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EVALUATION OF

THE CHEMICAL DEPENDENCY TREATMENT PROGRAM

IN

DEPARTMENT OF CORRECTIONS' INSTITUTIONS

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EXECUTIVE SUMMARY

The Department of Corrections began its chemical dependency treatment program in 1984. Thousands of inmates have received that treatment in the intervening years. After some initial changes the program acquired its present structure as a somewhat longer version of intensive outpatient treatment: a combination of education, group therapy and individual counseling. Individual assessments and the treatment program are provided by two agencies, Lakeside and STOP (Social Treatment Opportunity Programs), operating through contracts with the Department.

An evaluation soon after the program started found that inmates who completed treatment had fewer infractions while still in prison than did inmates who left the program prematurely. The treated inmate also had fewer arrests in his or her second year (following release from an institution) in the community than inmates in an untreated control group.

This study selected inmates referred to or participating in the chemical dependency treatment program between July 1, 1991 and December 31, 1991. A total of 1550 inmates were in the study. Some of them completed their treatment during those six months; some completed during the first three months of 1992. The entire study group was followed until July, 1992. A sub-group of 101 inmates released with some type of community supervision was followed into the community.

Data on their personal characteristics and criminal history came from the Department's computerized files. Treatment data came from the treatment agencies and the Division of Offender Programs. All treatment staff were interviewed, as were many DOC staff with direct involvement in the program.

Many inmates referred for a chemical dependency assessment were young, first offenders with drug and property offenses. Even so, they were found to be in the middle and late stages of their drug dependencies. The most common dependency was alcohol, followed by cocaine. Just over half of those referred were treated during the nine months of the study. All received the same treatment.

Those inmates who finished treatment were less likely than they had been to have an ensuing prison infraction of any kind. They were *less* likely than the controls to have an infraction for violent behavior. They were *as* likely to have a chemical dependency infraction. Their prison infraction rates (numbers controlled for years of incarceration) were lower than those of the controls.

The full report suggests the following areas in which policies and procedures might be reviewed: identification of the population to be treated, referral and assessment procedures, treatment modalities, linkages between prison treatment and community supervision, and measures of outcome.

BACKGROUND FOR THE STUDY

INTRODUCTION

The study reported here was initiated by the Washington Department of Corrections (DOC), prompted by staff interest in the effectiveness of their prison-based chemical dependency treatment program. This program began in 1984 at the request of the Washington State Legislature.[1] It was evaluated by DOC staff following two years of operation and found to be effective at reducing rule violations in prison and recidivism out of prison.

The treatment offered was and is a form of intensive outpatient treatment, including four hours of individual counseling, 27 hours of group therapy, and 60 hours of classroom education. The assessment of the need for treatment and the actual treatment is provided by contract agencies certified by the Washington Division of Alcohol and Substance Abuse. Department of Corrections staff refer inmates for assessment and oversee the treatment process.

Since the inception of the program and the early assessment of its value, the program has been expanded to serve more inmates at more institutions. There are now two agencies that provide treatment services. Institutional response to inmate drug use has become more focused with the use of drug dogs and drug testing.

Perhaps of more significance has been the increased attention to drugs, to drug offenses and to the offender's need for drug treatment. The Sentencing Guidelines Commission has proposed legislation which would permit non-prison alternatives for some drug offenders. The Commission hosted a conference with sessions on drug treatment for offenders. The Department of Corrections sponsored a study of the demand and capacity for offender chemical dependency treatment.

This report re-examines the effectiveness of Washington's prison-based chemical dependency treatment. It describes those inmates assessed and treated in today's programs. It describes the screening process and treatment as it is now provided, looking in depth at treatment at selected sites. It replicates prison-based outcome measures of the previous study.

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1 House Bill 1079, establishing the FY84-85 operating budget for DOC, included $712,000 for "drug and alcohol rehabilitation treatment programs at appropriate state correctional institutions." This bill specified that inmates be identified through an assessment by "a qualified health professional" and "have less than one year remaining in their confinement to a state correctional facility. Such programs may include facilities for both residential and outpatient treatment." It should be noted that provisions within appropriation bills remain in effect only for the period of the appropriation.

What follows in this chapter is a review of relevant literature on chemical dependency, its treatment and outcomes, a synopsis of the previous evaluation of the DOC's treatment program, a short description of that program today and the design of this assessment.

LITERATURE REVIEW

The literature on chemical dependency treatment and its effectiveness provides a useful guide for this effort. Client characteristics, client attitudes and beliefs, and treatment characteristics affect treatment effectiveness. Which measures of treatment success are used can also be a factor.

Client characteristics, particularly the type of chemical dependency, the severity of that dependency, and the involvement with the justice system, are associated with treatment success. Client attitudes and beliefs about the use and abuse of drugs and alcohol affect dependency and treatment outcomes.

Characteristics of treatment are related to treatment success; for example, coercion has a positive impact as does length of treatment over 90 days. Treatment completion is a common measure of effectiveness, but is confounded by client amenability.

Another measure of success is remission; that is, abstinence or, if drugs or alcohol use continues, reduced abuse. When the treated are offenders whose chemical dependency may be associated with their criminal behavior, a decrease in recidivism is often a measure of treatment effectiveness.

DEPENDENCY AND OTHER INMATE CHARACTERISTICS

The presumption has been that the type of dependency, and particularly dependency on alcohol or on illicit drugs, should be central to the design of treatment programs. Much of the treatment literature is keyed to the dependency which is most apparent (primary) and the preferred treatment for that addiction. For example, a person with a primary dependency on heroin, who may also be addicted to alcohol, would be placed in a long term, possibly therapeutic community, treatment program known to be effective with heroin.

Treatment modalities are associated with specific dependencies and are assessed for their effectiveness with those dependencies (Gerstein and Lewin). Too often when these proven treatments are applied to other dependencies, there is no test of treatment outcomes with that new client group.

This singular approach to treatment design runs counter to the reality that increasingly the chemically dependent use multiple substances. A national survey of 10,000 drug and alcohol abusers found that, although nearly half used alcohol daily or weekly in the year

before treatment, they were primarily dependent on and were treated for dependency on an "illicit" drug (Hubbard).

Other client characteristics are associated with a type of treatment and with treatment success. The stage of addiction is one. For example, chronic alcoholics have better outcomes in residential programs than in outpatient programs (Sannibale). They do not do well in stand alone education programs (Alterman et al).

National surveys (DARP and TOPS) have found that criminal justice clients are less likely to have a serious or late stage drug addiction (Sells and Simpson; Hubbard). Since severity of addiction affects the results of treatment, this may be one reason offenders have positive outcomes.

TREATMENT CHARACTERISTICS

Coerced participation, duration, modality and quality of treatment are all characteristics that affect treatment outcome. Longer treatment is more effective. Some types of treatment are indicated for selected types of chemical dependency and others are contraindicated. Independent of modality and dependency, treatment characteristics, such as stable staffing, are associated with positive outcomes.

Coerced Participation

Coerced participation in treatment programs can be forced or required. Required participation encompasses court orders and other legally binding conditions. Forced treatment originates with incentives to participate; for example, work release is an option only for inmates who have completed prison-based treatment.

Legal coercion has been associated with positive outcomes. These results may stem from increased lengths of treatment since longer treatment does improve treatment outcomes (Anglin). Chaiken argues that forced treatment has more long term benefits with correctional clients.

Most incentives are negative. Although positive incentives may be offered, they usually are not.

Duration and Attrition

Dosage level is an important variable in medical research and increasingly assessed in other settings. Dosage levels can be measured in several ways. One has simply to look at the length of treatment.

Duration of treatment is significantly correlated with outcome. For example, the National Academy of Science review of drug treatment effectiveness found that successful outpatient treatment was positively related to length of treatment (Gerstein and Lewin).

The relationship between treatment duration and success may be the result of attrition. If good prospects stay and poor prospects leave, then those staying the longest have the best chance of success (Anglin and Hser).

TOPS data show that outpatient drug treatment programs have higher drop out rates than either residential or methadone maintenance programs (Hubbard). The high attrition rate in outpatient treatment may contribute to the finding that success in outpatient treatment is related to length of treatment.

Length of treatment effects are not solely associated with treatment for dependency on illicit drugs. The National Institute of Alcohol Abuse and Alcoholism (NIAAA) review of alcohol treatment effectiveness found persons receiving "sufficient" treatment had more positive outcomes than those receiving minimal treatment (Lettieri et al.).

However, attrition is also a factor with alcoholics. Fifty to 75 percent of the alcohol outpatients drop out within four sessions. Five to ten sessions are considered necessary for any positive impact and longer treatment periods increase the number of persons with positive outcomes (Gilbert).

The TOPS survey found that criminal justice clients stayed longer in both inpatient and outpatient treatment (Hubbard). A review of treatment for offenders found that all forms of drug (not alcohol) treatment programs (except detox) were more effective with that client group when the treatment lasted longer than 90 days (Anglin and Hser).

Modality

There are clear interrelationships between modality or type of treatment and effectiveness.[2] Again, these relationships must be examined by the type of primary dependency (Anglin and Hser, Gerstein and Lewin).

Outpatient treatment was developed initially for the non-opiate user and has since been extended to other types of dependency. Clients of these programs have higher success rates than the untreated (Gerstein and Lewin). Clinical outpatient treatment has a higher drop out rate than residential treatment or methadone maintenance (Gerstein and Lewin; Gilbert) and is less successful in reducing recidivism (Anglin).

2 The literature on treatment effectiveness was reviewed when the current DOC program was initially assessed. The studies then available suggested that although treatment had a positive effect on remission for alcoholics, there was no difference between types of treatment. Another study reported little impact on crime rates for heroin addicts.

Twenty-eight day residential treatment was an adaptation for those dependent on alcohol and then was extended to other drug dependencies. A review of studies with offender clients in 28 day residential treatment found that their use of cocaine decreased by 45 percent in the first year and their use of alcohol decreased by 75 percent (Anglin). This may be attributable to the lesser dependency of most offender clients.

Persons with severe alcohol problems do better in more intensive residential treatment than they do in 28 day programs (Sannibale). According to the National Academy of Science, 28 day residential treatment has had poor results with persons dependent on drugs other than alcohol (Gerstein and Lewin).

The therapeutic communities, which are highly structured, resocialization programs, were designed for heroin addicts and now serve mostly cocaine abusers. (Gerstein and Lewin) The optimal stay is 15 months (Anglin). The minimum is at least 90 days. Therapeutic communities achieve positive outcomes, but have high attrition rates (Gerstein and Lewin).

Prison therapeutic communities are found in few locations. The Stay'N Out Program operated at a New York medium security prison is one. Chaiken has reviewed four model prison programs, all involving this intensive, residential model. As with other chemical dependency treatment programs, prison TC programs show more positive results when lengths of stay are longer; nine months to a year in Stay'N Out. The National Academy of Science singled out the success of prison-based therapeutic communities with strong links to the community (Gerstein and Lewin).

Perhaps two-thirds of all prison treatment programs are some combination of outpatient program, self-help groups and classroom drug education. Outpatient prison treatment programs or their counterparts in community corrections typically do not maintain contact with inmates following release (73 percent). Sixty-five percent of the clients simply are referred to community services (Chaiken).

A 1990 survey of drug treatment in prisons found nearly 742 state institutions with drug treatment: 7,432 inmates in special residential units, 42,593 inmates in counseling, 32,427 in drug education, 37,646 under urinalysis surveillance, 2,864 in detoxification, and 2,801 in "other" forms of drug treatment (Harlow). The National Academy of Science noted the failure of prison treatment other than TCs to reduce recidivism (Gerstein and Lewin).

The outpatient treatment offered in Washington prisons was found effective in reducing prison rule infractions and reduced or delayed returns to prison (Hall-Milligan et al).

Quality of Treatment

Consistent (Hubbard), flexible (Angiin) treatment programs with minimal staff turnover (Gerstein and Lewin) have better results. With offenders the results are better if the

treatment is "firm but fair," modeling and reinforcing noncriminal behavior, providing opportunities to test their problem solving and learn new skills (Andrews et al).

Chaiken found that successful prison therapeutic communities offered clear rules quickly enforced, concerned and credible staff, provision of tools for avoiding further criminal behavior, and use of community resources. Kitchener and Teitelbaum found screening, mandatory participation, supervised aftercare, intensive parole surveillance, assistance in getting jobs, and motivation through sanctions or therapy were the keys to success in treatment programs for civilly committed addicts.

Positive working relationships between corrections and treatment staff are beneficial. Both must agree on goals, participants, duration of treatment, appropriate behavior while in treatment, and sanctions (Newman and Price).

Monitoring and Random Drug Testing as Adjuncts of Treatment

Monitoring by Treatment Alternatives to Street Crime (TASC) is often cited as an important determinant of outcome. In this context it is important to remember that TASC offenders are often referred pre-trial and then sentenced to community supervision and continued monitoring by TASC (Inciardi and McBride).

As noted above, significant numbers of prison inmates are subject to regular drug testing (Harlow). Others are subject to random testing. Just over half of all state prisons do random drug testing. Most use a combination of random testing and testing on suspicion. Harlow counts urinalysis as a type of prison-based drug treatment.

The TOPS survey did not find positive relationships between random drug testing and the desired treatment outcomes (Hubbard). Others believe that urinalysis does have an impact when combined with sanctions (Anglin). Some of the success associated with TASC may be the result of the testing which those programs routinely perform.

OUTCOME MEASURES

The effectiveness of chemical dependency treatment is typically measured using successful completion of treatment and remission. Negative urinalysis results can be a surrogate for remission and thus an outcome of treatment. In addition, other measures of effectiveness may be appended. These additional measures look toward a more functional lifestyle and include improvements in employment and decreases in criminal behavior, in the case of offenders.

Completion of Treatment

Treatment completion or its opposite, attrition, is a common measure of program effectiveness. The percentage of persons completing treatment is often reported. For example, DOC reports completion rates of 86 percent for its prison-based treatment. Our

reading of the literature suggests that attrition is highly correlated with duration of treatment and is another method of measuring dosage.

Attrition varies widely by type of treatment and by client characteristic. A recent study of completion rates for treatment authorized by the Alcohol and Drug Abuse Treatment Services Act (ADATSA) found that completion rates were higher for inpatient treatment than for outpatient. The same study found that completion rates were higher for persons whose primary dependency was alcohol (Wickizer and Maynard).

Remission

The TOPS survey found declining drug use among those receiving chemical dependency treatment.[3] The rate of decrease was less for those dependent on marijuana (Hubbard).

Between 60 and 70 percent of persons treated for dependency on alcohol control their drinking or cease to drink following treatment. These remission rates decrease significantly in the year following treatment until perhaps 25 percent remain improved (Emrick; Armor et al; Miller and Hester).

Urinalysis results might be used to support a claim of abstinence but they have limitations. Urine tests can only detect most drugs within 48 to 72 hours of use, and PCP and marijuana up to 30 days after use. The threshold set for the tests may let limited use pass undetected. This is especially true for marijuana. Scheduling of the tests, even on randomly selected inmates, can be deduced or uncovered by inmates. All facilities test only for selected drugs. Washington facilities rarely test for alcohol. Thus, it is possible to continuing using, but avoid detection.

The rate of detected use is quite low. A 1990 survey of inmates found that state prisons uncovered evidence of drug use in 1.4 percent of the tests for cocaine, 1.0 percent of the tests for heroin, 2.3 percent of the tests for methamphetamine and 5.8 percent of the tests for marijuana (Harlow).

Lifestyle Changes

Employment has been another measure of effectiveness. The TOPS survey found that employment rates were higher following treatment (Hubbard).

Recidivism

Recidivism, the most common outcome measure for offender treatment programs, is operationalized in several ways. The national drug surveys looked at re-arrest and found that treatment did reduce arrests (Sells and Simpson; Hubbard). Arrests for predatory crimes specifically were down by roughly half (Hubbard).

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3 The cessation of any drug use was the stated objective in this study.

Outcomes do vary by program type. The therapeutic communities have very high attrition. Those who remain for the full course of treatment in a TC have more positive outcomes. Prison TCs have a strong impact on recidivism, but other less structured prison programs do not (Gerstein and Lewin).

Clinical outpatient treatment programs have higher drop out rates than residential or methadone programs (Gerstein and Lewin; Gilbert) and are less successful in reducing recidivism (Anglin). Even so, clients of those programs do better than persons not treated at all (Gerstein and Lewin).

In-prison Infractions

Infractions, that is, misconduct while institutionalized, is a measure unique to prison-based treatment. Washington Department of Corrections used this measure to assess its prison treatment program shortly after its inception. Inmates who completed treatment were compared to those who were dropped from treatment. Infraction rates were significantly higher for those who were dropped (Hall-Milligan et al).

A recent study of prison rule violations by the Bureau of Justice Statistics found that state prison inmates with a history of drug use are more likely to commit rule violations, 57 percent as compared to 37 percent for non-users. Inmates housed in larger and maximum security prisons also have higher rates of rule violations. However, significant numbers (47 percent) of all state prison inmates were without rule violations.

Even inmates with relatively high rates of rule violation do not have many infractions annually. For example, inmates who had ever used drugs regularly averaged 1.8 infractions a year. The highest rate reported was for inmates with long criminal histories or whose first arrest was at an early age; that rate was only 2.4 infractions a year (Stephen).

These results suggest that infractions must be used cautiously as a measure of the effectiveness of prison chemical dependency treatment. The interaction between inmate characteristics, including a history of drug use, treatment and infractions must be considered.

SUMMARY

We know more about effectiveness of drug treatment than we do about the effectiveness of alcohol treatment. What we do know about chemical dependency treatment of offenders suggests they stay in treatment longer. Longer treatment is more often associated with positive outcomes. Prison-based treatment, particularly that modeled after the therapeutic community, has been described favorably in the literature. Success is defined variously as treatment completion, remission, changes in lifestyle, and/or reduced recidivism.

PRISON-BASED CHEMICAL DEPENDENCY TREATMENT

INTRODUCTION

Chemical dependency treatment was first offered in early 1984. Initially one or two institutions provided treatment for the inmates from several facilities within a catchment area. Treatment was provided by four private contractors, one in each of the four catchment areas. Treatment packages shared a focus on recovery, recognition of relapse, development of communication skills, assertiveness training, and grief and anger management. Programs included an information segment on drugs and alcohol.

Each contractor brought his or her own emphasis to the program. Two were structured, formal programs, lasting six or eight weeks and permitting no new admissions during the program. Another expected to spend the majority of time on release planning and referral to community treatment. They took new referrals as there were openings. Classes were provided by community colleges. The fourth established a three step, 12 week program beginning with education, followed by social skills and concluding with therapy.

PRIOR EVALUATIONS OF CHEMICAL DEPENDENCY TREATMENT

An 1983 DOC study estimated the population needing chemical dependency treatment at between 80 and 90 percent of the prison population (Substance Abuse Report). In 1986 and again in 1988, the Planning and Research Unit of the Department of Corrections did an assessment of prison-based chemical dependency treatment.

The program had two objectives: to reduce future criminal activity, specifically substance related crimes and parole violations; and to reduce chemical dependency activity and other rule violations during incarceration. The department had proposed adding its funds to community-based treatment programs serving offenders. In its appropriation for the new program, the legislature adopted the Legislative Budget Committee's recommendation for treatment within the prisons, directing DOC to serve offenders who were within one year of release and were identified as needing chemical dependency treatment.

The evaluation was designed to measure the accomplishment of those objectives. The control group (265 inmates) was randomly selected from inmates released during the four months prior to the start of the chemical dependency treatment program. The treatment group (774) was composed of inmates admitted to chemical dependency treatment during the 13 months between March, 1984 and March, 1985.

The control group included 17 percent who had no chemical dependency problem, 28 percent who abused alcohol, 15 percent who abused drugs, and 38 percent who abused multiple substances. Multiple abusers tended to be younger. Data on primary dependency are not reported for the treatment group. One must assume they were similar. There were no significant differences between the two groups on race, age, or, when early release was controlled, by type of crime.

Program participants were most often assessed as middle stage dependents; 25 percent were early stage or no problem and 20 percent were late stage. This distribution varied significantly from institution to institution and thus from treatment provider to treatment provider.

In 1984, there were four providers with quite different approaches to treatment. Thus, it was not surprising to see that treatment hours and treatment completions also varied significantly from institution to institution. Seventy-four percent completed; the high rate was 84 percent in two facilities and the low was 64 percent in two others.

The hours per completing participant varied widely. Treatment offered by one of the current contractors was quite structured and the average hours were high (68). Another provider focused heavily on pre-release planning and referral; they spent, on the average, less than 20 hours per completing participant. The other two providers were between these two extremes.

The report on outcomes was issued in 1988. The treatment group was reduced somewhat from the 774 admitted to treatment. Eighty-one were dropped because they were still in prison and could not be assessed for recidivism. There is no information regarding differences between those released and those still in prison.

Included were data on prison infractions, controlled for time in prison. Two analyses were done. One looked at overall infraction rates, for chemical dependency and for all infractions. There were significantly more infractions for the participants (those who completed and those who dropped) than for the controls and no significant difference on chemical dependency infractions.

The second analysis looked at program participants before and after treatment. There was a significant decrease in total infractions and in other major infractions. There was no significant difference in chemical dependency infractions.[4] Substantial numbers of inmates had no infractions. The percentage varied from one institution to another and affected any institution-based analysis of outcome.

Inmates dropped from the program had significantly higher infraction rates than those who completed. However, these differences did not remain when pre/post treatment rates were compared.

Comparisons of recidivism for controls and participants show similar rates of return to prison during the first year and significantly fewer returns by participants during the second year. The rate of return for participants continued to diminish during the second year. Participants who recidivated were more likely to be poly drug users and thus

4 It should be noted that during this period DOC introduced random drug testing which undoubtedly affected the number of substance abuse infractions.

probably younger. Release to inpatient treatment did not affect recidivism.[5] There are no reported findings which distinguish between those who completed and those who dropped out.

Inmates were asked at the end of treatment to complete an evaluation form. Most were satisfied with treatment, but would have liked a longer, more intense program with more group sessions. Community Corrections Officers (CCO) were also surveyed about persons on their caseloads who had been in treatment. Almost half did not know the parolee had been in treatment. Of those who did know, half believed the parolee had benefitted.

CURRENT LEVEL OF TREATMENT

Since 1984, the program has undergone major revisions, and has become more uniform. Programs were added in other institutions in the first few years so that all institutions presently have treatment programs.

There were changes in the contractors: one of the original four remains and a new contractor was introduced in 1991.

STOP (Social Treatment Opportunities Programs) provides treatment services in Catchment One at McNeil Island, Washington Corrections Center (Shelton), Washington Corrections Center for Women (Purdy), Cedar Creek and Larch. They also provide services in Catchment Two at Tacoma Pre-Release, Reynolds Work Release, Ratcliff Work Release and Yakima Work Release[6].

Lakeside Foundation provides treatment services in Catchment Two at Clallam Bay, Twin Rivers, Washington State Reformatory (WSR), Indian Ridge, Olympic, and WSR Farm. Lakeside also provides treatment services in Catchment Three at Washington State Penitentiary (WSP), Pine Lodge Pre-Release and Cornelius Work Release. In 1992, they added services at Coyote Ridge and Airway Heights; however, these latter two institutions were not part of this study.

The program now offered in each institution is modeled after community-based intensive outpatient treatment as defined by RCW and WAC and certified by the Washington Division of Alcohol and Substance Abuse (DASA). The DASA requirements for intensive outpatient treatment are one basis for assessing the treatment now provided.

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5 There are no specifics on the characteristics of inmates released to such programs, not even information on how many were so released.

6 Chemical dependency treatment at the work release facilities was not part of this study.

In brief, potential participants are assessed to determine the degree of their dependency; some are rejected and some refuse. Upon acceptance they are scheduled for the next available cycle. A maximum of twenty people are admitted to each cycle. There are no admissions during a cycle. There are five cycles per year at major institutions, and three at the minor institutions. Each cycle lasts approximately six weeks.

A cycle has 60 hours of classroom instruction. The classes provide education on alcohol and drugs, the progression of addiction, recovery, AIDS education, relapse prevention, spirituality, adult children of alcoholics (ACOA) issues, anger management, stress management, problem solving, goal setting, assertiveness, communication, family dynamics, grief and loss, and nutrition. Inmates can earn college credits for completing the course at some institutions.

Participants are provided four hours of individual counseling and 27 hours of group therapy. During group therapy participants deal with issues of personal growth, problem resolution, frustration ventilation, aftercare planning, assertiveness, and practice skills.

Participants are required to attend five meetings of a self-help group during treatment. Counselors are expected to recommend aftercare as a part of the discharge summary. Discharge summaries are shared with the inmate, appropriate DOC staff, and community-based treatment programs. For inmates not yet released into the community, voluntary aftercare may be provided by treatment staff once or twice a month.

Variations in institutional settings and inmate populations can be expected to introduce other differences in the treatment. Seven of the facilities are major institutions, housing inmates with three or more years until release and a security classification of medium or above. WSP houses offenders with long criminal histories.

One major institution houses only women. The program there deals with the multiple issues faced by incarcerated women: concerns with their children, a higher incidence of co-dependency, frequently a history of childhood abuse, a higher use of the more addictive drugs and of intravenous drugs.

Another major institution houses the Sex Offender Treatment Program. The men who have been in that program are more accustomed to the group process and are more willing participants in chemical dependency treatment. Their groups should form strong, cohesive bonds, a desired outcome for this modality.

Five programs are in minimum security institutions. Two house both men and women. Inmates in these facilities are typically younger, have shorter sentences, and shorter criminal histories. If other studies are predictive of outcomes, inmates treated at these facilities should show more positive results.

Two facilities are pre-release centers. Both have both female and male inmates. Inmates at pre-release centers are within 18 months of release and classified as minimum security. Their anxiety levels are high since they are close to release and facing many of the

problems that brings. They are also anxious because it is easier to break the rules and the consequences are more costly.

The last four are work release facilities, where treatment focuses on relapse prevention. Our concern with inmates in those facilities is limited to infractions that may occur during this time period.

STUDY DESIGN

The study reported here is largely a replication of the earlier assessment. What has not yet been replicated is the effect of chemical dependency treatment on recidivism in the community. What has been added is greater exploration of the treatment process and inmate differences across institutions, particularly between the programs at the Washington State Penitentiary (WSP) and the McNeil Island Correctional Center.

TYPES OF DATA

On the Study Population

The earlier study used recent releases as controls. This assessment uses persons accepted for treatment but not yet in treatment as a control group.

The subjects (1,550) are inmates who were in treatment on July 1, 1991 or who were assessed for treatment between July 1, 1991 and December 31, 1991. Some completed treatment during the first several months of 1992. All institutions and pre-release centers offering chemical dependency treatment are represented, but work release facilities were not included.

Descriptions of the study population were drawn from Offender Based Tracking System (OBTS) files, from central files, and from treatment records. Data compiled on all members of the study population included standard demographic variables, such as age, gender, and ethnicity. Criminal history information consists of number of prior offenses and, when available, the Sentencing Reform Act (SRA) criminal history score. Current offense and type of admission to prison were retrieved, as was whether the last sentence was handed down under the SRA or the earlier sentencing law. Several variables describe institutional history: date of admission, earliest release date, and facility.

Data on chemical dependency as recorded at reception were available for analysis. Three variables, depicting amenability to treatment, were collected for persons treated at the WSP and McNeil Island Corrections Center. They were dependency, primary and secondary; stage of addiction, early, middle, and late; and incentives to participate, i.e., legal coercion.

On Treatment

The parameters of treatment are defined by contract. Basic variations within those parameters were assessed at all sites. Additional data collection was done at the WSP and McNeil Island Correctional Center.

The assessment compared actual treatment to three paradigms for the delivery of chemical dependency treatment services: the requirements of DOC; the specifications for DASA certified intensive outpatient treatment; and national research findings regarding effective treatment strategies, particularly for prisoners.

Interview data describe treatment variations and augment individual measures of treatment. Place of treatment, date of treatment and type of exit from treatment are part of the data set for individuals. In addition, hours in treatment was used as a measure of dosage.

On Outcomes

There are two outcomes measures available for all participants in the study. One is treatment completion. The other is infractions.

The treatment completion data, as already noted, are a rough measure of dosage. Completion data in this setting are also confounded by the factors which cause one to prematurely exit treatment. These may be infractions of prison rules which result in segregation or other restrictions, infractions of treatment rules, or transfers to other institutions.

Infraction data are divided into violent, chemical dependency and all other infractions. Infractions were controlled for time in the institution.

Urinalysis (UA) tests are conducted randomly, on suspicion, or for cause, such as a conjugal family visit which offers opportunity and thus cause. UA test results were collected for participants at WSP and McNeil Island.

On Extraneous Variation

There are several sources of non-treatment variation which could affect the above outcomes. Client attributes have already been mentioned. These qualities also interact with institution features to produce a unique mix at each place of treatment.

Thus, the generally older, more seasoned criminals found at WSP would be expected to have unique chemical dependency characteristics and respond to treatment in their own fashion. Their response would not be the same as that of the younger inmates found at McNeil Island. Because institution and some client attributes are known, these interactions can be examined.

Other features of the institution could affect treatment completion. For example, other programs may compete with chemical dependency treatment and thus, the amount of other programming could be a factor in treatment completions. Work assignments also may affect treatment completion. Or features of the institution could affect infraction rates. An emphasis on drug testing for those associating with known drug dealers could quickly affect UA test results and chemical dependency infraction rates.

It would be unrealistic to track all possible sources of extraneous variation. It is realistic to note them during the course of the study and particularly to seek information on those variables during the interviews.

DATA COLLECTION

Some data were collected for all members of the study population and other data were collected only for those at WSP and McNeil Island. All data on individual program participants were drawn from secondary sources, such as OBTS, DOC central files, and treatment records. No data were collected directly from inmates or other primary sources.

Most data concern individual program participants. A small amount of treatment information was available only in its aggregate form. Staff of the Division of Offender Programs had compiled these data.

Much of the information describing how referral, screening, assessment and treatment work now and might work in the future comes from interviews with institutional staff, treatment staff, and, to a limited extent, inmates who volunteered.

Empirical data for this report were provided to the contractors by DOC via their management information system. Significant efforts were expended by DOC staff in order to access and modify offender records and generate data files which would assist this project's goals and objectives.

Given the complexity of the multiple data sets used, the contractors spent considerable time completing data cleaning and management tasks prior to analysis. Problems with offender numeric identifiers required reviewing individual records across data files. Out-of-range and illogical fields were also encountered and assessed.

The following data files were developed by DOC and forwarded to the contractor:

a) Offender demographic and incarceration measures
b) Infraction type and date
c) Chemical dependency treatment hours
d) Risk assessment scales at institutional admission

DATA ANALYSIS

The basic data files were used to create aggregated variables across data sets; to develop infraction measures; and to generate a master file of offender records, treatment indicators and infraction summaries.

Aggregation Issues

Three files were provided by DOC based on one data record per case (or offender). The demographic, treatment and initial assessment files were all organized at the individual case level. In contrast to this relatively standard approach to describing individuals, the infraction data reflected events—not people. For these data, one record equalled one infraction. Variables included in this latter data set described infraction type and the date it occurred. For example, each offender might have from one to some number of records and the total number of records reflected the offender's infraction history. (Offenders without any infractions had no records in this file.)

Analysis of infractions where cases had differing numbers of records required summarizing or aggregating multiple lines of data to the individual case level. The first step in this process was to define the aggregate infraction measures that would be generated.

Infraction Measures

About 9,000 infraction records were forwarded to the contractor. Given the focus on infractions in relation to treatment, it was necessary to merge selected variables from the demographic/incarceration file *into* the infraction data set.

Two measures were critical: admission date and the month treatment ended. The first of the measures was used to focus the infraction analysis on most recent incarceration. Without a complete history documenting institutional careers the most conservative approach to assessing the role of infractions was to limit them to the most recent period of institutionalization. This reduced the number of valid infraction records to 4,817.

After identifying the relevant infraction records the task was to generate summary variables at the offender level. We chose to develop various "counts" of infractions. The aggregate infraction measures were characterized by type, time frame, and location. The categorization of these measures was:

Infraction type: violent, chemical dependency, and other
Time frame: before and after treatment was initiated
Location: prison versus community setting

Thus, each offender was characterized by a series of aggregate variables. These were counts (or the number of):

Violent pre-treatment prison infractions
Substance related pre-treatment prison infractions
Other pre-treatment prison infractions

Violent pre-treatment community setting infractions
Substance related pre-treatment community setting infractions
Other pre-treatment community setting infractions

In addition, a similar list of variables was calculated for infractions occurring after treatment began. Importantly, the data are censored at both ends of offender careers. Given our focus on the most recent incarceration it is certainly the case that "opportunity" to infract is constrained. Likewise, DOC's infraction data set was forwarded to us during August, 1992. This allowed incorporating infractions through July, 1992. However, depending on when an inmate received treatment, this affects follow-up time frames.

The above approach to operationalizing infractions varied from prior techniques used within DOC. In a past report produced by DOC, infractions were annualized and expressed as a real number or rate (e.g., 0.02 infractions per month or some time frame) We also calculated rates but chose to focus most analyses on the aggregate counts of different infraction types. The above method was selected based on the following considerations:

a) Relatively few offenders had any infractions—this low base rate suggests re-conceptualizing study questions. A more powerful analysis then might focus on the likelihood of a certain type of infraction occurring rather than portraying a singular event as distributed over a particular time period.

b) Developing DOC-like infraction rates does not address time issues. The past development of rates (or real numbers as infractions per month) implies that all cases have the same opportunity or tenure in the system. By maintaining infractions as counts or events we can then add a covariate (time within the institution) to adjust for differing amounts of incarceration.

Regardless of this different approach taken to analyzing infractions, these data were re-examined in supplemental statistical procedures via their rates. Thus, the report has two sets of results to review. The first involves examining relationships between the likelihood of an inmate having any infractions (of various types) where time is incorporated as an independent covariate; the second approach parallels the rate analysis contained in prior DOC reports.

Master File

After aggregating infraction records, these variables plus treatment and intake assessment items were merged with the general offender data base. Importantly, the limiting factor for this process was the listing of DOC identification numbers for offenders in the demographic/incarceration file.

For example, the initial risk assessment data set was completed on approximately 60-70 percent of new inmates. This will limit the number of successful matches with the treatment and demographic data sets. This was not an issue with the chemical dependency treatment records because early data cleaning addressed problems in matching these records with demographic data.

Statistical Power

Statistical power is a central issue in data analysis. Power refers to the likelihood of finding statistically significant results (between groups or in relationships among measures) in a particular sample when, in fact, there are real differences in the theoretical population(s).

Thus, one may not have significant results in a sample not because there aren't any, but because there are too few cases in the analysis. Statistical power is a function of the effect one is seeking to detect, the significance level chosen, the type of hypothesis (directional or not), the kinds of statistical procedures used, and the number of cases in the sample.

In the present analysis an estimate of statistical power was calculated for the merged data set incorporating demographic, treatment and infraction measures. Based on seeking to detect small differences between those with and without infractions and sample group sizes of about 750 each, the statistical power was 0.93 (alpha= 0.05 and one-tailed test).

Thus, given our overall group sizes, we will be able to detect moderate differences—when in fact they exist in the population—virtually all the time. (Note: this does not address the issue of experiment-wise error when performing multiple tests. Ideally, alpha levels should be moved to more extreme levels to adjust for this practice.)

The practical implications for this study, though, involve making inferences at the institutional level. Many facilities yielded less than 100 total cases per site. Similar power calculations with 50 per group would yield statistical power of only 26 percent. Analyses within each institution, thus, would involve much lower levels of statistical power.

This technical issue generally works *against* program innovation since statistical analysis with limited group sizes (those in treatment versus those not) will often result in finding no differences between them simply because the statistical power was too low. That is,

non-significant findings were a function of sample size and may not, perhaps, reflect problems in treatment efficacy.

Given the statistical power issues, analyses were not performed for each institution. Rather, the sample as a whole was examined. Facility differences, though, were reviewed across case demographic and infraction measures. This sub-analysis would, at a minimum, inform some of the concerns about site variation.

Data Analysis Procedures

Data sets were analyzed with SPSS software. Frequencies and related summary statistics were computed for all key measures. Bivariate analyses were chosen based on item metrics and included cross-classifications, product-moment correlations, and analyses of variance (or t-tests for two group comparisons).

These procedures were performed for demographic variables (race/ethnicity, age, facility, length of institutional stay, gender), treatment group, and infraction frequency and characteristics. Final analyses involved multivariate procedures, specifically logistic regression for dichotomous outcomes (e.g., presence/absence of chemical dependency infractions).

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THE INSTITUTIONAL STUDY POPULATION

INTRODUCTION

All study participants were in chemical dependency treatment on July 1, 1991 or were referred to treatment between July 1, 1991 and December 31, 1991. Some members of the study population completed treatment during the first several months of 1992.

Not all inmates referred to treatment were assessed as needing that treatment. Some inmates refused treatment. Others were accepted but unable for a variety of reasons to enter treatment during the study period.

The following material describes the study population as whole. Later chapters distinguish treated inmates from those not treated.

BASIC DESCRIPTORS

There has been increased recognition of the problems women have with chemical dependency. And there are increasing numbers of women in prisons.[7] Still the majority of prison inmates are male[8] and the majority (89 percent) of the study participants were male. In those facilities housing both male and female inmates the majority (80 percent) were still male.

Chemical dependency treatment in Washington prisons is intended for persons in the late stages of chemical dependency. One might expect this to mean that most study participants are older, i.e., over the age of 30. In fact, their average age was 31; 13 percent were 40 or older.

The participants in this study were primarily Caucasian. The distribution of study participants by race and ethnicity is not significantly different from that for the prison population as a whole. (See Table 1.)

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7 Between 1985 and 1990, the number of women in state and federal prisons increased 76 percent; in Washington prisons that number increased by 44 percent. Bureau of Justice Statistics, Correctional Populations in the United States, 1985 and 1990. U.S. Department of Justice, December, 1987 and July, 1992.

8 In 1990, 95 percent of all federal and state inmates were men; 96 percent of Washington inmates were men. BJS, Correctional Populations in the United States, 1985 and 1990.

Table 1

RACE AND ETHNICITY:
ALL INMATES[9] AND STUDY PARTICIPANTS

RACE AND ETHNICITY	ALL INMATES #	(%)	STUDY PARTICIPANTS #	(%)
Caucasian	6013	(68.4)	998	(66.5)
African American	1843	(21.0)	428	(28.5)
Native American, Alaska Native	336	(3.8)	64	(4.3)
Asian Pacific Islander	98	(1.1)	11	(0.7)
Other and Unknown	498	(5.7)	0	(0.0)
Hispanic Origin	1273	(14.5)	176	(11.4)
Non-Hispanic	7178	(81.7)	1369	(88.6)
Unknown	337	(3.8)	0	(0.0)

CRIMINAL HISTORY AND CURRENT OFFENSE

The Sentencing Reform Act (SRA) went into effect on July 1, 1984 and all inmates arrested following that date serve sentences under its provisions. Inmates arrested prior to that date remain under the auspices of Indeterminate Sentencing Review Board (ISRB).

The ISRB, previously called the Parole Board, reviews an inmate's progress and determines his/her release date. Inmates within its domain are under supervision while completing their sentences in the community. Parolees may be returned to prison for failure to comply with conditions of release. ISRB caution about release can result in a recommendation or requirement for chemical dependency assessment and, when appropriate, treatment.

9 Those people in institutions and work release centers on June 30, 1991. "Client Characteristics and Population Movement Report for Fiscal Year 91," Washington Department of Corrections. Division of Management and Budget, Planning and Research Section.

Some, but not all, offenders sentenced under the SRA are supervised once they are released to the community. They may also be prepared for release into the community by transfer to pre-release or to work release, both of which permit offenders to spend some time in the community before being fully released. DOC caution about those placements has resulted in directives requiring chemical dependency treatment for those who can benefit.

The majority of the study participants were sentenced under the provisions of the SRA. Less than 15 percent were sentenced under the older law. A few fell under both laws. (See Table 2.)

Table 2

SENTENCING PROVISIONS AFFECTING
ALL INMATES[10] AND STUDY PARTICIPANTS

SENTENCING LAW	ALL INMATES		STUDY PARTICIPANTS	
	#	(%)	#	(%)
SRA	6082	(69.2)	1204	(78)
ISRB	1710	(19.5)	190	(12)
Both	845	(9.6)	154	(10)
Other/Unknown	151	(1.7)		
TOTAL	8788	(100)	1548	(100)

The SRA was designed to place violent offenders in prison and property offenders in jail and the community. Later amendments added drug offenders to the list of violent offenders, with the effect that they are more likely to be sentenced to prison. Offenders with longer criminal histories were also to be sent to prison under its provisions. Previous studies indicate that those objectives have been accomplished. (Fallen, 1987)

Almost half the participants in this study (44%) were convicted of crimes against persons. Thirty-two percent had committed a drug offense. Seventeen percent were convicted for burglary. The handful remaining had committed other property offenses. (See Table 3.)

10 Ibid.

Table 3

DISTRIBUTION OF OFFENSES
ALL INMATES[11] AND STUDY PARTICIPANTS

OFFENSE	ALL INMATES #	(%)	STUDY PARTICIPANTS #	(%)
Crimes against persons	5434	(62.0)	688	(44.4)
Drug crimes	1822	(21.0)	498	(32.1)
Property crimes	1532	(17.0)	363	(23.4)
TOTAL	8788	(100)	1549	(100)

This is a significant deviation from the distribution of offenses for all prisoners. The number of study participants convicted of offenses against persons is less than would be expected. And a higher number of study participants are drug and property offenders.

The SRA emphasizes prison sentences for the more serious offender. Criminal history is one measure of severity. Just over half (53% men and 51% women) of the study participants had prior convictions.

INSTITUTIONAL INFORMATION

Participation in chemical dependency treatment is slated for late in an offender's incarceration. Yet sentences are fairly short. The average prison sentence, imposed during FY91, was 42 months. If the longer sentences for Murder 1 and 2 are omitted, the average sentence is 36.5 months. If the offender earns the maximum good time, his average prison term will be two years. (Fallen and Knobel, 1992)

Dates of admission show that over 65 percent of the study participants had been in prison less than 12 months when they were assessed or entered treatment; 42 percent had been in prison less than 6 months.

The typical study participant was a new admission, i.e., had committed a new offense for which s/he had received this sentence to prison. (See Table 4.)

11 Ibid.

Table 4

REASONS FOR ADMISSION TO PRISON
ALL INMATES[12] AND STUDY PARTICIPANTS

REASONS FOR ADMISSION	ALL INMATES		STUDY PARTICIPANTS	
	#	(%)	#	(%)
New admission	3036	(66.0)	1012	(65.3)
Community custody inmate (CCI) violation	162	(3.5)	0	(0)
CCI termination	36	(0.8)	0	(0)
Parole violation and new sentence	111	(2.4)	71	(4.6)
Parole violation	314	(6.8)	187	(12.1)
Readmission	927	(20.2)	272	(17.6)
Other	5	(0.1)	6	(0.4)
TOTAL	4592	(100)	1549	(100)

RELEASE INFORMATION

The originating legislation specified that chemical dependency treatment programs be scheduled for the last year of incarceration; DOC targets the last six months. Study participants included persons who had been assessed, but were not yet scheduled for treatment. Less than half the participants were within six months of their earliest release date when assessed or treated. Of those released during the study, 80 percent had been assessed or treated in the last six months of their incarceration.

The chances of continued treatment following release may be enhanced by post-prison supervision. Certainly any effort to monitor post-prison treatment is limited if there is no post-prison supervision. Half of the inmates are discharged without supervision.

12 Ibid.

Types of release are shown in Table 5. However, there were only 771 inmates for whom release date and type were known.

Table 5

TYPES OF RELEASE
ALL INMATES[13] AND STUDY PARTICIPANTS

TYPES OF RELEASE	ALL INMATES #	(%)	STUDY PARTICIPANTS #	(%)
Discharge	1616	(49.0)	392	(50.8)
Community Custody	1095	(33.4)	317	(41.1)
Community Placement	219	(6.7)	19	(2.5)
Parole	255	(7.8)	43	(5.6)
Other	92	(2.8)		
TOTAL	3277	(100)	771	(100)

INSTITUTIONAL VARIATIONS

There are differences in the study population across facilities. These differences could affect treatment outcomes. They are, in part, a function of the classification of the institutions. They may also be influenced by decisions to refer and to assess made by institution and treatment staff at these facilities. Our data limit exploration of these various possibilities.

As mentioned above, both men and women are housed in two minimum security institutions: Cedar Creek and Indian Ridge, and in the two pre-release facilities: Pine Lodge and Tacoma. Men and women at these facilities participate together in chemical dependency treatment.

13 Ibid.

Table 6

DISTRIBUTION OF INMATES BY INSTITUTION

INSTITUTION	ALL INMATES ADP - FY 91		STUDY PARTICIPANTS	
	#	(%)	#	(%)
Clallam Bay CC	561	(7.4)	44	(3.0)
Cedar Creek CC	116	(1.5)	76	(5.0)
Indian Ridge CC	108	(1.4)	52	(3.0)
Larch CC	130	(1.7)	51	(3.0)
McNeil Island CC	953	(12.5)	111	(7.0)
Olympia CC	254	(3.3)	115	(7.0)
Pine Lodge Pre-Release	151	(2.0)	233	(15.0)
Tacoma Pre-Release	347	(4.6)	200	(13.0)
Twin Rivers CC	883	(11.6)	55	(3.5)
Washington Corrections Center	1538	(20.2)	184	(12.0)
Washington CC for Women	296	(3.9)	56	(4.0)
Washington State Penitentiary	1731	(22.8)	206	(13.0)
Washington State Reformatory	531	(7.0)	116	(7.5)
Washington State Reformatory Farm			51	(3.0)
Total	7599	(100)	1550	(100)

Washington State Penitentiary (WSP) and Pine Lodge have more Hispanics in the study than all the other institutions combined. African Americans are a higher percentage of the study population at Indian Ridge, McNeil Island and TPR. Caucasians are a higher percentage at Washington Corrections Center (WCC), Clallam Bay and Twin Rivers.

Persons with a prior criminal history are disproportionately represented in the chemical dependency treatment population at Tacoma Pre-Release. They are underrepresented in the treatment populations at Indian Ridge and Twin Rivers.

Study participants were housed in one of fourteen facilities as shown in Table 6. Because chemical dependency treatment is scheduled toward the end of the sentence, those facilities housing inmates close to release (the pre-release facilities and minimum security institutions) had more study participants than would be expected given their share of inmates.

The medium security institutions, with the exception of WSP and WCC, had their expected share or fewer. WCC and WSP programs tend to have more participants than their share of inmates would suggest.

SUMMARY

Study participants, that is persons referred for chemical dependency assessment, are similar to other inmates in terms of gender, race, and ethnicity. They are more likely to be sentenced under SRA provisions, to have no prior convictions, and to be convicted of a drug or property offense. Most have been in prison for less than one year, half for less than six months. Most still have more than six months to serve to their earliest release date.

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ACCESS TO INSTITUTIONAL TREATMENT

INTRODUCTION

The enabling legislation specified that inmates be assessed by a "qualified health professional" to determine their need for chemical dependency treatment, and that they be within one year of release.

DOC has centralized reception into prison. During an offender's initial stay in the reception units one set of diagnostic tests addresses his/her chemical dependency. An assessment occurs when the inmate is referred for treatment by the institution staff.

The following section describes the treatment assessment process as it was expected to work and as it does work, provides information on dependency and other requirements for treatment, and concludes with the acceptance for treatment.

THE EXPECTED PROCESS

Reception Unit (R-unit) Screening

Every male and female inmate enters the Washington prison system through the Reception Center at the Washington Correctional Center. Both men and women go through a similar process. During the inmate's stay in reception, s/he is evaluated for chemical dependency. The results of this evaluation are placed in his or her file. Also in this file are any court orders or other mandates.

Institutional Referral

The expectation is that classification counselors will refer selected inmates within one year of release to the treatment agency staff for assessment. In addition to release date there are two criteria primary to that referral: a legal requirement for assessment and/or treatment and evidence of serious chemical dependency.

The Reception Center evaluation is one indicator of dependency. Another is information from the pre-sentence report. Inmates may acquire alcohol or other drugs while imprisoned, and this behavior may result in chemical dependency infractions. These infractions may be another indicator of dependency.

Inmates can also be required to participate in treatment by the ISRB or others. The ISRB in reviewing the progress of the offenders under its jurisdiction may suspect that chemical dependency was a factor in their criminal behavior and request an assessment or require treatment. Twenty-two percent of the study population were under the jurisdiction of the ISRB.

The SRA severely limits the conditions under which an offender can be required to enter treatment. The effect is that no offender sentenced to prison has, as a corollary of that sentence, a requirement to receive chemical dependency treatment.

Thus, offenders who have shown evidence of a chemical dependency problem prior to their present sentence, at reception, or during their incarceration may be referred for assessment by the classification counselor in their living unit. Some are required to be assessed by other agencies, such as the ISRB.

Treatment Assessment

In theory, one would assume that the number of inmates who could benefit from treatment is much greater than the number of treatment slots, and that the treatment assessment would limit the number who receive treatment even further.

The assessment is standardized. Both treatment providers use the same forms. Assessments are conducted by the same staff who provide the treatment. Up to one hour is allocated to these interviews.

The same standard tests are used at both the Reception Center and at the institution. Inmates are queried as to their use and abuse of alcohol and drugs. The tests are designed so that the greater the number of positive answers, the greater the dependence. Staff of the treatment agencies identify the inmates most in need of treatment.

Thus, from a pool of inmates identified by the classification counselors as probably having a chemical dependency problem and ordered to have treatment by some additional authority, treatment staff identify those with the greatest need for that treatment.

The inmates whom Reception Center staff had identified as probable substance abusers would "pop up" as their release date approached. The classification counselor would check on their institutional behavior; i.e., did they have any chemical dependency infractions. The classification counselor would also determine if there were any legal requirements for them to receive treatment. When the conditions of apparent chemical dependency and mandated treatment were met, treatment staff would be asked to do an assessment. In practice the process does not work that way.

ACTUAL PROCESS

The information reported below comes from interviews with DOC and treatment agency staff. Site visits were made to Washington Corrections Center (WCC), Tacoma Pre-Release (TPR), McNeil Island Corrections Center and WSP. The data reported here came from OBTS and case records.

The WCC at Shelton performs three functions: testing; classification or custody screening; and training.

The R-units staff perform testing on incoming inmates, which includes psychological, mental health, and chemical dependency. They also determine where the inmate will be placed, depending on offense, court orders, and program needs. For inmates whose term is short, R-unit chemical dependency evaluations and ADATSA eligibility assessments pave the way to chemical dependency treatment outside the prison system.

The "TC" or training center functions like other facilities; an inmate may request various programs, and the unit counselors determine which programming is appropriate. That portion of the WCC's activity is treated separately in the next chapter on treatment.

Reception Units (R-unit): Testing

As part of the initial testing, staff in the R-units do a variety of diagnostic tests. Results are included in the inmate's central file which follows him/her from facility to facility and from incarceration to incarceration.

Two staff administer the chemical dependency tests (MAST and DAST) as part of a larger battery of tests.[14] The battery takes a full day to complete.

Some of the tests are scored by hand, others by computer. The results are entered, by hand, onto a single sheet with "significant scores" highlighted. The result is either a recommendation for or a recommendation against "chemical dependency education." This sheet becomes part of the Central File and goes to the classification counselor as part of the classification referral.

Staff and room capacity limit the number tested to a maximum of 17 people per day. An average of 88 people per week came into the R-units in FY 91[15]. Staff report they test 70 percent to 85 percent of the new entrants.

Files of 11,813 inmates assessed between January, 1988 and October, 1991 were reviewed.[16] It was found that 24 percent had no specific problem with chemical dependency; 3 percent were users, but not dependent; and 14 percent were found to abuse

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14 The acronyms are: MAST (Michigan Alcohol Screening Test) and DAST (Drug Abuse Screening Test); the other tests are IQ (Intelligence Quotient), ABE (Adult Basic Education), MMPI (Minnesota Multiphasic Inventory).

15 There were 4,592 new inmates admitted to the R-Units in FY 91. "Client Characteristics and Population Movement Report for Fiscal Year 91," Washington Department of Corrections. Division of Management and Budget, Planning and Research Section.

16 Interdepartmental memorandum from S. Thomas Barkley to Ruben Cedeno, dated November 21, 1991. A total of 13,724 were assessed in the 45 months between January, 1988 and October, 1991. Another 1,911 inmates were assessed but their records were not found or were incomplete. A later memorandum amends these results, counting users as early stage, combining abusers and early stage as middle, and combining middle and late stage as late. We have chosen to use the figures from the more detailed memorandum as the more accurate account of the findings.

substances, but not be dependent on them. The remaining 59 percent of the 11,813 assessed inmates were found to be chemically dependent. Sixteen percent were early stage; 22 percent were middle; and 21 percent were late.[17]

Reception Units (R-unit): Classification

During the R-units classification process any court or ISRB requirements for treatment surface. These are already part of the central file. If mandates for treatment should be a consideration in initial or later classification, this is when that information begins to influence placement decisions.

Prior to sentencing reform a judge could and did order offenders into treatment, including chemical dependency treatment. If the judge did not do so, then the Parole Board, now the ISRB, could and did. Since the advent of sentencing reform, the limits on court ordered treatment are so narrow that effectively no one serving a prison sentence is ordered to receive chemical dependency treatment.[18]

Judges and others still may *recommend* treatment. During an earlier examination of more than 3,400 Judgment and Sentence records in various counties, this research team found very few instances in which a judge *required* chemical dependency treatment, but many instances in which a judge *recommended* chemical dependency treatment, if space was available (Bell and Fallen 1990).

Some mandates for treatment are introduced after a prison sentence begins. The ISRB may require treatment following a Board hearing. Thus not all mandates are known at the time of initial classification.

Institution

Once an offender has been transferred to his/her institutional home, the classification counselor manages his/her program, including the process of referral for chemical dependency treatment evaluation.

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17 Most inmates (74%) assessed using that measure were found to have some degree of dependency; only 26 percent did not. Twenty percent were found to be chronic or late stage drug or alcohol abusers. R-unit test results complied by Dr. Ron Jemelka. Only about half these data matched this study population, so a merge was not done. These data are incomplete. Half have no test results for drug abuse. Half have no test results for alcohol abuse. Still they can be combined into a single measure of dependency.

18 First time offender waivers are one way to order treatment. These sentences do not include prison time. Sex offenders can be ordered to treatment. Residential treatment can be substituted for jail time but not for prison time.

Institution: Referral for Assessment

It is the responsibility of the classification counselor, usually working with a team of his/her peers, to refer inmates for assessment by the chemical dependency program counselor. The specifics of how these people manage and handle referrals varies from institution to institution.

Field instructions unique to an individual institution detail those procedures. Field instructions also incorporate instructions from other divisions within DOC or from outside agencies. The field instructions may include how to meet the requirements of ISRB, the conditions for placement on work release, and the results of institution infractions.

The referral form itself requires the classification counselor to indicate three documented examples of chemical use/abuse. Staff are to use specific examples from sources, such as rap sheets, drunk driving offenses, pre-sentence investigations, the chemical dependency section of the central file, and/or institutional infractions.

Staff team recommendations, offense history, and inmate requests were the most common reasons listed in the records we examined. Mandates were *not* common. In reviewing the central office records for the study participants (N=1,550), we could find only 220 people with mandates to treatment.

The form concludes with information on requirements for evaluation and for completion of the program. With each requirement the classification counselor specifies who has made the requirement: ISRB, the Superintendent, Work Release, the Court, or Headquarters (Olympia). Any requirement is to be accompanied by a "copy of the mandate." We saw many forms in which "required" was crossed out and replaced by "recommended" or "requested." We saw very few copies of the mandate. All were from the ISRB.

Two events prompt the classification counselor to assess an offender's need for chemical dependency treatment. One is the custody review. The other is the approaching release and the need to meet any requirements before that date. Perhaps of even greater importance is that the inmates ask to be assessed.

Custody Reviews

The custody review occurs yearly or bi-yearly, or as the result of significant behavior. The review is handled by the classification counselor(s) and may include other staff of the living unit. They generate a score for each offender.

The score combines five pieces of information: current custody designation; infraction behavior; program behavior; detainers; and escape history. That score is critical to an inmate moving to a lower custody level. Lower custody levels provide access to more activities, family visits, better jobs, and treatment programs.

Two of these are central to the treatment of the chemically dependent inmate. One, s/he may have chemical dependency infractions and consequently may score poorly. Two, s/he wants to get into chemical dependency treatment in order to earn program credits and gain access to other activities.

The inmate can earn a maximum score of 12 points a year through programming. S/he earns program credit during a given month if s/he:

> Programmed at least 66 hours (per month) or was on an approved waiting list; and was not terminated for cause from a work assignment, did not quit a work assignment without proper approval, or did not refuse a work assignment.
>
> Was on PC status, in reception, medically restricted, or in other similar circumstances and met the expectations of the status and did not refuse any work assignments.
>
> Was in work release or pre-release and met the minimum work/program expectations of the facility.

Mandates

There are four mandates which affect whether an offender is referred for chemical dependency assessment and, to some degree, the priority order in which they are referred.

The court may mandate treatment. In this case, the inmate's judgment and sentence (J & S) includes a referral to chemical dependency treatment. With the limits on court ordered treatment, this is more truly a recommendation for a chemical dependency assessment and treatment, if needed. These are the cases for which treatment is required according to the Judgment and Sentence form.

- Only 2 percent of the inmates in the study population were mandated by the court.

The ISRB may mandate treatment. The inmate wants to appear before the parole board at an 0.100 hearing, to determine if s/he is eligible for early release. The Board may require that the inmate be assessed for chemical dependency or complete a chemical dependency program before this hearing. This stipulation is based on file materials, including his/her offense history and indications of chemical dependency.

- Six and one half percent of the inmates were mandated by the ISRB.

The Division of Community Corrections or Division of Prisons staff may mandate treatment. A committee/team of Community Corrections classification staff or Division of Prisons classification staff determines whether or not an inmate needs chemical

dependency treatment. Then, the superintendent of the institution where the inmate is living "signs off," thus mandating the committee's deliberations.

This mandate arises primarily from Community Corrections' stipulation that persons going to work release have chemical dependency treatment, if such was needed, before being placed in work release.[19] Per Division Directive (EX300D-W), *work release is prohibited* for offenders who:

> "have a documented chemical dependency history or pattern directly related to the offense and have not had a chemical dependency assessment or have refused a chemical dependency assessment; or have not completed the required Division of Prisons/Pre-Release Chemical Dependency Program and for whom no other treatment options have been indicated."

- Five percent of the inmates were required to have treatment in order to meet the conditions of the classification committee.

Most of these conditions were required prior to approving an inmate for work release. However, the precise number for which treatment was a condition of work release *placement* is not known. We heard inmates, institutional and treatment staff describe the unavailability of treatment as an impediment to placement in work release.

The Headquarters Community Screening Committee (HCSC) may also mandate chemical dependency treatment. This Olympia-based committee may determine whether or not an inmate needs chemical dependency treatment to proceed to work release. This is usually an override to a field decision in which classification staff cannot agree on a recommendation.

- One percent of the inmates were required to have treatment because of an action by the HCSC.

There may be another mandate which affects treatment: one which Child Protective Services (Division of Children and Family Services, Department of Social and Health Services) places on women offenders who have had their children removed from their home. We were told by WCCW staff that this requirement may result in certain women being referred for treatment. Whether this situation exists at any other institution that houses women or men, we do not know.

A mandate is believed, by institution and treatment staff, to be the determining factor for referring an inmate to chemical dependency assessment. However, only 14 percent of the inmates studied had such a mandate. The research team's review of 300 treatment agency records found only a handful in which the word "mandate" was used.

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19 This policy is currently (12/92) being changed.

As noted earlier, classification staff making referrals are required to list the reasons for a referral. The research team coded the reason listed first unless there was a secondary reason which was more nearly a mandate. The results are shown in Table 7.

Table 7

REASONS FOR REFERRAL TO CHEMICAL DEPENDENCY ASSESSMENT

REASON	PERCENT
Required for work release	(1.7)
Psychological evaluation	(0.3)
Offense history	(22.7)
Inmate request	(22.7)
Unit classification team/counselor	(9.0)
Court	(2.3)
DCC (Division of Community Corrections)	(1.0)
HSCS	(1.0)
ISRB	(17.0)
None	(22.3)

In those records we saw frequent use of the word "recommend." If a recommendation for treatment means an inmate does or does not get into work release, then the recommendation carries as much weight as a requirement. Both institution and treatment staff often interpreted "recommendation" to mean "requirement."

Even ISRB *requests for assessment* became requirement for treatment. And the monthly data forms transmitted to headquarters reflect the mutation of request and recommendation into requirement.

Earliest Release Dates

Institutional staff calculate and recalculate earliest release dates. These dates are based on sentence lengths and the provision of good time. As the inmate accumulates

infractions or gains good time, the date changes. For staff and inmates it is a marker against which progress is measured.

Treatment requirements become critical as release dates approach. This is particularly significant for chemical dependency treatment since, according to headquarters staff, it is supposed to occur within the last months of incarceration.

Most people in the field assume the referral period to be three years before release. So that, if someone had a planned earliest release date, commonly called a PERD, of 6/30/94, s/he would be eligible for assessment after 7/1/91.[20] Per headquarters staff the referral should be timed to precede treatment by weeks, not months or years.

Assessing the timing of treatment and release with available DOC data proved to be difficult. The data provide only a rough estimate (based on "treatment" date) of when an inmate ends treatment or is assessed.[21] But no specific information on when s/he completes treatment. Further, release dates for approximately half of the study population involve projected dates (PERD), which adds another measure of uncertainty to the data.

Thus, analysis of this issue was confined to those in the study population (N=771) with an actual release date following their "treatment" date. These data indicated that approximately 80 percent were in treatment or had been assessed within six months of their release date.

Treatment Assessment

If a person has been assessed at one institution and transfers to another before entering treatment, it is common that s/he is assessed again. In some instances treatment staff will try to get a person's treatment record from his former institution in order to avoid repeating this step, but this was not usual practice during the study period. This is particularly evident from examining the breakdown of treatment hours by individual. Assessment referrals go from the classification counselor in the living unit to the Chemical Dependency Correctional Unit Supervisor (CDCUS). There are three CDCUSs: one at McNeil Island, one at Washington State Reformatory (WSR) and one at WSP.

The CDCUS at McNeil Island manages chemical dependency programs at seven institutions. The CDCUS at WSR manages the programs at five institutions plus four

20 ERDs, or earliest release dates, are slightly different and assume the worse case, i.e., the parolee does not get released when the ISRB next hears his case.

21 Treatment date here is the last month in which a client had contact with treatment staff as reported to the Division of Offender Programs.

work release facilities. The CDCUS at WSP manages programs at three institutions plus one work release facility east of the mountains.[22]

Evaluation referrals come from unit classification counselors on a regular basis. The CDCUS turns to OBTS to confirm the inmate's PERD and to discover if the inmate has been assessed previously or completed treatment within DOC. If he learns that the inmate has a DOC treatment history, he requests the previous record of assessment or completed treatment.

When the CDCUS determines the inmate should be assessed, he notifies the classification counselor to prepare the inmate for an assessment. The classification counselor already has on hand a packet of information which the inmate must fill out before his assessment appointment with a treatment counselor.

The packet includes the drug abuse rating battery, the revised alcohol abuse rating battery (Jellinek)[23], a social history, which includes chemical dependency history, and a release of confidentiality. The information requested at this point varies from one agency to the other, but both use the same rating batteries. One agency focuses on family history of chemical dependency; the other is more concerned with psychological factors.

The inmates chosen for assessment are "called out." That is, they are notified through a bulletin board posting of the scheduled interview time. For those with jobs in the institution this may mean getting excused from work, or trading work assignments with someone else.

The actual assessments are performed by treatment counselors, who are employees of one of the contractor agencies: Lakeside Foundation or Social Treatment Opportunity Programs (STOP). In some instances the Department of Corrections CDCUS performs assessments in order to alleviate a backlog of referrals.

Usually the same counselor who will lead the next class in a living unit assesses potential clients for that class. Many counselors believe this is an opportunity to meet the client privately, and to establish contact, if not rapport.[24]

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22 By the end of 1992, DOC will provide treatment programs at two more institutions: Coyote Ridge and Airway Heights.

23 Both the drug abuse rating battery and the alcohol abuse rating battery are the same instruments the inmate completed while in the Reception Units at WCC.

24 At this point the inmate is called a client. This may seem a minor matter to some, merely a semantic difference. However, the chemical dependency counselors believe this change in terminology is the first step in enhancing the inmate client's self worth, and hence, the first step in his/her recovery.

The counselor generally does not assess inmates while conducting classes. This means that assessments occur within a several week block following one class and preceding the next. The result can be a backlog of assessments, which may be picked up by a treatment counselor who comes from another institution just to assess clients.

Inmates complete the assessment packet materials in their living areas and bring these with them to the assessment. Each counselor reviews the materials with the client during the one hour interview, asks additional questions, and makes a judgment about the client's dependency.

Although some counselors complain about the amount of paper to be reviewed and discussed in the interview, they acknowledge the paperwork is necessary for an accurate assessment of the client's chemical dependency. Some counselors state that they can make the judgment within one half hour.

Others may break the interview into two parts. Sensing that the client is in denial from their answers to questions about their drug and alcohol history, the counselor will break off the interview and schedule the second half for a later date. In the interim they review materials in the client's central file to see what others have learned about this offender's chemical dependency, or what prior treatment s/he may have had.

Counselors changed the level of dependency from that shown in the rating batteries. The rating batteries in the treatment files would suggest that the person had little or no problem with chemical dependency, the counselor assessed him/her as a late stage dependent. Counselors argue that this occurs when clients deny their addiction. The infrequent reader of the file may miss the change from one to the other.

This would suggest that the treatment counselor relies more on his or her own judgment of the client based on the assessment interview than on any written tests.

The ATR (assessment and treatment recommendation) form is the result of the treatment counselor's meeting with the client. The form begins with several questions, which, if answered negatively, will keep one from proceeding further.

In some cases the counselor determines that the inmate has no symptoms. In the 300 case files reviewed at WSP and McNeil Island, there were 12 cases in which no dependency was found.

If the inmate has a dependency, s/he is then assessed for which substances are the primary and secondary dependencies and the stage of each dependency. The most common dependency found in the 300 cases reviewed was alcohol, either alone or in combination with marijuana or cocaine. Two-thirds were found to be dependent on alcohol, 14 percent on alcohol alone, 21 percent on alcohol and cocaine, and 22 percent on alcohol and marijuana. (See Table 8.)

Table 8

PRIMARY AND SECONDARY DEPENDENCIES
WSP AND MCNEIL ISLAND INMATES ASSESSED FOR TREATMENT

		SECONDARY						
		Alcohol	Cocaine	Marijuana	Heroin	Other	None	TOTAL
PRIMARY	Alcohol		29	49	6	15	41	140
	Cocaine	33		18	4		8	63
	Marijuana	16	9			4	9	38
	Heroin	11	18	5			2	36
	Other	2	1	4	1		2	10
	TOTAL	62	57	76	11	19	62	287

Of the 287 WSP and McNeil Island inmates assessed as chemically dependent, half were late stage in their primary dependency. Those who were middle stage were more likely to be dependent on alcohol, cocaine or marijuana. Few persons addicted to heroin or other drugs were assessed as early or middle stage. Only 5 percent of the group were considered early in their primary dependency.

Secondary dependencies were less likely to be late stage. A significant number of inmates (22%) were found to have no secondary dependency. Among those inmates assessed as having both a primary and a secondary dependency there was a high and statistically significant correlation between stages of both dependencies; that is, if the inmate was assessed as middle stage on the primary dependency, the probability is quite high that s/he would be assessed as middle stage on his/her secondary dependency.

Finally, the counselor recommends one of several types of treatment s/he considers appropriate for this client. The recommendations are a combination of prison-based and community-based treatment, of the various residential, outpatient and aftercare modalities.

Table 9

CLIENT ACCEPTANCE OF TREATMENT BY INSTITUTION

INSTITUTION	REJECTED BY STAFF		REFUSED BY INMATE		ACCEPTED		TOTAL
	#	(%)	#	(%)	#	(%)	
Clallam Bay	1	(2.2)	1	(2.2)	42	(95.5)	44
Cedar Creek	12	(15.7)	2	(2.6)	62	(81.6)	76
Indian Ridge	4	(7.6)	0		48	(92.3)	52
Larch	4	(8.0)	1	(2.0)	45	(90.0)	50
McNeil Island	7	(6.4)	3	(2.7)	98	(90.7)	108
Olympic	5	(4.3)	1	(0.8)	109	(94.8)	115
Pine Lodge PR	21	(9.0)	1	(0.4)	209	(90.5)	231
Tacoma PR	18	(9.0)	1	(0.5)	181	(90.5)	200
Twin Rivers	3	(5.4)	2	(3.6)	50	(90.9)	55
WCC, Shelton	4	(2.1)	5	(2.7)	175	(95.1)	184
WCCW	0		4	(7.1)	52	(92.9)	56
WSP	0		1	(0.5)	204	(99.5)	205
WSR and WSR-F	11	(7.0)	10	(6.4)	135	(86.5)	156
Total	90	(5.9)	32	(2.0)	1410	(92.0)	1532

At this point the client may choose to accept treatment or may refuse it. All the treatment counselors interviewed were clear in pointing out that it is the client's option to refuse the chemical dependency program. Within the study population of 1550, only two percent refused the program. (See Table 9.)

It is here that the client's denial, which is part of his/her dependency, may be greater than his/her need for treatment. At the same time the counselors were honest about encouraging clients with serious dependencies to accept treatment.

The client's acceptance or rejection of treatment marks the end of the assessment process. Following the assessment process, the treatment counselor then returns the ATR form to the classification counselor.

At this point the inmates presented for assessment have been divided into two groups: those who refuse (2%) or are rejected for treatment (6%), and those who accept treatment (92%).

This group was also examined by the following variables: age, race, gender, type of offense and prior offenses, and there were no differences found between those who refuse or are rejected for treatment and those who accept it.

Selection for Treatment

Acceptance does not necessarily mean participation in treatment. There are several ways by which an inmate can accept, but fail to enter, treatment. For example, some inmates may have been transferred by the time a treatment slot is available. Others may infract prison rules, and not be available for treatment.

There is considerable variation from one institution to another in how clients are selected for treatment. Usually the Correctional Program Manager (CPM), or living unit supervisor and the classification counselor(s) recommend a group of 20 plus inmates for each program cycle, and the chemical dependency CUS makes the final selection.

Generally the treatment counselor is not part of this process, although some participate on occasion. Most treatment counselors do not like being part of the selection process, preferring to remain separated from the decision(s) that result in a client coming to treatment.

It is here that the treatment counselor's reputation with other inmates (previous clients) first becomes apparent. If the counselor is perceived to be a "good guy," a "square shooter," the reluctant inmate is more likely to agree to participate.

Nearly all inmates are eager to "program" as this will increase their point score and move them toward less restrictive housing, work release, or release from incarceration. However, some with paying jobs at the institution find the scheduling problems more onerous.

The research team heard from treatment staff that scheduling was sometimes a problem for inmates. But institution staff interviewed say no. They were emphatic that chemical dependency treatment gets the highest priority of any programming in the institution. It

is possible that this priority may not be as clear among institution staff directly responsible for work assignments.

The decision to participate in treatment appears to be left to the inmate, but there is considerable pressure on him to participate. As someone has pointed out, this is not college, and this program is not an elective. Thus, some who initially said they would not participate ultimately do so.

SUMMARY

The expected process links Reception Center diagnostics, mandated requirements for treatment, pending release dates within the year, and recent behavior as measured by infractions, etc., to referral for assessment by the unit classification counselor. In fact, the Reception Center diagnostics appear to play a minor part. There are few mandates, less than 15 percent.

With the exception of ISRB requests for evaluation, reasons for referral have more to do with offense history and the inmate's desire to be reclassified or placed on work release. Sentences are short so most of these inmates are already within the time frames by the time they are transferred from WCC (Shelton).

The expected process has significant numbers of inmates referred and *assessed* by treatment staff[25]. In practice, as many as 80 percent of those nearing release are assessed. Inmates complete forms detailing their histories for treatment staff. These materials plus an hour interview comprise the assessment.

Only six percent of those assessed are rejected as inappropriate. The majority are found to be middle or late stage in their dependency. Most are probably dependent on alcohol, in conjunction with cocaine or marijuana. File documentation of these findings is largely the inmate's self report of abuse.

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25 The study participants included all persons assessed during a six month period and those in treatment in July 1991, having been assessed earlier. An estimate of annual assessments can be made by removing those treated in July and early August. Just over 2,500 were assessed. During FY 1991, 3,277 were released.

REFERENCES

Bell, M. M. and Fallen, D. Changes in Jail Felony Populations: Comparing 1982 to 1988. Sentencing Guidelines Commission, Washington State Department of Corrections, Olympia, WA, 1990.

THE INSTITUTIONAL TREATMENT PROGRAM

INTRODUCTION

Prison-based chemical dependency treatment is provided by two non-profit agencies, operating on contract with the Department of Corrections. The form of that treatment follows the basic outline of community-based intensive outpatient treatment. Each client is provided four hours of individual counseling, 60 hours of classroom instruction, and 27 hours of group therapy. S/he is required to attend five meetings of a self-help support group, such as Alcoholics Anonymous or Narcotics Anonymous. Discharge plans provide clients with recommendations on the next steps in recovery.

Twenty-six FTE treatment staff assessed 1,593 clients in FY91. Ninety-two percent were assessed and accepted for treatment. Seventy percent entered treatment. Ninety percent of those who entered treatment completed its requirements.

The cost in FY91 was $1,053,178 or $661 per person assessed; $1,020 per person entering treatment. This cost does not include facility and other services provided by DOC. If these costs were added, it would still compare favorably to the $1,275 per person approved by the Division of Alcohol and Substance Abuse for publicly funded community-based intensive outpatient treatment (Bell and Murray).

Table 10 shows the number of people (984) entering treatment during the study time period. This figure is based on the number of people who were accepted for treatment (1410) less the number of people who did not enter treatment.

Those not entering treatment represent the backlog of people waiting for treatment. There is a considerable variation in the backlog from institution to institution. Many of these people may have been admitted to treatment following this study. Others were released or transferred without receiving treatment.

There were no differences between those who entered treatment and those who did not based on age, race, gender, type of offense and number of prior offenses.

Table 10

CLIENT ENTRANCE INTO TREATMENT BY INSTITUTION

INSTITUTION	DID NOT ENTER		ENTERED		TOTAL ACCEPTED
	#	(%)	#	(%)	
Clallam Bay	2	(5)	40	(95)	42
Cedar Creek	25	(40)	37	(60)	62
Indian Ridge	21	(44)	27	(56)	48
Larch	16	(36)	29	(64)	45
McNeil Island	18	(18)	80	(82)	98
Olympic	46	(42)	63	(58)	109
Pine Lodge PR	46	(22)	163	(78)	209
Tacoma PR	39	(22)	142	(78)	181
Twin Rivers	11	(22)	39	(78)	50
WCC, Shelton	108	(62)	67	(38)	175
WCCW	11	(21)	41	(79)	52
WSP	11	(5)	193	(95)	204
WSR and WSR-F	72	(53)	63	(47)	21
Total	426	(30)	984	(70)	1410

The following descriptive materials come largely from interviews with treatment agency and DOC staff. Their willingness to discuss their program responsibilities and their concerns adds significantly to this section. They describe the treatment program in some detail, including information on themselves and the treatment they provide.

TREATMENT PROGRAM

Treatment is divided into three segments based on the community-based intensive outpatient program developed by the Division of Alcohol and Substance Abuse: classroom instruction, group therapy, and individual counseling. Clients are also expected, in some facilities required, to attend five meetings of a self-help group during treatment. This treatment program lasts approximately six weeks, with classroom instruction and group therapy taking half days four or five days each week and individual interviews (counseling sessions) the other half days.

Intake

All counselors and clients discuss, in detail, the information packet which the client has filled out in his own unit. Everyone agrees that a skilled interviewer can learn as much from the client face-to-face as s/he can learn from the forms and tests. All counselors speak of denial in this client population as the first obstacle to overcome in proceeding with treatment.

The research team examined individual treatment files at McNeil Island (N=94) and WSP (N=206). The social history information on each client was incomplete, probably because the client fills out this information prior to his first appointment with a treatment counselor. Further, each agency asks different questions about a client's social history.

Fifty-five percent of the WSP clients (N=104) and 67 percent of the McNeil Island clients (N=48) had been in one treatment program previously. Twenty-three percent of each group had been in treatment twice previously.

The average age at which these clients first used chemical substances, mostly alcohol, was 15.7 years. Thirty-two of them had first used chemical substances under age ten, several under age five.

STOP, the agency which runs the treatment program at McNeil Island, asks questions about family history, including use of alcohol and drugs. Lakeside, the agency which runs the treatment program at WSP, asks questions about mental health. Hence, responses to family history are for McNeil Island clients only and responses to mental health questions for WSP clients only.

McNeil: Several questions were asked about other family member's drinking and use of drugs. Twenty-nine of thirty clients responding answered yes when asked if family members drank regularly; twenty-seven clients answered yes when asked if family members got drunk. Six out of seven clients who responded answered yes when asked if family members used drugs.

WSP: Several questions were asked about the client's thoughts of suicide and attempts at suicide. Eighteen percent responded that they had thought of

suicide, and 11 percent had made a suicide attempt. Ten percent had a history of depression.

The two treatment agencies perform intake differently. Lakeside counselors combine assessment and intake into one step, using their interviewing skills to elicit accurate information from the client. They rely heavily on the alcohol and drug history (Social and Emotional Behavioral Assessment) to ferret out inaccuracies in the client's life history.

STOP counselors take a chemical dependency profile at assessment and a second at intake. The latter looks at how much of what drug(s) was taken when. They discuss, in detail, a client's lifestyle, probing for honest disclosure. They also begin to develop a treatment plan with a set of case notes with the client. Intake, then, is the first one-on-one counseling session.

Whichever agency procedure is used, the net result is the same: to discover the client's dependencies and to get the client to acknowledge these dependencies.

It is, of course, more difficult to schedule two interviews before the program begins than only one, and the scheduling at some institutions may seriously inhibit this process. But there appears to be benefit—to the client and to the program—in the two step approach.

Instruction

The classroom instruction is 60 hours of education on alcohol and drugs, their pharmacology and effects on the body; the progression of addiction, and the influences of family and friends on addiction; group therapy, characteristics of chemically dependent persons and personalities; sexually transmitted diseases and AIDS education; anger management and stress management; decision making, problem solving and goal setting; communications; grief and loss; relapse and aftercare.

Nearly every counselor will add to or subtract from the materials within the education component to suit his or her own teaching style and personality. Some use videos with lecture materials; some use client participation to present materials (such as reading aloud one segment, then discussing it); some use outside speakers to enhance and illustrate the written materials. Nearly all insist that clients write out their thoughts and feelings during treatment.

The STOP program uses a large workbook which has assignments (homework) for nearly every topic discussed. The client has his/her own copy of the workbook, and uses it throughout the treatment sessions.

The Lakeside program also uses a handbook which has materials relevant to each topic discussed. However, the handouts or assignments are left to the individual counselor to devise and develop.

Independent of this study, DOC asked a group of approximately 150 clients who completed chemical dependency treatment about their knowledge of alcohol, both pre- and post-treatment and drugs, pre- and post-treatment. The results can be found in the following talbes.

Clients scored well on the alcohol test prior to treatment. The differences between knowledge of alcohol pre- and post-treatment were slight—in part, because most already knew the correct answers. There were, however, four of the fifteen questions with significant differences.

1. Which parts of the brain were affected by the sedative effect of alcohol.
2. The blood alcohol level at which a driver is legally under the influence of alcohol.
3. The factors which would result in lower blood alcohol level for a given quantity of alcohol.
4. The early warning symptom of alcoholism.

From 23 percent to 56 percent more knew the correct answer to these questions following treatment.

The results of the drug knowledge test were quite different. Generally speaking the level of knowledge about drugs was much lower, and the improvement in knowledge was much greater.

There were only six questions out of 35 in the drug test in which answers pre- and post-treatment were similar.

They did know:

1. Drugs which create a physical dependence cause emotional and physical craving and a need to increase dosage.
2. The description of a person who has taken more than a prescribed amount of a barbiturate.
3. The description of a person who has taken more than a prescribed amount of a narcotic drug.
4. What happens when an unborn baby's mother is a narcotic opiate addict.
5. Which mental faculty (imagination) is intensified by taking hallucinogens.
6. Caffeine is a drug found in tea, coffee and coke.

On the remaining questions scores were noticeably improved from pre- to post-treatment.

Group Therapy

The group therapy sessions, which are 27 hours, are folded into the classroom instruction period. Participants discuss and ventilate frustrations, try to resolve problems, practice assertiveness in place of aggressiveness, and deal with issues around their own personal growth.

Many counselors will rearrange the space for the group session, removing tables and arranging chairs either in a circle or a square. Most believe this is an important signal that the emphasis of the treatment program has shifted from instruction to participation.

Most counselors describe the group component as the opportunity to discuss the day's educational topic as it relates to the participant's experiences. Although clients are permitted to express themselves freely, they are still cautioned to respect other's opinions and feelings. The underlying structure of the program is still maintained.

The education and group components of treatment are held in a typical classroom atmosphere in an area of the institution or facility where other classes, such as English, math, and computer science are taught. There are large windows opening on the halls, and the doors may be open. There is very little privacy in this environment, and one wonders how open and expansive a client may be willing to be.

Of course, the atmosphere of a prison institution, itself, is not conducive to "sharing" one's feelings. The inmates' pecking order of offenses, their lifestyles, and their ethnic backgrounds all influence their openness. In fact, many counselors comment that they are surprised clients reveal themselves *at all* in group sessions.

<u>One-on-One Interviews</u>

The one-on-one interviews with clients are individual counseling sessions, at least four per person, lasting about one hour per session. During these sessions the treatment plan is worked out, discussed, and refined.

The treatment plan, developed at intake (STOP) or during the first one-on-one (Lakeside), is the outline around which the counseling sessions are based. It usually includes some of the following issues: lack of knowledge of disease, need for sober support systems, education about one's dependency(s), and understanding relationships with family members. During each session the client and counselor agree on the next steps the client needs to take, and the client acknowledges his agreement by signing the treatment plan.

The treatment plans we examined had a generic look to them as though nearly everyone had the same problems. Although this may be true to some degree among an incarcerated client population, we inquired about the plan's lack of specificity.

Several counselors mentioned their concern about who may read a client's file, particularly someone who might use that knowledge against a client. They also say that a fellow counselor, filling in for a day or so, can read between the lines to discover what are the specific issues for this client.

The one-on-ones are often scheduled all at once at the beginning of a treatment cycle: every Tuesday at 1:00 for five weeks is one client's assigned time. Counselors find this serves two purposes: to give the client a specific time and place to discuss his/her own

issues; and to give some leeway for institution activities that may conflict with an interview.

Interviews are usually held in a different setting than the classroom. If the counselor has a private office, the interview is held there. If not, it is held in a conference room, or other private space. Some people with glass windows in their offices have requested blinds or curtains to protect the clients' privacy. They want a setting in which the client will feel safe to express him/herself.

A self evaluation survey was conducted during the study period; 205 clients in five institutions participated. Their satisfaction level with chemical dependency treatment was high. Nearly all rated their instructor(s) great or good; nearly all would recommend the program to other inmates.

When asked about which parts of the program were most helpful, clients were equally divided between individual counseling and group sessions. About three quarters felt they got as much individual counseling as they wanted. When asked which of six skills were most helpful, the clients found problem solving, communications, and assertiveness equally helpful.

These comments were similar to those which research team members heard from clients at WSP and McNeil Island. A request for longer program sessions was also heard, both from self evaluations and direct conversations.

As noted previously, there were some clients with 91 hours of treatment (which is the minimum number of hours for completion) and others with considerably more hours (up to 150). Initially we were told that those with additional hours were clients who had returned to talk with a treatment counselor following their treatment.

However, a careful examination of the treatment hours by individual client showed that about 10 percent of the people with additional hours had entered treatment, been discharged and re-entered, usually in a different location.

Structure of Treatment Program

WAC requirements specify that DASA funded programs shall limit group counseling sessions to no more than twelve clients. DOC requires the treatment agency to begin each class with 20 clients. The format is open exit, closed entry; that is, clients may drop out during the program cycle but they are not added after the first day.

The length of each day's session, the number of sessions each week, and the number of weeks the program runs varies from one institution to the next. Despite these variations, each cycle lasts 91 hours.

Three and one half hours is the average length of each day's session; this is usually divided into two thirds education and one third group, with one or two breaks between. Breaks are often determined by "movement" or "count" by institution staff.

Treatment program sessions are usually held at the same time of day as other educational programs, generally in the morning. At many institutions college credit is given for completing this program.

The program usually runs four days each week with the fifth day set aside for completing treatment notes or other outstanding paper work. Some counselors use this day for individual counseling appointments; others prefer to squeeze them in during the four days of program.

Depending on the press of pending clients, some counselors work four ten-hour days, taking the fifth day off. This is always done with the approval of the agency director and the CDCUS.

Six or seven weeks is the typical length of the program cycle although Tacoma Pre-Release runs its treatment program in five weeks.

The frequency of the treatment cycle also varies from one place to the next. At Tacoma Pre-Release, Pine Lodge Pre-Release and WSP treatment cycles start one week after the next. If there are three counselors available, there are three programs running, each of them running in succession to the other. Thus, treatment staff can help one another problem solve a situation, or spell one another, if one person is ill.

At WSP, the counselors run the treatment program in a specific living unit: maximum security (inside), medium security, minimum security, and protective custody. Further, there is a counselor who comes into the institution to run a Spanish speaking treatment cycle as the number of clients accumulates.

At McNeil Island, there are two counselors, one at the main institution and one at the Annex. Each operates his/her program independently of the other, primarily because they are physically separated by a mile or so.

At the rest of the institutions there is only one treatment counselor, who must arrange cycles to fit the institution's schedule and his agency's commitments.

At Larch, Cedar Creek and Indian Ridge, for example, the treatment cycles are arranged to fit the institutional schedule for fighting fires. Generally there is no treatment program during the dry months of the year.

Treatment Follow-Up

A discharge plan is written for each client who completes the treatment program. It, like the treatment plan, is somewhat generic. Even so, it is unusual for a counselor *not* to

recommend aftercare. This is over and beyond recommendations to AA or NA, which are considered seminal to recovery.

Unfortunately, institutional aftercare is not a clearly organized or defined program. At the present (10/92), aftercare is running only at WCC (Shelton) and McNeil Island; it is soon to start again at WCCW (Purdy). The counselor must stimulate interest in aftercare by contacting former clients, talking with them about their own recovery issues, and encouraging them to attend the sessions. Without this steady promotional activity (in advance of the session), aftercare seems to fall flat.

Because aftercare operates as a voluntary program, clients in the institutions are free to attend or not. Further, it occurs at a time of day when clients may have other activities scheduled, such as work or physical recreation.

Institution staff, who support the idea of aftercare, say it is a difficult program to monitor as it usually runs during evening hours after program staff go home. Because they cannot see it operating, they wonder how it is operating.

This is a program that everyone, institution and treatment staff, endorses but few implement. From our reading of treatment literature it is apparent that the longer the treatment the better the outcomes. Aftercare certainly contributes to the longevity of the treatment process.

Treatment staff also recommend post-prison treatment. The treatment can be either while on work release, in the community, or both. The most common recommendation is aftercare; half were told they should seek aftercare. Just over a third were told to enter an outpatient program, 16 percent an intensive outpatient program. Less than five percent were told they should enter an inpatient program.

Institutional Setting

The research team anticipated finding different circumstances in various institutional settings that might affect treatment. For example, programming conflicts might impact an inmate's ability to participate in the treatment program. The need to take certain classes for a GED, or work assignments might take precedence over treatment classes.

All of the institution program managers stated emphatically that the treatment program took precedence over any other programming, including work, in the institution.

TREATMENT STAFF

When the chemical dependency program was begun in Washington's institutions, there were four treatment agencies, each of whom was responsible for a catchment area of institutions. Today there are two agencies, each responsible for portions of three catchment areas. Together they employ 19 people who run treatment programs full-time at the institutions and one person on contract.[26] This is fewer FTEs than the program employed in the last biennium.

Agencies

Lakeside Foundation, headquartered in Bothell, Washington, is responsible for treatment at WSP and Pine Lodge in Eastern Washington and Clallam Bay, Indian Ridge, Washington State Reformatory, WSR Farm, Twin Rivers, and Olympic Corrections Center in Western Washington. They presently employ 11 people who run treatment programs at these locations: four at WSP; three at Pine Lodge; one each at Clallam Bay, WSR, Twin Rivers, and Olympic. The person at Indian Ridge alternates program there with program at WSR-Farm. There is also one person under contract who runs Spanish speaking program at WSP as need arises.

STOP (Social Treatment Opportunity Programs), headquartered in Olympia, Washington, is responsible for treatment programs at Cedar Creek, Larch, McNeil Island, Washington Corrections Center (WCC), Washington Corrections Center for Women and Tacoma Pre-Release, plus aftercare at WCC and McNeil Island. They presently employ 8 people who run treatment programs at these locations: two at McNeil Island; two at TPR; and one each at Cedar Creek, Larch, WCC, and WCCW. The people at Cedar Creek and Larch alternate program at these institutions with program at TPR.

Our concern was with the programs at the institutions, not the work release facilities. So the information that follows is confined to these locations.

Counselors

The treatment counselors are, without exception, a thoroughly dedicated, committed group of people who care deeply about their clients. But they are not "bleeding hearts." In fact, they are quite stern of demeanor and demanding of standards.

Starting with assessment they begin the process of getting the clients to take responsibility for their actions, including those which have brought them into prison.

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26 This figure does not include the directors of each agency or staff support people at each agency who compile data. Staff assigned exclusively at the work release centers, which were not part of this study, are also not included.

As long as the client is willing to work within the program's limits, the counselor will spend time inside and outside class talking, advising, and counseling the client. However, should the client choose to ignore the program's rules, or refuse to work on his/her own issues, the treatment counselor may dismiss the client, and will not permit him/her to re-enter the class.

Their Personal Experiences

DASA requires that qualified counselors have:

> "no history of alcohol or other drug misuse for a period of two years immediately prior to the time of employment as a chemical dependency counselor and no misuse of alcohol or other drugs while employed as a chemical dependency counselor..."

Most of the counselors are recovering alcoholics or addicts. Only three of the group we interviewed are not, and they have family members who are abusers. Everyone who is recovering talks openly about his or her recovery, and shares these experiences with their clients in the classroom. Some attend AA or NA in the institution alongside their clients.

Two-thirds of the group have been offenders themselves: some with a history of DWIs, others with felony convictions. They generally share these experiences with their clients, too.

Their Professional Experiences

DASA also requires that qualified counselors:

> " have obtained a minimum of 24 quarter hours (16 semester) credits of course work in an accredited institution of higher learning (college or university) which must include distinct courses in survey of chemical dependency; physiological actions of alcohol and other drugs; chemical dependency counseling techniques; group process in chemical dependency treatment; chemical dependency in the family; case management of the chemically dependent client. The remaining credits may be in other courses that will enhance competency, such as alcoholism and other drug problem course work, counseling, psychology, sociology, speech, and social work.
>
> "...have completed and documented 2,000 hours (one year) of full-time work as a trainee in an approved (by DASA) facility; and have maintained qualifications by completing 60 hours of continuing education during each two year period following qualification (WAC 275-19-145)."

The counselors are both educated and trained in the field of chemical dependency. All have taken college level classes in chemical dependency subjects; many of them have degrees.

It was not the purpose of this study to audit the counselors' qualifications. However, it appears most are fully qualified, and maintain their qualification through continuing education.

For those people with other experience in the chemical dependency field the range of experience is from two to sixteen years (5 years average), outside the present institutional setting.

Their range of experience within a DOC institution is from one year to two and one-half years.

How They Organize Work

While the treatment program is in progress, counselors usually spend their days either in class or in one-on-one counseling sessions.

It would appear that commuting from office to class would not be an issue in a restricted setting, but this is not the case. For some counselors this means moving from one building to another through several security check points, a process that may take 15 to 25 minutes. For others it may only mean opening the door of the office and walking across the parking lot.

If this movement occurs during the time that inmates are moving also, the counselor may stop to chat with current, former or prospective clients.

During class sessions the counselor will usually arrange two breaks, which generally coincide with the institution's count time. During these periods the counselor will move outside with the class, usually visiting with clients. At no time is the class left unsupervised.

Following class session the counselor will return to his or her office for several one hour individual counseling sessions, which follow one after another for the rest of the day.

The period of time when the counselor writes case notes or prepares for the next day's class is sandwiched between appointments or takes place during the early evening. Many of this group work a ten hour day during treatment sessions, taking several hours off at the end of the week.

Most counselors talk about accommodating their personal schedule to coincide with the client's schedule. If, for instance, a one-on-one cannot be scheduled during the half day left after class, the counselor will arrange to come early in the morning or late in the afternoon to see the client.

If the counselor also responds to requests from former clients for individual visits, this also must be scheduled into the day.

During the non-program period counselors complete their paperwork from the previous class, and prepare for the next class. This is the time in which assessments and intake interviews are scheduled.

Each assessment is usually 45 minutes to one hour and 25 or so assessments are scheduled for each class. Each intake interview is also one hour, and there are usually 20 or so of these. So assessment and intake for a program cycle can take 45 hours.

Counselors carrying caseloads in DASA funded programs are not to exceed 100 hours of face-to-face contact per month (WAC 275-19-140). Face-to-face contact includes classroom, group therapy, and individual counseling time plus assessment and intake sessions.

From our observations and conversations with treatment staff it would appear that many counselors exceed this 100 hours regularly. The only time their face-to-face contacts are reduced is during those three weeks in which counselors are not running a program.

Workload Management

In the six months of this study (7/1/91 through 12/31/91), 951 clients were enrolled in chemical dependency programs. This number was served by 17.5 staff in 49 treatment cycles in 13 institutions. Only at the WSP, and the two pre-release centers were there more than one treatment staff during this time period.

The number of cycles ranged from two cycles each at Cedar Creek, Twin Rivers, Clallam Bay, and WCCW (Purdy) to 10 cycles at the WSP. This latter figure is broken down among programs which were held at the maximum, medium and minimum sections of the WSP. The number of clients per cycle ranged from 16.3 to 22.3 with an average of 19.4 clients per cycle.

The average number of treatment cycles per staff person was 2.8.

COMPLETION RATES

Completion rates for clients in chemical dependency treatment have been broken down into clients accepted for treatment, clients who entered treatment and clients who completed treatment.

In Table 10, Client Entrance into Treatment by Institution, the number of clients accepted was separated into those who entered treatment and those who did not. In Table 11, the

number of clients who entered treatment has been separated into clients who were discharged during treatment and those who completed.[27]

The groups were compared on the following variables: age, race, gender, type of offense and prior offenses. There was a slight difference found in age: a spread of two years between those completing and those discharged, with those completing being older. There was a slightly greater proportion of women than men discharged during treatment. And more violent offenders than those with property crimes were discharged without completing treatment. However, none of the variables were statistically significant.

27 The tables include people already in treatment on 7/1/91 and people who completed treatment after 12/31/91, but who had been assessed during the six month time period, 7/1/91 to 12/31/91.

Table 11

CLIENT COMPLETION OF TREATMENT BY INSTITUTION

INSTITUTION	ENTERED #	DISCHARGED #	COMPLETED #	COMPLETED (%)
Clallam Bay	40	8	32	(80)
Cedar Creek	37	4	33	(89)
Indian Ridge	27	0	27	(100)
Larch	29	2	27	(93)
McNeil Island	80	9	71	(89)
Olympic	63	2	61	(97)
Pine Lodge PR	163	8	155	(95)
Tacoma PR	142	7	135	(95)
Twin Rivers	39	1	38	(97)
WCC, Shelton	67	9	58	(87)
WCCW	41	10	31	(76)
WSP	193	29	164	(85)
WSR and WSR-F	63	5	58	(92)
Total	984	94	890	(90)

SUMMARY

Treatment provided by the staff of both treatment agencies consists of the same elements: classroom instruction, group therapy and individual counseling over 91 hours. These are the DASA specifications for intensive outpatient treatment, and they are followed very carefully. It is how each treatment staff person tailors the material provided for his or her use where differences are observed. As would any teacher or group leader, each person adapts the materials (written, verbal and visual) to fit circumstances.

When DOC tested alcohol and drug knowledge among a group of clients who had recently completed treatment, they discovered that alcohol knowledge was very high, and the increase from pre- to post-treatment was low. On the other hand drug knowledge was low, and the increase in that knowledge from pre- to post-treatment was high.

When a different group of clients who were completing treatment was asked about their satisfaction with the treatment program, they responded very favorably. They found both group sessions and individual counseling equally helpful, and found problem solving, communications and assertiveness skills most helpful.

Seventy percent of the people accepted for treatment entered a treatment program. Ninety percent of the clients who entered treatment during the study period completed treatment.

Aftercare is the one area of treatment in the institutions that might be expanded. It is presently operating in only two institutions. And it should be noted that the national research suggests increases in treatment effectiveness, if treatment modalities are matched with client need. At present DOC offers only a single modality.

REFERENCES

Bell, M. M. and Murray, C. Publicly Funded Substance Abuse Programs for Adult Offenders in Washington State. Washington State Department of Corrections, Olympia, WA, May 1992.

LINKS WITH COMMUNITY CORRECTIONS AND COMMUNITY TREATMENT

INTRODUCTION

It is commonly believed that any form of chemical dependency treatment should be followed with some form of monitoring, support group participation, and/or a less intensive type of treatment. Still, evaluating whether or not follow-up treatment occurs is difficult.

If people, who are the focus of this study on prison-based treatment, participate in self-help groups upon release, it is generally not as a requirement of their supervision and their participation can only be known by asking them. If they participate in structured follow-up treatment, their participation is usually dependent on their assessment and acceptance by ADATSA, whose requirements are quite specific. Thus, their failure to participate may not be of their own doing.

Still, the treatment literature and the treatment staff emphasize the importance of links or bridges between the treatment an inmate receives while s/he is incarcerated in prison and the treatment s/he receives after entering the community. How the Community Corrections Officer (CCO), who supervises inmates after their release, contributes to these bridges was the focus of our concern.

Some inmates are released directly into the community without any supervision being required. This group of people, although they were part of the original study population, could not be tracked into the community.

A group of the institutional study population (N=452) were released to Community Corrections under several categories: community custody, post-release supervision, parole, and parole to work release. They had been released from a DOC institution between 7/1/91 and 7/31/92. Those persons released *without* supervision were not included in this sample.

A random sample of 150 clients was selected for follow-up in the community.

The research team contacted, by telephone, the Community Corrections Officer (CCO) responsible for supervising each person, and asked each CCO these questions:

1. What s/he knew about the person's treatment in prison.
2. What s/he knew about recommendations for follow-up treatment.
3. What kind of community-based treatment (if any) the person had participated in since leaving prison.
4. If the person was presently using alcohol or drugs.
5. What kind of evidence did the CCO have concerning that use.

Seventy-three CCOs, some of whom supervised more than one person, responded with information concerning 101 people. Each interview took about 15 minutes.

This chapter describes what those CCOs knew about the chemical dependency history of those clients, the treatment they were now receiving, if any, and their progress in the community.

CCO KNOWLEDGE OF PRISON ASSESSMENT AND TREATMENT

Prior to bringing an offender onto his caseload a CCO may conduct a community placement investigation. This investigation consists of reviewing the sentencing order(s), looking at the criminal history, the incident report (for the current offense) from the arresting officer, and looking at prison records (through computer) for infractions, health record, various programming (including chemical dependency). If he notices discrepancies in this record, he may also contact the institution classification counselor for clarification.

Ideally, a paper trail would follow a client from his/her assessment by the chemical dependency counselor, through the client's discharge from the treatment program out to the Community Corrections Officer, who could monitor the client's treatment progress. However, this is not what the research team found. Instead, the CCO learns what s/he knows about the client's dependency and treatment from two sources: the classification counselor and the client.

The classification counselor writes a summary of the client's activities in prison. This summary, which is usually one or two pages in length, details infractions, health conditions, and programming units. Participation in chemical dependency treatment is mentioned under programming.

The offender client is the other source of information for the CCO. If s/he has participated in prison-based treatment for chemical dependency, the client may volunteer that information. In some cases CCOs told us that clients had brought their certificates of treatment completion as evidence of their veracity.

CCOs identified 78 percent of the clients released to community supervision as having a problem with alcohol or drugs. They often presumed that clients with drug offenses have a chemical dependency problem. But they are not alone in this assumption. Institution staff interviewed expressed a similar opinion. The CCO may also question the offender about his/her possible dependency.

Many CCOs told us they usually did not receive information concerning a client's treatment from the prison summary. If the CCO did know about a client's treatment for chemical dependency, it was because the CCO had researched the client's history through OBTS (Offender Based Tracking System) or because the client had volunteered the information.

CCOs were asked if they knew whether or not these clients had been treated for chemical dependency in prison (or pre-release). They could identify 58 people of the 88 clients who were known to have accepted or completed prison-based treatment.

Most CCOs do not regard the chemical dependency program within the prison system as "treatment." They call it "class" or "education." "Treatment" to this group generally means something more invasive, such as methadone maintenance or inpatient treatment.

Follow-up treatment recommendations had been seen as part of the discharge summaries in all the WSP and McNeil Island files the research team examined. Furthermore, the treatment counselors had consistently described the time and effort they spent on discharge summaries, on an exit interview with the client, and on the client's prognosis for successful abstinence.

Although the CCOs occasionally received these discharge summaries from treatment staff, most of the follow-up recommendations they described were the result of the classification counselor's summary of the client's activities while in prison, rather than the actual treatment discharge summary. CCOs saw follow-up recommendations for 44 percent of the survey group.

OFFENDER BEHAVIOR UPON RELEASE

Approximately one-third (37%) of the offenders in this sample had proceeded to some form of community-based treatment. The programs they had chosen were self help groups (11%); outpatient treatment programs, such as TASC (18%); inpatient treatment programs, which are usually funded by ADATSA (7%); and methadone (1%).

From the treatment perspective the small number of clients who had participated in self-help groups seemed surprising as *everyone* who completes treatment in one of the institutions is recommended to community self-help groups. In fact, attendance at self-help groups during the institutional treatment process is a treatment requirement. Yet, the CCO has no way of knowing this requirement based on the few discharge summaries they saw, and several commented that participation in a self-help groups would be difficult to monitor.

Despite the absence of obvious connections between treatment in the institutions and treatment in the community, the percentage of offenders who were known to be using or abusing alcohol and/or drugs was moderate (28%). CCOs were emphatic about their knowledge of use and abuse, primarily because they monitored this condition. In fact, 89 percent of the offenders were monitored, either through random urinalysis (UA) or through observation.

Some CCOs discussed their reliance on a network of informants, such as housemates or relatives to learn if an offender is using. Some visit the offender's residence or work and interview associates to get a sense of how the offender is doing. Still, it is monitoring

with random urinalysis that appears to be the definitive way CCOs know what's going on with an offender.

The conditions for persons on community placement say "you shall not consume controlled substances except lawful prescriptions." Many CCOs interpret this to mean that they may only test for illegal drugs, not for alcohol which is a legal substance. Unless alcohol is specifically mentioned in the sentencing order or in the incident report, the CCO may pay little or no attention to it.

From conversations with CCOs alcohol use is seen as a problem if it impairs a client's ability to function. That is, unless the CCO sees evidence of bottles in the home or alcohol on a client's breath, s/he is not apt to test for alcohol. Some CCOs mentioned that s/he knew a client was drinking, but the drinking appeared to be "moderate." This position is inconsistent with that of treatment staff.

Treatment staff at McNeil Island and WSP assessed 202 out of 287 clients (70%) with a primary or secondary dependency on alcohol; all but eight were perceived to be middle or late stage alcoholics. Local treatment staff believe that middle or late stage alcoholics are not able to engage in "moderate" drinking. This would suggest that CCOs should be concerned about the alcohol use of this population.

As a way to elicit more open-ended information, we asked where the offender-client was living at the time of our phone interview. Of the 101 people in community supervision 66 were living in the community, 18 were presently in custody (either jail or prison) and 22 were missing, having absconded or disappeared from supervision.

We discussed with CCOs the sequence of events since each offender had left prison. Some had already violated terms of their community supervision, been charged, served time and were back out in the community. Others had violated terms of supervision, been charged, had been served with warrants and were missing. And there were people who had been released from prison, followed the terms of their supervision, and were living independently.

CCO KNOWLEDGE AND OFFENDER BEHAVIOR BY TREATMENT COMPLETION

The treatment section of this report divided the study population into those who had been accepted for treatment but did not actually enter the treatment program (the controls), those who had refused or been rejected for treatment and those who had completed treatment. The people who were in community supervision were examined in the same categories.

Seventy-four had completed treatment, 14 had been accepted for treatment by were not treated, and 13 were either refused or rejected for treatment (9), or discharged from treatment (4).

People who completed treatment: N=74

The CCOs were aware that...

...of the 74 in this group: 61 had a chemical dependency problem;
...of those 61: 33 had recommendations for follow-up in their file;
...of those 33: 30 were participating in treatment as follows:
7 in self help groups, 15 in outpatient programs, 7 in inpatient programs, and 1 in methadone treatment.

...of the 74 in this group: 19 were presently using or abusing drugs or alcohol.

...of the 74 in this group: 47 were known to be living in the community;
...of those 47, 22 were participating in treatment as follows:
7 in self help groups, 10 in outpatient programs, 4 in inpatient programs, and 1 in methadone treatment; so that 25 were either not participating in community-based treatment programs or their participation was not known to the CCOs.

...of the 74 in this group: 11 were in custody and 15 were missing.

People who were accepted for (but did not enter) treatment: N=14

The CCOs were aware that...

...of the 14 in this group: 11 had a chemical dependency problem;
...of those 11: 7 had recommendations for follow-up in their file;
...of those 7: 6 were participating in treatment as follows:
4 in self help groups and 2 in outpatient programs.

...of the 14 in this group: 7 were presently using or abusing drugs or alcohol.

...of the 14 in this group: 6 were known to be living in the community;
...of those 6: 4 were participating in treatment as follows:
2 in self help groups and 2 in outpatient programs; so that 2 were either not participating in community-based treatment or their participation was not known to the CCOs.

...of the 14 in this group: 4 were in custody and 4 were missing.

People who were refused or rejected for treatment, or discharged from treatment: N=13

The CCOs were aware that...

...of the 13 in this group: 7 had a chemical dependency problem;
...of those 7: 4 had recommendations for follow-up in their file;
...of those 4: 1 was participating in an outpatient program.

...of the 13 in this group: 3 were presently using or abusing drugs or alcohol.

...of the 13 in this group: 9 were known to be living in the community;
...of those 9: 1 was participating in an outpatient program; so that 8 were either not participating in community-based treatment or their participation was not known to the CCOs.

...of the 13 in this group: 3 were in custody and 1 was missing.

Overall, CCOs were aware that 29 percent of those under community supervision were using or abusing drugs or alcohol. Yet, 62 percent were living in their communities.

COMMUNITY SUPERVISION AND DISCONTINUED DRUG ABUSE

When CCOs were queried as to what causes some offenders to comply with community placement requirements and others to violate these requirements, they talked about two factors: the offender's age, particularity his/her maturity and the years s/he has spent in the corrections system. They believe the offender is "just tired" of the same old stuff, of repeating the same bad patterns.

They noted that offenders will cite various reasons for remaining drug free. Some will talk about the impending death of a parent. Some will talk about a new marriage to a clean and sober person. Some will talk about caring for a minor child.

But the common denominator is that the offender *decides* to change his/her lifestyle.

SUMMARY

Community Corrections Officers are definitely concerned about the well-being of their offender clients. They talk about how they have assisted clients with employment placements or problems. They are knowledgeable of their clients' personal relationships. They are aware of a client's living arrangements, and many have visited clients in their home settings.

What the CCOs know about their clients in prison is limited to what the classification counselor may say in the summary s/he writes about every client, and what the client may

tell the CCO. Little of the information about chemical dependency which the treatment agency staff develops gets to the Community Corrections Officers.

Many CCOs commented that they cannot require community-based chemical dependency treatment if it has not been ordered as part of the client's original sentence. For those clients who initiate contact with community-based treatment, the CCOs facilitate entrance and support participation in these programs. For those clients without the motivation or self determination to pursue treatment, the CCOs do not involve themselves.

THE EXPECTED BENEFITS OF TREATMENT

Prison-based chemical dependency treatment is expected to have positive effects on inmate behavior, both within the institution and following release. Inmates should be less likely to break prison rules, that is, have fewer infractions; be less likely to commit a new offense upon release; and be less likely to use or abuse substances while in prison or in the community. There should be other positive lifestyle changes, such as increased periods of employment and more stable personal relationships.

Infractions and evidence of chemical dependency through urinalysis testing were the measures used in this study. Both reflect behavior while still incarcerated. The length of the study did not permit an examination of recidivism or other measures of behavior following incarceration.

In this chapter we will review the desired outcomes: treatment completion, reduced infractions, remission of drug/alcohol dependency. And we will lay out the baseline data for those outcomes. In the next chapter we will use those data to assess whether participation in treatment changed outcomes.

TREATMENT COMPLETION

- 90 percent who entered treatment during this study completed treatment.[28]

Treatment completion is frequently a measure of program effectiveness. The Department of Corrections routinely reports the percentage of inmates entering treatment who complete it. The Division of Alcohol and Substance Abuse recently released a report of completion rates for its programs funded under the provisions of the Alcohol, Drug Abuse and Substance Abuse Treatment Act.

However treatment completion is not really an outcome measure: that is, an assessment of the effect of treatment. It is a process measure: that is, an assessment of dosage or its converse, attrition. There is little doubt that the duration of treatment or dosage is related to outcome such as recidivism, remission.

Attrition from treatment is caused by many factors. In the prison setting inmates can be removed from treatment for infractions, for transfer to another level or supervision or facility, or because treatment staff decide they are uncooperative or otherwise disruptive to the program. (See Table 12.)

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28 DOC reports a FY 91 completion rate of 85.9 percent.

Table 12

REASONS FOR REMOVAL FROM TREATMENT

REASON FOR DISCHARGE	CLIENTS
Chemical dependency infraction	1
Release	4
Transfer	25
Placement in segregation	18
Staff termination	42
Self termination	4
Total	94

Almost half were discharged because they were asked to leave by the staff. Just over one-fourth were transferred during their time in treatment although some DOC staff told us that they intercepted transfer orders for persons in treatment. About 20 percent were placed in segregation. Only one person left treatment because of a chemical dependency infraction. Four left of their own volition. Four were released.

REDUCED INFRACTIONS

When the Department of Corrections evaluated the original chemical dependency treatment program, the focus was on two measures of effectiveness: reduced infractions while imprisoned and reduced recidivism upon release. In that earlier study inmates who completed treatment had significantly fewer infractions than those who were discharged without completing.[29] Inmates who completed treatment had significantly fewer arrests in the second year following release than inmates in the control group.

29 There was no comparison of infraction rates between controls and those entering treatment.

Infractions are indicators of the offender's behavior while in prison or under community supervision. Infractions as a measure of treatment outcome are confounded by other relationships.

Effects of Offender Characteristics on Infraction Levels

The following results from a recent national survey of prison infractions by James Stephen suggests how infraction outcomes are affected by age, criminal history, and other variables. The same national data also provide comparisons between the infraction levels of these Washington inmates with national data.

The national survey of prison infractions found that half of all inmates are charged with rule violations at least once during their sentence. The percentage was the same in the 1986 survey as in a 1979 survey. But the percentage of inmates charged is somewhat lower in the West, 46.8 percent as compared to 52.7 nationally (Stephen).

In the national study inmates with a history of regular drug use, thus comparable to this study population, were more likely to have an infraction than inmates who did not use regularly. Fifty-nine percent of those with drug histories had an infraction.

- 60 percent of the study population committed an infraction during their incarceration. (See Table 13.)

Table 13

DISTRIBUTION OF INFRACTIONS

NUMBER OF INFRACTIONS	STUDY PARTICIPANTS #	(%)
None	611	(39.7)
One	313	(20.3)
Two	191	(12.4)
Three	135	(8.8)
Four to ten	200	(13.0)
Eleven or more	90	(5.8)
Total	1540	(100.0)

In the national study regular drug users had an annual rate of rule violations of 1.8 as compared to a 1.0 rate for those who did not use drugs regularly.

- The mean rate for the study population was 1.4 rule violations per year.

About a third of all inmates in the national survey had committed more than one infraction; 20 percent had committed two to five infractions; 6 percent had committed six to ten, and 8 percent had committed eleven or more. Still the average number of infractions per year is quite low: 1.5 per year for all inmates in the study.

The national survey found that the probability of rule violation is linked to inmate and facility characteristics. The rate of violations was also linked to inmate and facility characteristics.

In that study men (53%) were more likely than women (47%) to be charged with rule violations, but the rate of violations per year was higher for women (2.0) than for men (1.4).

- Among the Washington study population men and women were *equally* likely to be found in violation of prison or community supervision rules.

Nationally, younger inmates, 18 to 24 years of age, were more likely (60%) to have infractions than older inmates; their rate of violation per year was 2.7 a year.

- Among the study population, younger inmates were significantly *more* likely to have infractions; 73 percent had one or more infractions.

Although younger Washington inmates were more likely than the national population to have one or more infractions, the Washington group had lower annual rates. The annual rate for study inmates under the age of 24 was 2.2. Study inmates, ages 25 to 34, averaged 1.4 per year, those 35 to 44 averaged 0.8 and the over 44 group averaged 0.5 per year.

In the national study Caucasians were less likely (51%) to be charged with a rule violation than African Americans (57%), but their rates per year were the same: 1.5.

- In this study population Caucasians (58%) and Hispanics (56%) were also significantly *less* likely to be charged with a rule violations than African Americans (66%).

Their rates were also significantly different; Caucasians committed an average of three violations per year; African Americans committed an average of four per year.

Offense and offense history also were found to affect national infraction rates. Persons convicted of violent crimes averaged 1.4 infractions a year; property offenders averaged

1.8, and drug offenders averaged 0.9. When prior incarcerations were assessed, offenders with no prior incarcerations averaged 1.2 infractions a year.

Washington inmates were more likely to have *one* rather than *many* infractions if they were convicted of a drug offense. These inmates were somewhat more likely to have multiple infractions if they were convicted of a property crime. Those convicted of property crimes had a significantly higher annual infraction rate (1.8) than did those convicted of other offenses (1.25).

First time offenders were less likely to have an infraction. First time offenders had a lower rate (1.3) than those with prior offenses (1.5). These relationships were not statistically significant.

Infraction Levels by Type of Infraction

Washington data on infractions can be subdivided into rule violations, such as possessing a weapon, fighting, and assault that are analogous to violent offenses, and to drug offenses. The remainder are a mixture of property offenses and the type of behavior that is not a crime outside an institution, but is unacceptable inside the institution, such as refusing or failing to work, lying, or poor conduct.

The previous assessment of Washington prison-based chemical dependency treatment used infraction rates as a measure of outcome. The control group, inmates released during the same time period, had a total infraction rate of 1.3 and a chemical dependency rate of 0.35.

As noted above, a significant percentage of the inmates in the study population had no infractions of any kind; 40 percent had no infractions and 60 percent had one or more. The percentage of inmates with a specific type of infraction is smaller.

- 33 percent had one or more infractions for the equivalent of a violent offense.
- 22 percent had a chemical dependency infraction.
- 43 percent had other infractions.

Forty-five percent had a prison infraction. Twenty-two percent had community infractions, committed while the offender was in a community facility, including Tacoma and Pine Lodge Pre-Release and the various work release facilities.

Table 14

OFFENDERS WITH ONE OR MORE INFRACTIONS
BY TYPE OF INFRACTION

TYPE OF INFRACTION	NUMBER OF OFFENDERS[30]	
	#	(%)
Prison infraction for violent behavior	433	(28)
Prison infraction for chemical dependency use	182	(12)
Other prison infractions	496	(32)
Community infraction for violent behavior	110	(7)
Community infraction for chemical dependency use	174	(11)
Other community infractions	241	(16)
Total	929[31]	(60)

The baseline data on infractions suggest that, when looking for the effect of treatment on infractions, one should control for age and prior offense history. And the variations in the baseline data suggest that one should subdivide infractions by type and by place, that is, whether the infraction occurred in prison or in a community facility.

30 This is an unduplicated count. If an inmate committed multiple infractions of a certain type, s/he is only counted once.

31 The total number with one or more infractions is less than the sum of the column because some inmates have more than one type of infraction.

REMISSION

Remission or the cessation of drug and alcohol use is the preferred outcome of most treatment staff. Some accept reduced use as an acceptable outcome.

Treatment is expected to reduce a person's rate of drug and alcohol abuse. Surveys of drug and alcohol treatment programs find that significant numbers of clients cease to use or decrease their use of these chemicals following treatment.

Urinalysis (UA) results might be used to support a claim of remission for offenders still incarcerated although there is a problem with prison drug testing as evidence of remission. The rate of detected use is quite low, less than five percent nationally except for marijuana, which is just over five percent (Harlow).

Drug testing was introduced into the Washington prison system in 1984.[32] Testing procedures are set forth in field instructions, establishing the circumstances under which testing occurs: suspicion, random selection, extended family visitation, transfer, or court orders.

Random tests are conducted when inmates have been identified by central office. In theory, 10 percent of a facility's inmates should be tested each month so that in a year all inmates would be tested. In practice not all inmates whose number appears on the random list can be tested, and some just do not get selected.

A test can also be conducted if there is probable cause (suspicion) to believe that the inmate has been or may be using drugs. Tests under those conditions require the approval of a correctional shift supervisor or a correctional unit supervisor.

All other tests are prompted by an external event, such as a visit, a transfer, or a court order. The drug testing program operates within constraints. The result is, of necessity, a prioritization. Inmates being moved, including those with extended family visits, are always tested. Inmates suspected of drug use appear to come next in priority. Randomly selected inmates may not always be tested.

Drug test results are affected by the test cutting points. For example, a positive result for marijuana, 100 nanograms, is above the level of small use. Drug test results are also affected by the drugs for which tests are run. Tests are rarely run for alcohol use.

Some inmates test positive because they are on medication. These positives are set aside. In the end only a few inmates test positive and are sanctioned.

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32 Much of the information here was obtained in interviews with DOC staff responsible for drug testing at WSP and McNeil Island.

For example, at the Medium Security Unit of WSP between February and August 1992, only sixteen inmates tested positive. Two were involved in the chemical dependency treatment program; both were known to be taking medications that resulted in the positive test results. Some of the others may have been on medications also. Four tested positively on the first test, but not on the re-test. Their test results were inconclusive and reported as negative. This left ten MSC inmates with positive UAs between February 27, 1992 and August 20, 1992.

The relatively high level of negative UA results for this group of inmates should not suggest that the prisons are without drugs or inmates are without opportunity for a positive UA test. Staff at McNeil Island and WSP both stated that drugs are less easily obtained than a dozen years ago, but still can be found. After the advent of drug testing WSP staff temporarily tested inmates who associated with known drug users. During that period 12 percent of those tests were positive.

Between July, 1990 and August, 1992, over 500 drug tests were conducted on 253 McNeil Island and WSP inmates, who were part of this study population.[33] A few had 15 or more tests, almost all of which were associated with a family visit. Others had only one.

Of the 205 inmates in the WSP study population, there were 142 whose records were still in central files. The 142 inmates had only a handful of positive UA results during the entire test period. Most were the result of medication usage and were effectively negative. Only one was positive and his drug use occurred in August, 1990. This inmate successfully completed treatment in January, 1992.

Of the 111 inmates in the McNeil Island study population, records of drug test results were available for everyone. Nine tested positive: eight for marijuana and one for cocaine. Three were discharged from treatment, and their positive tests occurred about the same time as their discharge. Six successfully completed treatment following their positive tests, including the inmate who tested positive for cocaine.

- 98 percent of the tests were negative.

This is consistent with test results for the general inmate population. Less than one percent of the WSP inmates tested positive for drugs; only eight percent of the McNeil Island inmates tested positive. The percentage of both groups with positive UAs was lower than the percentage of all study participants with a chemical dependency infraction.

Every inmate with a positive urinalysis result should have a chemical dependency infraction. But inmates with some chemical dependency infractions, such as dealing

33 Test results are not a standard item in the automated data set of OBTS. The results reported here were collected from central files and disciplinary records for study participants at WSP and McNeil Island.

drugs, would not result in a positive UA. Hence, chemical dependency infractions may be a more comprehensive measure of outcome than urinanalysis testing.

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THE EFFECTIVENESS OF TREATMENT

INTRODUCTION

One way to assess the effectiveness of the chemical dependency treatment program is to compare it to these benchmarks: effective treatment programs, including those in prisons elsewhere and state standards for community-based intensive outpatient treatment.

National studies indicate that inmates respond well to coerced participation in treatment; DOC uses a modified form of coercion. Studies indicate that treatment lasting over 90 days leads to a higher success rate; DOC programs last 35-45 days. Studies indicate that treatment modalities specific to the type of chemical dependency are more effective; DOC uses only one form of treatment. Studies indicate that programs are more effective if the treatment staff uses "firm but fair" methods; DOC treatment staff does employ those methods. Studies indicate that treatment programs are more successful when there is minimal staff turnover; treatment staff average two years on the job.

Standards for certified programs (DOC programs do not require certification) are specified by the Washington Administrative Code: WAC 275-19-660. They require that intensive outpatient treatment programs combine educational sessions, and individual and group counseling for a minimum of 72 program hours. DOC provides those services for a total of 91 program hours. Standards specify group counseling sessions have a maximum of 12 clients; DOC targets 20 clients to a group.

Another way to assess the effectiveness of treatment is to compare the outcomes it did achieve to the outcomes it was expected to achieve.

- Did it have the impact on offender or client behavior that it was designed to have?
- Did the chemical dependency treatment reduce the number of inmates with infractions and the rate of infractions?

This study found that:

- Treatment reduces the percentage of offenders with violent infractions and the rate of violent infractions.
- Treatment's effect on violent infractions remains the same when age, prior history of violent infractions, offenses, gender and race are controlled.
- Treatment does not reduce the already low percentage of offenders with drug infractions, nor does it reduce the rate.

COMPARISONS TO BENCHMARKS

National Research Findings

Forced participation, duration, modality and quality of treatment affect treatment outcome.[34] Forced treatment, based on incentives or penalties for participation, may have more long term benefits with correctional clients. Legal coercion has been associated with positive outcomes, however this may be the result of longer treatment periods. Most DOC inmates are forced rather than coerced into participation. Some request treatment.

Longer treatment (over 90 days) is significantly correlated with positive outcome. The relationship between treatment duration and success may be the result of attrition. If good prospects stay and poor prospects leave, then those staying the longest have the best chance of success. In the DOC program, the attrition of those entering treatment is low; both good and poor prospects remain in treatment. All DOC programs last between 35 and 45 days and provide 91 hours of treatment.

Matching modalities of treatment with types of chemical dependency is preferred. The more serious the dependency on alcohol or drugs the more intense the treatment required. The most successful prison-based residential treatment occurs in therapeutic communities. Outpatient treatment works better with less serious addictions. These results are confounded by the effects of attrition. DOC offers one form of treatment for all types of dependency.[35]

Independent of modality and dependency, consistent, flexible treatment programs with minimal staff turnover have better results. The results are better if the treatment is "firm but fair," modeling and reinforcing noncriminal behavior, providing opportunities for clients to test their problem solving and learn new skills.

Successful prison treatment offers clear rules quickly enforced, concerned and credible staff, provision of tools for avoiding further criminal behavior and for using community resources.

In 1991, DOC contracted with a new treatment agency. Treatment staff working for both contractors average two years on the job. Treatment staff appear to establish clear rules for inmates while they are in the program and to enforce these rules. Although we did not interview clients, from the perspective of outsiders staff are concerned and credible. The program is designed to provide tools for avoiding further criminal behavior and for

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34 Various studies, conducted in other jurisdictions, are the sources of the findings listed below. Specific findings and studies were detailed in the first chapter.

35 A more intensive residential program with aftercare is planned for Pine Lodge Pre-Release.

using community resources. Staff provide opportunities for testing problem solving and help inmates learn new skills.

When compared to characteristics of other programs which are successful with offenders, this program has several desirable attributes. It has sufficient incentives to prompt positive outcomes. It has the program elements, such as credible staff and an appropriate curriculum, associated with positive outcomes.

It lacks other preferred characteristics. It is shorter than considered essential to success, particularly for persons addicted to heroin or cocaine. It does not match modality to client. Instead it offers the same treatment to all regardless of their dependency, the phase of their addiction, or their social and offense histories.

State Standards

Intensive outpatient treatment, as defined by WAC, is "a combination of educational sessions, individual therapy, group therapy, and related activities to detoxified alcoholics and detoxified addicts and their families." (WAC 275-19-929 (i))

The required services are an assessment of each client's needs regarding specific alcohol and drug-related problems and a minimum of 72 hours of treatment services within a maximum of 12 weeks. The treatment services must include within the first four weeks a minimum of three sessions of at least one hour each on three separate days of the week; individual counseling sessions every 20 hours of treatment and additionally as needed; education regarding alcohol, alcoholism, and/or drugs and drug addiction; group therapy sessions; and referral to a structured aftercare program following completion of outpatient treatment. (WAC 275-19-660)

The DOC program exceeds those requirements by 29 hours. However, there are requirements for community-based intensive outpatient treatment that the DOC program cannot meet. For one, WAC specifies that facilities shall limit group counseling sessions to no more than twelve clients. DOC tries to have 20 clients in each session.

The Division of Alcohol and Substance Abuse has a checklist for auditing an intensive outpatient client file. The research team did not conduct a systematic audit of files. However, most of the files reviewed by the team had all the necessary pieces but would fail because the information was not sufficiently detailed. File notes were often indistinguishable from one file to another. The absence of detail grew in importance as the reviewers realized that there really was no treatment plan, no progress notes, and no discharge plan, only the appearance thereof. Treatment staff are reluctant to disclose more detail because their files are not closed to other staff within the institution.

WAC requires that the treatment counselors and treatment programs be certified. The treatment counselors assert, with one exception, that they are certified. We required no independent verification.

As a state agency, DOC is not required to be certified and has not requested certification of its treatment program. Thus the audit which precedes certification has not occurred. That is the real test of whether the DOC program would meet the WAC requirements.

ASSESSMENT OF TREATMENT OUTCOMES

The study population includes four categories: the 122 clients who were either rejected as inappropriate for the treatment or who refused it;[36] the 426 who were accepted but did not enter the program during the study; the 94 who entered but did not complete the treatment; and the 890 who completed treatment.

Theoretically, all sub-groups should begin with the same pre-treatment infraction levels (percentage with one or more infractions) and rates (infractions per year of incarceration).[37] If treatment works as expected, the group finishing treatment should have the lowest post-treatment levels and rates. The group who left treatment prematurely should have the highest levels and rates. The control group, or those accepted but not entering, should have average levels and rates.

In fact, the violent infraction levels of the treatment group were significantly improved following treatment. However, the drug/alcohol infraction levels of the treatment group were indistinguishable from the control group. (See Table 15.)

Pre-Treatment Differences in Infraction Levels and Rates

The three groups did not have similar pre-treatment levels of infractions nor did they have the same infraction rates:

- When pre-treatment levels and rates were compared, the treatment group looked worse than the control group.

The inmates accepted but not treated (controls) had the lowest percentage (27%) with pre-treatment infractions. Those who completed treatment were indistinguishable from the average: 38% had a pre-treatment infraction.

The controls also had low rates of pre-treatment infractions, 0.69 per year. Treated inmates had a pre-treatment rate of 0.87. The average was 0.97.

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36 Those who were rejected or refused treatment are a mixture; it is difficult to predict their levels and rates. Their levels and rates can be found in the data tables but are not discussed below.

37 We looked at differences from before and during treatment to after treatment. When the inmate had not been treated, we used the month s/he was assessed as the division between pre- and post-treatment. The last month of treatment marks the division between pre- and post-treatment for the inmates who entered treatment.

The 94 inmates who failed to complete treatment were significantly more likely to have a pre-treatment infraction than members of any other group and their rates were higher. Almost two-thirds of those inmates had a pre-treatment infraction of some kind. In contrast, just over a third (37%) of the whole population had a pre-treatment infraction. (See Tables 16 and 17.) Inmates failing to complete treatment averaged 2.87 infractions a year and the group as a whole averaged 0.97.

When pre-treatment rates for rule violators only are compared, these differences only become more pronounced.[38] The accepted inmates had the lowest percentage with a pre-treatment infraction (27%) and the lowest rates for rule violators (1.26 per year). (See Table 18.) The treated inmates had an average number with infractions (38%) and a somewhat below average rate for rule violators (1.47).

Since the inmates who left treatment early had an above average number with infractions (65%), they also had an above average rate for rule violators (3.38).

The differences in pre-treatment infraction levels and rates is due to the differences in infractions for violent behavior and for minor infractions, and not to differences in chemical dependency infractions.

The significant differences in pre-treatment numbers and rates between the early departure group and the others may be a function of our division between pre- and post-treatment. Many of those who left treatment early did so because they were found in violation of prison rules. Others were asked to leave because their actions were disruptive to the program; these are the kinds of behavior that can result in an infraction. We could not make those distinctions.

Pre-treatment infraction levels and rates for those who completed treatment and the controls were not the same. Pre-treatment levels for violent infractions were higher for the treatment group than for the controls. Their rates were more similar.

Post-treatment Differences in Infraction Levels and Rates

If treatment had the expected effect, those completing treatment should have lower post-treatment infraction levels and rates than the controls and lower levels and rates than those exiting treatment prematurely.

- When post-treatment levels and rates were compared, the treatment and control groups looked the same.

38 We also compared the annual infraction rates for the different types of infractions. One comparison of infraction rates includes the entire study population in the calculation: that is, those with infractions and those without. We will identify discussions of that set of rates by referring to them simply as infraction rates. Another includes only those inmates with one or more infractions. Those will be identified as rates for rule violators.

There is no significant differences between the percentage of the treatment group and the percentage of the control group committing one or more post-treatment infractions. Both groups had an average number committing a post-treatment infraction, 39 percent for those treated and 42 percent for the controls.

The infraction rates for treatment and control groups are indistinguishable: 1.34 for treated and 1.32 for controls. The rate for treated rule violators (2.26) is slightly lower than it is for rule violators from the control group (2.51), but this difference is not significant.

The group discharged from treatment had a significantly higher number committing post-treatment infractions.

The post-treatment rate for the rule violators among the discharged inmates is significantly higher, 4.55.

The treatment and control groups are only slightly distinguishable when post-treatment infractions are broken down by type.

The average number of those with a post-treatment violent infraction is 17 percent: 13 percent of the treated and 20 percent of the controls. The average number with a post-treatment chemical dependency infraction is 13 percent: 14 percent of the treated and 12 percent of the controls.

Post-treatment infraction rates by type are equally similar for the treatment and control groups, as are the rates for rule violators only.

The group leaving treatment early is significantly different. The number with a post-treatment violent infraction (40%) is higher, their infraction rate is higher (3.80), and their rate for rule violators is higher (4.55).

The picture changes when post-treatment rates are sub-divided into those infractions committed while in prison and those committed while in a community facility (pre-release or work release). Fewer of the treatment group and more of the controls have post-treatment infractions while still in prison. The control group has significantly more violent infractions. Prison rates for rule violators are noticeable higher for controls. Treated inmates experienced a significant reduction in their levels and rates of violent infractions.

Community infraction levels are near the average for both the treatment and control groups. Community infraction rates are somewhat below average for the control group and above average for the treatment group. When rates for violators only are compared, the treatment group has significantly higher rates overall than the controls and significantly higher rates of chemical dependency infractions.

Although disturbing, these high rates may be the result of the treatment group's higher numbers in community facilities. We have no way of separating the study population so that we can create a rate for those who spent time in a community placement.

Differences in Infraction Levels and Rates from Before to After Treatment

Another way to assess the impact of treatment is to look at the change in levels or rates from before to after treatment. This approach controls for the effects of different levels and rates before treatment was started. If treatment was effective, the treated inmates have the greatest reduction in infractions despite their higher pre-treatment levels.

- Treatment clearly reduces the number of inmates with violent infractions and it dampens the increase in the number with infractions of any kind.

Both the treated and the control group had higher percentages with infractions following treatment than they had before treatment. The increase was slight for the treated group, just over one percent. Fourteen percent more of the control group had a post-treatment infraction than had a pre-treatment infraction.

Four percent more controls had a post-treatment violent infraction than had one before treatment. Ten percent fewer treated inmates committed a post-treatment violent infraction than committed a pre-treatment infraction of the same type.

When only prison infractions are compared, the persons completing treatment show even greater improvement and the control group is stable as predicted.

Treated inmates have a *smaller* increase in total infraction rates than do controls. They have *decreased* violent infraction rates. Finally, treated inmates have a *greater increase* in their rate of drug infractions.

When rates for rule violators only are compared, the differences are more pronounced. The rule violators among the treated and control inmates both have higher rates after treatment. This sub-group of treated inmates has less of an increase than the control group and has a decrease in its violent infraction rate. And the treated inmates have a greater increase in their drug infraction rate than does the control group.

Relationship Between Treatment and Outcomes, Controlling for Other Sources of Variation

Infraction rates for this population are correlated with age and offense history. If age and prior history are controlled, will the differences between treated, partially treated and untreated inmates disappear?

- Treatment remains a significant predictor of violent infractions when other variables are controlled.

Earlier analyses focused on bivariate relationships between outcomes (e.g., infraction rates) and predictors (such as inmate gender or treatment group status). These prior results do not take into account the likely relationships among predictors or their joint effects on outcomes. Exploratory multivariate procedures were completed to assess more realistically the independent impacts of subjects' characteristics on the likelihood of post-treatment infractions. Step-wise logistic regression analyses were performed on two outcome measures: post-treatment infractions of any type and post-treatment violent infractions.[39]

Predictions of likelihood of post-treatment ***violent*** *infractions* are presented in Table 19. A number of points should be highlighted.

First, treatment group was a significant predictor of violent infractions even after controlling for inmate age, history of prior violent infractions, offense type, gender, race, and offense type. Compared to controls, completers were least likely to commit a post-treatment violent infraction; discharged inmates were most likely to have at least one violent infraction after leaving the program. (Inmates refusing to participate were comparable to controls.)

Second, females, blacks, younger inmates, and those with violent or other offense types were more likely to commit a violent infraction after treatment. In addition, time until

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39 The dependent measures were dichotomized as "none" vs. "one or more" infractions. Predictors in the analysis included: pre-treatment infractions, inmate age at treatment, facility type, offense type, priors, race, sex, chemical dependency treatment status, and time incarcerated pre- and post-treatment. Pre-treatment infractions were dichotomized as none vs. one or more. Violent infractions prior to the intervention were used in predicting the likelihood of post-treatment infraction; total infractions were used as an independent measure for the second analysis involving likelihood of any type of infraction after the chemical dependency classes.

Most of the remaining predictor measures were categorical or nominal. Treatment age was categorized as: a) 24 or under; b) 25–34 years; and c) 35 or older. The additional "collapsing" of older inmates (45 years or higher) was done after reviewing bivariate results. There were also too few cases in this cell to reliably predict this group.

Offense type included: a) substance abuse; b) violent; and c) other. Inmate race/ethnicity was also further recoded from prior analyses due to limited cell sizes. The final categories were: a) Caucasian; b) African American; and c) Other. The variables for prior convictions and inmate sex were dichotomies (no/yes and male/female, respectively). Time incarcerated and pre- and post- remained interval measures. Pre-treatment time was measured in years; post-treatment was re-calculated in months. These last two variables were included to adjust for inmate "opportunities" to infract.

Logistic regression is a robust procedure and avoids some of the problems associated with assumptions within a linear analysis of infraction *rates* in the original metric. The latter involves problems of multivariate normality and the calculation of extreme rate values based on censored time variables.

Regardless of how measures were coded, missing data were not an issue in the analysis. Over 95% of the sample was included in each logistic regression. In addition, one technical point should be raised. P-values to enter (and possibly exclude) variables from the step-wise procedure were altered from default settings. They were modified as follows: a) p-value to enter=0.15; b) p-value to exclude=0.20. The statistical literature suggests that maintaining more extreme values (e.g., PIN=0.05) is unduly conservative and results in models which will exclude significant predictors (Hosmer and Lemeshow).

system exit was positively related to the increased likelihood of violent infractions. Thus the more time the inmate remains in the system the more opportunity s/he has to infract.

Finally, two measures were found not to be related to the outcome: priors and length of time incarcerated prior to treatment.[40]

Predictions of likelihood of any post-treatment infractions are described in Table 20 which provides results of the logistic regression analysis of post-treatment infractions of any kind. The outcome was the absence/presence of any infraction of any type after treatment began. Not surprisingly, the results for this more general look at the data parallel the prior findings.[41]

Again, treatment condition significantly predicted the likelihood of any infraction after chemical dependency classes began. In this case, though, completers did not show any improvement over controls, but each group was less likely to commit an infraction compared to discharged cases or those refusing to participate. Again, those dropping out of treatment were most at risk for a subsequent infraction. Younger inmates were, again, more likely to infract as were those at pre-release sites. An infraction prior to treatment was predictive but it should be noted that the adjusted odds-ratio (1.66) suggests that the increased risk was relatively small compared to the effects of other variables, such as age or treatment status (dischargees). African American inmates were also more likely to have had a post-treatment infraction of any kind compared to white subjects in the sample.

SUMMARY

Treatment has the greatest effect on violent infractions. It has less effect on total infractions. It appears not to effect drug infractions.

Although both treated and control group inmates had a post-treatment increase in the numbers with infractions and in the number of infractions per year, treatment dampens that increase. It reduces the percentage of inmates with violent infractions, and it reduces the rate of violent infractions.

Treatment does not have the desired effect on drug infractions. The percentage of those with drug infractions is slightly higher than that for controls; and the rates of drug

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40 The latter finding seems counter to national research on the importance of long periods of treatment and may be the result of the mixture of chemical dependencies within the treatment group.

41 Minor differences were detected between examining the two dependent measures but these should be viewed cautiously. Variables can enter (or be excluded) based on sample idiosyncracies (e.g., outliers). No summary tests were performed on the adequacy of model fit and specification. (The dichotomized table of observed vs. predicted cases is completely inadequate for addressing these issues.) Finally, the complex issue of identifying and testing interaction terms was not addressed.

infractions are higher for the treated group. The rates remain higher whether calculated for all treated inmates or only for those with rule infractions. The desired reduction in levels and rates does not occur.

This may result from a selection bias. The control group is comprised of inmates accepted for treatment, but not in treatment when this study's data were compiled. The treatment group had entered. If the treatment group was perceived as having the greater need for treatment, then they might be expected to have more drug infractions. This hypothesis cannot be tested with these data.

The multivariate results provide support for the bivariate relationships found between treatment and infractions. It appears that, despite many other inmate characteristics, their presence in the chemical dependency program—and their ability to stay in it until completion—is related to their diminished problems after treatment. They have significantly fewer violent infractions.

Table 15

DIFFERENCES IN PRE/POST INFRACTION LEVELS AND RATES
TREATED AND CONTROL GROUPS

TYPE OF INFRACTION	PERCENT WITH ONE OR MORE INFRACTIONS		INFRACTION RATES		INFRACTION RATES	
			ALL INMATES		RULE VIOLATORS	
	CONTROLS	TX	CONTROLS	TX	CONTROLS	TX
Violent	-3.8	+10.0	-.12	+.05	-.25	+.09
Drug	-2.4	-1.8	-.12	-.19	-.22	-.34
Total	-14.1	-1.3	-.63	-.47	-1.25	-.79

Note: Positive numbers indicate pre-treatment levels higher than post-treatment levels.
Negative numbers indicate pre-treatment levels lower than post-treatment levels.

Table 16

INFRACTION LEVELS BY TYPE OF TREATMENT
ALL INMATES
Pre- and Post-Treatment, Prison (P) and Community (C)

Infractions		Pre (P&C) #	Pre (P&C) %	Post (P) #	Post (P) %	Post (C) #	Post (C) %	Post (P&C) #	Post (P&C) %
Refused or Rejected	Violent	23	19.3	15	12.3	12	9.8	26	21.3
	Drug	11	9.2	7	5.7	13	10.7	19	15.6
	Other	35	29.4	20	16.4	27	22.1	44	36.1
122 cases	Total	46	38.7	29	23.8	40	32.8	62	50.8
Accepted but not treated	Violent	66	16.0	69	16.0	19	4.5	83	19.8
	Drug	38	9.1	13	3.1	35	8.4	48	11.5
	Other	80	19.1	80	19.1	37	8.8	115	27.4
426 cases	Total	115	27.4	122	28.6	68	16.0	177	41.5
Discharged	Violent	41	43.6	33	35.1	5	5.3	38	40.4
	Drug	16	17.0	10	10.6	4	4.3	14	14.9
94 cases	Other	55	58.5	42	44.7	13	13.8	52	55.3
	Total	61	64.9	57	60.6	15	16.0	67	71.3
Treated	Violent	204	22.9	74	8.3	44	4.9	115	12.9
	Drug	106	11.9	23	2.6	99	11.1	122	13.7
890 cases	Other	216	24.3	117	13.1	126	14.2	234	26.3
	Total	336	37.8	166	18.7	201	22.6	348	39.1
All	Violent	334	21.9*	191	12.5*	80	5.2	262	17.1*
	Drug	171	11.2*	53	3.5*	151	9.9	203	13.3
1532 cases	Other	386	25.4*	259	16.9*	203	13.3*	445	29.0*
	Total	565	36.7	376	24.3	324	20.9	656	42.3

* $p < .01$: compares figures within the same column

Table 17

ANNUAL INFRACTION RATES BY TYPE OF TREATMENT
ALL INMATES
Pre- and Post-Treatment, Prison (P) and Community (C)

Infractions		Pre (P&C)	Post (P)	Post (C)	Post (P&C)
Refused or Rejected 122 cases	Violent	.43	.30	.18	.48
	Drug	.11	.11	.22	.34
	Other	.50	.30	.57	.85
	Total	1.04	.71	.98	1.69
Accepted but not treated 426 cases	Violent	.30	.35	.08	.42
	Drug	.08	.05	.15	.20
	Other	.31	.52	.22	.70
	Total	.69	.91	.42	1.32
Discharged 94 cases	Violent	1.08	1.17	.13	1.29
	Drug	.17	.15	.10	.25
	Other	1.60	1.83	.37	2.23
	Total	2.87	3.19	.61	3.80
Treated 890 cases	Violent	.36	.19	.11	.31
	Drug	.12	.05	.26	.31
	Other	.40	.31	.41	.71
	Total	.87	.55	.79	1.34
All 1532 cases	Violent	.40*	.36*	.11	.41*
	Drug	.11	.08*	.22*	.28
	Other	.46*	.40*	.36*	.82*
	Total	.97	.82	.69	1.51

* $p < .01$: compares figures within the same column

Table 18

TYPE OF TREATMENT AND ANNUAL INFRACTION RATES
INMATES WITH INFRACTIONS ONLY
Pre- and Post-Treatment, Prison (P) and Community (C)

Infractions		Pre (P&C)	Post (P)	Post (C)	Post (P&C)
Refused or Rejected	Violent	.60	.44	.15	.71
	Drug	.16	.17	.32	.49
	Other				
84 cases	Total	1.55	1.04	1.40	2.49
Accepted but not treated	Violent	.54	.64	.14	.79
	Drug	.15	.10	.27	.37
	Other				
228 cases	Total	1.26	1.69	.82	2.51
Discharged	Violent	1.29	1.40	.15	1.57
79 cases	Drug	.20	.17	.12	.30
	Other				
	Total	3.38	3.77	.71	4.55
Treated	Violent	.61	.33	.19	.52
530 cases	Drug	.19	.08	.44	.53
	Other				
	Total	1.47	.93	1.32	2.26
All	Violent	.66*	.50*	.18	.68*
916 cases	Drug	.19	.10	.36*	.46
	Other				
	Total	1.60*	1.37*	1.14*	2.53*

* $p < .01$: compares figures within the same column

Table 19

PREDICTORS OF POST-TREATMENT VIOLENT INFRACTIONS

MEASURE	BETA	STANDARD ERROR	ADJUSTED ODDS RATIO
Pre-treatment violent infractions, any	0.52	0.16	1.68
Treatment age: 35+, reference group			
24 or younger	0.86	0.21	2.36
25-34	0.84	0.19	2.32
Offense type: Other, reference group			
Chemical dependency	-0.38	0.21	0.68
Violent	-0.07	0.18	0.93
Post-treatment incarceration in months	0.098	0.03	1.10
Treatment level: Controls, reference group			
Completers	-0.44	0.17	0.64
Discharged	0.99	0.27	2.68
Refused	0.07	0.27	1.07
Race: Caucasian, reference group			
African American	0.58	0.16	1.78
Other	-0.02	0.23	0.99
Gender: female	0.76	0.22	2.14
Constant	-3.11		

Table 20

ANALYSIS OF ALL POST-TREATMENT INFRACTIONS

MEASURE	BETA	STANDARD ERROR	ADJUSTED ODDS RATIO
Pre-treatment infractions, any	0.51	0.12	1.66
Treatment age: 35+, reference group			
24 or younger	1.24	0.16	2.46
25-34	0.70	0.14	2.02
Offense type: Other, reference group			
Chemical dependency	0.06	0.16	1.06
Violent	-0.30	0.15	0.74
Post-treatment incarceration, months	0.18	0.03	1.20
Treatment level: Controls, reference group			
Completers	0.08	0.14	1.09
Dischargees	1.30	0.28	3.67
Refused	0.25	0.23	1.28
Race: Caucasian, reference group			
African American	0.52	0.13	1.67
Other	-0.46	0.17	0.64
Facility: Pre-release, reference group			
Minor	-0.54	0.18	0.58
Major	-0.45	0.15	0.64
Constant	-2.31		

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AREAS FOR PROGRAM AND POLICY REVIEW

THE TARGET POPULATION

A critical question in the design of an effective treatment program is identifying the persons whose symptoms suggest they need treatment, and whose prognosis suggests they could benefit from that treatment. This was not a study of the prevalence of people with chemical dependencies in the prison population. It was not really a study of the process by which inmates are referred for treatment although we did learn some things about how that works. Despite the absence of hard data on prevalence and referral we can make some observations about the target population.

THE NUMBER NEEDING ASSESSMENT

When the chemical dependency treatment program was being designed, data from a random sample of 228 inmates indicated 90 percent of all inmates had histories of chemical dependency.

A second review of prevalence was done as part of DOC's assessment of chemical dependency treatment in which recently released offenders formed the control group. The records of 265 were examined. Eighty-two percent included "evidence of substance abuse problems." At that time about 2,500 offenders were released annually and that study's authors estimated that "some 2,000 inmates per year constituted the treatment target population."[42]

More recent national prevalence studies suggest that many inmates have chemical dependency problems serious enough to merit treatment. However, these studies set a higher threshold for entry into treatment than that used in the DOC study and thus do not suggest rates as high as found in Washington prisons. There is increasing evidence substantiating the prevalence of serious chemical dependency among prisoners.

There is no longer doubt that many offenders use drugs and alcohol. For example, recent studies using urinalysis with new arrestees report high percentages (three-fourths) testing positive for drugs or alcohol (Wish et al, and Drug Use Forecasting). However, the presence of trace amounts of drugs or alcohol following arrest is not necessarily congruent with chemical dependency of sufficient severity to require treatment.

Gerstein and Harwood estimate a third of all prison inmates need treatment for *drug* dependencies. In an earlier study of Washington's publicly funded chemical dependency programs Bell and Murray estimated that 41 percent of all Washington prisoners needed treatment for chemical dependency.

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42 Findings from the Substance Abuse Report of February 1983, reported in Hall-Milligan et al, 1986.

Other studies looking directly at national prison populations have estimated 62 percent or more of the prison population used illegal drugs once a week or more during the month before their last arrest (Chaiken). In 1986, forty-three percent of state prisoners reported daily use of illegal drugs during the month of their offense (Bureau of Justice Statistics, 1989).

National studies of the prevalence of alcohol and drug abuse have examined both household and prison populations. These studies suggest lifetime prevalence rates may be as high as 56 percent for alcohol abuse, 54 percent for drug abuse, and 72 percent for either alcohol or drug abuse.

Annual prevalence rates for drug abuse are lower, perhaps 19.45 percent for male prisoners and 45 percent for female prisoners. Annual alcohol abuse prevalence rates for male and female prisoners together may be 26 percent (Regier et al).

DOC reception staff collect data on alcohol and drug use and potential abuse. The results from this assessment are not routinely compiled nor are they available for all inmates. Thus there are no specific recent data on the number of newly admitted offenders who are identified as probable chemical abusers. A survey of those inmates assessed for chemical dependency during reception found 43 percent were middle or late stage dependency.[43]

The type of offender going to prison has changed significantly since 1984 when DOC first estimated prevalence. For example, there are more persons convicted of violent and drug offenses. These changes in inmate characteristics are thought by some to increase the prevalence of chemical dependency.

Whatever the true prevalence rate is, there are significant numbers of offenders in Washington prisons who are dependent on either alcohol, drugs or both. In FY 91, 4,592 inmates entered the prison system. Approximately three-fourths of that number (3,277) exited the system in FY 91.

If 80 percent is a valid estimate of prevalence, then nearly 3,700 of the offenders admitted annually could be referred for assessments for chemical dependency treatment. Under that scenario nearly 2,600 of the annual releasees could be candidates for chemical dependency treatment.

If 43 percent is a more valid estimate of prevalence, as suggested by the study of inmates during reception, then nearly 1,500 of the annual releasees could be candidates for chemical dependency treatment in the year preceding their release.

Initial discussions with DOC and treatment staff suggested that the number of persons meriting assessment might be two or three times the number being assessed. We found

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43 Interdepartmental memorandum from S. Thomas Barkley to Ruben Cedeno, dated November 21, 1991.

1,550 assessed between the weeks just prior to July 1, 1991 and December 31, 1991. This suggests that annual assessments could approach 2,700.

This figure is considerably higher than the more conservative estimates of chemical dependency among Washington prisoners. And it exceeds the even more conservative estimates based on national studies of annual prevalence rates.

The number to be assessed should be derived annually from the number of expected prison releases and the most recent estimate of prevalence provided by the R-unit staff.

DIVERSION

The Department, the Sentencing Guidelines Commission and the legislature continue to review the options for diverting first time and drug offenders. These data offer some insights into those deliberations.

Half of the inmates participating in chemical dependency treatment have no prior history. Their sentences are short. Many are convicted of property and drug crimes. They are the type of offenders being considered for diversion to community-based options.

The Substance Abuse Capacity study found that diverting these offenders to a mix of residential and outpatient chemical dependency treatment combined with intensive supervision was cost effective. This study suggests that there are significant numbers of candidates for such diversion already in the prison system, and they are receiving chemical dependency treatment while there.

THE REFERRAL AND ASSESSMENT PROCESS

DIAGNOSTICS AT THE RECEPTION CENTER

As noted above, the material collected at the Reception Center might be integral to the assessment process, but it is not. Is there a reason to have inmates fill out the same screening batteries (MAST and DAST) twice: once at the Reception Center and again during the pre-treatment process?

The Reception Center staff could submit a monthly list of new entrants whose diagnostic tests indicate a need for chemical dependency assessment. This list could then be cross-referenced with assessment referrals to ensure that all inmates originally scored as middle or late stage are referred to treatment staff for a full assessment of their possible dependency.

DEPENDENCY, AMENABILITY AND NEED FOR TREATMENT

It would be useful to recognize in the referral and assessment process that *dependency* is not equivalent to *amenability* to treatment, and neither are equivalent to a *need* for treatment. Some people with early stage dependency are amenable and could benefit from treatment. Some people with late stage are not amenable, but need treatment none the less.

The present system presumes that those with middle and late stage dependencies should have priority for treatment. Since some people with early stage dependency should also have priority, this presumption may have encouraged the assessors to label everyone middle and late stage.

MANDATED TREATMENT

At one time most treatment was court ordered. The current sentencing structure limits the number of sentence related requirements for treatment. Only ISRB cases can be ordered to treatment. The DOC requirements for placement in work release, reductions in custody levels, and access to special privileges, such as family visitation, are now what might be called "mandates" for treatment.

If treatment slots are limited, then requiring treatment as a pre-condition for work release, custody reductions, or special privileges can reduce the number of inmates who become eligible. This is not a constraint across all facilities; it is a constraint in some facilities.

For example, at the Washington State Penitentiary, there are only five treatment classes a year within the Main Institution. But treatment is a requirement for movement to the Minimum Security Unit. It becomes a very narrow funnel.

The relationship between treatment slots and access to other institutional prerogatives could be reviewed institution by institution. This review might occur every other year since the relationships change as inmate populations and programs change.

DESIGN OF TREATMENT

SINGLE OR MULTIPLE MODALITIES

The present treatment program varies little from one staff person to another. It is not supposed to differ. The program offers the same mix of educational material, group therapy and individual contacts whether the participant is an aging alcoholic or a young crack addict. Treatment is timed to precede release from prison by a few weeks. It is relatively short, about six weeks in length.

Research available when the program was designed ten years ago supported this configuration. Present research suggests otherwise. Ideally those scheduled for treatment would be divided into sub-groups and receive treatment tailored to the needs of their group.

This study was not designed to collect specific data with which to alter the program configurations. It is clear, however, as suggested above, that some of the present participants could be diverted to a community-based treatment program.

The remaining more serious offenders with a middle to late stage dependency would benefit from treatment that begins soon after reception. The initial phase might be the same mix of education and therapy as now. The latter phases should include a more intensive form of aftercare than now available. Some with more intractable problems should be effectively in a residential program, housed together as they leave reception.

Other inmates, particularly those convicted of drug crimes, might be required to participate in a more intensive, prison-based version of the alcohol and drug information schools now available in the community. Education about the dangers of drugs and alcohol is seen by institutional, community, and treatment staff as beneficial to certain types of offenders.

WORKLOAD

During the course of this study 1,550 inmates were assessed for chemical dependency. Most were found to need treatment. Just over two-thirds entered treatment during the nine months of the study. Almost 500 did not.

The current program operates in every institution. Some are too small to need a treatment staff person full-time; others are small enough to need only one. A few institutions have more than one treatment staff person.

Staff perform assessments and lead the program. Their daily schedules are disrupted by institutional demands. They speak of their long hours and the intense activity. Some move their base of operations from one institution to another as the program schedule requires.

DASA requires that chemical dependency counselors spend no more than 100 hours a month in face-to-face contact with clients. During the remaining hours they expect counselors to make collateral contacts and complete case notes and other paperwork. The treatment counselors in the institutions have a higher level of face-to-face contact, very few collateral contacts, and limited paperwork.

The current contract does not speak to the number of programs expected nor does it reference the number of assessments per program.

When treatment staff have program following program with a three week intermission for assessments, and when they conduct two or more assessments for every client admitted, then treatment staff are busy. In the smaller institutions and where other scheduling considerations reduce the number of treatment programs per year, this level of activity does not occur. When staff assess only enough to fill the next program, this level of activity does not occur.

If the program undergoes major revision, the level of staff activity becomes moot. If the program remains as it is, then workload should be reviewed.

FOLLOW-UP TREATMENT

Many see participation in self-help groups both within the prison system and in the community as central to long term success. For some clients aftercare while still in the prison system may be important. For others booster sessions may be important.

We looked only at the core program: the 91 hours of chemical dependency treatment. We were told about self-help groups, about aftercare, and about relapse prevention. Our impression is that these activities do not receive the emphasis that they should.

At minimum while the inmate remains in the facility where s/he received treatment, the treatment staff should monitor his/her participation in any follow-up treatment.

LINKAGES WITH COMMUNITY TREATMENT

Chemical dependency treatment requires follow-up, whether in a self-help group or another treatment modality. Treatment staff prepare discharge plans, discuss these with their clients, and send copies to the classification counselors. These plans specify the type of follow-up treatment staff think appropriate.

Classification counselors and the offenders themselves are the information bridge between the institutional system and community supervision. The classification counselors' report documents any chemical dependency discharge plan.

About half the time this transfer of information does not give Community Corrections Officers (CCO) a clear understanding of the offender's need for further chemical dependency treatment. When it does, the CCO often does not have any legal authority to require participation in treatment. Treatment is often not available or too expensive.

Despite these obstacles offenders on community supervision do get into treatment of various kinds. They do reduce their abuse of alcohol and drugs.

The Central Office should emphasize the need for connections between institutional treatment and community supervision. Classification counselors should document

chemical dependency discharge plans when the soon-to-be-released inmate has participated in treatment. Community Corrections Officers should review that plan with the offender, offering assistance in making connections to further professional treatment or self-help.

OUTCOME MEASURES

This study and the previous ones relied on infraction rates, including chemical dependency infractions, as the measure of program effectiveness. There was no impact on chemical dependency infractions. There was an impact on infractions for violent behavior. There was no good measure of remission or cessation of drug and alcohol use.

We would recommend that DOC continue to monitor the program using *violent* and *all* infractions as the measure. We suggest that both percentages and rates be used and that prison and community infractions be merged.

We suggest that for those offenders under community supervision the results of urinalysis be the measure of remission. If so, then for those offenders with an alcohol dependency, alcohol should be added to the test battery.

If a multiple modality program is developed, then the outcome measures should reflect the short-term results associated with the specific modalities. For example, inmates in an education program should be routinely tested before and after the program to determine if they have learned the material.

Since under any restructuring of the treatment program, the present intensive outpatient treatment will continue, at least for some inmates, short-term results should be assessed. For example, the efforts to help inmates develop skills in problem solving can be tested.

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APPENDICES

ATTITUDES AND BELIEFS ABOUT DRUG/ALCOHOL ADDICTIONS

Attitudes and beliefs about the use and abuse of drugs and alcohol must have an impact on the patterns of use and on the treatment for abuse. These relationships seem self-evident. There is little empirical information available on the specific attitudes and beliefs and their impact. Collectively we spent several weeks reviewing the literature. What we uncovered is not much.

The Institute of Medicine has compiled two significant pieces of work, one on the treatment of alcohol and the other on the treatment of drug addiction. These publications distill the most useful work on attitudes and beliefs.

The Institute of Medicine of the Division of Mental Health and Behavioral Medicine recently released a study on the treatment of alcoholism (Broadening the Base of Treatment for Alcohol Problems) which includes a section (IV) on "Special Populations in Treatment."

This section has four pertinent chapters: "An overview and definitions"; "Populations defined by structural characteristics" (including women, adolescents, the elderly, American Indians, Asian Americans and Pacific Islanders, African Americans, Hispanic Americans); "Populations defined by functional characteristics" (including drinking drivers, dual-diagnosis psychiatric patients, homeless persons, college students, children of alcoholics); and "Conclusions and recommendations" (Glaser et al). Each chapter in this volume has an extensive bibliography.

The authors conclude that "despite the current emphasis on subtype variability, the treatment blend of individual characteristics, attitudes, traits, and special population membership nuances have yet to be empirically determined."

In the same year the Institute of Medicine completed a study of substance abuse treatment, Treating Drug Problems: Volume 1 (Gerstein and Harwood, 1990). Chapter 3: "The Need for Treatment" includes some material on attitudes. However, this information is much sketchier than that available on alcohol use and abuse, perhaps because the patterns of illicit drug use change with some rapidity.

The most recent volume in the Institute of Medicine's series: Treating Drug Problems: Volume 2 includes a chapter on "Repeating Cycles of Cocaine Use and Abuse," by Ronald Siegel, which describes the changing attitudes toward the use of that drug (Gerstein and Harwood, 1992).

The inclusion of attitudes and beliefs in other books and articles does not appear to be systematic. For example, some of the learning theorists are interested in attitudes and beliefs and use alcohol and drug addicted populations in their work. As a result they may

report some findings that are relevant to DOC's interest, but are tangential to their interest.

For example, Fishbein and Ajzen have combined learning and cognitive dissonance theories to show the relationships between attitudes and beliefs and alcoholic behavior. They hypothesize that when the alcoholic's attitudes and beliefs about the use and abuse of alcohol are too dissonant with those of his/her friends and family, then s/he is more amenable to treatment.

This approach suggests that understanding the differences in attitudes about alcohol and drug use is critical to tailoring the design of a treatment program to the needs of the persons being treated.

There are other scattered findings, primarily about alcohol.

Judd, Owens and Self note that attitudes about drinking are formed early, by eight or ten years of age, and are significantly influenced by family or other care givers. This is consistent with the finding that a family history of alcoholism is often a precursor of alcohol abuse (Penick et al; and Volicer et al).

The elderly with diminished social supports (and reinforcers of attitudes about drinking) are more vulnerable to alcoholism (Schonfeld). One function AA serves is to reinforce attitudes about drinking although attendance at AA does not distinguish between abstainers and those who relapse (Gilbert).

Another group of findings on attitudes and beliefs emerge from the literature on efficacy and health care, which is an interest often associated with nursing. Women who generally have more positive attitudes about health care than men, do not have these positive attitudes if they are alcoholic. Thus, women who enter alcoholism treatment must have other motivating factors which overcome their attitudinal opposition to treatment (Beckman and Amaro).

One study of treatment for alcoholism tried to modify beliefs in treatment with some success, but had no effect on attrition rates (Rees, 1986). An earlier study at the same location found that persons who believed their problems were less serious and that the clinic could be of little help were more likely to drop out early (Rees, 1985).

Some work has shown that persons who believe they are powerless to affect their drinking are more likely to remain abstinent following treatment (Gilbert). Yet, another study shows that belief in self-efficacy at intake was not associated with successful treatment for alcoholism (Miller et al).

Another thread in this literature comes from marketing. Ingram and his colleagues use marketing theory to develop an alcoholism assessment model which postulates relationships between personal attributes, such as attitudes and beliefs, and decisions

regarding when and how much to drink, commitment to treatment, and success in treatment.

Judd, Owens and Self use research findings regarding alcohol use and abuse to describe market groups. In the process they discuss a number of findings on attitudes and beliefs. Native American seventh and eighth graders expressed positive attitudes toward drinking, but Asian Americans have cultural taboos against heavy drinking. Hispanics view alcoholism as a moral weakness, not a condition needing treatment.

These materials suggest few specific additions to the data now collected by DOC or treatment agency staff. One fruitful area might build on the cognitive dissonance work of Fishbein and Ajzen, and query inmates about their attitudes and those of their families and friends about drinking and drug use.

Given the poor quality of the data now reported by inmates to treatment staff on family drinking patterns, which are also relevant, and on psychological correlates, such as suicide ideation, there seems little to be gained in adding data elements.

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DOC: CHEMICAL DEPENDENCY TREATMENT PROJECT

CODING MANUAL: 9/15/92
(Developed from a combination of DOP treatment and OBTS files)

___ 1. OBTS number (DOCNUM): numeric, 6 digits

___ 2. Date of birth (DOB): mm/dd/yr

___ 3. Date of current admission (ADMDATE): mm/dd/yr

___ 4. Date of earliest possible release (ERD): mm/dd/yr

___ 5. Date of release from previously completed imprisonment (RELDATE): mm/dd/yr

___ 6. Name as recorded in OBTS (NAME): alpha, all caps

___ 7. Name as recorded in treatment file, or alias (LOTNAME): alpha, caps and lower case

___ 8. Gender (SEX): numeric
01 = Male
02 = Female

___ 9. Race (RACE): numeric
01 = White
02 = Black/African American
03 = Native American Indian
05 = Asian or Pacific Islander
06 = Eskimo
07 = Aleut
08 = Other, please specify
09 = Unknown

___ 10. Inmate status (OFFSTAC): numeric
01 = Active - Field
02 = Active - Inmate
03 = Closed

___ 11. Offense (OFF): numeric
11 = Murder 1
12 = Murder 2
21 = Manslaughter 1 & 2
22 = Vehicular Homicide
41 = Rape 1
42 = Rape 2
43 = Rape other
44 = Rape of a child
45 = Violent sex, child
46 = Indecent liberties
47 = Non-violent sex, child
48 = Other sex crimes
51 = Robbery 1
52 = Robbery 2
53 = Extortion 1
54 = Extortion 2
61 = Assault 1
62 = Assault 2
63 = Vehicular assault
64 = Assault other
65 = Kidnap 1
66 = Kidnap 2
71 = Arson 1 & 2
72 = Burglary 1
73 = Burglary 2
74 = Theft
75 = Auto theft
76 = Forgery
77 = Welfare fraud
78 = Other property
81 = Drug crime
91 = Other felony
92 = Other misdemeanor
99 = Unknown

___ 12. Prior convictions (PRIORS): alpha
Yes
No

___ 13. Seriousness of offense (SERLEVEL): numeric
Level (0 through 15; 99 = "missing")

___ 14. Criminal history of offender (SRASCORE): numeric
Score (0 through 9; 99 = "missing")

___ 15. Sentenced under what law (ISRBSRA): numeric
01 = SRA
02 = Pre-SRA
03 = Both

___ 16. Current DOC institution (CURLOC): alphanumeric
B01 = Clallam Bay Correction Center
I01 = McNeil Island Corrections Center
G01 = Twin Rivers Corrections Center
H01 = Washington Corrections Center
F01 = Washington Corrections Center for Women
E01 = Washington State Penitentiary
D01 = Washington State Reformatory
O01 = Cedar Creek Corrections Center
K01 = Indian Ridge Corrections Center
N01 = Larch Corrections Center
M01 = Olympic Correctional Center
J01 = Pine Lodge Correctional Center
D03 = Washington State Reformatory Farm
708 = Eastern Washington Pre-Release
709 = Tacoma Pre-Release

___ 17. Type of admission (ADMTYPE): numeric
07 = Community Custody Inmate (CCI) Violation
08 = CCI Termination
10 = New admission
11 = Parole violation and new sentence
13 = Parole violation
14 = Readmission
17 = From other state
87 = Boarder
99 = Other

___ 18. Institution released from (RELFROM): alphanumeric
B01 = Clallam Bay Correction Center
I01 = McNeil Island Corrections Center
G01 = Twin Rivers Corrections Center
H01 = Washington Corrections Center
F01 = Washington Corrections Center for Women
E01 = Washington State Penitentiary
D01 = Washington State Reformatory
O01 = Cedar Creek Corrections Center
K01 = Indian Ridge Corrections Center

N01 = Larch Corrections Center
M01 = Olympic Correctional Center
J01 = Pine Lodge Correctional Center
D03 = Washington State Reformatory Farm
708 = Eastern Washington Pre-Release
709 = Tacoma Pre-Release

___ 19. Type of release (RELTYPE): numeric
40 = Discharge
43 = Community custody inmates (CCI)
44 = Post-release supervision (PRS)
60 = Parole
61 = Parole to work release
75 = Death
77 = Death

___ 20. Office responsible for community supervision (OFFICE): numeric
001 = Tacoma
106 = Spokane
107 = Wenatchee
108 = Spokane
110 = Spokane
112 = Pasco
115 = Yakima
118 = Sunnyside
119 = Kennewick
121 = Clarkston
220 = Everett
222 = Lynnwood
224 = Mt. Vernon
225 = Everett
226 = Bellingham
228 = Seattle
230 = Seattle
231 = Bellevue
232 = Burien
235 = Northgate
236 = Seattle
237 = Renton
239 = Seattle (Capitol Hill)
242 = Seattle (Warrants)
243 = Seattle (Capitol Hill)
244 = Seattle
351 = Bremerton
352 = Lakewood
353 = Tacoma

354 = Tacoma
355 = Puyallup
360 = Lakewood
363 = Longview
364 = Olympia
365 = Port Angeles
366 = Vancouver
368 = Shelton
370 = Vancouver
371 = Port Townsend

___ 21. Community status (STATUS): numeric
10 = Closed
20 = Unsupv. appeal
30 = Inactive mtrg.
33 = INS custody
34 = Deported
35 = CDFS
38 = Inactive, P-W/R
40 = Active, fld.
42 = Active, det. jail
43 = Inact, det. P/WR
44 = Active, SPC
46 = Active, IPT
47 = Active, JUV
48 = Active, CCT
50 = Suspend
56 = SUS, det. jail-OS
58 = SUS, det. jail
60 = Bench warrant
61 = BW action pend.
66 = BW det. jail-OS
68 = VW det. jail
70 = Abscond
71 = ABS, action pend.
74 = Detained jail
76 = ABS, det. jail-OS
78 = ABS, det. jail
79 = ABS, det. prison
80 = CCI (escaped)
85 = OOS
86 = CCI escaped, det OS
88 = CCI escaped, det JL
90 = Deceased

___ 22. Classification upon release (BODY): alpha

FA = Community placement special sex/drug units, close supervision
FB = Community placement special sex/drug units, medium supervision
FC = Community placement special sex/drug units, minimum supervision
FD = Community placement special sex/drug units, limited contact
IA = SRA Waivers/Crime Related Prohibitions (CRP), close supervision
IB = Criminally insane, medium supervision
IC = SRA W/CRP, minimum supervision
ID = SRA, limited contact
MA = Indeterminate entry, close supervision
MB = SRA without CRPs, with community service and/or treatment and/or affirmative conduct, medium supervision
MC = SRA without CRPs, with community service and/or treatment and/or affirmative conduct, minimum supervision
MD = SRA without CRPs, with community service and/or treatment and/or affirmative conduct, limited contact
QA = Mail-in (conditions) and 6 month reviews
QD = Limited contact
UA = Bench warrant
UB = B/I Phone reporting
UC = Pending bench warrants for UB cases, inactive, parole absconders, community custody escapees, CDFS (??), deportation, unsupervised appeal, inactive/prison
UD = SRA Legal Financial Obligation; SRA without
CRP= Community service, treatment or affirmative conduct, limited contact

___ 23. Spanish origin (HISPANIC): alpha

H = Yes
N = No
U = Unknown

___ 24. Last month of substance abuse treatment (MONTH): alpha

___ 25. Institution where treatment received (FAC): alphanumeric

B01 = Clallam Bay Correction Center
I01 = McNeil Island Corrections Center
G01 = Twin Rivers Corrections Center
H01 = Washington Corrections Center
F01 = Washington Corrections Center for Women
E01 = Washington State Penitentiary

D01 = Washington State Reformatory
O01 = Cedar Creek Corrections Center
K01 = Indian Ridge Corrections Center
N01 = Larch Corrections Center
M01 = Olympic Correctional Center
J01 = Pine Lodge Correctional Center
D03 = Washington State Reformatory Farm
708 = Eastern Washington Pre-Release
709 = Tacoma Pre-Release

___ 26. Highest treatment level completed (LEVEL): alphanumeric
A = Accepted
D = Discharged
C = Completed
R = Refused evaluation

RE =	Refused evaluation
RP =	Refused treatment
RJ1 =	Rejected, no significant problem
RJ2 =	Rejected, substance abuser no dependency
RJ3 =	Rejected, medical/psychiatric/other problem
D1 =	Discharged due to chemical dependency infraction
D2 =	Discharged due to release
D3 =	Discharged due to transfer
D4 =	Discharged due to segregation
D5 =	Discharged due to staff termination
D6 =	Discharged due to self termination
21 =	Recommend Work Release intensive out-patient and/or community-based in-patient
22 =	Recommend work release intensive out-patient and/or community-based intensive out-patient
33 =	Recommend work release out-patient and/or community-based out-patient
44 =	Recommend work release aftercare and/or community-based aftercare

DOC: CHEMICAL DEPENDENCY TREATMENT PROJECT
TREATMENT DATA COLLECTION FORM

MCNEIL ISLAND AND WASHINGTON STATE PENITENTIARY

___ Date of birth (mm/dd/yr) (DOB)

___ OBTS number (DOCNUM) (numeric)

___ OBTS Name

___ TX Name (if not the same)

___ Institution where treated
01 = Washington State Penitentiary
02 = McNeil Island Corrections Center

___ Substance abuse treatment order
1 = ISRB or parole board (M1)
2 = Headquarters screening committee (HCSC) (M2)
3 = DCC/DOP (M3)
4 = Court (M4)
5 = Classification counselor or unit team
6 = Inmate request
7 = Offense history
9 = No request

___ Highest grade completed

01 = Less than 8th grade
02 = Completed through 8th grade
03 = Completed through 10th grade
04 = Completed through 12th grade
05 = Completed GED
06 = Post high school education

___ Usual occupation

1 = Laborer
2 = Maintenance worker
3 = Pipe layer/fitter
4 = Barber
5 = Forklift operator
6 = Fisherman
7 = Landscaper

8 = Carpenter
9 = Mechanic
10 = Construction worker
11 = Custodian
12 = Sheet metal worker
13 = Materials handler
14 = Forestry worker
15 = Tow truck operator
16 = Cook
17 = Plumber
18 = Machine operator
19 = Welder
20 = Electrician
21 = Logger
22 = Woodworker
23 = Hunting guide
24 = Cabinet builder
25 = Crane operator
26 = Warehouser
27 = Clerk/typist
28 = Dishwasher
29 = Musician
30 = Nurse's aid
31 = Longshoreman
32 = Salesman
33 = Grocery worker
34 = Machinist
35 = Carpet installer
36 = Dock worker
39 = Painter
40 = Delivery truck driver
41 = Film/video technician
42 = Roofer
43 = Garbage collector
44 = Teamster
45 = Fruit packer
46 = Roughneck
47 = Insurance agent
48 = Baker
49 = Artist
50 = Body shop worker
51 = Waiter
52 = Counselor
53 = Contractor
54 = Landscaper
55 = Meat cutter

56 = Restaurant worker

___ Marital status

01 = Married, or in union
02 = Separated
03 = Divorced
04 = Never married
09 = Unknown

___ Number of children

___ Significant medical problems, other than substance abuse

01 = Yes
02 = No

___ If in substance abuse treatment before, how many times in treatment?

___ Was the inmate in the military?

01 = Yes
02 = No

___ Did s/he use alcohol/drugs while in the military?

01 = Yes
02 = No

___ Was the inmate released from the military to a substance abuse treatment program?

01 = Yes
02 = No

(the following data were collected at McNeil Island only)

___ If family members use alcohol, how many do so?

___ Are there members of the:

01 = Immediate family
02 = Extended family
03 = Both

___ Did a family member drink regularly?

01 = Yes
02 = No

___ Did family members get drunk?

01 = Yes
02 = No

___ Were these members of the:

01 = Immediate family
02 = Extended family
03 = Both

___ Did members of the family have problems with alcohol?

01 = Yes
02 = No

___ Was a family member treated for alcohol problems?

01 = Yes
02 = No

___ Did any of the grandparents have a problem with alcohol?

01 = Yes
02 = No

___ Did any family member use drugs?

01 = Yes
02 = No

___ Did any family member have a problem with drugs?

01 = Yes
02 = No

(the following data were collected at Washington State Penitentiary only)

___ Is s/he unusually fearful?

01 = Yes
02 = No

___ Has s/he had thoughts of suicide?

01 = Yes
02 = No

___ Has s/he made a suicide attempt?

01 = Yes
02 = No

___ Does s/he have difficulty with violent behavior?

01 = Yes
02 = No

___ When out, does s/he have problems at work or school?

01 = Yes
02 = No

___ Does s/he have problems with institutional work or school?

01 = Yes
02 = No

___ Does s/he have a history of depression?

01 = Yes
02 = No

___ Has s/he been hospitalized or treated on an outpatient basis for an emotional or related problem?

01 = Yes
02 = No

___ When out, does s/he have difficulty socializing with new friends without drugs/alcohol?

01 = Yes
02 = No

___ On the street, is s/he depressed?

01 = Yes
02 = No

___ On the street, is s/he agitated?

01 = Yes
02 = No

___ On the street, is s/he anxious?

01 = Yes
02 = No

___ On the street, is s/he confused?

01 = Yes
02 = No

___ On the street, is s/he fearful?

01 = Yes
02 = No

___ On the street, is s/he angry?

01 = Yes
02 = No

___ On the street, is s/he ashamed?

01 = Yes
02 = No

___ On the street, is s/he hostile?

01 = Yes
02 = No

___ How does s/he rate own self esteem?

01 = low
02 = satisfactory

___ Does s/he believe in a higher power?

01 = Yes
02 = No

___ Does s/he have hopes for recovery?

01 = Yes
02 = No

___ On the street, how much does s/he spend per week on alcohol or drugs?

___ Does s/he have drug debts?

01 = Yes
02 = No

(the following data were collected for both McNeil Island and WSP clients)

___ Date evaluated by treatment staff (yy/mm/dd)

___ No problem. (01=yes; 02=no)

___ Substance abuser, no signs/symptoms of dependency. (01=yes; 02=no)

___ Primary dependency.

01 = Alcohol
02 = Cocaine
03 = Heroin
04 = Barbiturates

05 = Narcotics
06 = Tranquilizers
07 = Amphetamines
08 = Hallucinogens
09 = Marijuana
10 = Other, please specify

____ Phase.

01 = Early
02 = Middle
03 = Late
04 = Fatal

____ Means of consumption

01 = Inhale
02 = Ingest
03 = Inject

____ Secondary dependency.

01 = Alcohol
02 = Cocaine
03 = Heroin
04 = Barbiturates
05 = Narcotics
06 = Tranquilizers
07 = Amphetamines
08 = Hallucinogens
09 = Marijuana
10 = Other, please specify

____ Phase.

01 = Early
02 = Middle
03 = Late
04 = Fatal

____ Means of consumption

01 = Inhale
02 = Ingest
03 = Inject

___ At what age did s/he first use drug on which *primarily* dependent?
___ At what age did s/he last use drug on which *primarily* dependent?

___ At what age did s/he first use drug on which *secondarily* dependent?
___ At what age did s/he last use drug on which *secondarily* dependent?

(for McNeil Island)

___ What was the usage (primary drug) when last used?

01 = Not at all, never
02 = Less than once a week, tried one or two times, once a month, two or three days monthly
03 = weekly or more

___ What was the usage (secondary drug) when last used?

01 = Not at all, never
02 = Less than once a week, tried one or two times, once a month, two or three days monthly
03 = weekly or more

(for WSP)

___ What was the usage during the last (3) months before jail?

01 = Not at all, never
02 = Less than once a week, tried one or two times, once a month, two or three days monthly
03 = weekly or more

___ What was the usage during the last (3) months before jail?

01 = Not at all, never
02 = Less than once a week, tried one or two times, once a month, two or three days monthly
03 = weekly or more

(for both groups)

___ Date treatment was completed.

URINALYSIS (from institutional records)
(for both groups)

____ First test

____ Date sample taken (yy/mm/dd)

____ Reason sampled

01 = Randomly selected
02 = Suspected drug use

____ Confirmed test

01 = Yes, positive
02 = No

____ Type of drug

01 = Alcohol
02 = Cocaine
03 = Heroin
04 = Barbiturates
05 = Narcotics
06 = Tranquilizers
07 = Amphetamines
08 = Hallucinogens
09 = Marijuana
10 = Other, please specify
11 = Polydrug

Repeat for each individual if there are more tests

DOC: CHEMICAL DEPENDENCY TREATMENT PROJECT
INTERVIEWS: TREATMENT AGENCY DIRECTORS

1. What are the objectives of your institutional intensive outpatient treatment?

   a. What are the activities?

   b. What are the desired outcomes?

2. What are the differences between the intensive outpatient treatment you provide within the institutions and the one you provide in the community?

3. How do you monitor your staff performance?

   In the institutions?

   In the community?

4. How do you monitor your treatment outcomes?

   In the institutions?

   In the community?

DOC: CHEMICAL DEPENDENCY TREATMENT PROJECT
INTERVIEWS: CORRECTIONAL PROGRAM MANAGERS

1. What types of inmates are sent to this institution?

2. What are the unique characteristics of this institutional setting?

3. What types of programs are available at this institution?

   Industry: _____

   Academic: _____

   Vocational: _____

   Treatment: _____

   Other: _____

4. What other programming is available at the same time as substance abuse treatment?

   Do these programs compete?

5. How are inmates selected for substance abuse treatment evaluations?

6. What do you consider desirable outcomes of substance abuse treatment?

7. How would you describe the relationship between what happens during treatment and the outcomes of treatment?

8. Does the treatment program here have unique characteristics?

9. Do the related substance abuse treatment activities, such as self help groups, have unique characteristics here?

DOC: CHEMICAL DEPENDENCY TREATMENT PROJECT
INTERVIEWS: CDCUS'

1. How are inmates selected for treatment assessment?

2. What characterizes those selected for treatment?

3. Is there other programming available at the same time?

   Do these programs compete?

4. What are the unique characteristics of treatment in this institution?

5. Are there unique characteristics of this institution that influence substance abuse treatment?

6. What do you consider desirable short term outcomes of substance abuse treatment?

7. How would you describe the relationship between what happens during treatment and the outcomes of treatment?

8. Do the related substance abuse treatment activities, such as self help groups, have unique characteristics here?

10. Are potential participants lost between assessment and actual participation?

11. Who is your designee here when you are at another institution?

DOC: CHEMICAL DEPENDENCY TREATMENT PROJECT
INTERVIEWS: TREATMENT AGENCY STAFF AND SUPERVISORS

1. Tell me about treatment in this facility.

2. What hours are you in the facility?

3. What are your class hours?

4. How do you handle group counseling: as part of the class sessions or at a separate time?

5. What is the structure to the group therapy sessions?

6. When do you schedule individual counseling?

7. How much contact with individual clients did you have in the last month in which you had a group in treatment?

8. How much contact with individual clients did you have in the last month in which you did not have a group in treatment?

9. What are the criteria for assessment?

   For admission to treatment?

10. Are there inmates who enter treatment using drugs/alcohol?

11. Do you prepare a treatment plan?

    What does it include?

12. Are clients given a copy of their plan?

13. How often do you review treatment plans?

14. How do you follow the curriculum prepared by your agency?

15. Do you write a discharge plan?

    What does it typically include?

16. How do you encourage inmates' participation in self-help groups?

17. How long have you been here?

18. What are your qualifications for this job:

    Educational:

    Work experience:

19. Do you have a history of chemical dependency?

20. Have you been in trouble with the law yourself?

21. When was your last performance evaluation?

22. Who conducted the evaluation?

23. What is your relationship with your supervisor?

24. How often do you see him or her?

25. What kind of training are you getting?

26. Are you feeling burned out?

27. What are the unique characteristics of treatment in this institution?

28. What are the unique characteristics of self help in this institution?

29. What do you think is most effective about this program?

DOC: CHEMICAL DEPENDENCY TREATMENT PROJECT
INTERVIEWS: COMMUNITY CORRECTIONS OFFICERS

TO FOLLOW-UP ON OFFENDERS RELEASED INTO COMMUNITY

NAME OF OFFENDER _____ DOC NUMBER _____

1. Do you know if (name) has a problem with substance abuse?
2. Was (name) treated prior to his/her release from prison?
3. Did you see anything in his/her file about a prison substance abuse assessment?
4. Did you see anything in his/her file about a prison substance abuse treatment?
5. Is (name) in some kind of treatment now?
6. What kind of treatment is s/he in?
7. Is s/he drinking or using now?
8. Please specify which or both.
9. If yes, on what do you base this assessment?
10. Has his/her use/drinking reached the point of serious abuse?
11. If yes, on what do you base this assessment?
12. Where is (name) living presently?

INFRACTIONS**

Violent

Assault/hospital (502)
Extortion (503)
Sexual acts (504)
Fighting (505)
Threatening (506)
Holding hostage (521)
Setting fire (553)
Possessing explosive or ammunition (601)
Possessing weapon (602)
Rioting (650)
Inciting riot (651)
Strong-arming (663)
Dangerous infraction (701)
Assault/non hospital (704)
Operational risk (800)
Assault/hospital (801)
Assault (802)
Sexual acts (804)
Fighting (805)
Threatening (806)
Possessing explosives or ammunition (817)
Possessing weapon (819)

Substance abuse

Possessing narcotics (603)
Refusing test (607)
Refusing breath test (608)
Making drugs (655)
Possessing narcotics/drugs (703)
Possessing alcohol (843)
Possessing marijuana (844)
Possessing narcotics (845)
Refusing test (846)
Making drugs (875)

Other

Other felonies/misdemeanors (507)
Throwing objects (508)
Furlough violation (525)
Escape (550)
Lying to hearing (551)
Lying to staff (552)
Destroying property (554)
Theft (555)
Refusing search (556)
Refusing to work (557)
Staff interference (558)
Gambling (559)
Tampering with lock (600)
Possessing clothing (605)
Group demonstration (652)
Interfering with count (653)
Counterfeiting/forgery (654)
Offering bribe (656)
Four general infractions, within six months (657)
Failure to perform (658)
Resisting sanctions (659)
Possessing money (660)
Fraud (662)
Attempting infraction (700)
Possessing unauthorized tool (702)
Poor conduct (705)
Lost future good time credit (799)
Failure to maintain room and board (810)
Unauthorized contract (811)
Failure to report income (812)
Unaccounted time or absence (813)
Violating a special condition of work release (814)
Violating laws or court orders (815)
Tampering with lock (816)
Possessing tool (818)
Violating conditions of furlough (825)
Escape vol. ret. (830)
Failure to return (831)
Escape (832)
Escape apprehension (834)
Lying to hearing (851)
Lying to staff (852)
Destroying property (854)
Theft (855)

Refusing search (856)
Refusing work (857)
Interfering with staff (858)
Gambling (859)
Possessing money (860)
Interfering with count (873)
Counterfeiting/forgery (874)
Four general infractions within six months (877)
Failure to perform (878)
Loss of good time credit (899)
Attempted infraction (900)

** Numbers 500 through 799 are prison infractions
Numbers 800-900 are community infractions