referrals can be generated by inmates or DOC staff, and each are tracked according to an automated system that lists inmates according to their minimum and referral dates. According to the Inmate Handbook, referrals from DOC staff could include the Corrections Counselor, Unit Manager, or DATS. A vote sheet system is then initiated with the Deputy Superintendent having the final decision. As per Policy Statement 7.4.1 HOU4, inmates self-referring should complete form DC-135A, and staff-generated referrals should use a DC-134 form.

4. What are the specific **eligibility** requirements for this program (e.g., type and seriousness of D & A problem, time remaining in sentence)? Are exceptions made? **[Source: program documents].**

The Summary states that the only eligibility requirement for entry into this program is that the individual be referred by himself, by his Corrections Counselor, or any other staff member.

5. **Decision to admit (or not):** Who makes the decision? What are the most important criteria? About what percentage of referrals are rejected? **[Source: program documents].**

No information available.

Intake, Exit, and Follow-up Procedures

6. Describe the **intake/admission process** (e.g., What happens to an inmate when they first attend this program? Is there an orientation, intake interview, etc.?) **[Source: program documents].**

The Guidelines and Lesson Plan for Session I illustrates that the inmates are orientated to the expectations of the course through the group guidelines and they are informed of the course content.

7. What is the normal **program enrollment**? (i.e., at one specific time) **[Source: program documents].**

The Summary states that normal program enrollment is limited to 45 individuals.

8. What is the normal **length of stay** for an inmate in this program? **[Source: program documents].**

The Summary says that the group will last approximately one hour a week once a week, and there will be a total of 15 sessions.

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9. What are the **criteria for successful program completion? For an unsuccessful discharge**? **[Source: program documents].**

According to the guidelines, for successful completion of the program the participant must attend the first session, the last session, complete an Aftercare Plan, attend 12 out of 15 sessions, and pass the test.

Specific Program Content and Structure

10. **Describe** (a) the different **program components or activities** (see survey question # 19 for examples of specific educational or treatment activities), and (b) the **intended result or objective of each activity [Source: staff interviews, observations, program documents]**. Include the following in the report:

- Provide a **title and brief description** of the activity.
- How many **hours** weekly do inmates participate? How often do they meet?
- Describe a few **examples of program content** from lesson plans, printed program descriptions, observations, and interviews (i.e., what do they do and how?)
- For each **activity or group**, what is the **intended result or objective?** (i.e., what change in inmate attitudes or behaviors is expected)?

According to the Relapse Prevention Lesson Plan for Session I, the group is expected to perform quite a few objectives each time they meet. In the first session, the participants are given an explanation of the group guidelines and the course outline. Participants are expected to gain a better understanding of the dynamics of the Relapse Process and to develop skills to combat the Relapse Continuum.

In Session II, participants go over background information on relapse and sobriety and how their meanings have changed over the years as more has been learned about addictions and how the work. They learn about myths regarding the recovery process. Participants are encouraged to think about relapse prevention planning and the steps in developing a relapse prevention plan.

Session III looks at the difference between internal and external pressures that participants may face in their recovery of their addiction and how to cope with these pressures. Participants are given 21 Points to consider when confronted with internal/external pressures. Participants are taught to identify internal and external high-risk situations.

In Session IV, participants are taught to be able to identify personal relapse warning signs and symptoms and they are given their own warning signs and symptoms checklist.

Session V teaches inmates about mistaken beliefs regarding relapse.

Session VI of the lesson plan states that the inmates are taught to identify defense mechanisms (such as denial, rationalization, projection, etc.) and to understand how these defense mechanisms work.

In Session VII, cognitive restructuring is examined. Participants are taught to identify irrational thoughts and to be able to dispute irrational thoughts. They are shown the difference between rational vs. irrational thoughts.

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Session VIII also looks at cognitive restructuring. This session focuses on Ellis' 15 irrational ideas and the inmates must fill out a Rational Emotive Therapy (RET) handout sheet. They are taught the RET A-B-C Theory of Emotional Disturbance. Participants are also given three hypothetical situations they must answer.

Session IX of the lesson plan states that the objective is to help the inmates understand the concept of Sponsorship, in such programs as NA and AA, and the ways to go about obtaining a sponsor.

In Session X, participants are expected to examine a relapse incident and the circumstances and events surrounding it. By examining a relapse incident, participants can understand what led to a return to using. When examining a relapse, each item of the relapse is identified, such as the internal/external pressures, the relapse signs and symptoms, the defense mechanisms, the mistaken beliefs about relapse, and what could have been done differently. Examples of specific stories are examined.

According to Session XI of the lesson plan, inmates are taught refusal skills, which are the information and methods used to avoid high - risk situations.

Session XII looks at the image of relapse, which are basically beliefs about relapse and how individuals perceive it.

In Session XIII, Aftercare Planning is discussed.

11. How is treatment structured to address **individual inmate needs** (e.g., **individual treatment planning**)? [Note: some researchers believe that effective treatment requires matching appropriate treatment services with specific inmate needs]. Describe how **D & A needs assessments and treatment planning** are done (if applicable). **[Source: staff interviews, program documents]**.

N/A.

12. What types of **program records** about inmate participants are kept, and how (e.g., client needs, attendance, level of participation, treatment progress, etc.)? Are these records adequate? **[Source: inmate case file reviews]**.

N/A.

Program Staff

13. Provide a brief description of the primary staff for this program (1 paragraph each). **[Source: staff interviews]**. Include the following for each (or note if all have the same duties):

- **Name and background** (e.g., educational degree, specialized training, D & A experience)
- **educational/ treatment duties** in this program (i.e., who does what?)
- **other duties and responsibilities (i.e., non-treatment)** (e.g., see survey Q#42)

*See Individual Program Report for Houtzdale, Courage to Change Therapeutic Community (CCTC). All TC staff share additional responsibilities for education and outpatient programming with general population inmates.

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Results of Process Evaluation

Program Observations

[provide representative answers to questions and examples from **observation forms**. Give examples that illustrate what the program actually provides in terms of treatment or education, using the program model as a guide]

1. Describe the physical setting. Does it appear adequate for educational or treatment needs? Why or why not?

Chairs in single rows, five chairs deep, ten across, facing a large greaseboard. Nice large space.

2. Describe inmate attendance and participation: Do inmates appear enthusiastic? Interested?

About 30 inmates attended. Seemed engaged in conversation, listening closely to staff and responding to questions. Nice tone among members.

3. How do staff handle any discipline problems?
N/A

4. How do staff interact and communicate with inmates? Give one or two examples. Do different staff members have different styles of interaction with inmates?

Staff gave out handouts, asked questions relevant to lesson, had good sense of humor, and gave positive feedback.

5. Briefly describe what kind of content was covered in the group or session you attended (see survey Q#19). Give one or two examples.

Topic discussed was Defense Mechanisms. Discussed automatic reactions, avoidance devices, and perception v. reality.

6. What kind of treatment format was used? (e.g., lecture, video, peer- or staff-led group: See survey Q#18).

Staff-led class, with an interactive lecture.

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7. From your observations, was it possible to determine what kind of treatment approach was used (e.g., cognitive-behavioral, rational emotive therapy, etc.? (See Survey Q#12).

More educational, rather than treatment.

8. Based upon what you know about this program so far, were the activities you observed relevant to the program's goals? Why or why not?

Topic was relevant for recovery. Defense mechanisms were discussed in the context of recovery.

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Inmate Interviews

[Provide representative answers to questions from inmate interview forms]

1. How did you **first hear about this program**, and what (if anything) did you need to do to **get into** the program (e.g., get a referral? fill out an application? get interviewed by staff or inmates in the program?)

The inmate that was interviewed said that when you first arrive, everyone is given information on programs in orientation. He then put in a request in the request box on his housing unit.

2. How long did you have to **wait** to get into this program?

He waited about three weeks. He further explained that he had to wait until that current cycle ended before he could start in a new one.

3. Why did you want to participate in this program?

He wanted to participate in this program because he feels that any education he can receive is to his benefit. He explained that if it is like a program he has had before, information could be presented from a different angle and he may get a new perspective, like pieces of a puzzle.

4. Could you describe a **typical day** in this program? For example, what kinds of activities or treatment **methods** are used most often: lecture, video, written assignments, individual counseling, peer-led group discussion, or staff-led group discussion? (**See survey Q#18**).

He stated that some people are in this program because they are referred; others really need help. This program has been a real learning experience for him. He said that in group they have lecture, video, and interaction that is led by a staff member.

5. What kinds of **issues (content)** are addressed in this program? (e.g., impacts of drug use, problem solving skills, relapse prevention, etc.). Could you give one or two examples? **(see survey Q#19)**

Issues that are addressed are preventive techniques, early warning signs, different behaviors for setting self up for relapse, identification on what relapse consists of, and that inner thoughts must be convinced to change.

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6. In this program, what has been:

(a) most helpful to you?

Most helpful has been his attitude and helping himself. He said that he needed a change of behavior and attitude.

(b) least helpful to you?

Least helpful is also the same as what is most helpful to him, himself as an individual. If his feelings and behavior do not adapt, then he might not be able to comprehend what he needs to do. He needs to be able and willing to look at himself.

7. What do you think about the **staff** in this program? (e.g., How well do staff **interact** with inmates? Are inmates treated with **respect**? Are the staff **fair** with all inmates?)

Said that staff handle themselves professionally.

8. What kinds of **rewards and punishments** are used in this program? (e.g., are there consequences for good participation? Poor participation?) Please explain.

He explained that after someone misses two classes, they are removed and must start all over again as a punishment and that rewards are gaining more knowledge and insights in dealing with certain situations and gaining a certificate of completion.

9. Do the inmates in this program have any **input into program structure or activities**? If "yes," please describe briefly:

According to him, inmates are able to voice their opinion and are requested to participate.

10. Have you had any difficulty **accessing** treatment services? If so, please explain.

He said that he had no trouble, he was able to complete Substance Abuse Education, Addictions Education, Relapse Prevention, and is now on the waiting list for the TC.

11. Have you participated in any **other treatment programs** in Pennsylvania state prisons?

No.

If yes:
(a) In what ways is your experience in this program **similar?**
(b) In what ways is your experience in this program **different?**

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12. Would you **recommend** this program to someone you know? Why or why not?

He stated that he would not recommend it because if a person wants it or needs it, they should do it for themselves. You must go through treatment for yourself.

13. What, if anything, would you **change** about this program?

He felt that there should be a stronger acknowledgment of the connection between recovery and spirituality, faith, and beliefs. There are conflicting beliefs based on different religions, but there is a common thread. Staying on the path of light and giving hope. He further stated that he has transformed himself into a talker. Before, he didn't want people to know him, but now he has nothing to hide. The institution has acted like a cocoon, helping him change from a caterpillar to a butterfly.

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Conclusions and Recommendations

1. Program Strengths (note briefly)

- Ambitious objectives for a 15-week program (15 hours of total programming).
- Lesson plans and group activities are very well-structured and relevant.
- Staff are perceived by inmates as hard working, fair, and respectful.

2. Program Weaknesses (note briefly)

- Eligibility criteria are vague. Assessment of inmate needs and/or suitability for this program is weak. Very little information is available about how decisions are made to admit inmates into this program. Do they need to have completed other programs, for example? Written policies are unclear.
- It is not clear how successful program completion is tested.

3. Recommendations for Program Evaluation

- Review the role of Relapse Prevention in concert with D & A Education and Outpatient Treatment within DOC. For example, should education, outpatient, and relapse prevention be combined into one coherent, 3-stage program that is reserved for inmates who really need it?
- If inmates could be validly assessed as *low* drug involvement and *low* need for treatment, they might be required to complete the Substance Abuse Education, the Addictions Education, and the Relapse Prevention programs together (33 hours total), building a good foundation either for further in-prison treatment or community aftercare.
- Consider how scarce staffing and programming resources should be best allocated to different programs.

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INDIVIDUAL PROGRAM REPORTS: DOC-TEMPLE RESEARCH PARTNERSHIP

Institution: Houtzdale

D & A Program: Young Adult Offenders Unit

Program Description

General Program Goals and Intervention Philosophy

1. What are the **general goals** or **mission** of this program? What does it try to do? Length: 2-3 paragraphs. **[Source: program documents, staff interviews].**

According to the DATS Supervisor at Houtzdale, the Young Adult Offenders Unit has programs that are exactly like the Addictions Education Program and the Substance Abuse Education Program, only they are specifically designed for young adult offenders and are separate from the adult programs. No additional program documents were available.

According an interview with staff member Heather Hastings, there are three goals. The first goal is to separate the juveniles from the adults. The scenario at Houtzdale – a juvenile unit within an adult facility – only occurs in 2 other states, Florida and Colorado. Another goal is to keep kids in school and in treatment. Kids are in school for 4 hours in the morning and then in treatment 4 hours in the afternoon, or vice versa. The third goal is to provide treatment and to keep kids out of the hole.

2. What is the main **treatment approach** or **philosophy** used in this program? (e.g., see survey Q#12). Could you give one or two examples of *how* this approach is used? **[Source: staff interviews, program documents].**

According to Heather, the main treatment approach of this program is Cognitive Restructuring. Also, "some empowerment counseling" and "choice theory," which is learning to make choices based on consequences that you want to have happen. She goes on to say that there are many people at Houtzdale who haven't worked with kids before, and it's important to have a treatment approach that has rewards built into different phases that include different incentives.

Target Population and Target Selection

3. **For this program**, describe inmate **recruiting, outreach, or referral procedures** (e.g., How do inmates hear about this program? Who makes referrals? What are the reasons for referral)? **[Source: program documents].**

N/A

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4. What are the specific **eligibility** requirements for this program (e.g., type and seriousness of D & A problem, time remaining in sentence)? Are exceptions made? **[Source: program documents].**

N/A

5. **Decision to admit (or not):** Who makes the decision? What are the most important criteria? About what percentage of referrals are rejected? **[Source: program documents].**

N/A

Intake, Exit, and Follow-up Procedures

6. Describe the **intake/admission process** (e.g., What happens to an inmate when they first attend this program? Is there an orientation, intake interview, etc.?) **[Source: program documents].**

N/A

7. What is the normal **program enrollment**? (i.e., at one specific time) **[Source: program documents].**

N/A

8. What is the normal **length of stay** for an inmate in this program? **[Source: program documents].**

N/A

9. What are the **criteria for successful program completion**? **For an unsuccessful discharge**? **[Source: program documents].**

N/A

Specific Program Content and Structure

10. **Describe** (a) the different **program components or activities** (see survey question # 19 for examples of specific educational or treatment activities), and (b) the **intended result or objective of each activity [Source: staff interviews, observations, program documents]**. Include the following in the report:

- Provide a **title and brief description** of the activity.
- How many **hours** weekly do inmates participate in each activity? How often do they meet?
- Describe a few **examples of program content** from lesson plans, printed program descriptions, observations, and interviews (i.e., what do they do and how do they do it?)
- For each **activity or group**, what is the **intended result or objective?** (i.e., what

N/A

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11. How is treatment structured to address **individual inmate needs** (e.g., **individual treatment planning**)? [Note: some researchers believe that effective treatment requires matching appropriate treatment services with specific inmate needs]. Describe how **D & A needs assessments and treatment planning** are done (if applicable). **[Source: staff interviews, program documents].**

Staff member Heather Hastings said that they address inmate needs through education. They try to upgrade the information they present so it applies to inmates, and try not to use dated materials. There are no treatment plans for kids. This unit has 8 correctional counselors, so they have a lot of individual sessions, but it is difficult because some staff who have no training or experience in working with kids can't get the kids to talk openly about their issues.

12. What types of **program records** about inmate participants are kept, and how (e.g., client needs, attendance, level of participation, treatment progress, etc.)? Are these records adequate? **[Source: inmate case file reviews].**

N/A

Program Staff

13. Provide a brief description of the primary staff for this program (1 paragraph each). **[Source: staff interviews]**. Include the following for each (or note if all have the same duties):

- **Name and background** (e.g., educational degree, specialized training, D & A experience)
- **educational/ treatment duties** in this program (i.e., who does what?)
- **other duties and responsibilities (i.e., non-treatment)** (e.g., see survey Q#42)

*See Individual Program Report for Houtzdale, Courage to Change Therapeutic Community (CCTC). Heather Hastings is the only DATS who has responsibilities for the YAOU. YAOU was not the subject of our research study, and no other YAOU staff to our knowledge provide D & A education or treatment.

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Results of Process Evaluation

I. Program Observations

[Provide representative answers to questions and examples from **observation forms**. Give examples that illustrate what the program actually provides in terms of treatment or education, using the program model as a guide]

1. Describe the physical setting. Does it appear adequate for educational or treatment needs? Why or why not?

Programs that were observed included the Addictions Education Meeting in the YAOU, and the YAOU Group. The classes took place on the juvenile unit on the main floor. It was bright and clean, and the inmates sat in plastic stacking chairs and used plastic square tables to write on. During the YAOU Group Meeting, an activity occurring on the second floor was distracting the members of this meeting and the floor was being mopped. Also, the last 10 minutes of the group was disrupted because inmates were returning from hearings and school. It was nearly impossible to keep the students focused.

One observer also attended the Multidisciplinary Team Staff Meeting for the Young Adult Offenders Unit. This meeting took place in a medium sized conference room in the security wing of the institution. There was a long rectangle shaped conference table with approximately 12 seats around it, which were all taken. The room had carpet and no video equipment. The chairs were upholstered and the room was bright and clean. At the MTS Meeting there were 12 staff members present, both security and civilian staff, including Deputy Superintendent Johnson. Everyone seemed to be participating.

2. Describe inmate attendance and participation: Do inmates appear enthusiastic? Interested?

About nine inmates attended the Addictions Education program. Most were enthusiastic and all but 2 participated, with some more than others. They all sat in a circle. There were a lot of sidebar conversations and getting off track.

Ten inmates participated in the YAOU Group. One inmate from the adult TC came to act as a tutor and to speak about his experiences. Some inmates sat at the table with pen and paper in front of them. Others sat away from the table, leaning back in chairs. Some were interested and enthusiastic, while others were not. There was a lot of cursing.

3. How does staff handle any discipline problems?

The YAOU Group was somewhat disorganized due to the lack of attentiveness of the inmates and other activities going on in the unit. They were constantly asking questions off the topic and would not proceed until all their questions were answered

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concerning the implications of their participation in this class for parole and for receiving certificates. The staffperson had to constantly try to keep inmates on topic and consistently had to raise her voice to get their attention.

4. How do staff interact and communicate with inmates? Give one or two examples. Do different staff members have different styles of interaction with inmates?

Staff at the Addictions Education class had to exercise great patience. She was friendly and professional. She had to be very clear and had to keep the group moving. She seemed to be presenting updated and accurate material regarding the content of the group.

Staff for the YAOU Group was professional and good-natured. She needed to raise her voice to be heard and keep everyone on the subject. She did a good job of not getting flustered or manipulated into getting off the topic.

At the MTS Meeting, staff were professional with each other. They were discussing specific inmate's cases, and staff seemed good natured and friendly among one another.

5. Briefly describe what kind of content was covered in the group or session you attended (see survey Q#19). Give one or two examples.

The topics for the Addictions Education class concerned the concepts of powerlessness and unmanageability. They spoke about four categories of drugs and also discussed physical v. psychological dependence.

The topic for the YAOU Group was cognitive restructuring. It should be noted that this was the first day for this group. Many inmates had questions about the group and how it would help with getting them parole and certificates. They also wanted to know other basic information about the class. Inmates also took a self-assessment test to determine if they are in need of exploring their own cognitive structuring.

The members of the MTS Meeting discussed the RHU, how many inmates were released, and then spoke of specific inmate cases the remainder of the meeting.

6. What kind of treatment format was used? (e.g., lecture, video, peer- or staff-led group: See survey Q#18).

The Addictions Education class and the YAOU Group were both staff led classes. Approach was primarily educational.

7. From your observations, was it possible to determine what kind of treatment approach was used (e.g., cognitive-behavioral, rational emotive therapy, etc.? (See Survey Q#12).

In the Addictions Education Class, the approach centered on 2 steps of the 12-step program.

In the YAOU Group, the treatment approaches used were cognitive restructuring and rational emotive therapy.

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8. Based upon what you know about this program so far, were the activities you observed relevant to the program's goals? Why or why not?

In the Addictions Education class the activities were relevant to the program's goals. Using one TC inmate within the group (although he wasn't there that day) is empowering and enables staff to provide a positive role model for inmates to follow. The topics centered on drug abuse; accurate and updated information was provided.

IN the YAOU Group the activities were relevant to the program's goals also. The session was about self-exploration and provided the foundation for continued exploration of thinking and feeling.

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II. Staff Interviews

[Provide representative answers to questions from staff interview forms]

1. How would you describe the **relationships** between staff at this institution (e.g., is there a sense of teamwork)?

(a) Relationships between D & A staff:

Professionally they all get along well, although this particular staff member felt like an outcast because she is now assigned exclusively to the juvenile unit. She and other staff on this unit take a lot of verbal mocking from some of the other staff working in general population. She has not seen this kind of verbal mocking elsewhere in the facility.

(b) Relationships between D & A staff and security:

Relations between staff and security are terrific. Unit officers on the block work as a multidisciplinary team along with a group of other people.

(c) Relationships between D & A staff and other correctional staff or departments:

This staff does not really communicate with others in other departments. She has a closer relationship with some teachers since many kids are in school and the YAOU also gets first preference regarding school, which may cause some of the antagonism towards the juveniles on behalf of other inmates and staff.

2. What, if anything, would you **change** about this program?

More drug treatment needs to be offered instead of drug education. Some of the curriculum needs to be rewritten for juveniles.

3. What kind of **input,** if any, do staff in this program have into **modifying program structure or activities?**

Staff requests are usually just an issue of time. There isn't enough time to implement all of the things they would like to do, but it is not because the supervisor does not give them a lot of latitude.

4. What kinds of inmates **do well** in your program? What kinds of inmates present the **most challenges**? Please describe.

Eventually most inmates do well in the program, it just depends on how soon. The program is only 2 1/2 years old and as staff get better at their knowledge, so will the

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kids. Kids that do the best are those that come from a family where at least one parent is stable, generally the mother. Those that do the worst are those who come from families in which the parent supported them to go out and sell drugs. Often there is parental abuse going on that sets up the scenario for lack of trust in others.

5. About what percentage of inmates admitted are **discharged early from this program**? Why?

N/A

6. Do you ever make **treatment-related referrals to other programs or departments within DOC? To outside agencies**? If so, please describe:

N/A

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III. Inmate Interviews

[Provide representative answers to questions from inmate interview forms]

1. How did you **first hear about this program**, and what (if anything) did you need to do to **get into** the program (e.g., get a referral? fill out an application? get interviewed by staff or inmates in the program?)

There were two inmates interviewed for this program. The first one stated that he was in this program because it is mandatory. He said that his CO said that he had to go, even though he claims he does not have a drug problem.

The second inmate interviewed said that he was also placed in the program because "...it's mandatory he takes what Mrs. Hastings teaches."

2. How long did you have to **wait** to get into this program?

Both inmates stated that there is no wait for this program, that you are automatically put into it.

3. Why did you want to participate in this program?

Both inmates stated that it is a mandatory program, and that parole requires it. Both inmates claimed that they do not have a drug problem, but that this program is just assigned to everyone. It is just assumed they have a drug problem.

4. Could you describe a **typical day** in this program? For example, what kinds of activities or treatment **methods** are used most often: lecture, video, written assignments, individual counseling, peer-led group discussion, or staff-led group discussion? (**See survey Q#18**).

Inmate #1 said that a typical day in this program is attending group meetings, once a week for about an hour, talk about effects of different drugs, watch some videos, and have a combination of discussion and lecture (about 50/50), although this varies from one session to the next.

Inmate #2 said that he attends a small group run by his corrections or unit counselor during which all they talk about is "what's going on on the block." He also said that he attends a psychiatric group in which he "doesn't know what the purpose of the group is – that maybe it has something to do with emotions." And he attends a D & A group, where they learn about the history of AA. They meet once a week, and discuss their thoughts. Sometimes a member for the TC comes and talks with them.

5. What kinds of **issues (content)** are addressed in this program? (e.g., impacts of drug use, problem-solving skills, relapse prevention, etc.). Could you give one or two examples? **(see survey Q#19)**

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Inmate #1 stated that issues that are addressed in this program are effects of drugs, stress management and anger. The counselor hands out a paper and asks someone to read it with a group discussion afterwards.

Inmate #2 stated that issues that are addressed are the history of AA, what is an addiction, and labeling the different kinds of drugs.

6. In this program, what has been:

(a) most helpful to you?

Inmate #1 stated that he did not want to be in this program because he did not use drugs.

Inmate #2 said that the most helpful thing for him was that Ms. Hastings is a really nice person, who shows respect, makes it easy for them to understand things, and she answers everyone's questions.

(b) least helpful to you?

Least helpful for Inmate #1 was that those with a real drug problem don't get a lot from the program. Also that it takes too long to get a certificate (6 months or longer). The unit in general offers fewer privileges than other units, and the CO's on this unit are cruel to inmates.

Inmate #2 just said that it was too early in the morning to answer (it was 10am).

7. What do you think about the **staff** in this program? (e.g., How well do staff **interact** with inmates? Are inmates treated with **respect**? Are the staff **fair** with all inmates?)

Inmate #1 said that Ms. Hastings was "good".

Inmate #2 said that, "Ms. Hastings got her ways of putting things across. She'll work with you until you get a full understanding."

8. What kinds of **rewards and punishments** are used in this program? (e.g., are there consequences for good participation? Poor participation?) Please explain.

Inmate #1 stated that it was hard to say. That they hardly ever graduate anyone on this block (maybe 1 every other month or so), and that overall the YAOU is NOT a good program at all.

Inmate #2 said that a reward is receiving a certificate when you finish a course and that a punishment is being sent back to your cell if you are not being respectful to others or are being rude.

9. Do the inmates in this program have any **input into program structure or activities**? If "yes," please describe briefly:

Inmate #2 stated that if it were up to Ms. Hastings, inmates would have input. They have made a lot of suggestions but no one above her will support her, like the unit managers.

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10. Have you had any difficulty **accessing** treatment services? If so, please explain.

No – all mandatory services.

11. Have you participated in any **other treatment programs** in Pennsylvania state prisons?

No.

If yes:
(a) In what ways is your experience in this program **similar?**
(b) In what ways is your experience in this program **different?**

12. Would you **recommend** this program to someone you know? Why or why not?

Inmate #1 would recommend the drug program and Ms. Hastings but not the YAOU.
Inmate #2 would only recommend this program if someone needed it for parole.

13. What, if anything, would you **change** about this program?

Inmate #1 stated that some counselors care, some CO's care but that there are 120 guys on the block and only six counselors. They only have group 2 times per week with a block counselor. He also said that taking away their stuff is not fair, and that it would also help if participation in the program was voluntary. Stated that inmates have to show somebody they really want to change, but staff also has to show that people really care.

Inmate #2 just stated "Get that mandatory program for juveniles." This is a program that he explained as being a drug program that is required by his prescriptive program but is not offered by the institution to the juveniles.

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V. Conclusions and Recommendations

1. Program Strengths (note briefly)

D & A Staff on the YAOU are praised by inmates. Research observations confirmed that D & A programs on YAOU are run by experienced, professional staff.

2. Program Weaknesses (note briefly)

No written objectives, policies, or procedures. No lesson plans available.
Inadequate staffing for D & A programming (one DATS per 120 inmates). Large groups include a certain number of unmanageable, difficult juveniles.
According to all sources of information available (observations, inmate interviews, and lack of written policies), this program does not adequately assess whether juveniles have a drug problem or not, and just automatically places them in required drug programs. There should be a drug screening procedure (assessment of drug involvement and need for treatment) when the inmate first enters the unit. If inmates are simply placed in drug programs automatically to help deter them from using drugs, then this is a poor use of scarce resources. A pattern of previous drug use needs to be established and admitted to, and some index of severity used.
There was a sense among inmates that the juveniles are not treated as fairly or equally as adult inmates. Some of their suggestions should be heard, so that they can feel like they actually have a say about the kind of treatment they are receiving.
Staff of the YAOU should be treated fairly and equally by other staff at this institution. There may be a problem of disrespect by other staff that contributes to low morale.
There is a perception by inmates (reinforced by researcher observations) that the unit is chaotic and disorganized. Too many distractions for positive change to occur.

3. Recommendations for Program Evaluation

Overall, programming on the YAOU Unit deserves careful monitoring and review. D & A staff are very professional, but their efforts are mitigated by an atmosphere of chaos and/or inmate disinterest in treatment. Staffing issues are paramount when working with such a large, difficult young offender population as the YAOU.

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Appendix 6:

Individual Program Reports: SCI – Huntingdon

Living Sober Therapeutic Community (LSTC)

Addictions Treatment (Outpatient)

Substance Abuse Education

Addictions Education

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INDIVIDUAL PROGRAM REPORTS: DOC-TEMPLE RESEARCH PARTNERSHIP

Institution: Huntington

D & A Program: Living Sober Therapeutic Community

Program Description

General Program Goals and Intervention Philosophy

1. What are the **general goals** or **mission** of this program? What does it try to do? **[Source: program documents, staff interviews].**

According to the LSTC Community Inmate Handbook, a Therapeutic Community is a group of individuals living together and helping each other in a constructive way within a closed environment through social learning. All staff and residents are part of the Treatment Community. All inmates of the LSTC are required to use the various areas of treatment, the proper use of the therapeutic tools and procedures of the activities that they are obliged to participate in during their stay in the program. This knowledge should help the inmates come to the understanding of the objectives and goals of any treatment they may receive, on how to utilize the tools, and how to gain the most benefits from each activity within the program. This is a behavior-driven program that is seen as both a treatment program as well as an up-close examination of inmate behaviors in a community setting. Daily interaction with other inmates, DATS Staff and Corrections Officers provide a rich source of information that can be used by the DOC for making decisions about the inmate's potential for rehabilitation, recidivism, and behaviors not readily observed in a standard housing unit with cells.

2. What is the main **treatment approach** or **philosophy** used in this program? (e.g., see survey Q#12). Could you give one or two examples of *how* this approach is used? **[Source: staff interviews, program documents].**

The LSTC Community Inmate Handbook states that their main treatment approach is to combine drug/alcohol treatment (group and individual) with education in a therapeutic atmosphere, which helps the inmate to focus on his addiction, behavior, attitudes, and criminality. The last phase of this program involves goal planning and a structured reintegration into the community. All inmates of the LSTC are required to follow unit rules and procedures, participate in the various components of treatment, and learn the proper use of therapeutic tools. This knowledge should help the inmates understand the objectives and goals of the treatment they receive, and how to gain the most benefits from the program.

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Target Population and Target Selection

3. **For this program**, describe inmate **recruiting, outreach, or referral procedures** (e.g., How do inmates hear about this program? Who makes referrals? What are the reasons for referral)? **[Source: program documents].**

According to Policy 7.4.1 – HUN 1 and the SCI-Huntingdon Addiction Counseling Overview, inmates are informed about the LSTC at an orientation through their assigned correctional counselor and through institutional TV and routine interviews via a call list. Referrals can be made by their counselor, who is to provide the group leader with the inmate's name, number, and housing and work assignment on a standard "memorandum report form". The counselor is also to identify the target date on this memo, which could be the minimum release date or another important date (such as Pre-release staffing date, minimum date, etc.). This allows enough preparation time for proper programming efforts. Referrals can also result from inmate interviews. Referrals can be made by counselors or by the inmates themselves. Admission to the LSTC can be initiated by the established institution staffing procedure, by using the DC-46 Vote Sheet, which includes a space for the DATS Supervisor as a voting member.

One Inmate Case File (D.H.) was also reviewed. According to his file, he was self-referred, using the DC-135A form "Inmate's Request to Staff Member" dated 7/9/98, but there was no reference to how he heard about the program. Also in his file were the application to participate in the TC and the vote sheet for DATS staff.

4. What are the specific **eligibility** requirements for this program (e.g., type and seriousness of D & A problem, time remaining in sentence)? Are exceptions made? **[Source: program documents].**

A Condensed Summary of the LSTC says that the DATS Supervisor makes the decision about the inmate's needs and appropriateness for TC treatment based on a drug & alcohol interview and assessment conducted by the DATS Supervisor.

For one specific inmate whose case file was examined, a variety of different pieces of information could have informed the assessment (although we cannot tell to what degree which pieces of information were actually used). Information in the inmate's file included the inmate's PACSI score (Pennsylvania Substance Abuse Dependency Scale): he scored a 9 on the 0-10 scale; the Housing Performance report (which is completed by the C/O's, like a vote sheet), and the Work Supervisor Evaluation form.

5. **Decision to admit (or not):** Who makes the decision? What are the most important criteria? About what percentage of referrals are rejected? **[Source: program documents].**

Policy 7.4.1-HUN 1 illustrates ten specific criteria items that are considered when an inmate is referred to the LSTC.

- It cannot be less than 6 months to their minimum parole date.

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- The inmate must have documented drug and/or alcohol dependency.
- The inmate cannot display any psychosis or intellectual functioning that precludes comprehension of objectives and participation in program activities.
- There must be voluntary commitment to complete the program.
- They must have medical clearance. Inmates that are referred cannot be undergoing other forms of treatment that will interfere with their ability to participate in the program.
- The inmate must be literate or at least have the capacity to become so. A major portion of the program involves reading and maintaining a written journal. Education is also a major component.
- Must be double cell status.
- The inmate cannot have any misconduct related to escape, assaultive behavior, and over-all problematic institutional adjustment. These actions may preclude consideration.
- The inmate may have to undergo a current psychological evaluation that may have significant impact on final approval and should be available. The need for this evaluation will be determined by the Living Sober Therapeutic Community staff during their preview of the case.
- The referral must secure approval of the Major of the Guard and the Inmate Program Manager via the DC-46 Vote Sheet.

Intake, Exit, and Follow-up Procedures

6. Describe the **intake/admission process** (e.g., What happens to an inmate when they first attend this program? Is there an orientation, intake interview, etc.?) **[Source: program documents].**

The *LSTC Outline of the Four Phases* states that participants in the LSTC, while in Phase I, will have to read, understand, and sign a consent to treatment form which clearly outlines participants' and the department's expectations within the therapeutic community. The inmate will participate with his individual counselor on the development of a comprehensive therapeutic treatment plan. This plan will include the specific goals of the Therapeutic Community and also address the individual needs of the participant. The inmate will have to participate in an Introduction to Group Process, which is a lecture on skills that are needed to be able to participate in a group properly. The purpose of this group is to assist the participant in understanding how to be a productive and contributing group member. They will also have to participate in an Introduction to Communicative Dynamics lecture that will teach the verbal and non-verbal skills needed to effectively communicate and listen to other group members.

According to researcher observations of one inmate's case file, forms that the inmates need to fill out for admission and orientation are: Various written consent forms, inmate rights and client rights forms, D & A Department Disclosure of Admission/Discharge and Consent to Treatment criteria, Psychosocial History,

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Psychoactive Substance Abuse/Dependency Scale, Multimodal Life History Questionnaire, Medical History, Classification Summary, and Intake Orientation sheet.

7. What is the normal **program enrollment**? (i.e., at one specific time) **[Source: program documents].**

An Executive Summary prepared by DATS Staff illustrated that normal program capacity is 36 inmates. The unit is usually full. The waiting list consists of around 275 or more inmates at any one time.

8. What is the normal **length of stay** for an inmate in this program? **[Source: program documents].**

According to the LSTC Community Inmate Handbook, the program will usually take 8 to 13 months to complete, based on the completion of various behavioral objectives. Actual time in the program may be more or less than this "ideal" time frame.

9. What are the **criteria for successful program completion**? **For an unsuccessful discharge**? **[Source: program documents].**

The LSTC Community Inmate Handbook says that successful program completion occurs upon an inmate's satisfactory fulfillment of behavioral objectives as designated in the inmate's Individual Treatment Plan.

Neutral discharge from the program occurs when an inmate is unable to complete the program through no fault of his own (e.g. medical problems, emotional problems, sentence status change, etc.). Neutral discharge means that no negative consequences or implications will occur as a result of leaving the program.

Unsuccessful discharge or program failure may result based in a rating of Unsatisfactory Performance or the award of a Class I or Class II Misconduct (i.e. violation of the Inmate Handbook's rules and regulations); decision of staff via vote sheet based on non-fulfillment of treatment plan; or commission of a felony or misdemeanor or failure to adhere to the individual treatment plan or to program guidelines.

Specific Program Content and Structure

10. **Describe** (a) the different **program components or activities** (see survey question # 19 for examples of specific educational or treatment activities), and (b) the **intended result or objective of each activity [Source: staff interviews, observations, program documents]**. Include the following in the report:

- Provide a **title and brief description** of the activity.
- How many **hours** weekly do inmates participate in each activity? How often do they meet?

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- Describe a few **examples of program content** from lesson plans, printed program descriptions, observations, and interviews (i.e., what do they do and how do they do it?)
- For each **activity or group**, what is the **intended result or objective?** (i.e., what change in inmate attitudes or behaviors is expected)?

The LSTC Summary states that the program components are broken down into four Phases.

Phase 1

Inmates in Phase I focus on an orientation and probation period in which the inmate and staff have time to determine if the TC is effective for the individual and how he affects other members of the TC.

This phase has several main objectives, according to the Phase I Treatment Plan. The first one is to define treatment issues by having the inmate sign a consent form, complete a life history questionnaire, complete a chemical history questionnaire, complete a global treatment sheet, and to meet with a counselor to discuss Phase I's Units A, B, C, & D.

The second objective is to initiate a Phase I treatment plan by meeting with a counselor, agreeing to and signing a Phase I treatment plan, being assigned to a committee, and going to each member and have them initial a sign-up form.

The third objective is to obtain a passing score on the Design for Living Tests by attending sessions A, B, & C of the Design for Living program. These sessions explore the nature of drugs and drug use, additional risks associated with chemical use and to introduce the relationship between criminal thinking and chemical use, and to understand and change awareness.

The fourth objective is to obtain a better understanding/awareness of self by attending five therapeutic journal classes in which the inmate is expected to maintain a daily written journal and review in individual sessions. They are also expected to participate in individual counseling once a month and identify and review issues discussed during small group participation.

The fifth objective is to obtain knowledge of interpersonal skills and group processes by attending 14 sessions of interpersonal skills classes, completing all homework assignments satisfactorily, and attending all small group therapy sessions 2 times per week.

The sixth objective is to obtain knowledge of the basic concepts of recovery by attending 8 sessions of the Basic Concepts of Recovery Class and obtaining a passing score on the test. The Basic Concepts class introduces basic vocabulary and concepts of addiction, treatment, recovery, and self-help programs, provides a foundation of key recovery and treatment concepts that will help participation into other therapeutic activities, develops an understanding of the depth of problems experienced by an individual who is a chemically dependent offender, confronts the complexity and depth of the recovery process so that they can understand a need for a full-time, long-term commitment to addiction treatment, aftercare, and recovery, and introduces and

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explains basic principles of the 12 Step Programs, self-help and the role of spirituality in the treatment/recovery processes.

The seventh objective is to sustain recovery utilizing 12 Step Support System by attending AA/NA support group and completing requirements of a treatment plan supplement.

The eighth objective is to utilize a Helping Measure System by initiating at least one encounter or one pull-up while in Phase I.

The final objective is to advance to Phase II by having been successfully staffed, having received peer recommendation by means of a pop sheet, having maintained at least an average score on the Program Participation Index, having had functioned as a member of 2 different committee's, having initiated a Phase II Treatment Plan, having obtained approval for Phase II ITP from small groups and having each member give feedback for advancement to the next phase, having demonstrated understanding/use of recovery tools and giving a seminar on "What tools I learned in Phase I."

Phase II

In Phase II, the inmate enters into more focused psychoeducational programming, including interpersonal communication, criminal thinking, cognitive restructuring, and relapse prevention. The inmate is also required to participate on 2 committees, be more actively involved in group therapy and the pull-up system. This phase involves several specific objectives according to the Phase II Treatment Plan.

The first objective is for the inmate to obtain knowledge and begin to understand realistic self-examination/intrapersonal skills. This objective is reached by attending the Intrapersonal Skills Training Class and by completing all the homework assignments to the satisfaction of the instructor. The inmate is expected to verbalize in small group therapy sessions what they were thinking at the time they committed their offense and to listen as others share what their thoughts were during their own experiences.

The inmate is to identify at least 3 examples of behaviors, emotions, and thoughts which could trigger relapse, discuss these triggers with others in at least 9 small group sessions, and then review with their counselor in an individual session.

The inmate is expected to demonstrate mastery of assertiveness skills. They are to demonstrate this mastery by listing 10 examples of aggressive behavior and then listing an alternative assertive behavior for each, show assertiveness instead of passive or aggressive behaviors in at least 3 small groups, and discuss assertiveness during individual counseling sessions.

The inmate is also expected to begin the process of cognitive restructuring by attending 8 sessions of Cognitive Restructuring Group. This group's objective is to for the inmate to learn to employ rational emotive techniques in everyday life. This objective is reached by having participants understand how cognitive restructuring (changing beliefs) can change the course of one's future and prevent taking paths of self-defeating and socially damaging behaviors. They are to develop and understand the nature and importance of emotions and look at Albert Ellis' 11 irrational ideas and how to challenge them.

The inmates are also expected to complete 10 satisfactory homework assignments that address addiction, criminal behavior, authority figures, underachievement, and

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family/relationships, and complete an essay on "What I learned and what helped me most from the Cognitive Restructuring Classes."

The second objective is obtain an understanding of the Twelve Steps and receive a passing score on the tests. Participants are to accomplish this by attending and participating in 14 Twelve-Step Study Classes.

The third objective is to attend 19 sessions of Spirituality, Sexuality, and AIDS Education and obtain a passing score on the test. Participants must also write an essay and discuss "What I learned and benefited from in Spirituality, Sexuality, and AIDS Classes."

The fourth objective of Phase II is for the inmate to obtain practical knowledge of Steps 1 through 3 by attending sessions D through H of the Design for Living Program and write an essay on what they learned from that program.

The fifth objective is for the inmate to sustain recovery by attending an AA/NA support group 3 times a week, submit 6 AA/NA Attendance/Log/Reaction Sheets, maintain a journal that they review with a counselor monthly, tell their own story in one AA or NA meeting, complete the requirements of the treatment plan supplement, complete an educational activity, an exercise program, and they are also expected to begin to address spiritual issues during counseling sessions.

The sixth objective of Phase II is for the inmate to advance to Phase III. They are advanced to Phase III after they have been successfully staffed, received peer recommendations by pop sheets, maintained an average score on the Program Participation Index, obtained small group approval for Phase III ITP, and have demonstrated that Phase II treatment goals have been completed and learned/retained.

The last objective is for the inmate to utilize the Helping Measure System by initiating at least 1 encounter or 1 Pull-up per month during Phase II.

Phase III

In Phase III the inmate focuses more on intrapersonal/intrapsychic issues dealing with anger management, individualized inventorying of criminal history, thinking and behavior. This phase focuses specifically on the inmate dealing with and understanding denial; demonstrating a mastery of cognitive behavioral techniques by successfully modifying his moods in a stable and socially appropriate manner; and continuing to develop group process skills. This Phase has several key goals according to the Phase III Treatment Plan.

The first goal is for the participant to understand and deal with the issue of denial. This goal is accomplished by having the inmate identify and confront their own denial, point out denial symptoms in 3 different members of their group, identify examples of people or things who strengthen that denial, and complete cognitive restructuring exercises.

The second goal of this phase is to have the participants obtain practical knowledge of Steps 4 - 9 by attending sessions I - N of the Design for Living program and writing an essay on what they learned.

The third goal is for the inmate to sustain recovery by attending AA/NA support groups 3 times a week, maintain a journal, meet individually with a counselor, and tell their life story in a combined AA/NA meeting. They are also expected to continue to attend

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spiritual recovery, participate in an educational activity and an exercise program, and discuss examples of addiction.

The fourth goal is for the inmate to gain insight into criminal thinking. They are to acquire this insight by attending 5 Criminal Thinking classes and discussing why they themselves are criminals and their own criminal thinking. They are also given a relapse warning sign list for criminal behavior that will help them understand how they may return to criminal behavior, even though they don't want too.

The fifth goal of this phase is for the participant to utilize the helping measure system by initiating 9 Pull-Ups per month.

For the sixth goal, they are expected to demonstrate understanding/use of recovery tools in Phase III, by giving a seminar on 5 tools they have learned and used, discussing what they have learned in Phase III and receive feedback on issues that still need to be addressed, and discussing their own strengths and weaknesses with their individual counselor.

The seventh goal of this phase is the advancement to Phase IV. They are advanced to Phase IV after they have been successfully staffed, received peer recommendations by pop sheets, maintained an average score on the Program Participation Index, obtained small group approval for Phase IV ITP, and completed requirements of the treatment plan supplement. The treatment plan for this phase requires that the inmate think about future plans, such as their general goals, their personal goals for their home life, employment, education, and their own personal improvement.

The final goal of this phase is for the inmate to learn productive strategies for expressing and coping with anger. They are expected to attend 13 sessions of Basic Anger Management. In these sessions they are to identify what anger is and learn constructive anger management techniques. Inmates also receive Cage Your Rage: An Inmate's Guide to Anger Control, a book by Murray Cullen that will help them understand their anger and how to control it.

Phase 4

Finally, in Phase IV the inmate is given the chance to integrate his knowledge and experiences and plan for reentry into general population and/or progressive moves to a lower custody level housing unit and/or a CCC. Part of aftercare planning includes a periodic staff follow-up questionnaire or interview.

This phase focuses specifically on the inmate demonstrating and presenting a written plan to utilize the support services within the community to which he will be discharged; writing an extensive and personalized individual essay regarding his own recovery and future recovering, which will be reviewed by staff and group members and will be used as a therapeutic tool to assess the individual's readiness for treatment termination and discharge; engaging in group termination and group closure exercises; counseling geared towards the continuity of addictions treatment within the specific community to which referral was made following discharge from the SCI; demonstrating effective utilization of 3 relaxation techniques; being involved in the Activities Department's Life Skills/Leisure Activities Program, being involved in a standardized parent

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education training program(PET); and continuing to practice his assertiveness skills with specific progress towards relapse prevention.

Inmates must show knowledge of stress management techniques, life skills and leisure activities, relapse prevention, assertiveness skills, community support services, show recovery tools that they use, and demonstrate positive leadership skills.

When all Phase 4 activities are successfully completed, the discharge process begins. Inmates will be successfully discharged after they have been successfully staffed (i.e., vote sheets are completed), they have received peer recommendations via POP sheets, they have maintained an average PPI score (participation points index) weekly, they have conducted a final farewell speech to members of the LSTC, and they have completed and reviewed an Aftercare Plan.

11. How is treatment structured to address **individual inmate needs** (e.g., **individual treatment planning**)? [Note: some researchers believe that effective treatment requires matching appropriate treatment services with specific inmate needs]. Describe how **D & A needs assessments and treatment planning** are done (if applicable). **[Source: staff interviews, program documents].**

According to documents describing Phase I of the LSTC, an individual treatment plan is devised when the inmate first enters the program, which is constructed, by the inmate and his individual counselor. The primary function of the treatment plan is to give the individual insight into past behavior, values, goals, and how these traits have helped or hindered him in living within the expectations of society. The treatment plan is an introduction, as well as a chronology of what he believes are significant events in his life. This plan may also be used in various other ways, such as requesting for a modification of sentence, requesting for employment, and introducing the individual to an aftercare agency.

According to on-site Case File Reviews conducted by researchers, a standardized checklist is used for treatment planning, and only rarely do staff make individualized entries for specific inmates.

12. What types of **program records** about inmate participants are kept, and how (e.g., client needs, attendance, level of participation, treatment progress, etc.)? Are these records adequate? **[Source: inmate case file reviews].**

According to on-site Case File Reviews conducted by researchers, diverse records reflect upon an inmates' participation and treatment in TC, including their Prescriptive Program Plan, the Vote Sheet, their Treatment Plans for all 4 Phases, Cumulative Adjustment Records, Review, Update, and Case Consultation of Treatment Plan with a monthly check off, Global Goal Treatment Sheet, a Certificate of Completion of such goals as Life Skills Sessions, Anger Management Skills, and Computer Skills, Pull-Ups, Group Psychotherapy Notes, Approval for Phase Advancement Form, Rating Scale form, Stress and Anger Management Group Therapy Notes, and seminar evaluations.

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Program Staff

13. Provide a brief description of the primary staff for this program (1 paragraph each). **[Source: staff interviews]**. Include the following for each (or note if all have the same duties):

- **Name and background** (e.g., educational degree, specialized training, D & A experience)
- **educational/ treatment duties** in this program (i.e., who does what?)
- **other duties and responsibilities (i.e., non-treatment)** (e.g., see survey Q#42)

Howard West is DATS II at SCI-Huntington. He received his BA in East Asian Studies from Penn State University and his Masters of Education from the University of Pittsburgh in Cross Cultural Counseling. He also had one semester in a Ph.D. program at Penn State in Early Childhood Intervention. He has three years previous experience as a D & A counselor and has been at his current job for 3 1/2 years. He does not have his CAC but has a few hundred hours of continuing education in D & A education. Mr. West's educational/treatment duties consist of teaching Basic Concepts, Design for Living, Cognitive Restructuring, and occasional impromptu seminars in the TC. He teaches Addictions Education for the general population and conducts staff trainings. His treatment duties involve conducting formal individual counseling sessions once a month for 12 TC inmates on his caseload, as well as informal counseling sessions, with a minimum of 20 hours each month. He also conducts group therapy twice a week for two hours each, pull-ups, supervises AA, NA, and Alumni Group meetings, and oversees public relations and inmate activities committees on TC unit. Non-treatment duties include Cultural Sensitivity Trainer for DOC staff, member of Automation Committee, and member of the Steering Committee for the Temple/DOC Partnership.

Will Matthews is DATS I at SCI-Huntington. He received a BA in Vocational Rehabilitation and a BA in Psychology at the University of Nebraska. He also received his Master's degree at Indiana University of Pennsylvania. He has worked at various rehabs and has worked with the DOC for nearly 2 years now. His educational/treatment duties are running the Substance Abuse Education program and the outpatient programs, Alanon and AA. He is also in charge of the RHU Drug Program, drug screening when needed, psychosocial assessment, the discharge summary, parole staffings, and an annual review in each inmate's prescriptive plan. He also has nine inmates on his current caseload that he meets with at least one hour per month. Other duties he has are weekly trainings, some paperwork, the D & A Consortium for training twice a year, and required trainings every six months on such things as AIDS, sexual harassment, and defensive tactics.

Frank Hartnett is a DATS I at SCI-Huntington. He received a BA in Education and a M.Sc. in Counseling from Duquesne University and his MA in Business Management

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from Webster University. He also has his CAC diploma. He did program development for Air Force D & A programs and worked with the Department of Defense developing a drug survey with Research Triangle Institute and developed a drug testing program and standards for outpatient programs. He also has worked at a Community Mental Health Center and at various private treatment facilities in the area. His educational/treatment duties consist of having 9 inmates on caseload; conducting small group twice weekly, morning meetings, seminars, and phase class in TC one morning per week; pull-ups on TC; AA meetings on the TC unit; and NA (outpatient) meetings once per week. Other non-treatment duties Mr. Hartnett has are participating in In-service Training, staff meetings, and case reviews on Fridays.

Joseph Jackson is a Correctional Officer for the TC unit at SCI-Huntington. He has no D & A experience and was in the Air Force in earlier years. He has been a Correctional Officer for the last seven years and will retire in three years. He has been on the TC block since January 1999. His main duty is security. He enforces the unit rules and regulations and calls guys on things they are not supposed to be doing. For example, he has stopped some of them from going to the barbershop and commissary instead of going to their required treatment groups.

Arlene Duffy is a Vocational Counselor at SCI-Huntington. She conducts GED programs in the afternoons for many guys in the TC unit who have treatment programs in the mornings. She received her MA in Educational Counseling and another MA in Rehabilitation Counseling, both from Penn State University. Her duties as a Vocational Counselor are to get inmates qualified for vocational job training, such as print shop, barber, auto shop, etc. Preparation activities include Job Skills Class, Career Assessment, and GED classes. She also teaches a Business Education class, which involves some computer instruction.

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Results of Process Evaluation

I. Program Observations

[Provide representative answers to questions and examples from **observation forms**. Give examples that illustrate what the program actually provides in terms of treatment or education, using the program model as a guide]

1. Describe the physical setting. Does it appear adequate for educational or treatment needs? Why or why not?

The TC is located in the basement of a very old prison, underneath a larger housing block.

Several TC Phase I and II classes, Morning Meeting, TC Seminars, Small Group (Counselor Matthews), Nicotine Anonymous, are all held in the regular meeting room on the TC unit. It is a long, narrow room with a long, board type table and chairs. There are several 12-step slogans and pictures on the walls, several church pews at the back of the room, and numerous loose chairs for extra seating. Windows on the right open up to the TC dormitory area, so people in the room are visible from the outside. It is fairly quiet, but toilets can be heard flushing at the back of the room, since the room is right next to the bathrooms and the plumbing runs right through the meeting room with pipes overhead. A leak in the pipe was noticed. It was observed that when the room is full it is almost impossible to see who is speaking unless he is right in front of you. It was suggested that a circular arrangement would be better. It was cool in the room from the air conditioning. White concrete walls and gray concrete floors. Bright florescent lights which made it easier to see. Clean environment, but old. It was observed that the room felt somewhat awkward but appeared to be functional.

Several of the TC Small Groups, Pull-Ups (Helping Measures), and AA are held in the second meeting room near the back of the unit. There is a large window in this room that opens to Mike Ciaverella's office, but file cabinets mostly block the view. The color of the room was distracting but size and acoustics seemed okay. A window in the door allows observation from the outside, and the Unit CO occasionally patrols the unit and looks in.

The Modular Housing Unit is located in a trailer outside the main prison. It is a minimum security unit for those who have earned a lower security clearance to work outside the prison. Inmates here have more freedom of movement. NA groups for this population are offered. It is not connected to the TC at all, but several of the NA group members are TC graduates who are awaiting parole hearings. The unit includes a large conference room with a lot of chairs that are arranged in a circle. It has good sound and pleasant surroundings. One problem was that even though there were signs up on the doors indicating that a group was in session, several other inmates still walked in, looked surprised, then left to go through another entrance.

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2. Describe inmate attendance and participation: Do inmates appear enthusiastic? Interested?

Most inmates appeared to be interested in the groups. Many offered examples and definitions of concepts. Quite a number shared personal experiences and offered praise to others in the group. Most groups had excellent feedback and discussion. Inmates seemed appropriate and supportive of each other in most cases. They tended to challenge one another. Counselors used numerous examples from real life and from movies, which seemed to go over well.

Many inmates had questions for the Temple observers, which showed some genuine curiosity about the research project.

There was occasionally some disinterest or resistance. In the "Cage Your Rage" class there was resistance by some to the idea that anger and aggression can (or should) be controlled in prison. There was some complaining by smokers in the Nicotine Anonymous meeting because the unit is a "no smoking" area. Inmates were not actively engaged in one Morning Meeting observed; they seemed to be distant and had no connection with each other.

3. How do staff handle any discipline problems?

Before the Morning Meeting, it was explained that someone had stolen a number of program signs done by a TC inmate and this was causing some annoyance among inmates. This issue was addressed at the meeting.

In a Helping Measures (pull up) session, one inmate whose case was being discussed listened to the feedback given by other inmates with clear disgust, making faces and squirming in his seat. None of this behavior was addressed by the inmate committee or by the counselor. At the end of the case hearing for this inmate, the counselor made several brief comments and dismissed the inmate. No sanction or corrective feedback was given, no warning about inappropriate behavior.

4. How do staff interact and communicate with inmates? Give one or two examples. Do different staff members have different styles of interaction with inmates?

Staff behaved in a very professional manner. Staff displayed excellent therapeutic skills and good rapport with inmates, who tended to open up very quickly. Staff were generally very direct with inmates and gave much feedback. Although there was some slang and profanity, it was not overdone. During inmate-led groups, staff mainly listened and watched over the group. One observer suggested that one staff member seemed to keep interactions with inmates on a more formal, detached, wisdom-dispensing level and avoided more direct confrontation.

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5. Briefly describe what kind of content was covered in the group or session you attended (see survey Q#19). Give one or two examples.

Concepts were reviewed and examples were given; personal issues and treatment issues were addressed; readings were conducted; sharing by inmates; lectures; films and discussion on films viewed in group; and numerous open discussions among inmates about treatment issues. Topics discussed in the different groups included anger management, confidentiality, religion, immediate gratification and greediness, rejection, recovery, relationships, criminal issues, and looking toward the future.

6. What kind of treatment format was used? (e.g., lecture, video, peer- or staff-led group: See survey Q#18).

Some groups (small group, Phase I class, Phase II class, morning meeting, and pull-ups) used staff-led lecture and discussion, while others (Morning Meeting, TC Seminars, and Nicotine Anonymous, AA) had more inmate-led group discussion with staff supervision. Staff often used readings or handouts in their groups, videos occasionally.

7. From your observations, was it possible to determine what kind of treatment approach was used (e.g., cognitive-behavioral, rational emotive therapy, etc.? (See Survey Q#12).

Phase I classes used primarily a 12-step approach. Phase II class emphasized Cognitive - Behavioral techniques. A counselor in one Small Group used mainly a psychotherapeutic approach, while another counselor used mainly a 12-step approach with some concepts from Rational Emotive Therapy. Another small group counselor used group psychotherapy and rational emotive therapy. Morning Meeting, Inmate Seminars, Nicotine Anonymous, and AA all used a 12-step approach. Pull-Ups used positive peer pressure.

8. Based upon what you know about this program so far, were the activities you observed relevant to the program's goals? Why or why not?

Most activities were relevant to the program's goals. Good discussions, handouts, lectures, sharing, and feedback. All observers expressed positive reactions to these activities.

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II. Staff Interviews

[Provide representative answers to questions from staff interview forms]

1. How would you describe the **relationships** between staff at this institution (e.g., is there a sense of teamwork)?

(a) Relationships between D & A staff:

Staff is trusting, supportive, and have good teamwork. They all work well together and have good relationships with other programs. Staff is cooperative and are a close team.

(b) Relationships between D & A staff and security:

Staff feels that security is very professional, with a few exceptions. Security does a good job and has positive relations with staff. They have a cooperative relationship.

(c) Relationships between D & A staff and other correctional staff or departments:

There is a good relationship with the Education Department. D & A staff have some contact with the Psych. Department, but there appears to be some tension between the two. Generally there is good communication among the departments.

2. What, if anything, would you **change** about this program?

Generally staff would like to see more staff and more resources. Need more emphasis on treatment and not education. Not enough placements and no tracking devices. They would also like to see the leaks in the pipes fixed, and could use a unit secretary.

3. What kind of **input,** if any, do staff in this program have into **modifying program structure or activities?**

Most staff expressed a good deal of flexibility in structuring their small group sessions. Phase classes are more "pre-packaged," although staff can run groups as they choose.

4. What kinds of inmates **do well** in your program? What kinds of inmates present the **most challenges**? Please describe.

Those who do well are mainly those in mid - to late 30's. Especially those who are facing some sort of crisis that precipitates a change. They are highly motivated, they recognize the devastation of their lives and are able to overcome denial. Those who do well are also those who have a fair bit of time. Those who don't do well are younger inmates, mentally ill inmates, those that lack motivation to change for either

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social or psychological reasons, and those whose gang affiliation is more important to them than their family. Those who can't read or write well also have problems.

5. About what percentage of inmates admitted are **discharged early from this program**? Why?

Roughly 55 - 75%. Most of the time it is for a violation of institutional rules, misconducts, and hot urines.

6. Do you ever make **treatment-related referrals to other programs or departments within DOC? To outside agencies**? If so, please describe:

Referrals are made to vocational education. They don't make referrals to psychology, except for psychological assessments when required. Psychology staff are described as forensic psychologists, not much focus on treatment. Outside referrals are made by parole.

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III. Inmate Interviews

[Provide representative answers to questions from inmate interview forms]

1.How did you **first hear about this program**, and what (if anything) did you need to do to **get into** the program (e.g., get a referral? fill out an application? get interviewed by staff or inmates in the program?)

Eight TC inmates were interviewed, as well as two from the TC Alumni Group. We summarize three examples here.

A. first heard about the program from someone in the yard. He saw a big change in another inmate who had been a heroin user, so he felt he could use a change also. After receiving a dirty urine test, A. realized he really needed help and put in a request for the TC program. He was then interviewed by Mr. Lawler (DATS Supervisor at the time), was staffed (vote sheets), and then got into the program after a short wait. M. heard about the program from a friend in the hole. He signed up to get in and then waited to see if he was approved. L. was told about the program by one of the alumni. He sent in his request slip, got an interview, and then got staffed.

2. How long did you have to **wait** to get into this program?

A. waited 6 months, M. waited 6 months, and L. had to wait 3 months.

For A., before he was accepted in the TC, he was on the waiting list but had too much jail time left, so they told him to come back when he had two years left.

Of the 7 others, five stated that they had TC waiting periods ranging from a few weeks up to six months. Two waited longer (one waited 2 years; another 27 months). It would appear that those who waited longer had substantial time remaining on their sentences, and thus exceptions to normal program selection criteria were needed (i.e., most TC inmates are within 2 years of their minimum release date). Most had well-documented drug problems and a clear need for treatment (e.g., hot urines while in prison; drug-related convictions). Note that inmates must also have a six-month misconduct-free period to be eligible for TC, although one was finally admitted to TC after receiving one of many trips to the hole for a hot urine. In his case, he says, he "practically begged for help," and received it.

3. **Why** did you want to participate in this program?

A. wanted to participate in this program because he wanted to do something different. He has been in jail 30 out of his 50 years in jail. He stated that the program offers more than just help with drugs, that it's more of a holistic approach. M. stated that he wanted to participate in the program because it could help in getting him released early from prison. He admitted he didn't want recovery, just a way out. But after being in

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the program his motivation changed. He realized his thoughts were only on drugs and that he had a lot of anger and resentment. He was then set back from parole and still entered the program, even though it would not help him get released early. L. wanted to participate in the program because he knew he needed help. He had been using alcohol to help him with his problems, and he realized that way was not working.

4. Could you describe a **typical day** in this program? For example, what kinds of activities or treatment **methods** are used most often: lecture, video, written assignments, individual counseling, peer-led group discussion, or staff-led group discussion? (**See survey Q#18**).

A. described his typical day as getting up at 4:30-5:00 am to write in his journal while it is quiet. Then he participates in morning meeting, then phase class or study periods, then small group, recreation, and AA/NA meetings, which pretty much concludes the day. L. described his day as waking up and having breakfast, going to morning meeting, and then checking the schedule to see what he has to do next. He could have phase classes, Jails Anonymous (JA), positive pull-ups, group meetings, and sharing. He says that it varies from day to day. He also explains that on Friday they only have a half a day and they are off on the weekends.

5. What kinds of **issues (content)** are addressed in this program? (e.g., impacts of drug use, problem solving skills, relapse prevention, etc.). Could you give one or two examples? **(see survey Q#19)**

A. explained that everyone has different issues, but that the issues that are important to him are criminality and drug addiction. M. stated that his big issue is anger, since he committed two homicides. Other issues that he says that are addressed are criminal thinking and mentality. L. said that the issues that are addressed are criminality, sexuality, and dealing with other people, especially the issue of why he does the things that he does. Although he was under alcohol's influence when he committed his crime, his behavior was also influenced by his heredity, peer pressure, and/or needs inside of him.

6. In this program, what has been:

(a) most helpful to you?

What was most helpful to A. is meeting with his counselor, and also small groups, and JA (Jails Anonymous). He states that he got to learn about how and why things affected his life and he got to think about certain scenarios and alternative solutions. He really liked the fact that the TC is a thinking process. L. stated that the positive attitude in the community was the most helpful for him. He felt the community was very supportive and that sharing with others in the TC really helps. If you have a craving, there's always someone to talk to – inmates or staff.

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(b) least helpful to you?

For A., the least helpful thing for him is Nicotine Anonymous. He explains that jail is a stressful place and smoking helps relieve stress. For M. the least helpful thing is the fact that he's been in the system for a long time. He felt that there needs to be more discipline from within and more no-nonsense counselors. For L., the least helpful thing was other people's attitudes. Once the counselors leave for the day, some guys revert back to bad attitudes and go against the grain.

7. What do you think about the **staff** in this program? (e.g., How well do staff **interact** with inmates? Are inmates treated with **respect**? Are the staff **fair** with all inmates?)

A. felt that the program was understaffed, but that staff have good interactions with the inmates. He explained that the counselors don't belittle them and are fair and respectful. M. stated that he could relate to some staff better than others. He said that in his first session with his counselor, he could tell that the counselor really cared. L. said that the staff gives all of them a fair shot. He explained that the reason he is there is because of one particular counselor who he feels is very honest and really sets people straight. L. really respected this counselor because he opened up to the inmates and shared his own problems with them one morning.

8. What kinds of **rewards and punishments** are used in this program? (e.g., are there consequences for good participation? Poor participation?) Please explain.

According to A., rewards come in the form of higher self-esteem. Punishments are sanctions for breaking a rule, and can be in the form of writing an essay or doing a seminar. M. said that rewards are things you have to earn, such as positive pull-ups that make you feel better about yourself. Regular pull-ups (for inadequate participation, minor rule violations, etc.) are punishment. L. explained that some rewards include becoming "Resident of the Month" and gaining a certificate for completing a class. Also, you feel good for yourself when you accomplish a goal and get recognized for this accomplishment. Punishments are that you get thrown out if you do not follow the rules, and if you cannot let go of old issues, there could be sanctions or pull-ups.

9. Do the inmates in this program have any **input into program structure or activities**? If "yes," please describe briefly:

A. explained that inmates can make suggestions, but staff dictates the way things are run. If someone suggested something profound, staff would probably take the suggestion. M. felt that inmates run the TC, and the counselors supervise them. When staff isn't around, they rely on positive inmates to keep the negative inmates in check. L. stated that everyone can voice their opinions, but that whether or not your opinion is accepted depends on who you are. Trustworthy people are credible, if not, you won't have your suggestion acted on.

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10. Have you had any difficulty **accessing** treatment services? If so, please explain.

Once you are in the TC program, according to most, there are no problems accessing treatment. If anything, they are surprised at how much treatment services are available in the program. Major difficulties reported had more to do with getting into one D & A one program or another prior to TC: "You can't get into programs that are available unless the institution directs you to get into the program." One inmate claimed he had not had an individual counseling session in six months, but he also stated that he wanted a session with the therapist he had before entering TC, so it may be that he is referring to this request. One inmate emphasized that it is up to the individual to seek the help he needs and take advantage of what is offered, not just wait for someone to come and give it to you.

11. Have you participated in any **other treatment programs** in Pennsylvania state prisons?

Some had D & A education at Huntingdon; a couple had received treatment at county level or elsewhere.

If yes:
(a) In what ways is your experience in this program **similar?**
(b) In what ways is your experience in this program **different?**

12. Would you **recommend** this program to someone you know? Why or why not?

Generally, a resounding "yes" to this question. A. stated that he would definitely recommend the TC program to others. The TC can help if someone wants to change their life and learn something. M. states that TC really works if you want to change and that you learn tools that you can use in your life. L. also would recommend the program to someone if they wanted help, because this program can really help people. None of the eight said they would not recommend it, although a few re-emphasized that the individual inmate must be motivated and willing to change.

13. What, if anything, would you **change** about this program?

A. would add and incorporate things such as job skills, aftercare services, and have counselors there 24 hours a day, not just eight. M. would like to see more of an ethnic variety of staff, instead of all white men. He would also like to be totally separated from general population, like the Jericho program (TC program at SCI-Graterford). When some inmates graduate TC, they are put right back on the block, which one inmate feels is an even greater challenge than when you are sent home. L. felt that more counselors are needed and a more normal schedule. L. felt that there were a lot of changes (more security, more counts) going on after the escapes (an escape from the RHU at Huntingdon had occurred about one month earlier).

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Conclusions and Recommendations

1. Program Strengths (note briefly)

Very experienced, professional staff. Excellent therapeutic skills and rapport with inmates.
Treatment activities are very well structured and organized.
Inmates take on a good deal of responsibility for treatment.

2. Program Weaknesses (note briefly)

Understaffing (contributing to several inmates falling behind-- e.g., phase classes that had not yet been offered).
Physical repairs should receive attention. The treatment environment can significantly influence inmate reactions treatment (e.g., Moos, 1974).
Eligibility criteria are clear, but actual assessment of drug involvement and need for treatment seems somewhat subjective. Decisions to admit any one inmate seem to depend upon staff discretion.

3. Recommendations

Review procedures for administering and supervising pull-ups. This is a source of some inmate dissatisfaction, even among inmates who acknowledge their usefulness. Researcher observations suggested that more direction by staff may sometimes be needed at pull-up hearings. Perhaps closer scrutiny is also needed of procedures that inmates are supposed to follow for writing up and submitting pull-up slips to the inmate committee, and/or procedures for inmate committee review of pull-up slips, administration of hearings, and use of sanctions.
Make sure inmates receive regular monthly counseling sessions and that individual treatment plans are up to date. Examination of several treatment files suggest that either record keeping is lagging behind or some inmates are not receiving regular (monthly) individual counseling sessions and review of treatment plans.
The TC program is definitely ready to be evaluated: clear, measurable goals and well-implemented treatment activities.

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INDIVIDUAL PROGRAM REPORTS: DOC-TEMPLE RESEARCH PARTNERSHIP

Institution: Huntington

D & A Program: Addictions Treatment

Program Description

General Program Goals and Intervention Philosophy

1. What are the **general goals** or **mission** of this program? What does it try to do? **[Source: program documents, staff interviews].**

According to the Addictions Treatment Summary, the program goals are to provide both an introduction and a general exposure to group process. This should enable the participants to better identify issues that need to be further addressed. Participants are expected to participate in the discussion to the extent that they are free from undue group pressures concerning participation in group exercises, decision making, disclosure of private matters, or acceptance of suggestions from other group members. They are required to sign a Consent To Treatment form and complete all treatment objectives. Note: Due to physical plant renovations, this program was not operating in the summer of 1999 when we did our on-site research.

2. What is the main **treatment approach** or **philosophy** used in this program? (e.g., see survey Q#12). Could you give one or two examples of *how* this approach is used? **[Source: staff interviews, program documents].**

The Addictions Treatment Summary states that Addictions Treatment is an outpatient treatment group within SCI - Huntington with a specific treatment approach of group therapy. Program documents did not clearly emphasize any particular treatment approach. The primary means of transmitting information is through group discussions, lectures, and printed material.

Target Population and Target Selection

3. **For this program**, describe inmate **recruiting, outreach, or referral procedures** (e.g., How do inmates hear about this program? Who makes referrals? What are the reasons for referral)? **[Source: program documents].**

N/A

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4. What are the specific **eligibility** requirements for this program (e.g., type and seriousness of D & A problem, time remaining in sentence)? Are exceptions made? **[Source: program documents].**

The Summary says that the requirements for membership in this group are that members must be advanced enough in their recovery so as to be able to identify their need for continued therapy and they must be willing to address their addiction. They also have to be part of the General Population and they must have completed Substance Abuse and Addiction Education D & A classes.

5. **Decision to admit (or not):** Who makes the decision? What are the most important criteria? About what percentage of referrals are rejected? **[Source: program documents].**

N/A

Intake, Exit, and Follow-up Procedures

6. Describe the **intake/admission process** (e.g., What happens to an inmate when they first attend this program? Is there an orientation, intake interview, etc.?) **[Source: program documents].**

According to the Addictions Treatment Session Outline, participants are given an orientation during their first session. During this session, they are asked to sign Consent to Treatment forms and a Release of Information form, and complete a basic questions list. They are also given the requirements for participation and the group rules.

7. What is the normal **program enrollment**? (i.e., at one specific time) **[Source: program documents].**

According to the Summary, program enrollment is limited to 15 - 20 members.

8. What is the normal **length of stay** for an inmate in this program? **[Source: program documents].**

The Summary states that the group meets for approximately 1 - 1 1/2 hours once a week for eight weeks.

9. What are the **criteria for successful program completion**? **For an unsuccessful discharge**? **[Source: program documents].**

The Summary states that participants must attend all eight sessions.

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Specific Program Content and Structure

10. **Describe** (a) the different **program components or activities** (see survey question # 19 for examples of specific educational or treatment activities), and (b) the **intended result or objective of each activity [Source: staff interviews, observations, program documents]**. Include the following in the report:

- Provide a **title and brief description** of the activity.
- How many **hours** weekly do inmates participate in each activity? How often do they meet?
- Describe a few **examples of program content** from lesson plans, printed program descriptions, observations, and interviews (i.e., what do they do and how do they do it?)
- For each **activity or group**, what is the **intended result or objective?** (i.e., what change in inmate attitudes or behaviors is expected).

According to the Addictions Treatment Session Outline, there are eight different sessions.

Session I is basically the introduction to the rules and regulations of Addictions Treatment. In this session, participants are informed of confidentiality of releases and records and are told the requirements for participation and group rules. There are also basic, introductory questions about the D & A treatment. Inmates are expected to sign a Consent to Treatment form, sign a Release of Information form, and complete a basic questions list.

In Session II there is a review of psychoactive drugs, their trade names, street names, and drug names. Inmates are expected to complete a psychoactive substance inventory of drugs they have used.

Session III involves the symptoms of addiction such as the physical problems, tolerance, impairment, and withdrawal. The inmates are expected to complete a D & A questionnaire on these symptoms.

Session IV also involves the symptoms of addiction, but focuses more upon the behaviors and consequences of addiction, such as neglect of activities, time spent using, hazardous use, and using despite experiencing problems. Inmates are asked to fill out a D & A questionnaire on these symptoms.

Session V discusses family history, neighborhood influences, and predisposition to alcoholism/addiction. Participants are asked to complete a family/neighborhood worksheet.

In Session VI, addiction as a disease is discussed. Includes a detailed definition of addiction, the DSM-IV diagnostic criteria, evidence that addiction is chronic, progressive, and potentially fatal, and the "J" Curve: Part I- Stages I, II, III of the disease of addiction. Inmates complete a "J" Curve Disease Process worksheet.

Session VII focuses on recovery, relapse, and treatment. Basic recovery process, levels of treatment, groups, classes, and therapeutic activities, and AA are all discussed.

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Inmates are given a handout on "'J" Curve: Part II - Recovery Process. They are asked to complete a D & A Program Participant Questionnaire.

In the final session, Session VIII, there is an interview with staff, a final assessment and treatment placement recommendations. The staff person fills out a final assessment and recommendation sheet to be initialed by the inmate.

11. How is treatment structured to address **individual inmate needs** (e.g., **individual treatment planning**)? [Note: some researchers believe that effective treatment requires matching appropriate treatment services with specific inmate needs]. Describe how **D & A needs assessments and treatment planning** are done (if applicable). **[Source: staff interviews, program documents]**.

According to the Program Summary, several program objectives address individual inmate needs. First, staff assess the inmate's status as an addict and/or alcoholic. Then the program provides inmates with knowledge and structured inventory for self-assessment and records the inmate's self-assessment of his D & A problem. The program also wants to identify areas affected by individual denial, by comparing differences between the level of addiction assessed by D & A staff and the inmate's self-perception of his problem.

Inmates are educated about various treatment options and self-help programs for those with addiction and from there a treatment placement decision can be made based upon addiction assessment, for either self-help programs or therapeutic communities.

Inmates are separated into two categories: those who acknowledge their substance abuse problem and/or need treatment and those who are unwilling to acknowledge their substance abuse problem and/or need for treatment. This program also identifies and informs SCI-H administrative staff of specific inmate issues and problems that would prevent them from participating in treatment despite the inmate's explicit desire to participate in further treatment.

12. What types of program records about inmate participants are kept, and how (e.g., client needs, attendance, level of participation, treatment progress, etc.)? Are these records adequate? [Source: inmate case file reviews].

N/A

Program Staff

13. Provide a brief description of the primary staff for this program (1 paragraph each). **[Source: staff interviews]**.

*See Individual program Report for Living Sober Therapeutic Community (LSTC). All TC staff share additional responsibilities to provide education and outpatient treatment to general population.

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Conclusions and Recommendations

Note: program was not operational during summer of 1999 when process evaluation was conducted. Thus, no interviews with staff or inmates were conducted, and no program observations were completed. Comments are based upon program documents.

1. Program Strengths (note briefly)

Program appears reasonably well-structured in terms of treatment activities.

2. Program Weaknesses (note briefly)

Primary treatment approach is not clear from Program Summary.
Inmate recruitment and screening process is not clear.

3. Recommendations for Program Evaluation

Program is not currently operating.
Low intensity: aprox. 8-10 hr. total programming. Expected impact is low.
Outcome evaluation is not warranted at this time.

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INDIVIDUAL PROGRAM REPORTS: DOC-TEMPLE RESEARCH PARTNERSHIP

Institution: Huntington

D & A Program: Substance Abuse Education

Program Description

General Program Goals and Intervention Philosophy

1. What are the **general goals** or **mission** of this program? What does it try to do? **[Source: program documents, staff interviews].**

According to the Substance Abuse Education Rules and Guidelines, the goals of this program are to educate participants and increase knowledge and understanding about substance abuse and addiction. These goals will be achieved by participants attending classes, listening to lectures, and taking a final examination at the end of the course.

2. What is the main **treatment approach** or **philosophy** used in this program? (e.g., see survey Q#12). Could you give one or two examples of *how* this approach is used? **[Source: staff interviews, program documents].**

The Summary states that this program utilizes the Design for Living curriculum, Units A, B, and C with 14 individual educational modules. Lecture-guided discussion and printed material facilitate the need to examine past drug using behavior. At the end of the program, the inmate will have the opportunity to evaluate the program to ensure quality assurance.

Target Population and Target Selection

3. **For this program**, describe inmate **recruiting, outreach, or referral procedures** (e.g., How do inmates hear about this program? Who makes referrals? What are the reasons for referral)? **[Source: program documents].**

N/A

4. What are the specific **eligibility** requirements for this program (e.g., type and seriousness of D & A problem, time remaining in sentence)? Are exceptions made? **[Source: program documents].**

According to the Summary the only eligibility requirement for entry into the program is that there is an identified drug and alcohol abuse problem; assessed either through self-admission or review of inmate records. The level of addiction or severity of the problem may be to any degree.

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5. **Decision to admit (or not):** Who makes the decision? What are the most important criteria? About what percentage of referrals are rejected? **[Source: program documents].**

N/A

Intake, Exit, and Follow-up Procedures

6. Describe the **intake/admission process** (e.g., What happens to an inmate when they first attend this program? Is there an orientation, intake interview, etc.?) **[Source: program documents].**

N/A

7. What is the normal **program enrollment**? (i.e., at one specific time) **[Source: program documents].**

The Program Summary states that normal program enrollment is limited to 40 individuals.

8. What is the normal **length of stay** for an inmate in this program? **[Source: program documents].**

The Summary states that the participants meet weekly for four one - hour sessions.

9. What are the **criteria for successful program completion**? **For an unsuccessful discharge**? **[Source: program documents].**

For successful completion of the program, according to the Summary and the Guidelines, the participant must attend all four sessions and receive a passing score on an examination. Participants will not receive a certificate if they miss any classes, disrupt class, or do not complete the final examination.

Specific Program Content and Structure

10. **Describe** (a) the different **program components or activities** (see survey question # 19 for examples of specific educational or treatment activities), and (b) the **intended result or objective of each activity [Source: staff interviews, observations, program documents]**. Include the following in the report:

- Provide a **title and brief description** of the activity.
- How many **hours** weekly do inmates participate in each activity? How often do they meet?
- Describe a few **examples of program content** from lesson plans, printed program descriptions, observations, and interviews (i.e., what do they do and how do they do it?)

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- For each **activity or group**, what is the **intended result or objective?** (i.e., what change in inmate attitudes or behaviors is expected)?

The Unit A lesson plan explains that the main objective is to explore the nature of drugs and drug use. This plan consists of several key themes or ideas.

First, staff explain the history of drug use. A second key theme is that a person does not need chemicals, but once they are addicted, they cannot stop. Third, mood-altering chemicals deliver 3 types of effects: they relax you, excite you, or play with your senses. A fourth idea is that drug use has many negative mental and physical effects. Chemicals produce "imitation" serenity and spirituality. Also, genuine serenity and spiritual highs are available all the time through natural means. The intended outcomes of this lesson are to have inmates understand what mood-altering chemical drugs are and how they affect people. Inmates should hopefully understand their own natural means of getting calm or getting "high" without the ill effects that chemicals produce.

The Unit B lesson plan explains that its main objective is to explore additional risks associated with chemical use and to introduce the relationship between criminal thinking and chemical use. This plan also has several key ideas. The first idea is to explain that using certain chemicals can put you at risk for HIV infection and that using chemicals during pregnancy endangers the baby's health and life. The lesson also points out that physical abuse stems from and leads to chemical abuse and that emotional scars from childhood sexual abuse may lead to chemical abuse, but healing is possible. Another key idea is that criminals act in harmful or illegal ways without caring about their actions and that their thinking involves a consistent series of assumptions that are not based on reality. It is pointed out in this lesson that chemical abusers also often think this way, like criminals. They act inappropriately without caring and they try to hide what they do. The intended outcomes for this lesson are to have participants know the basics of protecting themselves against AIDS, to understand the importance of getting counseling to deal with abusive relationships, past or present, and to have the inmates begin to recognize how their chemical abuse affects others.

The Unit C lesson plan states that the main objective in the final stage is to awaken participants to the three dimensions of their whole selves and the way chemical use relates to each. The main ideas of this lesson are that a person's basic physical needs are food, safety, and sexual expression, and that their basic emotional needs are nurturing, self-esteem, and ambition. If these needs are not met, then the person is not a whole person and they may turn to chemical use. Chemical use is shown to stunt development. The intended outcomes of this lesson are to have inmates understand how they have chosen chemicals to cover up their pain from unmet needs and that they should start seeing themselves as whole people.

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11. How is treatment structured to address **individual inmate needs** (e.g., **individual treatment planning**)? [Note: some researchers believe that effective treatment requires matching appropriate treatment services with specific inmate needs]. Describe how **D & A needs assessments and treatment planning** are done (if applicable). **[Source: staff interviews, program documents].**

N/A

12. What types of **program records** about inmate participants are kept, and how (e.g., client needs, attendance, level of participation, treatment progress, etc.)? Are these records adequate? **[Source: inmate case file reviews].**

N/A

Program Staff

13. Provide a brief description of the primary staff for this program (1 paragraph each). **[Source: staff interviews].**

*See Individual Program Report for Living Sober Therapeutic Community (LSTC). All TC staff share additional responsibilities to provide education and outpatient treatment to general population.

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Results of Process Evaluation

Inmate Interviews

[Provide representative answers to questions from inmate interview forms]

1. How did you **first hear about this program**, and what (if anything) did you need to do to **get into** the program (e.g., get a referral? fill out an application? get interviewed by staff or inmates in the program?)

One inmate, R., was interviewed about the Substance Abuse Education program at Huntington. According to R., the program was recommended to him in his prescriptive treatment plan. His counselor then told him about it, and he submitted a request slip and was put on the list.

2. How long did you have to **wait** to get into this program?

R. came to Huntington in November 1998, and waited about three months to get into the program.

3. Why did you want to participate in this program?

He wanted to participate in this program because he wanted to change his life. He is mainly a drug dealer, and there are no drug dealing programs at Huntington, and he said he had to take something. He wanted to take the program, but he was also required to take this program. He hoped to get something out of it.

4. Could you describe a **typical day** in this program? For example, what kinds of activities or treatment **methods** are used most often: lecture, video, written assignments, individual counseling, peer-led group discussion, or staff-led group discussion? **(See survey Q#18)**.

R. said that they talked a lot about how drugs affected them, even though R. does not have a drug problem, since he was only a seller. At the end of the program, they take a test with no pass or fail; it is just to test their level of understanding. Inmates in this program cannot miss any classes, or they get kicked out and have to sign up for the program again.

5. What kinds of **issues (content)** are addressed in this program? (e.g., impacts of drug use, problem solving skills, relapse prevention, etc.). Could you give one or two examples? **(see survey Q#19)**

Issues addressed in this program are drug, alcohol, tobacco, and crack use and being addicted and what measures people took to stop. R.'s personal issue was the fact that

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he was addicted to money, and that this addiction was based on want, not need, which is similar to actual drug addiction.

6. In this program, what has been:

(a) most helpful to you?

Most helpful to R. was that people took time to share their personal life and histories with each other and there was no pressure for someone to talk if they didn't want to.

(b) least helpful to you?

There was nothing that was least helpful to R.

7. What do you think about the **staff** in this program? (e.g., How well do staff **interact** with inmates? Are inmates treated with **respect**? Are the staff **fair** with all inmates?)

R. stated that one particular staff person touched base on many of his personal issues. R. felt that this staff member was knowledgeable, fair and respectful.

8. What kinds of **rewards and punishments** are used in this program? (e.g., are there consequences for good participation? Poor participation?) Please explain.

Rewards in this program are that inmates receive a certificate of completion when they finish the program. Punishments are that inmates get kicked out if they do not attend all six sessions.

9. Do the inmates in this program have any **input into program structure or activities**? If "yes," please describe briefly:

R. stated that topics of this program are dictated by staff and that they follow lesson plans and have no input from the inmates.

10. Have you had any difficulty **accessing** treatment services? If so, please explain.

No. R. attempted to get into a computer class, but was told his time was too short.

11. Have you participated in any **other treatment programs** in Pennsylvania state prisons?

No.

If yes:
(a) In what ways is your experience in this program **similar?**
(b) In what ways is your experience in this program **different?**

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12. Would you **recommend** this program to someone you know? Why or why not?

R. stated that he would recommend this program to someone he knew. He further stated that if the person has a drug problem, this class would not make them stop their addiction automatically, but that it does touch home base.

13. What, if anything, would you **change** about this program?

R. would want to have inmates pick the topics, but he stated that they would have to be no-nonsense topics. Some topics he would want to see covered are drug dealing, selling, criminal behavior. He would also like to look at some books and movies that show drug dealing and reformed junkies.

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Conclusions and Recommendations

1. Program Strengths (note briefly)

- Very ambitious objectives for a 4-week program (4 hours of total programming).
- Program lesson plans are well structured and relevant.
- Staff are perceived by inmates as knowledgeable, fair, and respectful.
- If inmates complete both the Substance Abuse Education and the Addictions Education programs (14 hours total), they may build a good foundation for further (more intensive) treatment.

2. Program Weaknesses (note briefly)

- Eligibility criteria are extremely broad, and assessment of inmate needs and/or suitability for this program is weak. Very little information available about how decisions are made to admit inmates into this program.
- It is not clear that program objectives can be achieved in such a short period of time.

3. Recommendations for Program Evaluation

- Review the proper role of D & A Education within DOC. Consider how scarce staffing and programming resources should be best allocated to different programs.
- Review the role of Substance Abuse Education, Addictions Education and Addictions Treatment within DOC. For example, should these 3 programs be combined into one coherent, 3-stage program that is reserved for inmates who really need it?
- If inmates could be validly assessed as *low* drug involvement and *low* need for treatment, they might be required to complete the three programs together (22 hours total), building a good foundation either for further in-prison treatment or community aftercare.
- Program evaluation is not warranted at this time. Expected impact is low.

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INDIVIDUAL PROGRAM REPORTS: DOC-TEMPLE RESEARCH PARTNERSHIP

Institution: Huntington

D & A Program: Addictions Education

Program Description

General Program Goals and Intervention Philosophy

1. What are the **general goals** or **mission** of this program? What does it try to do? **[Source: program documents, staff interviews].**

The Addiction Education Guidelines state that the goals of this program are to educate participants and increase knowledge and understanding about the disease of addiction and the treatment of this disease. Another goal of this group is to show individuals what help is available to those who have a drug or alcohol problem. Participation in this group will help participants realize that there are others also in the beginning stages of recovery and that help is available if they are motivated to change.

2. What is the main **treatment approach** or **philosophy** used in this program? (e.g., see survey Q#12). Could you give one or two examples of *how* this approach is used? **[Source: staff interviews, program documents].**

According to the Guidelines, the goals of this program are achieved by participants attending classes, listening to lectures, watching videos, reading handouts, and taking a final examination.

Target Population and Target Selection

3. **For this program**, describe inmate **recruiting, outreach, or referral procedures** (e.g., How do inmates hear about this program? Who makes referrals? What are the reasons for referral)? **[Source: program documents].**

N/A

4. What are the specific **eligibility** requirements for this program (e.g., type and seriousness of D & A problem, time remaining in sentence)? Are exceptions made? **[Source: program documents].**

The Summary states that the only eligibility requirement for entry into the program is that there is an identified drug abuse problem, either through self-admission or review of inmate records. The level of addiction or severity of the problem may be to any

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degree. In the majority of cases, eligible participants are required to have completed the Substance Abuse Education program.

5. **Decision to admit (or not):** Who makes the decision? What are the most important criteria? About what percentage of referrals are rejected? **[Source: program documents].**

N/A

Intake, Exit, and Follow-up Procedures

6. Describe the **intake/admission process** (e.g., What happens to an inmate when they first attend this program? Is there an orientation, intake interview, etc.?) **[Source: program documents].**

The Addiction Education Lesson Plan states that inmates are orientated to the expectations of the course through the group guidelines and they are informed of the course content.

7. What is the normal **program enrollment**? (i.e., at one specific time) **[Source: program documents].**

The Addiction Education Summary says that enrollment in the group is limited to 35 individuals.

8. What is the normal **length of stay** for an inmate in this program? **[Source: program documents].**

The Summary states that the group meets weekly for one hour for a total of eight weeks.

9. What are the **criteria for successful program completion? For an unsuccessful discharge**? **[Source: program documents].**

The Guidelines state that for successful completion an inmate must attend the first and last class, and at least six out of eight classes. They must also pass the final examination. For an unsuccessful discharge, the Guidelines state that an inmate will not receive a certificate if he misses more than 2 classes, disrupts class, or does not complete the final examination.

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Specific Program Content and Structure

10. **Describe** (a) the different **program components or activities** (see survey question # 19 for examples of specific educational or treatment activities), and (b) the **intended result or objective of each activity [Source: staff interviews, observations, program documents]**. Include the following in the report:

- Provide a **title and brief description** of the activity.
- How many **hours** weekly do inmates participate in each activity? How often do they meet?
- Describe a few **examples of program content** from lesson plans, printed program descriptions, observations, and interviews (i.e., what do they do and how do they do it?)
- For each **activity or group**, what is the **intended result or objective?** (i.e., what change in inmate attitudes or behaviors is expected)?

According to the Addiction Education Lesson Plan, Session I is an introduction to historical and contemporary beliefs about addiction. Inmates should gain a better understanding of the evolution of Alcoholics Anonymous and Narcotics Anonymous and to understand contemporary beliefs in these programs. In this session, participants are given the course outline and the group guidelines, and they watch a film entitled "It Sure Beats Sitting In a Cell".

In Session II, inmates are expected to evaluate themselves and gain an understanding of the dynamics of AA and NA. They are also given information on various self-help groups and on different types of AA and NA meetings. Inmates watch the film "The Twenty Questions with George Kennedy".

Session III focuses on having the inmates achieve a better understanding of the disease concept of addiction by comparing alcoholism to another non-communicable/infectious diseases. The inmates are provided with knowledge of the symptoms of addiction as an illness/disorder and the needs for treatment.

In Session IV the concept of defense mechanisms is explained, the different kinds of defense mechanisms (such as, denial, rationalization, displacement, etc.), and how they relate to addiction/alcoholism.

Session V focuses on teaching inmates to identify Criminal Thinking errors and to be aware of alternatives to Criminal Thinking. The relationship between criminality and substance abuse is also examined. Inmates are shown the film "Criminality and Substance Abuse: A Cognitive Intervention for Substance Abusing Offenders."

The Lesson Plan for Session VI states that its main objectives are to illustrate the concept of chemicals and to assist inmates in being able to identify and understand degrees of powerlessness and unmanageability in their lives. Personal examples of powerlessness and unmanageability are explored. Inmates should gain a better understanding of STEP #1 of the 12 STEP program.

According to the Session VII Lesson Plan, participants are to become aware of potential "relapse warning" signs and to learn to recognize their own relapse warning signs.

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11. How is treatment structured to address **individual inmate needs** (e.g., **individual treatment planning**)? [Note: some researchers believe that effective treatment requires matching appropriate treatment services with specific inmate needs]. Describe how **D & A needs assessments and treatment planning** are done (if applicable). **[Source: staff interviews, program documents].**

N/A

12. What types of **program records** about inmate participants are kept, and how (e.g., client needs, attendance, level of participation, treatment progress, etc.)? Are these records adequate? **[Source: inmate case file reviews].**

N/A

Program Staff

13. Provide a brief description of the primary staff for this program (1 paragraph each). **[Source: staff interviews].**

*See Individual Program Report for Living Sober Therapeutic Community (LSTC). All TC staff share additional responsibilities to provide education and outpatient treatment to general population.

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Conclusions and Recommendations

1. Program Strengths (note briefly)

- Very ambitious objectives for a 8-week program (8 hours of total programming).
- Program lesson plans are well structured and relevant.
- Staff are perceived by inmates as knowledgeable, fair, and respectful.
- If inmates complete both the Substance Abuse Education and the Addictions Education programs (12 hours total), they may build a good foundation for further (more intensive) treatment.

2. Program Weaknesses (note briefly)

- Eligibility criteria are extremely broad, and assessment of inmate needs and/or suitability for this program is weak. Very little information available about how decisions are made to admit inmates into this program.
- It is not clear that program objectives can be achieved in such a short period of time.

3. Recommendations for Program Evaluation

- Review the proper role of D & A Education within DOC. Consider how scarce staffing and programming resources should be best allocated to different programs.
- Review the role of Substance Abuse Education, Addictions Education and Addictions Treatment within DOC. For example, should these 3 programs be combined into one coherent, 3-stage program that is reserved for inmates who really need it? If inmates could be validly assessed as *low* drug involvement and *low* need for treatment, they might be required to complete the three programs together (20 hours total), building a good foundation either for further in-prison treatment or community aftercare.
- Program evaluation is not warranted at this time. Expected impact is low.

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