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Research Report

"Boot Camp" Drug Treatment and Aftercare Intervention: An Evaluation Review

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"Boot Camp" Drug Treatment and Aftercare Intervention: An Evaluation Review

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Chapter One: Introduction

The Center for the Study of Crime, Delinquency and Corrections at Southern Illinois University at Carbondale was awarded a research grant in fall 1991 by the National Institute of Justice to conduct an assessment of drug treatment and aftercare programs for offenders in boot camp prisons. The purpose of the research was to "inform Federal, State, and local agencies about possible ways to incorporate drug treatment into the inprison and aftercare phases of boot camp programs and to highlight particularly innovative programs that may be expected to reduce drug use successfully" (National Institute of Justice, 1991: 87). The specific objectives associated with this broad purpose include:

* Surveying and examining current drug education and drug treatment programming for offenders in boot camp prisons and during community supervision following release from boot camp.

* Identifying and describing innovative and effective drug treatment in boot camp prisons and in aftercare programs for offenders.

* Identifying these programs' common elements and developing recommendations for improving drug treatment for offenders.

* Producing a comprehensive report and executive summary for policymakers and practitioners that convey the results of this study.

This document is the project's comprehensive final report and presents researchers' findings and results. Whether the purposes of the research have been adequately accomplished will be left to the final determination of the readers. It is our conclusion, however, that certain objectives have been accomplished more effectively than others. Extensive descriptive research was conducted to assess drug treatment programming during the inprogram phase of the offenders' boot camp experience. Less complete information was available on what happened to boot camp graduates once they left the boot camp. Information was particularly incomplete for drug treatment services that may or may not have been delivered to boot camp participants. This is because the systematic delivery of drug treatment services during aftercare is commonly not clearly demarcated or well structured.

Even more problematic for researchers has been identifying "effective" drug treatment programming for boot camps during their inprogram and aftercare phases. Evaluative research that has direct bearing on this issue is simply not available. Rather, the present research identifies innovative and *potentially* effective programming on the basis of what is known about effective drug treatment programming in correctional environments and the free-world communities.

Problem Statement

Shock incarceration programs, more commonly known as boot camps, are one of the fastest growing forms of correctional intervention. Politically popular, these programs have generated a great deal of media attention and have been the subject of increased attention from the professional and academic community. Boot camps have also received generous financial and technical assistance from the Federal Government. Despite this attention and support, shock incarceration programs remain poorly understood.

Limited evaluative research has been available to inform sound policy and program development in the boot camp area. For instance, despite common knowledge that boot camps vary tremendously on a variety of dimensions related to the achievement of goals articulated by boot camp proponents, to date, correctional officials designing or modifying boot camp programming have not had access to a body of knowledge that identifies the essential components of effective boot camp drug treatment programs. Many boot camp supporters and correctional officials commonly call attention to the rehabilitation of criminal offenders as the primary goal of boot camps. Some boot camps have been designed to make positive impacts on drug abusing offenders, and even those boot camps not designed that way often include substance abuse programming. Yet little is known about such programming efforts.

Consequently, there are at least three germane research needs relating to substance abuse programming in boot camps that warrant attention. First, the nature of drug treatment interventions in boot camps' inprogram and aftercare phases needs to be assessed. Second, the treatment validity of these programs in light of what is known about drug treatment efficacy must be assessed. Third, those treatment components best suited to both boot camp environments and participants and those with the greatest potential to reduce recidivistic behavior of program participants need to be identified.

The goal of this research has been to fill these information gaps and to provide policymakers, practitioners, and researchers with a body of empirically based knowledge that can be used to improve the development,

functioning, and efficacy of adult shock incarceration programs, particularly with regard to their drug treatment and aftercare components.

Scope of This Report

There is some debate in the field as to what is meant by a "boot camp" and whether the term is even an appropriate descriptor of the many distinct types of programs and facilities that have recently emerged, which are loosely described as boot camps. Many jurisdictions do not use this term at all, even though their programs resemble "boot camps" in other jurisdictions and contain strong elements of a military model. For instance, "shock incarceration" is commonly used as an alternative term because it allows for broader connotations of what is meant by the correctional programming in question. Because of the interchangability of these terms, "shock incarceration" (SI) will be used as the primary referent throughout this report, although the term "boot camp" also will be used. Notwithstanding the acceptance of particular terms to classify the topic of interest, there is still a need to provide a meaningful and workable definition of the correctional phenomenon of interest in this study.

A recent review of shock incarceration presented a meaningful definition of what constitutes an SI program: (1) participation representing a sentencing alternative to a longer term in prison; (2) a boot camp atmosphere, with strict rules and discipline; (3) a requirement that offenders participate in military drills and physical training; and (4) a requirement that offenders be separated from other prison inmates (MacKenzie, 1990).

Using these criteria, the inclusion of a military model of drills and training was requisite for a program to be considered a shock program. We considered these criteria to be unduly constraining. It appears that some programs are emerging that abandon or lessen the emphasis on military-style training yet remain highly structured, intensive, and regimented, and share the common goals of boot camp programs (e.g., the U.S. Penitentiary at Lewisburg program and the Work Ethic Camps in Washington State). Alternatives to the military model exist—wilderness stress-challenge, job corps, and industrial models—that attempt to instill discipline and responsibility among program participants. Accordingly, a program was included in this analysis if the sponsoring correctional agency considered the program to be a shock incarceration program, the program included an intensive training component not necessarily based on a military model, and the program was considered to be an incarceration-based alternative to a traditional prison sentence. These broad criteria made it possible to conduct a nationwide review of innovative programs that were essentially similar to

"boot camps" and that might contain promising drug treatment and aftercare components.

The present research includes within its scope the identified universe of shock incarceration programs for adult offenders existing as of fall 1992, including facilities operated by Federal, State, and local governments. It must be emphasized that since fall 1992, it appears that many additional boot camps have opened their doors, especially those programs administered by local governments. These newer programs may exhibit characteristics quite different from those typically found in older programs. Thus, findings from this review may not be generalizable to the current universe of adult shock facilities.

Excluded from this assessment are juvenile shock incarceration programs, which are the subject of separately funded evaluations awarded by the National Institute of Justice to the American Institutes for Research. Although very little information is currently available on juvenile boot camps and their drug treatment and aftercare components, it is our impression that juvenile programs are incorporating innovative drug treatment programming. The lessons learned at juvenile camps are largely applicable to adult boot camps. It is also important to note that because the minimum age for adult court jurisdiction varies across the States, some adult boot camps house individuals who would be considered juveniles in other States. For instance, New York State's shock incarceration program includes large numbers of 16- and 17-year-olds. In other States, those individuals might be placed in juvenile programs. In effect, it can be argued that New York State operates the largest juvenile boot camp program in the Nation, and thus, in a limited fashion, this national assessment of programming efforts includes juvenile subjects.

Analytic Framework

This report draws upon a number of information sources and an analytical framework that go beyond the shock incarceration program surveys that have tended to simply identify facilities' major structural and program characteristics (e.g., MacKenzie, 1990; U.S. General Accounting Office, 1993; American Correctional Association, 1993). An integral part of this study's methodology was developing a structure that could be used to examine the "effectiveness" of drug treatment and aftercare programming in shock incarceration facilities that did not include the conduct of followup examinations of program participants.

One assumption supporting the development of boot camps is that these correctional environments bring about positive behavior change in targeted offenders more effectively than do traditional correctional environments. Another assumption is that some of the causal factors of criminality in these

offenders can be neutralized by treatment within the structured boot camp environment and subsequent postrelease programs. For instance, substance abuse often is considered a prime causal factor in criminal behavior, and thus, shock facilities commonly emphasize substance abuse treatment.

To evaluate the effectiveness of these programs, two dimensions must be considered. First, does the drug treatment paradigm competently deal with the offender's drug problem? Second, does the drug treatment program fit within the context of the larger boot camp/aftercare effort? Essentially, the first of these is a treatment issue, and the second is a program/policy issue. Thus, the structure of this inquiry revolves around these concepts: treatment competence and program/policy efficacy.

Using these two conceptual dimensions, inprison drug treatment and aftercare services are examined at three distinct levels of analysis—the system, the institution, and the individual. The structure of this methodology permits the identification of key elements at each level that may impact drug treatment effectiveness. It also allows for an examination of the linkages or articulation between the three levels. For example, by first identifying the stated system goals, policies, and contexts associated with drug treatment programming, and then assessing how the program is actually operating in the institution, the consistency between the two levels can be ascertained. An examination of this type can be completed only if information is acquired from within and across correctional systems from differing key respondents.

Consistent with this analytical framework, the study surveyed officials working at various levels of the correctional system in the delivery of substance abuse and aftercare programming. These subjects included key officials at the system level (e.g., program managers responsible for program formation and development) and officials at the facility level (e.g., shock facility superintendents and substance abuse programming directors responsible for programming implementation and delivery). In addition, three case studies of shock programs that have promising treatment components have been conducted; they include information derived from surveys of shock inmates. Details on these and other data collection efforts can be found in chapter 3.

This report's methodology allows treatment programs to be evaluated for clinical relevance and theoretical soundness, considerations that are central to the assessment of treatment efficacy (see Andrews, Zinger, Hoge, Bonta, Gendreau, and Cullen, 1990). For example, if a boot camp/aftercare program purports to employ a *therapeutic community* treatment regimen, one can assess whether the treatment program, as implemented, adheres to that regimen's general principles and whether it contains the essential elements of therapeutic communities found to be effective in differing or noncorrectional settings.

Organization of This Report

Chapter 2 provides background information on the boot camp movement to help readers better understand the contexts in which substance abuse programming is provided to offenders and how these contexts change over time. Particular attention is paid to shock incarceration facilities' goals and program structures. Chapter 2 also presents a portrait of substance abuse programming in SI facilities based on a review of program documents. A review of boot camp evaluative research is included that focuses on drug treatment program efficacy, the impact of boot camp participation on substance abusing behavior, and boot camp success in reducing offender recidivism.

Chapter 3 presents an overview of this study's data collection efforts and methodology. It describes in detail the multilevel survey efforts utilized to assess both the treatment competence and programmatic fit of substance abuse and aftercare programming within the context and structure of the shock incarceration experience.

Chapter 4 discusses the responses of SI officials at both the system and facility levels to survey questions about their facilities' goals and programming structures. The congruence of responses among correctional officials in the same jurisdiction is assessed to determine how substance abuse programming fits into the larger correctional system.

Chapter 5 presents the results of this study's survey efforts and detailed analysis of substance abuse treatment and aftercare programming associated with shock incarceration facilities. Focus is placed on the mix of substance abuse education and treatment programming; the types of treatment modalities and interventions used in the delivery of substance abuse treatment programming; assessment processes; and staffing patterns. A separate section of chapter 5 provides descriptive information on aftercare programming for boot camp graduates. Conclusions regarding the treatment integrity and potential treatment efficacy of programming are also presented.

Chapter 6 includes a series of three case studies of shock programs that were identified as particularly innovative and/or potentially effective with regard to substance abuse programming. Significant issues that may hinder the potential success of even these programs are discussed.

Chapter 7 discusses issues involved in the delivery of substance abuse and aftercare programs in shock facilities and recommends ways to improve these programs. These recommendations are based on a review of recent literature on drug treatment programming in criminal justice environments and on factors associated with effective drug treatment in such environments.

Chapter Two: Substance Abuse/Aftercare Programming in Shock Incarceration Programs: Views from the Literature

Shock incarceration has been sold to the public largely on the basis of visceral appeal generated by media images of drill instructors barking commands at attentive and meek-looking young convicts. Perhaps because of this public perception, observers of the boot camp phenomenon have tended to emphasize the programs' rigid, paramilitary style of operation while neglecting their more traditional treatment components. It is not commonly recognized that in some shock incarceration programs participants spend an amount of time in rehabilitation activities that equals or is greater than the amount of time they spend working or engaging in physical training/drills (MacKenzie, 1990a: 45; see also Cronin, 1994: 27-29). Nor is it often acknowledged that in some jurisdictions the boot camp movement appears to have created an alternative correctional environment that integrates prison treatment and security functions into smoothly functioning daily activities and avoids many of the systemic problems commonly found in traditional prison facilities. For instance, in a review of prison drug treatment programming, Castellano and Beck concluded that New York State's shock incarceration program

> is built upon a model in which treatment goals are co-extensive with custody goals and correctional programming is designed to present strong articulation across organizational subsystems. Custody, treatment, education, housing, and release components are extensively intertwined to support rather than conflict with each other. . . . Widespread organizational change congruent with the establishment of a bona fide and widely accepted program of drug rehabilitation seems to have been achieved (1991: 133).

It is thus germane to assess how drug treatment and aftercare programming fits into the goals and programming structures of shock incarceration facilities.

The Goals of Shock Programming

According to Parent (1989) and Osler (1991), incapacitation, rehabilitation, retribution, and deterrence are all commonly espoused goals of SI programs. However, these traditional aims of the correctional sanction have not been used systematically to understand the motivations behind the emergence of boot camps or the decisions to employ particular program models.

In January 1990, 7 of the 14 States operating SI programs were chosen to participate in a multisite study sponsored by the National Institute of Justice (NIJ). These SI programs were selected because they exhibited similar characteristics that NIJ used to define such programs (e.g., all programs operated in a boot camp atmosphere with strict rules and discipline). One purpose of NIJ's research was to determine if SI programs were successful in attaining their stated goals. MacKenzie's work in this area (1990) presents clearly defined goals that apply to specific individuals or groups that are directly affected by SI programs: the correctional system, the offender, the public, and the individual correctional facilities. From interviews and official agency documents, the following goals were identified (MacKenzie, 1990):

System-Level Goals Reduce Crowding Establish Alternative to Longer-term Incarceration Reduce Cost Create Model for County Programs	**Public Relations Goals** Improve Image of Corrections Provide Politically Acceptable Alternative Enhance Public Safety
Prison Control/Management Goals Ensure Clean, Healthy, Secure Environment Create Environment Promoting Rehabilitation Promote Positive Offender/Staff Contact Develop Offender Accountability	**Individual-Level Goals** Change Offenders: Less Negative Behavior and Less Criminal Activity Change Offenders: More Positive Attitudes/ Behavior/Motivation Improve Confidence/Responsibility/Discipline/ Accountability Reduce Drug Use Increase Respect for Authority

Among programs in the seven States studied in 1990, MacKenzie reported a high number consistently identifying system-level goals, with the exception of the program to be used as a model for county programs. Individual-level goals were also reported by the majority of States. Specific goals, however, varied between States. Only a few States listed the public relations goals, and when mentioned, improving the image of corrections was

most commonly identified. Finally, only one of the seven States listed goals related to prison control/management as purposes of their SI programs (MacKenzie, 1990).

An additional survey was conducted by MacKenzie in 1992 to obtain updated information on the goals of shock incarceration programs. However, the multitarget goal classification (i.e., system-level, individual-level, public relations, and prison control/management) previously developed was not used. Instead, as seen below, the goal selections available to program respondents included a mix of core system aims, multitarget group goals, and programs elements.

Core System Aims	Multitarget Group Aims	Program Elements
Rehabilitation	Recidivism Reduction	Drug Education
Deterrence	Crowding Reduction	Work Skills
Punishment/Retribution	Prison Environment Safety	Vocational Education
		Drug Treatment
		General Education

A sample of 41 administrators responsible for developing and/or overseeing the boot camps were asked to rate the relative importance of these 11 possible program goals. Rehabilitation, recidivism reduction, drug education, and the reduction of prison crowding were ranked the highest by respondents. Vocational education and punishment were identified as less important goals (Elis, MacKenzie, and Souryal, unpublished; see also MacKenzie, 1993).

When discussing what is to be achieved by SI programs, a distinction should be made between program *goals* and program *elements*. Five of the 11 goals listed by Elis, MacKenzie, and Souryal are generally considered to be program elements—activities in which offenders participate—rather than program goals. That is, these program elements are the means rather than the ends of SI. Furthermore, three of the remaining six goals are core system aims which can be considered to be broader constructs subsuming more narrowly defined correctional goals (e.g., rehabilitation includes reduced recidivism).

In their review of boot camps, U.S. General Accounting Office (GAO) researchers asked boot camp administrators to rank boot camp objectives on a scale of "very great importance" to "little or no importance" (GAO, 1993). On this scale "drug treatment and education" was rated very highly by the respondents and was rated in a manner suggesting that this objective was almost as highly valued as meeting the "need for alternatives to traditional incarceration" and "improving self-esteem." Of the 53 respondents, 32 rated drug treatment and education as a "very great" objective, 13 rated it as a "great" objective, 7 rated it as a "moderate" objective, and 1 rated it as having only "some" importance. No one accorded the drug treatment objective as having "little or no" importance (pp. 19-20).

The GAO report suffers from some of the same problems found in earlier research on the shock facilities' goal structure, but it does suggest that making positive impacts on the behavior of program participants, especially in terms of reducing substance abusing behavior, is a primary goal of most SI programs. Survey data on the goals of adult boot camp programming generated by the American Institutes for Research during May-June 1993 further buttress this conclusion (Cronin, 1994: 14-15). Likewise, Austin, Jones, and Bolyard's 1993 study of jail boot camps revealed goal structures very similar to those previously reported for adult boot camps. All of the jail boot camps reported rehabilitation as a program goal. Drug education and drug treatment were also listed as important goals by all responding agencies. All agencies also reported drug education and/or counseling as a program component.

This report's review of SI program goals indicates that a wide number of goals seem to animate such programming. Unfortunately, attempts to measure goal orientations at different points in time have used different goal definitions and questionable goal classifications, making it difficult to trace how goal structures may have changed over time.

Moreover, the goal primacy attributed to offender rehabilitation and the value accorded substance abuse programming across shock facilities begs a number of programmatic and research issues. Perhaps most importantly, if boot camps are premised on goals seeking to change offender behavior, then detailed knowledge of specific program components is needed to inform policy debates and program development. For instance, at least some criticism of boot camps is based on their presumed inability to produce rehabilitated offenders because military-style basic training programs tend to generate attitudes and behavior (e.g., an unquestioned obedience to authority, aggression, and the use of force to resolve conflicts) that are inconsistent with prosocial behavior (see Morash and Rucker, 1990). Such criticism appears at least partially based on a lack of awareness of the traditional treatment components sometimes found in SI programs (see MacKenzie, 1990a, for a similar response).

Whether or not this criticism is valid, most observers of shock programming agree that there is a need for congruence between facilities' goals and program components. For instance, in a briefing report of New Jersey's Criminal Disposition Commission, Alternatives to Incarceration Committee, the importance of a direct link between program goals and activities/tasks was stressed:

> If states are pursuing rehabilitative goals, boot camp programs must devote resources toward that end to provide counseling and treatment services. These rehabilitative programs should be the primary focus of the boot camp experience since chemical dependency is unlikely to be eradicated through drill and discipline without treatment. Boot camps that aim to rehabilitate offenders must require *at least* six months participation and provide for 'intensive' supervision and aftercare upon release to allow for continuity in the reintegration experience. (Coyle, 1990: 7).

Thus, it is clear that successful goal achievement requires a strong articulation between program goals and program elements. It is also apparent, however, that goal achievement is likely only if efficacious program elements are put in place. Accordingly, the following section of this report presents basic information on correctional substance abuse treatment programming that treatment-oriented researchers and practitioners consider to be effective.

An Overview of Effective Drug Treatment in Correctional Settings

Despite longstanding beliefs that rehabilitative efforts aimed at substance abusing offenders are relatively ineffective (Lipton, Martinson, and Wilks, 1975; Carter and Klein, 1976), and more recent evidence that clients with extensive criminal involvement before treatment tend to exhibit poorer outcomes than do persons without such a history (Simpson and Sells, 1982; Hubbard, Marsden, Rachal, Harwood, Cavanaugh, and Ginzburg, 1989: 129–130), significant research results indicate that "correctional drug treatment programs can have a substantial effect on the behavior of chronic drug abusing offenders" (Anglin and Hser, 1990: 427). Moreover, effectiveness is not diminished when the criminal justice system coerces offenders into treatment prior to sentencing or as a postconviction condition of probation or parole.

Evaluations of substance abuse treatment programs, most of which until recently have been of community-based programs, also indicate that not all treatment programs are equally effective. Results can vary widely, depending to a large extent on how programs are implemented. Factors associated with

effective correctional drug treatment programs tend to parallel those associated with effective noncriminal programs.

Researchers have identified specific therapeutic strategies and program characteristics that have produced efficacious results among substance abusing criminal offenders. For instance, Andrews and Keisling (1980), The National Task Force on Correctional Substance Abuse Strategies (1991), Peters (1993), and Wellisch, Anglin, and Pendergast (1993) have each suggested comparable principles of effective correctional drug treatment. Moreover, many of these principles are similar to those associated with correctional treatment programs that have been found to result in reduced levels of offender recidivism (Gendreau and Ross, 1987; Andrews and Bonta, 1994). Some of these principles are listed below.

1. Develop political, organizational, and financial support within the correctional system to implement substance abuse and aftercare programming.

2. Use a coordinated approach in the design and implementation of substance abuse programs that involves both substance abuse and custody staff.

3. Establish standardized and comprehensive assessment procedures and case management systems. Match inmates to treatment services according to results of the assessment.

4. Provide multimodal treatment services that reflect a range of quality programs. Treatment activities should address the range of psychosocial problems and areas of deficit that may result in unsuccessful recovery.

5. Set up the treatment program to be independent (within security structures) of the prison administration. (The program should be autonomous with its own funding.) If this is not possible, provide a treatment unit that reduces the negative and corrosive influences of the general inmate population.

6. Enroll prisoners in treatment programs when their remaining period of incarceration is only as long or slightly longer than the length of the incustody part of their treatment programs. In doing so, encourage sustained participation in substance abuse treatment and ensure treatment lengths are at least 3 months.

7. Select a high-quality professional staff, composed mainly of those who have professional skills and those who can function as role models.

7a. Have program staff provide anti-criminal modeling that inmates can regard as behavior worth imitating. In addition, staff should develop quality interpersonal relationships with inmates, demonstrating their care and concern for their well-being.

8. Implement strategies that give participants a stake in the success of the program as a whole and in their rehabilitation.

9. Make continuing care during transition and return to the community, and a lengthy period of supervision in the community, integral parts of the treatment program.

9a. Plan for inmates' transition into the community early in program development.

9b. Use community resources to provide services relevant to inmates' needs.

10. Teach coping skills that may enable inmates to deal with high-risk situations that are likely to precipitate their return to or involvement in illegal activity upon release.

In the last chapter of this report, the quality of substance abuse treatment programming in correctional boot camps is assessed on the basis of adherence to these principles. Before the treatment efficacy of boot camp drug treatment programming can be assessed, however, it is first necessary to describe what is currently known about substance abuse programming in correctional boot camps. Providing effective drug treatment to clients in a correctional setting remains an imprecise and uncertain enterprise, but there is persuasive evidence that certain types of correctional drug treatment programs have proven to be effective with particular correctional subpopulations.

The Extent and Nature of Substance Abuse/Aftercare Programming in Shock Programs

Prior survey results. Most studies reporting information on the degree to which shock facilities target drug offenders or incorporate some form of substance abuse programming indicate that SI facilities emphasize both of these program areas. Unfortunately, these studies present little descriptive or relevant evaluative information.

Warnock and Hunzeker (1991) conducted a literature and statutory review of boot camps at a time when 23 States operated boot camps. They reported that New Mexico and Wisconsin specifically targeted certain drug offenders for participation in boot camps and that in Tennessee certain drug

offenders were statutorily excluded from participation. Warnock and Hunzeker also reported that statutes in at least 10 States specified that drug and alcohol education or treatment be provided in boot camps:

> In at least one State, DOC officials recommend to the sentencing judge that drug offenders be required to attend outpatient drug counseling upon release, and in a few other States the statute specifies that drug offenders be sent to drug treatment or educational programs upon release. Two States—Wisconsin and Indiana—statutorily require drug treatment upon release from boot camp (1991: 3).

In a related vein, Elis, MacKenzie, and Souryal's telephone survey of State and Federal correctional officials in March 1991 identified two boot camps specifically designed for drug offenders (1992).

An article published in *Corrections Compendium* in January 1991 included survey results from the 27 State boot camps then in existence. The article reported that 26 of the 27 facilities surveyed included (or would include) alcohol/drug treatment programs, 24 offered counseling, and 23 offered educational programming. The only State program that did not offer alcohol/drug treatment was Georgia, while Louisiana and South Carolina provided alcohol/drug education instead of alcohol/drug treatment (Marlette, 1991).

The fairly detailed 1993 GAO report on boot camps did not include much information on the drug treatment programming or aftercare components of SI programs (GAO, 1993). The GAO did state, however, that a hallmark of the typical boot camp "is its emphasis on providing the participants skills and assistance that will help them adapt to the outside world upon release" (1993: 18). Unfortunately, the GAO could not support this claim very well because no attempt was made by GAO researchers to identify the types and intensity of relevant programmatic components. For instance, the GAO reported that "treatment is often aimed at substance abusers, who represent a primary target group for boot camps" and that "personal and group counseling may also be available" (p. 18). However, no data were presented on the number of programs that actually reported having drug treatment services, and what those services actually entailed.

The GAO also reported sparse information on followup services provided to boot camp graduates. Only 1 State reported giving graduates unconditional release, 6 States reported releasing boot camp graduates to general parole, and 17 States reported releasing graduates to unspecified forms of special supervision. In seven States graduates may be sent to another correctional facility upon release from boot camp, and eight States reported

that graduates were subject to unspecified other types of supervision (p. 19). Thus, on the basis of this report, very little refined information is available on the types of aftercare services and supervision provided boot camp graduates, and whether drug treatment is a component of those aftercare services.

The American Institutes for Research 1993 survey of adult boot camps also presented some relevant information on drug treatment programming. This survey found that 17 of the 29 States then operating adult boot camps specifically targeted drug-involved offenders (Cronin, 1993:26). The study also found that "all 29 States included some type of drug or alcohol counseling or education in their programs, with several planning to upgrade these services in the future" (Cronin, 1993:26). However, great variability was reported in the percentage of a typical program day allocated to education, vocational education, and other counseling activities. Pennsylvania, for example, reported 70 percent of its typical program day being devoted to these activities; South Carolina, however, spent just 10 percent of a typical day on education and counseling. This survey effort did not attempt to measure the percentage of time devoted to drug treatment and/or education among these boot camps.

The Austin et al. (1993) survey of 10 jail boot camps revealed that every agency reported drug education and/or counseling as being a program component. The amount of time residents spent in drug education/counseling ranged from 4 hours a day (Nassau and Ontario, New York) to 4 hours a week (Travis, Texas). Seven of the 10 programs reported that special aftercare supervision was available for its graduates, most often provided by some combination of probation, parole, or jail staff. Of the seven agencies reporting specialized aftercare supervision, two indicated intensive supervision for all releasees, two indicated moderate supervision, two indicated limited aftercare supervision, and one indicated that supervision levels depended on offenders' risk levels. One of these agencies (Harris, Texas) reported that graduates were supervised intensively with monitoring devices and that halfway house placement was part of the postrelease supervision structure. Thus, great variability was apparent in aftercare programs, even among those agencies reporting that special aftercare services were provided to boot camp graduates.

The evolution of program elements. The above review and other related literature on SI programming suggest that the program content of early boot camps was generally consistent across facilities, and that changes have been made in programming features over time. Early programs tended to feature a strong military design in which offenders participated in physical training, drill and ceremony, and hard labor (Parent, 1989; MacKenzie, 1990; Coyle, 1990). As these programs emerged, basic rehabilitative elements such as substance abuse treatment and education (although commonly present) were overshadowed by a strong emphasis on structure and discipline. These early programs were roundly criticized by a number of observers. For instance,

Sechrest (1989) claimed that SI programs may be successful for certain inmates only if "they [SI programs] can be expanded to include education, job training, and skill development components starting in the facility and continuing into the community" (p. 20). Similarly, Osler (1991) remarked that while SI programs were successful in "tearing down" inmates, the programs released offenders before they could be "rebuilt." He claimed that these programs were not of sufficient duration to produce successful offender outcomes.

Correctional system officials responsible for SI programming in some States have acknowledged these concerns. Florida officials, for example, conceded that for some inmates "these unmet needs [substance abuse treatment and education, basic education, and job training] . . . may have negated any rehabilitative success in other areas" (Florida Department of Corrections, 1990:25). In a 1991 evaluation of Georgia's Special Alternative Incarceration (SAI) program, the necessity of enhanced substance abuse programming was also highlighted:

> At least three-fourths of the offenders who have gone through SAI have a problem with drugs and/or alcohol. They committed crimes while under the influence or to support their habits, or they were convicted of DUI or drug possession or sale. Strong substance abuse programs were needed, both in SAI and during the followup period of supervision and treatment (Georgia Department of Corrections, 1991: XI).

Correctional officials came to recognize that little evidence existed to support the idea that discipline and hard work, by themselves, would lead to longlasting behavioral changes.

In addition to the lack of emphasis placed on standard rehabilitative elements within the early boot camp programs, concern for the lack of aftercare services, especially for the substance abusing client, has been voiced as SI programs have grown in popularity. For example, in a study that examined the postrelease experiences of boot camp inmates from Louisiana, Shaw and MacKenzie (1991) noted that:

> the behavior of problem drinkers as a group was more varied than that of non-problem drinkers, emphasizing the importance of and the need for programs such as this [shock incarceration] to provide adequate support and aftercare for problem drinkers and substance abusers (p. 63).

Since the introduction of SI programs there appears to have been considerable modification in their structure. Whereas early shock incarceration programs emphasized structure and discipline, newer programs appear to be incorporating more substance abuse treatment into daily inmate programming and a stronger postrelease aftercare component. It is assumed that these changes in the structuring of programs reflect alterations in previously elaborated goals. However, available data have not been adequate enough for us to know the extent to which this relationship is true.

The preceding literature review indicates that most boot camps have stressed rehabilitation as a primary program goal, and that substance abuse and aftercare programming appear to have been highly valued by correctional officials who operate SI facilities. The overwhelming majority of SI programs are reported to include programming aimed at promoting the successful reintegration of boot camp graduates. This reintegration is to be accomplished, at least in part, by programs promoting the ability of participants to refrain from the abuse of drugs or alcohol. It also appears that SI programs have evolved since their inception. Starting with an emphasis on military drills, physical training and work, an increasingly larger number of SI facilities appear to be giving at least a co-equal emphasis to more traditional forms of treatment programming. Beyond these broad trends and patterns, however, we know little about the details of boot camps' substance abuse and aftercare programming.

A view from program documents. A number of States have released brochures, manuals, and descriptive and/or evaluative reports that present information on their SI facilities' substance abuse and aftercare programming. The following synopsis of that information is presented in a State-by-State format. This synopsis, while not comprehensive, highlights some of the variations in programming philosophy and efforts that exist across programs. It further serves to identify a number of important evaluative issues.

Michigan. The Michigan Department of Correction's 90-day boot camp program, called Special Alternative Incarceration (SAI), is heavily oriented toward work and physical training. Treatment programming is limited to evening hours and includes classes in life skills, stress management, group counseling, job seeking, substance abuse awareness, and adult basic education.

Substance abuse (SA) education services are provided to all program participants by licensed SA providers on an outpatient service basis. The education sessions are conducted over 10 weeks, with each weekly session lasting 70 minutes. As part of the boot camp intake process, clients are assessed for substance abuse problems. Information on substance abuse is not used to guide treatment programming while the client is in the boot camp, but is used by probation officers to individualize treatment services for clients after

they are released from the inprogram phase and living in the community (Michigan Department of Corrections, 1991 Annual Report—Special Alternative Incarceration, p. 3).

Michigan's intensive postrelease program may include a 120-day residential placement and electronic monitoring. All graduates are required to undergo a minimum of 18 months of community supervision, with the first 4 months including intensive daily supervision, if needed.

Mississippi. Mississippi's program is called Regimented Inmate Discipline (RID). Program documentation indicates that all RID clients participate in "psychological therapy and alcohol and drug counseling unless they are terminated within the first 30 to 60 days of entry" (Mississippi Department of Corrections, 1991: 6). The RID philosophy endorses the criminal personality perspective of Yochelson and Samenow (1976), and treatment appears premised on the development of moral and rational thinking. In terms of alcohol and drug treatment, a disease model is endorsed, and a modified Twelve Steps model has been adopted. It is believed that "life skills development, including a sound spiritual foundation, is the most appropriate approach to treatment."

The 3-month RID Life Skills Development Substance Abuse Program consists of six phases that are open to all RID offenders. Group therapy, which consists of substance abuse education and life-coping skills development, as well as personal and group counseling, are said to be modalities utilized within the program (see Rowe, undated).

Alabama. The 90-day Alabama Disciplinary Rehabilitation Unit (DRU) began in 1988, and like Mississippi's program is grounded in the treatment approach espoused by Yochelson and Samenow—the criminal personality model. Program components include drug and alcohol treatment, individual and group counseling, plus the Twelve Step program used by Alcoholics Anonymous (Burns, 1991: 20). Drug and alcohol services are emphasized in the program's second phase, which takes place during the second month of the program. The camp psychologist indicates that this phase:

> probably does not come across as a very specific alcohol and drug component to the inmates. I don't separate it out. When I teach the twelve steps, I show them that the 12 steps are good for whatever their problem happens to be. And I view crime as an addictive behavior, just as drugs are addictive. So that these 12 steps, properly used, can get you over your addiction to crime (Burns, 1991: 22).

Illinois. The Illinois program emphasizes a continuum of substance abuse treatments. (Karr and Jones, 1994: 26). Inmates are assessed at admission for substance abuse problems and need, and individual treatment plans are established. The program uses these assessments to classify inmates in one of three categories. Level 1 inmates are those diagnosed as having no probable substance abuse problem, but are nonetheless required to receive 2 weeks of substance abuse education. Level II inmates are considered to be probable substance abusers and, in addition to the 2 weeks of substance abuse education, are required to receive 4 weeks of drug treatment in which denial and family support issues are addressed in group therapy sessions. Level III inmates, those determined to have probable drug addictions, receive the same services as inmates in Levels I and II, but substance abuse therapy extends to a 10-week period. Substance abuse relapse, codependency, and addicted families are addressed in therapy sessions.

Additionally, AA and NA groups are available for inmates in the Illinois program who have finished their formal inprogram treatment but have not yet graduated. An individual therapy program is available to respond to crisis intervention concerns and mental health issues and a women's therapy group is available to address issues facing female inmates.

All of these substance abuse services are provided by a contracted external agency that is licensed by the State. Substance abuse services are provided both during afternoon and evening programming.

Substance abuse counselors, along with parole staff, work with Level II and III inmates to arrange community referrals when inmates are released. The conditions of release formulated by the Illinois Prisoner Review Board stipulate that inmates may or may not be required to receive substance abuse treatment in the community.

Conclusion. These program reviews suggest that great variability exists in the nature of substance abuse and aftercare programming provided across SI facilities. Even more importantly, the reviews raise a number of significant issues that must be addressed in an evaluation of the substance abuse and aftercare programming offered as part of the SI experience.

Related Evaluative Issues

A significant definitional issue raised by the literature review relates to the concept of "substance abuse treatment." Traditionally, a number of major treatment modalities have been used to treat drug abuse. Counseling is the cornerstone of most drug abuse treatment programs (Hubbard et al., 1989), including those offered in prisons (National Institute of Drug Abuse, 1981). Within community settings, counseling services are often integral parts of the

major drug treatment modalities (outpatient methadone maintenance programs, residential programs, and outpatient drug-free programs). These modalities do not apply equally to prison settings. Methadone maintenance programs are unacceptable politically in prison settings. Because prisons are the 24-hour residences of most inmates, all prison programs can be considered residential programs. In prison settings, however, it would be more appropriate to consider only therapeutic communities designed to address the substance abuse problems of residents as being residential programs.

Classifying prison treatment programs as substance abuse treatment programs becomes problematic when attention turns to "outpatient" programs that periodically deliver services (most prominently counseling services) to inmates. As illustrated above, and most specifically by the statements of the boot camp psychologist in Alabama, many boot camp treatment programs appear to be eclectic in nature, and vary in how corrections officials classify program components. Some shock incarceration programs, for instance, appear to classify drug education classes as part of their treatment regimes (e.g., Michigan, Alabama, Mississippi), while others appear to make clearer distinctions between drug treatment and education (e.g., Minnesota). Alabama's boot camp treatment program appears grounded on the "criminal personality" approach articulated in the writings of Yochelson and Samenow (1976), and it has been stated that it includes drug and alcohol treatment, individual and group counseling, and the 12-step program used in Alcoholics Anonymous (Burns, 1991).

It is difficult to distinguish, however, where one treatment component begins and another ends. If an inmate is being counseled about his prior drug abuse in an individual session but does not participate in the formally designated "drug and alcohol treatment" program, is it drug treatment? Similarly, Parent found that many distinct types of treatment approaches were used in boot camps in 1988, including drug and alcohol counseling, reality therapy, relaxation therapy, individual counseling, life skills training, and recreation therapy (1989). If, during a reality therapy session at one of these boot camps, extensive discussion focused on the negative consequences of drug abuse, would local corrections officials be justified in considering the program to have had a drug treatment component?

This discussion suggests that decisions by local boot camp administrators to classify particular rehabilitative efforts as "drug treatment" have been variable and uneven. The use of multimethod approaches in boot camps to substance abuse programming that employ some combination of life skills training, substance abuse education, and a variety of group and individual counseling techniques seems to have been common. Thus, an expansive definition of substance abuse treatment must be utilized in a review

and assessment of the potentially meaningful substance abuse interventions provided in SI facilities. For this analysis, any program component considered to be substance abuse treatment by local corrections officials has been included.

To assess the treatment validity of substance abuse interventions in SI facilities, SI intervention methods should be examined and compared to traditional drug treatment practices. However, information must also be collected on all other treatment and educational components provided in boot camps that may reinforce, supplement, or border "formal" drug treatment interventions as a mechanism of offender change. This process, which is used by researchers in this report, allows for a thorough description of the "black box" of treatment that may produce certain outcomes and stronger movement toward understanding how and why drug treatment may or may not work in boot camp settings. As stated by Hubbard and colleagues:

> While there is no question that treatment works, not enough is known about how and why it works. In general, outcomes have not been linked to the nature of the treatment that clients have received. Variables in the "black box" that is drug abuse treatment need to be better specified and their role in producing positive outcomes better understood (1989: 176).

The definition of aftercare also warrants attention. For purposes of this research, aftercare is considered to be any and all services and levels of offender supervision in the postrelease period considered by correctional officials to be a required part of the offender's sanction. This definition excludes an offender's voluntary decision to attend AA/NA meetings, but includes such mandated participation as a parole condition. The distinction is based on whether the use of community-based services is part of the continuum of boot camp services. Aftercare services provided to boot camp participants appear to vary widely and range from intensive parole supervision—which mandates substance abuse counseling, frequent urinalysis testing, and use of a variety of relapse prevention services—to programs that appear to have no additional aftercare services beyond those associated with normal parole supervision (e.g., MacKenzie, 1990b; Burns, 1991; New York State Department of Correctional Services and Division of Parole, 1991).

Boot Camp Impacts on the Lives of Substance Abusers

The research team for this study conducted an exhaustive literature review of evaluative research on SI facilities. This review did not uncover a single study that addressed the issue of whether particular forms of substance abuse treatment in shock programs resulted in improved levels of successful

offender reintegration into the community. Likewise, only very indirect evidence exists that variation in aftercare programming is related to offender adjustment patterns in the community.

The only studies to examine how boot camps affect the lives of substance abusers, as well as how differently they affect the lives of nonabusers, come from evaluations of Louisiana's boot camp program. A number of jurisdictions have received Federal funding to enhance the substance abuse treatment components of their SI programming (e.g., Texas, New York, Illinois, Oklahoma). Scheduled evaluations of at least some of these program enhancements, however, have not been undertaken. As a result, we currently know very little about the efficacy of drug treatment programming in SI facilities.

The Louisiana experience. The Louisiana program, called IMPACT, opened its doors in 1987 and features many of the characteristics associated with other boot camps across the Nation (e.g., voluntary offender participation, strict rules and authority, physical exercise and drill). IMPACT incorporates within its formal treatment programming ventilation therapy, reeducative therapy, substance abuse group therapy, and a prerelease group. Drug education and intensive community supervision are included in the program's postrelease phase. A formal drug treatment program is not offered, however, despite the presence of complementary treatment programs—a general program design consistent with successful therapeutic strategies for substance abusers and with the availability of AA and NA for program participants (Shaw and MacKenzie, 1992).

One relevant examination of the impact of Louisiana's boot camp program on substance abusers surveyed a population of problem drinkers (Shaw and MacKenzie, 1991). The study involved 112 shock inmates who entered the Louisiana program between October 1987 and October 1988 and eventually graduated, and a comparison group of 98 prison inmates who were legally eligible for the program but not recommended for placement. The two groups shared similar demographic characteristics (with the exception of age), legal histories, and measures of neuroticism, but the prison inmates were found to be less prosocial than the shock clients in terms of social maladjustment, alienation, and manifest aggression. A total of 58 inmates from both groups (20 percent) were identified as problem drinkers based on scores from the Problem Drinking Index.

Researchers found that problem drinkers in the shock sample became more prosocial after 3 months of boot camp participation. No change was reported in the antisocial attitudes of the problem drinkers in the prison sample. Problem drinkers in the shock sample also became less alienated after entering the program, while problem drinkers in the prison sample became

more alienated while incarcerated. Thus, the boot camp experience seemed to result in the improved attitudes of problem drinkers.

For each of the first 6 months a parolee was under community supervision, parole officers filled out a standardized evaluation form, the Prosocial Living Index, that attempted to measure each parolee's community adjustment. Much broader than a standard focus on recidivism, the Index contains measures of employment status, school status, performance in treatment programs, arrests, reconvictions, etc. It was found that the community adjustment of shock parolees was much more positive than the adjustment of inmate parolees, but that there was no difference in the adjustments of problem and nonproblem drinkers. No interaction was found between sample and drinker type, indicating that problem drinkers in the shock sample did not fare comparatively better while under community supervision than problem drinkers in the inmate sample. In general, the performance of problem drinkers was more sporadic over the 6-month period than the performance of nonproblem drinkers. The study's evaluators suggested that these findings underscore the desirability of implementing stronger aftercare components to address the specific needs of problem drinkers.

The Prosocial Living Index was also used to measure community adjustment in another extension of the research on Louisiana's boot camps. Findings reported by MacKenzie, Shaw, and Souryal (1992) covered a longer followup period (12 months) with the same samples, but did not focus on problem drinkers. After 1 year in the community, 37.8 percent of the shock graduates (N=74) were arrested at least once, 21.6 percent were in jail, 6.8 percent had their parole revoked, and 2.7 percent absconded. Shock graduates who succeeded under community supervision were more likely to be older, to be older at the age of first arrest, to be white, to have entered the program following new criminal activity rather than a probation violation, to be employed during the first month of community supervision, and to have scored higher on the Positive Social Adjustment Index. Shock graduates adjusted to the community significantly better than did the other sample subjects, but once the intensity of supervision was controlled, differences in positive social adjustment disappeared. Thus, it appears that the intensive supervision phase of the shock experience, not the inprogram phase, was the source of discerned differences in community adjustment. Also noteworthy was that as supervision intensity decreased (at about 6 months), differences in the community adjustment of shock graduates also decreased relative to subjects in the comparison samples.

Another study of the Louisiana program specifically examined the effect of the program on drug-involved offenders (Shaw and MacKenzie, 1992). The study compared the performance of offenders with a legal drug

history (i.e., prior drug arrests and convictions) to that of offenders needing community counseling for substance abuse.

Similar to the other studies reviewed in this section, the adjustments of a group of paroled shock offenders (N=74) were compared to the adjustments of a group of shock dropouts (N=92), probationers (N=108), and inmate parolees (N=74). Thirty-eight percent of the subjects were identified as having a legal drug history and 28 percent were classified as drug-involved because they had previously been required to attend community substance abuse counseling. While there was much overlap between these two groups, it is noteworthy that 52 percent of the offenders with a legal drug history were not required to attend community drug treatment. There was no difference across samples in the percentage of subjects with a legal drug history, but both SI graduates and regular parolees were more likely than probationers to be required to get drug treatment.

To assess whether drug-abusing offenders adjusted to the boot camp experience more negatively than did nondrug-abusing offenders, program dropout rates were examined. No difference in dropout rates was found between offenders with and without a legal drug history. Self-reported drug history information also appeared to be unrelated to dropout rates. Inprogram adjustment patterns apparently were not a function of offenders' prior involvement in drug abuse.

Four measures of failure were used to assess community performance, including positive drug screens, drug arrests, any arrests, and jailed/revoked. Sample subjects were tracked for 1 year. A series of logistic regressions run on each measure of community adjustment revealed complex patterns in the community adjustment of offenders. First, and consistent with the research discussed previously, the prison parolee sample and the probation sample did not experience significantly different failure patterns from those of the shock sample. Second, legal drug offenders were less likely to fail while under community supervision than were nonlegal drug offenders, especially when the effect of required treatment was partialled out. That is, offenders arrested or convicted of a drug offense who were not also judged to need treatment were less likely to fail while under community supervision than legal and nonlegal drug offenders who were also judged in need of treatment. A third finding may help explain this pattern. Although the supervision level was controlled in the logistic regression models, it is possible that those individuals in treatment had higher failure rates due to some aspect of supervision related to the requirement to attend treatment. In fact, higher failure rates (in terms of being jailed or revoked) among those offenders receiving community treatment was limited to those in treatment not making satisfactory progress (Shaw and MacKenzie, 1992: 514, 515).

In summary, the boot camp experience in Louisiana itself did not seem to have any differential or positive impact on the community adjustments of drug involved offenders. Differences in adjustment patterns appeared to have been more strongly determined by whether offenders were classified on the basis of legal criteria or personalized judgements and by the level of progress they made while in community drug treatment programs.

The Effectiveness of Boot Camps in Reducing Recidivism

The effects of substance abuse programming on the lives of boot camp graduates is still uncertain, and not much more is known about how effectively shock incarceration programs promote positive behavioral changes among program participants.

An objective of this study was to synthesize the results of relevant evaluative literature by conducting a meta-analysis. Unfortunately, only a limited number of significant process and impact evaluative research studies have been published on shock incarceration programs. Existing research studies tend to be in the form of agency reports or conference papers which are not widely available to the interested public and which are very uneven in their methodological and analytic sophistication (e.g., Florida Department of Corrections, 1990; New York State Department of Correctional Services and Division of Parole, 1991; Burns, 1991; Texas Criminal Justice Policy Council, 1990). Thus, the quantity and quality of available research on boot camp effects on recidivism is such that a meaningful meta-analysis could not be conducted. A more traditional literature review was conducted that focused on studies which illustrate lessons generalizable across jurisdictions and studies which have direct implications for substance abuse and aftercare programming. In the following pages, these studies are discussed.

New York. Perhaps the strongest relevant analysis of boot camp effects on the behavior of released participants generated by correctional officials comes from New York State.

A series of annual reports on SI programming in that State has detailed information relevant to program impacts on offender behavior. One measure of community adjustment examined in those reports and especially relevant to the present research effort is offender abstinence from the use of illegal narcotics. New York State employs a systematic urinalysis testing component as part of its intensive parole supervision program (termed "shock parole") for boot camp graduates. In the New York City area, where a large concentration of shock parolees receive a variety of aftercare services, shock parole staff conduct urinalysis exams on a regular basis. Results of urinalysis exams conducted from April 1 to September 30, 1991 (a time period in which an average of one test per month was administered per shock parolee), indicated

an abstinence rate of 94 percent. During the same period, the abstinence rate for the general parolee population in New York City was 82 percent (New York Department of Corrections, 1992: 117). The abstinence rate for shock parolees in upstate New York, where drug treatment services were not as readily available as they were in the New York City region, was also very high: 95 percent. Although the report does not comment on the urinalysis exams' sampling and testing procedures, the high absolute abstinence rate among shock parolees suggests that shock parolees remain largely drug-free during periods of intensive parole supervision.

A quasi-experimental design was employed to evaluate the effects of New York's SI program on offender readjustment in the community. The community adjustments of boot camp graduates ("Shock sample," N=3,578) were compared to those of parolees whose legal and demographic characteristics matched the eligibility criteria established for boot camp participation but who were imprisoned before New York's shock program was implemented ("Pre-Shock sample," N=2,378). Additional comparison groups included offenders who met eligibility criteria and were screened for program entry but who did not enter the program ("Considered sample," N=3,710), and a group of offenders who entered the boot camp program but were removed before graduation ("Removed sample," N=1,094). As expected, the shock graduates differed from the removed and considered comparison groups on a number of important legal (e.g., commitment charge, longer time to parole eligibility) and social variables (e.g., region of State, security risk, education level). The shock graduate group and the pre-shock group were more comparable on these variables, and thus selection biases are less likely to confound contrasts between these groups.

Employment status within 6 months of release from prison was examined across the four groups and it was found that shock graduates were much more likely to be employed (75 percent) than were the comparison group subjects ("pre-shock," 48 percent; "considered," 35 percent; "removed," 34 percent). In addition, shock graduates were much more likely than were comparison group subjects to be enrolled in community programs designed to assist them in their reintegration (New York State Department of Corrections, 1992: 121).

Recidivism rates, as measured by return to prison at 12, 18, and 24 months after release, indicated that shock graduates had slightly lower return-to-prison rates than did their counterparts at each time period, and that the effectiveness of shock incarceration seemed to wane over time. After 12 months, 14 percent of shock graduates were returned to prison compared to 19 percent of pre-shock offenders, 20 percent of considered offenders, and 22 percent of removals. These differences in return rates were found to be

statistically significant. In contrast, after 24 months differences in recidivism across the groups narrowed considerably (e.g., 40 percent return rate for shock graduates versus 44 percent for pre-shock offenders) and were not statistically significant.

The New York State evaluation suggests that shock incarceration results in more positive, immediate community adjustment of shock offenders, but also that over time the impact of shock incarceration and shock parole tapers off to the point where the recidivism rates of these individuals are comparable to those of offenders processed through the correctional system. While selection biases and differences in the length and intensity of aftercare supervision to some degree confound the interpretation of the New York State evaluation, these evaluative efforts are perhaps still the strongest evidence available indicating that shock incarceration may have at least a delaying effect on recidivism.

Florida. A small-scale evaluation of Florida's boot camp program found no evidence that the program was successful in reducing offender recidivism and suggested that the cause may have been deficient substance abuse programming. In this study, the reincarceration rates of 281 boot camp graduates were compared with those of 633 matched prison inmates. After 25 months of operation, the reincarceration rate was 25.3 percent for boot camp inmates and 27.8 percent for prison inmates. The introduction of statistical controls to examine the potential effects of subgroup differences on recidivism indicated only minor variations across subgroups. Black boot camp offenders who were older than 17 upon admission to prison and originally sentenced to between 1 and 2 years did slightly poorer than comparable members of the comparison group (Florida Department of Corrections, 1990).

The Florida evaluation reported that "inmates receive substance abuse counseling and training in psychological methods that promote responsibility and improve decisionmaking" while in the boot camp. A survey of boot camp graduates who were reincarcerated, however, indicated some discontent with the programming efforts. According to the report, "despite the inclusion of alcohol and drug counseling as a component of the boot camp program, a large majority of the recommitted graduates saw a need for further substance abuse treatment" (Florida Department of Corrections, 1990: 19).

In the resulting discussion, Florida researchers stated that "the program does not comprise basic education, job training, or treatment of drug abuse (beyond basic counseling). Inmates with deficiencies in these areas will therefore leave the boot camp with the same deficiencies." Corrections officials in Florida concluded that

> there is some question whether the current substance abuse counseling at Boot Camp is effective in meeting the need of all inmates. . . . We should consider incorporating within the Boot Camp agenda aspects of the multifaceted treatment program currently being conducted at other Department of Correction's institutions. . . . Florida's Boot Camp program could be strengthened by an improved followup component modeled after New York's "After Shock" program (Florida Department of Corrections, 1990: 25).

Louisiana. The strongest studies on the impact of any particular State-level boot camp on offender recidivism were conducted on Louisiana's program. Funded by the NIJ, Doris MacKenzie and colleagues studied a variety of topics relating to both the adjustment and performance of offenders both during and after their participation in the State's IMPACT program. In contrast to the other studies reviewed in this report, the MacKenzie study used arrests as a measure of recidivism. Moreover, the study examined arrest rates with more powerful and telling statistical analyses than were used in the other studies. MacKenzie and her colleagues generally found that the IMPACT program did not appear to result in significant decreases in the recidivism of boot camp graduates. MacKenzie's initial findings were described in a report submitted to the NIJ and in a variety of published journal articles (MacKenzie, Shaw and Gowdy, 1990; MacKenzie, 1991; Shaw and MacKenzie, 1991; Shaw and MacKenzie, 1992; MacKenzie, Shaw, and Souryal, 1992; MacKenzie, Shaw, and Gowdy, 1993; MacKenzie and Shaw, 1993).

MacKenzie and colleagues compared the performance of 74 IMPACT graduates to that of 108 probationers, 74 parolees, and 17 IMPACT dropouts during the first 6 months of release while under community supervision. The probationer and parolee comparison subjects selected were as similar as possible to the boot campers, and while adequate matches were found for some basic demographic and legal characteristics, overall the shock sample appeared to be a higher risk group, especially when compared to the probationers (MacKenzie, 1991). Another significant difference across the groups was that while all shock parolees were intensively supervised, the level of supervision of other samples depended on individualized risk assessments.

Failure rates, defined as absconding, revoked parole, or being jailed for a new offense or technical violation, and arrest rates after 6 months revealed that shock parolees did not differ significantly from comparison group members in their community adjustment. When age and past criminal record were controlled in the survival analyses conducted, no differences were found between offenders in shock incarceration and subjects from the other groups despite the shock sample's greater supervision levels and greater involvement

in positive activities such as work and school (MacKenzie, 1991). Simultaneous controls for supervision level and offender risk indicated that once risk was considered, the intensity of supervision was not significantly related to recidivism.

In other published reports, MacKenzie and her colleagues extended their analyses for longer followup periods and examined subgroup differences in recidivism. One study on Louisiana's program examined the behavior of shock incarceration releasees over a 2-year followup period (MacKenzie and Shaw, 1993). This study used a methodology similar to that of the MacKenzie studies described previously (i.e., same comparison groups), but examined two groups of shock graduates. These groups included a sample of 102 graduates who completed the program between when it opened in 1987 and September 1988, and a sample of 117 graduates who completed the program between May 1989 and March 1990. These groups were included in the study to assess if program modifications and maturation resulted in differing recidivism outcomes for the "old" and "new" shock samples. Outcome measures for the new shock sample were limited to a 1-year followup period. Outcome measures included dates of technical and new crime arrests, convictions, absconds, and technical and new crime revocations. Separate survival analyses were conducted for each outcome measure. Controls for a variety of risk factors and community supervision intensity were also introduced into the analyses.

The analyses revealed that failure rates due to new crimes—arrests, convictions, revocations—among parolees and probationers were higher than those for the shock sample. In contrast, shock offenders consistently had higher failure rates due to technical violations. The net effect was no difference in prison return rates across the groups. The only difference found between the old and new shock samples was in the technical violations category, with the new shock sample exhibiting a higher failure rate. Data from the analyses suggest that changes in the program over time did not affect offender behavior in the community. Researchers also found no difference in failure rates between shock graduates and shock dropouts.

In sum, the evaluative research on Louisiana's IMPACT program suggests a number of conclusions regarding the program's impact on offender recidivism and community adjustment. These conclusions remain tentative because the statistical power of the analyses conducted were limited by relatively small sample sizes and because a number of threats to internal validity remain at issue (e.g., selection biases). Nonetheless, it appears that the inprogram phase of Louisiana's boot camp experience has not had any discernible impact on offender recidivism or community adjustment. The generally more positive adjustment of shock graduates into the community (i.e., participation in positive social activities) and patterns in failure rates

(e.g., higher technical violation rates) appear most likely to be the result of the program's intensive supervision component. Furthermore, the program did not seem particularly effective in altering adjustment and recidivism patterns among particular subgroups within the shock population, including problem drinkers or substance abusers.

NIJ-sponsored multisite study. MacKenzie's NIJ-sponsored multisite evaluation of eight State-run correctional boot camps is the most important research that has been conducted in this area (MacKenzie, 1994). This multifaceted, quasi-experimental study of eight State-level adult boot camps, including those in Florida, Georgia, Illinois, Louisiana, New York, Oklahoma, South Carolina, and Texas, employed a methodology that paralleled the one used in the Louisiana studies. The types and number of subjects in the comparison groups varied across States somewhat, as did followup periods (1 and 2 years).

The study's results are generally quite consistent with the handful of minimally rigorous independent evaluations reviewed in this chapter. Boot camps do not appear to be reducing offender recidivism rates. The multistate study found that the boot camp experience did not result in a reduction in recidivism in five States. In only three States—Illinois, Louisiana, and New York—did boot camp graduates have lower recidivism rates than comparable inmates who served longer prison terms in conventional prisons on at least one measure of recidivism.

The three State boot camp programs that appear somewhat successful in positively impacting offender recidivism rates shared two important characteristics. First, intensive supervision of boot camp graduates is a program component in all three States, while prison releasees were generally not intensively supervised upon release from prison. Second, the institutional phases tended to be longer, contained a stronger rehabilitative focus, and generated higher inprogram dropout rates than the other boot camp programs examined. Other apparently unsuccessful programs also shared some of these characteristics, so it is unclear how these program characteristics influenced failure rates. The analyses could not disentangle the effects of particular program features (e.g., intensive supervision), although the research suggests that it is quite unlikely that the military atmosphere by itself had much impact on program participants.

The research just discussed leads to the conclusion that, at this point in time, there is no persuasive evidence that boot camps have a measurable or long-term impact on the recidivism of program participants. Although research suggests that programs with stronger treatment components and more intensive aftercare programs linked to their inprogram phases appear somewhat more successful than programs without such features, the results are far from

conclusive. Until evaluations that employ stronger quasi-experimental or experimental designs are conducted, the jury will be out on whether boot camps have a desirable effect on offender recidivism. These statements apply equally to what is known about the impact of substance abuse and aftercare programming on the lives of SI graduates.

Summary and Conclusions

The literature review presented in this chapter indicates that substance abuse programming in SI facilities is generally provided in a context in which positive offender change is widely articulated as a primary goal of the correctional experience. Moreover, at least some form of substance abuse programming appears evident in all adult boot camp programs. Thus, within this context, the potential for implementing efficacious substance abuse programming in boot camp environments appears to be great.

However, a review of program documents revealed great variability in the nature of substance abuse and aftercare programming provided across SI facilities. This review also raised a number of significant issues that must be addressed in an evaluation of the substance abuse and aftercare programming offered as part of the SI experience. They include, most prominently, definitional issues surrounding what is meant by substance abuse and aftercare programming.

This chapter also presented information on what is known about the impact of boot camps on the lives of substance abusers. Unfortunately, although some things are known about efficacious drug treatment in general and within prison settings in particular, to date not a single study has been designed specifically to evaluate a drug treatment program offered as part of the boot camp experience. Studies from Louisiana suggest that its program has not been especially successful with substance abusers or problem drinkers. That State's boot camp, however, has not offered much in terms of a bona fide substance abuse program. Coupled with the fact that we do not know at this time whether the boot camp experience results in improved offender adjustments to the community, as was detailed in a fairly comprehensive review of relevant evaluative research, it is clearly time for a major infusion of resources to conduct significant process and impact evaluations of SI facilities. In particular, new research should focus on those program elements most likely to result in desired outcomes—most prominently, substance abuse and aftercare treatment programming.

Chapter Three: Methodology

A methodology that successfully achieves the objectives listed in the first chapter would result in the identification and description of substance abuse education and treatment programming offered in the wide spectrum of adult shock incarceration facilities and during their aftercare components. Thus, a necessary first step is the identification of such facilities. This task is not as straightforward as might be assumed.

How Many Shock Facilities Are There?

Shock incarceration programs have proliferated throughout the Nation since the first boot camp opened in November 1983. There were at least 34 boot camps for adults in operation at the end of 1991 (National Institute of Justice, 1991: 87), up from 21 as of May 1990 (MacKenzie, 1990b: 8) and 15 at the end of 1988 (Parent, 1989: 1). More recent research has identified additional SI programs. For instance, the U.S. General Accounting Office (GAO) surveyed State and Federal correctional system officials by telephone in March 1992 and identified 26 jurisdictions that housed (or were about to implement) a total of 57 boot camps. Fourteen of these 26 jurisdictions stated that they had planned or were considering boot camp expansion (either in terms of new facilities or more inmates) over the next 2 years.

At about the same time of the 1992 GAO survey, Elis, MacKenzie, and Souryal also conducted a telephone survey of State and Federal correctional officials and identified only 41 shock programs. As of January 1993, the American Correctional Association (ACA) identified a total of 67 adult boot camps in 27 States and the Federal jurisdiction (American Correctional Association, 1993).

These figures illustrate a number of salient aspects of the boot camp movement. First, the number of shock incarceration facilities nationwide has grown rapidly, and the pace of this growth appears to have increased in the past year or so. This phenomenon is no doubt related to the political appeal of such programs. Moreover, the active support for boot camps at both Federal and State levels will likely result in even more rapid growth in the coming years.

The figures mentioned above also illustrate the point mentioned earlier in this report that there is some confusion as to which correctional facilities fall under the "boot camp" term. For instance, the ACA survey uncovered seven boot camps in Missouri, while the GAO and MacKenzie surveys (and that State itself) indicated no such facilities in that State. Likewise, the GAO survey revealed 19 boot camps operating or about to open in Georgia, while the more recently conducted ACA survey revealed 11. Both surveys relied on

self-reports of State-level officials to identify the number of boot camps in each State, and it appears that either the same or different officials in those States reported different information to researchers. This inconsistency suggests that there is a good deal of ambiguity, even at the State level, as to what constitutes a boot camp. Correctional officials may find it desirable in certain circumstances to stretch the definition of the term "boot camp" to include as broad a range of programs as possible.

In a related vein, the GAO report described the variations in programming found among the identified boot camps: "The programs typically offered some combination of drills, physical exercise, work, training, treatment, and education. Within these broad parameters, however, there were wide variations among and sometimes even within the individual programs" (1993: 17). This variation in programming clearly indicates that "boot camp" is a broad umbrella term, encompassing many distinct types of programs. Even within a particular State, variation in boot camp program goals, structures, clients, and components can be great.

Georgia's boot camp program, for example, was originally designed as an alternative to probation (Probation Boot Camps) and then expanded to also serve as an alternative to prison (Inmate Boot Camps). And recently, Georgia expanded the boot camp concept to include two additional types of incarceration programs. Probation Detention Centers were implemented for probationers who could not manage the physical requirements of more stringent boot camps or who have committed technical violations while on probation. Terms vary from 60 to 120 days, and probationers engage in community work and mandatory drug treatment programs. The other type of program, Intensive Discipline Units, are inprison programs designed for inmates who have had difficulty adjusting to the prison setting. Boot camp techniques are used in this 30-day program, which can be repeated as often as necessary, to improve the inmate's adjustment. While these two program types include some aspects of boot camp programming such as regimentation and a heavy emphasis on discipline, many would not consider them boot camps in the traditional sense of the term because they have very differing goal structures and target populations. Some studies have included these types of programs in discussions and analyses of boot camps (e.g., GAO), while others have not, and discrepancies in findings across different surveys will probably continue until a consensus emerges on what constitutes a boot camp.

The Survey Process

In light of the definitional issues surrounding shock facilities as highlighted above, a multistage survey process was undertaken to include as wide a range of substance abuse programming as possible and to ensure that the universe of adult shock programs was identified. First, States operating

shock incarceration programs were identified through the literature, through other researchers conducting SI research, and with the assistance of two Federal Government agencies: the National Institute of Corrections and the National Institute of Justice. Second, in late fall 1992 letters asking about the existence of SI facilities were sent to the Directors/Commissioners of the Department of Corrections in all 50 States plus the Virgin Islands, the District of Columbia, and the Federal Bureau of Prisons. Correctional officials who responded were given the opportunity to define whether correctional programming in their system included a shock incarceration facility. They were also asked if their jurisdiction contained "any program with an intensive training component, not necessarily based on a military model, that is, an incarceration-based alternative to a traditional prison sentence."

Rather surprisingly, given the fact that the survey letter did not make reference to boot camps and the program design of the facility was not constrained to a military model, these letters tended to solicit the identification of the same facilities as those listed in a number of contemporaneous boot camp surveys. The present boot camp survey, for instance, indicated that 43 State boot camps were operating in 29 States at the beginning of 1993, as well as 2 Federal programs. These estimates closely approximate those reported in a March 1992 census of boot camps: 41 boot camps in 26 States (MacKenzie, Shaw, and Gowdy, 1993). From among the facilities identified in the 1992 census, two programs in the same State had closed. The 1993 survey identified four new programs opening in different States and one recently opened Federal program. In addition, survey efforts revealed 12 planned boot camps in five States (7 in Georgia; 2 in Iowa; and 1 each in Illinois, Kentucky, and Oregon), due to be operational within 2 years after the study.

The 45 facilities identified in this survey are comparable in number to the 46 reported existing during 1992 and 1993 (MacKenzie, 1993). As compared to the MacKenzie survey, we identified one more shock program in Georgia and two fewer facilities in Michigan. Both this study and the MacKenzie survey reported far fewer shock facilities than either of the more recent GAO or ACA surveys. These lower counts are not because adult boot camp programs opened rapidly during 1993, but because the GAO identified 19 boot camps in Georgia while the ACA identified 11 camps in that State and 7 in Missouri. As indicated earlier, it is questionable whether the ACA figures represented the actual number of shock programs in Georgia and Missouri, even has they may have been defined by correctional officials in those States. Thus, it appears that the present research effort has been successful in identifying the universe of broadly defined adult shock facilities that existed in the United States at the end of 1992. Importantly, at least in the minds of correctional officials, it appears that a military model is the sine qua non of shock incarceration programming.

Austin, Jones and Bolyard (1993) conducted a national survey in spring 1992 to identify the number and characteristics of jail boot camps. Ten operational camps and 13 jurisdictions planning to open camps in 1992 or 1993 were identified. One jail boot camp, the Los Angeles Sheriff's Department Regimented Inmate Diversion program, closed down while the research effort of Austin et al. was taking place. Because that survey was conducted at approximately the same time as this report's research efforts, it was considered unnecessary to conduct a similar survey. Accordingly, all 10 of the operational adult jail boot camps identified as of spring 1992 were surveyed for the present research effort.

The next stage of the research aimed at describing and evaluating the drug treatment programming and aftercare services provided by the identified facilities. As discussed in Chapter 1, the goal of the research was to develop a framework by which the validity and efficacy of the substance abuse programming could be assessed. This framework was created using a multi-level survey design and a case study approach. These efforts are detailed below.

The data needed to achieve these research objectives were collected in four stages: system-level surveys, facility-level surveys, aftercare provider surveys, and site-level data collection.

System-level survey. During the system-level survey, telephone interviews were conducted with the correctional official most directly responsible for the planning, implementation, or oversight of SI programming (e.g., the Department of Correction's Central Office). Interview questions sought to elicit information on the correctional aims, program goals, and program elements of the shock facility.

Of the 30 jurisdictions previously identified as operating an SI program, 2 States indicated that the boot camps in their jurisdictions served specialized functions with different program operations (i.e., Oklahoma with 4 and Georgia with 2 distinct program types). Therefore, the officials surveyed from these States were asked to report separately on aims, goals, and elements for each distinct type of facility within their jurisdiction. This survey method resulted in 34 separate attempts at interviews with 30 different officials. From the total number contacted, 3 States declined participation in the study, resulting in a total of 31 completed interviews representing 26 States and the Federal system, a response rate of 91 percent.

This survey approach was not undertaken with the jail boot camps. Because no umbrella agency counterpart to the State Departments of Correction existed for these facilities, only the facility-level surveys, described below, were used.

Facility-level survey. The second stage of data collection began early in 1993 and was designed to capture detailed information on the facility-level contexts in which substance abuse programming was provided. Two questionnaires aimed at collecting information from facility-level personnel were mailed to each facility. The first questionnaire was directed to facility administrators and sought their views on correctional aims and program goals and elements. The questionnaire also requested a description of each facility's target population and selection criteria, daily scheduling, costs, and staffing.

The second survey form was included in the packet with the first, with instructions asking the facility administrator to forward the second questionnaire to the member of the facility's staff responsible for substance abuse treatment/education programming. The second questionnaire asked about substance abuse assessment procedures, treatment modalities and interventions, hours of education and treatment provided, aftercare programs, and information regarding the staff providing substance abuse treatment or education.

Similar to the system survey and the facility administrator's questionnaire, this survey solicited information from the program's provider of substance abuse treatment on correctional aims and program goals and elements of the shock facility. Data were collected in two stages to ascertain congruence in perceptions held by individuals responsible for programming at different levels of the correctional systems.

Survey respondents were also asked to send any relevant program documentation and evaluative reports about their facility/program to the research team. Many jurisdictions honored this request, and these documents and reports were used to verify information found in the questionnaires. In general, these different sources provided compatible portraits of the programs in question, although many of the documents did not provide as detailed information on substance abuse programming as did the questionnaire responses. Very few jurisdictions were able to present the results of evaluative research that had a bearing on the effectiveness of their boot camps in affecting offender recidivism or substance abusing behavior. As stated in chapter 2, most jurisdictions had simply not engaged in such efforts.

Facility response rates. One of the major difficulties with using mailed surveys to obtain research information, especially when questionnaires are extensive or involved, is getting identified respondents to return completed questionnaires. This was particularly true for the research team because a number of surveys, all aimed at generating a better understanding of boot camps, were being conducted at approximately the same time (GAO, MacKenzie, State of Arkansas, Correctional Services Group, Inc.). In this study, extensive followup efforts, which included repeated mail and telephone

contacts, were fairly successful in obtaining completed responses from unresponsive agencies.

Nonetheless, we encountered obstacles to obtaining complete information at the facility level. First, some of the responding facilities provided previously prepared material in the form of program descriptions, official policies, information provided to participants, etc., rather than directly responding to all of the questionnaire items. In these instances, the research staff analyzed the materials for information that would answer the survey's questions. This opened the possibility of staff misinterpretation. Consequently, when specific items were left blank by the respondents, the research staff filled in the information only when program documentation unambiguously answered the questions. Otherwise, the information was considered missing.

A second and more serious obstacle to obtaining facility responses was a preference by some State systems that a unified response, or one directed through a centralized agency research unit, be made to inquiries.

Unfortunately, while this policy may provide consistency in responses across facilities within the same jurisdiction, it does not reveal program nuances at the facility level, which our study considered important to understanding the implementation of substance abuse programming. For example, two States with extensive boot camp programming, New York and Georgia, did not complete responses for each facility. Instead, each State's central office sent individual responses and a program overview. These types of responses were deleted from the statistical summaries. The programs themselves, however, are discussed in other parts of the report. Appendix A provides a listing of facilities not included in the statistical tabulations. A breakdown of State, county, and Federal programs surveyed and their response rates is presented in Table 3–1.

Data for locally operated (e.g., jail) shock facilities indicated a very low return rate (30 percent). Because of this low response rate and the differing contexts associated with jail and prison boot camps, information from jail boot camps were excluded from all analyses. Excluding jail boot camps from survey response rates results in a 69 percent return rate for the administrative survey and a 64 percent return rate for the substance abuse treatment/education survey.

Table 3-1: Survey Response Rates

Administrative Surveys

Level[a]	No. of Facilities	No. of Responses	Return Rate (%)
Federal	2	2	100
State	43	29	67
Total	45	31	69

[a]Three county-level administrative surveys were also returned. They represented only 30 percent of that population and were excluded from all analyses.

Substance Abuse Treatment/Education Surveys

Level[a]	No. of Facilities	No. of Responses	Return Rate (%)
Federal	2	2	100
State	43	27	63
Total	45	29	64

[a]Three county-level substance abuse treatment/education surveys were also returned. They represented only 30 percent of that population and were excluded from all analyses.

Nonresponses for the administrative and substance abuse surveys were primarily due to response patterns from three States. New York State, with five facilities operating at the time of this survey, refused to participate in the facility-based survey component, claiming that all of their facilities had identical substance abuse and aftercare programming. Only three of Georgia's six facilities responded to both surveys and only one of Oklahoma's four programs returned the administrative questionnaire. These States represent 11 of the 14 administrative questionnaire nonresponses and 12 of the 15 substance abuse questionnaire nonresponses. Fortunately, programs in these States have been well documented and the nature of nonresponse bias can be estimated when the inclusion of these facilities would have altered general patterns in the findings.

To verify and update information provided by respondents, program summaries were developed in fall 1993 from information previously provided by the programs. A copy of the summary was mailed to each jurisdiction, and respondents were asked to both verify and update information on their programs. As a result, the program information presented in this report captures fairly well the dimensions of these SI programs as they existed in 1992.

Aftercare providers survey. The third data collection stage began in spring 1993. On the basis of information provided in the substance abuse treatment/education questionnaire, we attempted to distinguish those programs with aftercare components and to identify the programs' aftercare providers. Identification of specific aftercare providers turned out to be somewhat problematic, however, as most programs with aftercare components used a general referral model. In this model, shock incarceration participants are released under the supervision of a probation/parole authority who in turn may refer participants to local agencies such as mental health agencies or community substance abuse programs. Of the 29 responses to the substance abuse treatment/education questionnaire received, 22 indicated that an aftercare program existed, 1 did not know, and 6 left the question blank (presumably because the program did not provide substance abuse treatment). Yet of the 22 responses indicating an aftercare program, only 8 named a specific treatment provider. Another eight provided a more generic identification, such as "done on a county level," "various probation officers," "special probation officers," or "placement by judge"; six did not identify a particular treatment provider, but did indicate various contracted treatment services, community mental health programs, or programs such as Alcoholics Anonymous/Narcotics Anonymous.

In June 1993, eight surveys were sent to treatment aftercare providers identified by respondents to the substance abuse surveys. Additionally, eight surveys were sent to probation/parole authorities who had been identified by jurisdictions as their program's source of aftercare. In jurisdictions giving only general identifications, six surveys were sent to drug treatment programs that might provide services to boot camp releasees. (Names of these programs were obtained through a publication of substance abuse programs for offenders.)

The purpose of this data collection was to identify the type and scope of aftercare services provided to SI program graduates. Respondents were asked questions regarding service delivery, offender restrictions, and mandates. Each questionnaire packet included a postcard that was to be returned if the agency did not provide aftercare services to SI graduates. Respondents were asked to identify on the postcard who was in charge of aftercare services delivery so that another questionnaire could be sent.

Sixteen surveys and three cards indicating that the program did not provide services for SI boot camp graduates were returned. Three aftercare providers neither responded to the survey nor returned a card, yielding an 86 percent response rate.

Site-Level Data Collection

The final stage of research involved site visits to three SI facilities that the research team, after analyzing survey results, believed to have particularly unique, extensive, or innovative substance abuse treatment programs. The three programs selected were the Challenge Incarceration Program at Willow River, Minnesota; the Massachusetts Boot Camp at the Bridgewater Correctional Complex, and the Lakeview Shock Incarceration Program in New York.

These programs were selected because they exhibited potentially effective and/or innovative substance abuse treatment/education delivery features. Specifically, Minnesota was chosen for its use of both inhouse and outside vendors, small treatment groups, and innovative treatment techniques (i.e., acupuncture); New York for its use of only inhouse treatment providers, large treatment groups, and status as the first "treatment-oriented" SI facility in the Nation; and Massachusetts for its midrange size and use of the same outside vendor to provide both program-oriented and aftercare treatment services.

During the three site visits, the research team observed numerous programming sessions, including basic education, cognitive skills, chemical dependency group treatment and lectures, acupuncture, confrontation groups, exit group meetings, and nutrition. Other program features observed included work, physical training, intake, graduation, and drill and ceremony.

Both staff and inmates were interviewed during each visit. Questions on specific duties, perception of the program, and prior correctional employment/postemployment history were asked of program staff members during face-to-face interviews at the program sites. When possible, staff members from these key program areas also were interviewed: aftercare, casework, substance abuse treatment/education, security, and administration. All staff agreed to participate.

Offenders nearing release from incarceration were selected to be interviewed in a group setting. Information, solicited in written questionnaire form, included prior criminal history, perceptions toward program elements, opinion of drug services delivery, and prior substance use/abuse. An open discussion followed survey administration. During this time offenders were able to verbally relate to the research team their likes/dislikes and opinions on the shock program. A total of 77 offenders from the three programs were available during site visits and all consented to completing the questionnaire and participating in the group discussion.

Summary

The methodology used to achieve this study's research objectives produced fairly successful outcomes. Researchers collected a large body of descriptive data on substance abuse and aftercare programming from the vast majority of correctional agencies that sponsor shock incarceration facilities. The data collected for State and Federal facilities were fairly comprehensive and complete, but much less so for locally operated facilities. In addition, less complete data were made available to researchers on SI aftercare programming than on facility-based substance abuse programming due to the lack of strong links between facility-based programming and aftercare programming in many jurisdictions. Finally, the paucity of relevant evaluative research on SI programs and the substance abuse treatment components of such facilities rendered the ability to identify "effective" programs problematic. Nonetheless, the body of data collected allowed this research effort to make very significant strides toward its objectives.

Chapter Four: Views from the Survey Data: Aims, Goals and Program Elements of SI Facilities

To better understand the contexts in which substance abuse programming is provided in adult SI facilities, this section presents survey data on three issues: (1) system-level officials' perceptions of the importance of correctional aims, goals, and program elements; (2) a comparison of perceived importance of correctional aims, goals, and program elements between system-level officials, site-level administrators, and site-level substance abuse treatment/education providers; and (3) a comparison of correctional aims, goals, and program elements articulated by site-level administrators for programs that became operational between 1983 and June 1990 with those for programs that began after June 1990.

In this chapter, mean values are used as the average ratings. Caution is urged in the interpretation of these statistics. They are intended to convey the relative position of scores rather than their absolute value.

System Level Responses

Goal structures. Table 4–1 presents information on SI facilities' correctional aims, program goals, and program elements as reported by State correctional officials identified as being responsible for the delivery of jurisdictionwide SI programming (N=31).

All respondents were asked to rank the core correctional aims (e.g., retribution, incapacitation, rehabilitation, and deterrence) related to SI programming in their jurisdiction. The most important correctional aim was to be ranked as one, the second as two, and so forth. Slightly more than 50 percent of the respondents ranked rehabilitation as the most important correctional aim, the mean score being 1.52 (on a scale of 1 to 4). Deterrence was also ranked highly; it was given primacy by a third of the respondents and generated a mean score of 1.97. Conversely, none of the respondents ranked retribution as the primary correctional aim. Overall, retribution ranked least important with a mean score of 3.57. Relative to the mean scores, standard deviations were quite small, indicating a low level of variability among responses.

Respondents were also asked to rate on a one to seven-point scale (with one being very important and seven being not important at all) the relative importance of a variety of goals that parallel those identified by MacKenzie (1990). As seen in table 4–1, these goals were placed into one of three

Table 4-1: The Importance of Shock Incarceration Aims, Goals, and Program Elements[a] as Reported by System Level Officials (n=31)

	Importance						
	1 Primary	2	3	4 Least	Not Applicable	Mean	S.D.
CORRECTIONAL AIMS							
Retribution	0	6.5	25.8	58.1	9.7	3.57	.63
Incapacitation	12.9	9.7	45.2	25.8	6.5	2.90	.98
Rehabilitation	51.6	35.5	6.5	0	6.5	1.52	.63
Deterrence	32.3	41.9	16.1	6.5	3.2	1.97	.89

GOALS[b]	Mean	S.D.
System Level:	**2.78**	
Reduce Crowding	2.87	1.71
Improve Image of Corrections	3.58	1.48
Public Safety	1.58	1.03
Alternative to Longer-Term	1.55	1.03
Less Cost	2.32	1.28
Politically Acceptable Alternative	2.42	0.92
Model for County Programs	5.16	2.24
Individual Level:	**1.87**	
Instill Respect for Authority	1.71	1.10
Promoting Discipline	1.55	0.89
Less Criminal Activity	1.77	0.76
Improve Confidence	1.94	1.18
Reduce Drug Use	2.39	1.23
Positive Social Behaviors	1.84	1.00
Prison Control/Management:	**2.02**	
Clean, Healthy Environment	2.19	1.01
Offender Accountability	1.84	1.24
Positive Offender/Staff Contact	2.16	1.07
Environment Promoting Rehabilitation	1.90	0.91

ELEMENTS[c]	Mean	S.D.
Physical Training	1.55	.93
Alcohol Treatment	2.42	1.15
Drug Treatment	2.39	1.20
Substance Abuse Education	2.03	.98
Physical Labor	2.10	1.48
Drill/Ceremony	1.74	1.03
Basic Education	2.53	1.31
Vocational Education	3.36	1.45
Pre-Release Programming	2.79	1.40
Post-Release Service Delivery	2.13	1.19

[a]Elements identified by respondents as not being a program element were excluded from calculations of mean scores.
[b]Means of goals are based on a scale of 1 (very important) to 7 (not important at all).
[c]Means of elements are based on a scale of 1 (primary program element) to 6 (minor program element).
Caution is urged in interpreting mean scores due to the use of rating scales.

designations: system-level goals, individual-level goals, or prison control/management goals. Although MacKenzie (1990) developed four goal classifications, it is believed that the motivation to employ public relations goals at that time was similar to the motivation to employ system-level goals. Consequently, in this study public relations goals were collapsed into the system-level goal designations to provide greater clarity and specificity among the goal classifications.

Of the three goal groups, the system level exhibited the most variability in responses. The range of means was from 1.55 for "alternative to longer term incarceration" to 5.16 for "model for county programs." The individual-level goals ranged from a mean of 1.55 for "promoting discipline" to 2.39 for "reduce offender drug use." Finally, for the prison control/management goals there was little variability among responses; each goal was given relatively high priority.

Overall, individual-level goals were rated most important with a group mean of 1.87. Prison control/management goals rated second with a mean of 2.02, and system-level goals rated third with a mean of 2.78. Thus, behavioral change-related goals were strongly emphasized by system-level officials. Notably, the reduction of drug use was ranked lowest among the listed individual-level goals.

Programming structures. The final set of responses provided by system-level officials ranked 10 elements commonly found in shock incarceration programming. Respondents could select responses for each program element ranging from one (primary program element) to seven (not a program element). Scores of seven were excluded from the mean because this response indicates the absence of a program element, not a priority rating. Thus, the following mean scores for program elements reflect a priority rating *if* the shock incarceration program included those elements.

As seen in Table 4–1, the range of means was from 1.55 for physical training to 3.36 for vocational education. Besides physical training, the elements of drill and ceremony (mean of 1.74), physical labor (2.10), substance abuse education (2.03), postrelease service delivery (2.13), and drug treatment (2.39) were ranked high by respondents. On the other end of the spectrum, besides vocational education, prerelease programming (2.79) was rated as a lower priority program element. It should be noted, however, that many of the elements (e.g., physical labor, postrelease service delivery, and vocational education) exhibited moderately high standard deviations, indicating some variation across States in the primacy given these program elements. Notably, all system-level respondents indicated that SI programming in their jurisdiction included alcohol and drug treatment as well as substance abuse education.

The Extent and Priority of Substance Abuse Programming: Views from Facility Respondents

Table 4–2 presents ratings of correctional aims and goals by system-level officials, facility administrators, and individuals responsible for the delivery of substance abuse education and/or treatment at boot camp facilities. Only system-level officials from jurisdictions that returned a substance abuse questionnaire are included to ensure the direct comparability of responses for individuals working in the same set of correctional systems ($\underline{n}=24$).

The mean scores presented in tables 4–1 and 4–2 for system-level officials are very similar. For instance, the mean score for rehabilitation as a correctional aim and the array of scores associated with program goals (e.g., public safety, alternative to long-term incarceration, instill respect for authority, reduce drug use) are very comparable in terms of both magnitude and relative rank. Thus, it appears that the subset of facilities that returned site-level questionnaires are very similar to the universe of adult boot camps in terms of system-level program aims and goals. This similarity suggests minimal response bias in the pattern of questionnaire returns.

Table 4–2 indicates strong level of agreement on boot camps' aims and goals across system-level officials, facility administrators, and officials in charge of delivering substance abuse treatment and education to SI participants. Each group gave primacy to rehabilitation as a correctional aim of the boot camp and emphasized deterrence, incapacitation, and retribution in decreasing order. Each group also ranked alternatives to longer term incarceration and public safety as the top two system-level goals. The only discrepancy in score rankings (see table 4–2) relates to the primacy respondents gave to "reducing crowding," with facility-level administrators placing more emphasis on this goal than system-level respondents and substance abuse treatment/education providers. In contrast, the latter two respondent types rated "less cost" more highly than did facility-level administrators.

Interestingly, more notable variation in rankings across respondent types is found among the individual-level goals. While each group ranked instilling respect for authority and promoting discipline as the primary individual-level goals, facility-level administrators and substance abuse treatment/education providers did not rank the reduction of criminal activity as highly as did system officials. Conversely, system-level officials ranked reduced drug use as the least important individual-level goal (mean of 2.42) while facility staff ranked reduced drug use much more highly (mean of 1.63

Table 4-2: The Importance of Correctional Aims and Goals for Shock Incarceration Facilities as Reported by System-Level Officials, Site-Level Administrators, and Substance Abuse Treatment/Education Providers[a]

	System-Level Respondents (n=24)		Facility Administrators (n=27)		Substance Abuse Treatment/Education Providers (n=27)	
	Mean	S.D.	Mean	S.D.	Mean	S.D.
CORRECTIONAL AIMS						
Retribution	3.45	.67	3.75	1.12	3.74	.81
Incapacitation	2.91	1.08	3.00	1.23	2.91	1.07
Rehabilitation	1.48	.67	1.44	.71	1.50	.82
Deterrence	2.08	.88	2.74	.92	2.50	.88
GOALS[b]						
System Level:	**2.89**		**2.97**		**2.71**	
Reduce Crowding	2.83	1.81	2.37	1.75	2.85	1.81
Improve Image of Corrections	3.96	1.28	3.78	1.98	3.33	1.71
Public Safety	1.71	1.12	1.96	.28	1.67	.83
Alternative to Longer-term Incarceration	1.67	1.13	1.93	1.35	1.70	.99
Less Cost	2.29	1.33	2.63	1.82	2.11	1.05
Politically Acceptable Alternative	2.46	.93	3.48	1.74	3.18	1.78
Model for County Programs	5.29	2.24	4.63	.86	4.15	1.90
Individual Level:	**1.89**		**1.63**		**1.61**	
Instill Respect for Authority	1.62	.77	1.30	.54	1.18	.48
Promoting Discipline	1.58	.93	1.37	.74	1.15	.36
Less Criminal Activity	1.83	.82	2.30	1.35	2.07	1.17
Improve Confidence	1.96	1.20	1.63	.79	1.93	1.17
Reduce Drug Use	2.42	1.18	1.63	.88	1.67	.88
Positive Social Behaviors	1.92	1.06	1.52	.64	1.67	.92
Prison Control/Management:	**2.11**		**1.72**		**1.83**	
Healthy Environment	2.29	1.12	1.59	1.04	1.36	.57
Offender Accountability	1.87	1.19	1.81	1.64	1.74	.98
Positive Offender/Staff Contact	2.33	1.13	1.93	1.03	2.44	1.40
Environment Promoting Rehabilitation	1.96	1.00	1.56	.85	1.77	1.05

[a]For comparison purposes, only system-level respondents for jurisdictions with returned site-level substance abuse and system-level questionnaires were included (24 of 31 total).

[b]Means of goals are based on a scale of 1 (very important) to 7 (not important at all). Caution is urged in interpreting mean scores due to the use of rating scales.

for administrators and 1.67 for substance abuse providers) and at a level more comparable to mean scores for promoting discipline and instilling respect for authority.

Despite the slight differences across respondent types, in general there was a high level of agreement among system officials, facility administrators, and facility drug treatment\education supervisors on aims and goals of SI facilities. The data showed a consensus on rehabilitation as the primary aim of such facilities and an emphasis on instilling respect for authority and promoting discipline. Mean scores reveal some variation for the goal of reducing drug use—this goal was emphasized more by facility-based staff than by system-level administrators.

Table 4–3 presents responses of all three respondent types on whether their SI facilities incorporated particular program elements into their overall programming efforts. The vast bulk of respondents indicated that physical training, physical labor, basic education, and prerelease programming are facility program components. Conversely, vocational education is not commonly found in boot camps: only 46 percent of system-level respondents and 32 percent of facility administrators indicated that vocational education was a program element.

All system-level respondents indicated that alcohol and drug treatment services were provided in their SI facilities. However, 25 percent ($\underline{n}=7$) of site-level administrators and substance abuse treatment/education providers indicated that alcohol or drug treatment was not provided in their facilities. Thus, there appears to be considerable confusion among some respondents about whether drug treatment programs existed at certain facilities. Prior surveys that uniformly found drug treatment programming in boot camps may have overrepresented the reality of the situation because they tended to report findings derived from responses generated by system-level officials. Individuals closest to the delivery of such programming efforts indicated that one-quarter of adult boot camps had no alcohol and drug treatment programs.

Table 4–4 presents program element rankings by system-level officials, facility administrators, and substance abuse providers. These rankings appear to correspond to the level of importance the three groups gave to SI program goals (see table 4–2). All three groups ranked "instilling respect for authority" and "promoting discipline" as primary individual-level goals of their programs. The fact that all three groups rated physical training and drill and ceremony as primary elements suggests compatibility between the importance given to elements and to the regimentation goals that SI programs wish to achieve.

Table 4-3: The Percentage[a] of Facilities in Which Various Elements Exist as Reported by System-Level Officials, Site-Level Administrators, and Site-Level Substance Treatment Providers[b]

	System-Level Officials (n=27)	Site-Level Administrators (n=28)	Site-Level Substance Abuse Treatment/ Education Providers (n=28)
ELEMENTS	%	%	%
Physical Training	100	96	96
Alcohol Treatment	100	75	75
Drug Treatment	100	75	75
Substance Abuse Education	100	100	100
Physical Labor	100	96	96
Drill/Ceremony	100	100	100
Basic Education	96	93	100
Vocational Education	46	32	43
Pre-Release Programming	93	96	96
Post-Release Services Delivery	74	75	71

[a]Percentages have been rounded to nearest whole percent.
[b]In this table, percentages are presented only for those jurisdictions with system-level respondents (27 of 31), administrative survey respondents (28 of 32) and substance abuse survey respondents (28 of 29).

Similarly, there seems to be general agreement among the groups that education, and vocational education in particular, were not especially important program components. This finding is not particularly surprising given that most boot camp programs are relatively short (90, 120 or 180 days), making the implementation of extensive education programs problematic. The fact that less than one-half (see Table 4-3) of the survey respondents indicated the presence of a vocational education programs reinforces this notion.

With regard to substance abuse programming, system-level officials ranked (see Table 4-2) reducing drug use lower than facility respondents ranked this goal. This finding seems to correspond to the relative lack of importance given to both alcohol and drug treatment and to substance abuse education program elements (see table 4-4; mean ratings of 2.46, 2.42, and 2.04, respectively) by system-level officials compared to the importance attached to these elements by facility administrators (mean ratings of 1.32,

1.27, and 1.30) and facility substance abuse providers (mean ratings of 1.50, 1.45, and 1.92). It also may be notable that system-level administrators ranked substance abuse education higher than either alcohol or drug treatment. By contrast, facility administrators ranked drug treatment slightly higher than education, and substance abuse providers ranked both alcohol and drug treatment program elements higher than education. These findings seem to indicate a greater emphasis on substance abuse programming and treatment program elements at the facility level than at the system level.

Table 4-4: Ratings of the Importance of Program Elements[a] for Shock Incarceration Facilities as Reported by System Level Officials, Site-Level Administrators, and Site-Level Substance Abuse Treatment Providers[b]

	System-Level Officials (n=24)		Site-Level Administrators (n=28)		Site-Level Substance Abuse Treatment/ Education Providers (n=28)	
ELEMENTS[c]	**Mean**	**S.D.**	**Mean**	**S.D.**	**Mean**	**S.D.**
Physical Training	1.46	.83	1.58	1.10	1.23	.59
Alcohol Treatment	2.46	1.10	1.32	.78	1.50	1.00
Drug Treatment	2.42	1.17	1.27	.63	1.45	1.00
Substance Abuse Education	2.04	1.00	1.30	.61	1.92	1.24
Physical Labor	2.17	1.61	1.68	1.11	2.04	1.40
Drill/Ceremony	1.67	.96	1.70	1.10	1.52	.64
Basic Education	2.52	1.38	1.96	1.43	2.33	1.47
Vocational Education	3.40	1.51	3.50	1.85	3.90	1.91
Pre-Release Programming	2.73	1.49	1.54	.81	2.04	1.46
Post-Release Services Delivery	2.11	1.32	2.14	1.20	2.37	1.74

[a]Elements identified by respondents as not being a program element were excluded from calculations of mean scores.
[b]For comparison purposes in this table, only system level respondents for jurisdictions with a returned site-level substance abuse questionnaire are include' (24 of 31 total; some system level respondents have multiple facilities). Site level responses are reported only for those facilities also returning a substance abuse questionnaire.
[c]Means of elements are based on a scale of 1 (primary program element) to 6 (minor program element).

It is also noteworthy that despite the great emphasis placed on aftercare services as a necessary component to ease boot camp graduates' community reintegration, about one-quarter of respondents reported that postrelease service delivery was not a program offered at their facility.

In summary, substance abuse programming appears to be more available to boot camp participants than to general prison inmates. All responding boot camps reported having either a substance abuse treatment or a substance abuse education program. In contrast, a study by Lipton, Falkin and Wexler (1992) indicated that the percentage of State correctional systems offering different types of substance abuse programming ranged from 62 to 88 percent, with substance abuse education by far the more popular. In terms of the number of prison inmates receiving drug treatment, however, Chaiken (1989) estimated that about 11.1 percent of all inmates in the 50 States have received drug treatment. Nearly all boot camps have provided drug treatment as distinct from drug education only, and virtually all offenders in SI facilities have participated in substance abuse treatment.

"Older" Versus "Newer" Shock Incarceration Facilities

MacKenzie (1993), among others, has indicated that newer shock facilities were incorporating more therapy and treatment into their daily schedules than did earlier shock programs. To assess this observation's validity, especially as it relates to the existence of substance abuse programming, and to determine if these changes reflected modified goal structures at more recent programs, table 4–5 presents the mean rankings for correctional aims and goals reported by site-level administrators for programs that began before June 1990 ($\underline{n}$ = 13) and for programs that began after June 1990 ($\underline{n}$ = 17). Table 4–5 indicates that there is very little substantive difference in the rankings of correctional aims and facility goals by site-level administrators at older and newer facilities. Both groups endorsed rehabilitation very strongly, but, surprisingly, rehabilitation was rated higher by site-level administrators from older rather than newer facilities. System-level goals, however, were emphasized differently among the respondents. Newer facilities appeared more oriented to being an alternative to longer-term incarceration and to saving the system money than older facilities. Very little difference was found in the ratings of individual-level and prison-control management goals between site-level administrators of older and newer facilities.

Greater differences in mean scores were apparent when researchers examined the priority respondents gave specific program elements (see table 4–6). In general, administrators of newer facilities tended to rank programming elements higher than did administrators of older programs. One notable exception is the vocational education component, which was given a

Table 4-5: The Importance of Shock Incarceration Aims and Goals as Reported by Program Administrators Whose Programs Became Operational Between 1983 and June 1990 as Compared to Those Reported by Program Administrators Whose Programs Became Operational After June 1990.

	Site-Level Administrators 1983–1990 (n=13)		Site-Level Administrators 1990–1992 (n=17)	
	Mean	S.D.	Mean	S.D.
AIMS				
Retribution	3.60	1.17	3.83	1.19
Incapacitation	3.09	1.22	3.41	1.16
Rehabilitation	1.25	.45	1.65	1.06
Deterrence	2.50	.65	2.60	.99
GOALS[a]				
System-Level:	**3.27**		**2.74**	
Reduce Crowding	2.69	1.25	2.41	2.03
Improve Image of Corrections	4.23	1.96	3.71	1.86
Public Safety	1.92	1.32	2.06	1.39
Alternative to Longer-Term Incarceration	2.30	1.38	1.35	.70
Less Cost	3.08	1.85	2.12	1.27
Politically Acceptable Alternative to Prison	3.85	1.68	3.00	1.54
Model for County Programs	4.85	1.46	4.53	2.09
Individual-Level:	**1.67**		**1.58**	
Instill Respect for Authority	1.30	.63	1.18	.39
Promoting Discipline	1.31	.63	1.23	.44
Less Criminal Activity	2.00	1.15	2.53	1.42
Improve Confidence	1.85	.80	1.47	.72
Reduce Drug Use	1.77	.83	1.65	1.00
Positive Social E havior	1.77	.72	1.41	.62
Prison Control/Management:	**1.69**		**1.49**	
Clean Healthy Environment	1.30	.63	1.41	.79
Offender Accountability	1.77	1.69	1.53	1.46
Positive Offender/Staff Contacts	2.15	.99	1.53	.72
Environment Promoting Rehabilitation	1.54	1.13	1.47	.51

[a]Goal means are based on a scale of 1 (very important) to 7 (not important at all). Program goals identified as not applicable by a respondent are excluded from the mean calculation.

Table 4-6: Ratings on the Importance of Shock Incarceration Program Elements[1] as Reported by Program Administrators Whose Programs Became Operational Between 1983 and June 1990 as Compared to Those Reported by Program Administrators Whose Programs Became Operational After June 1990.

	Site-Level Administrators 1983-1990 (n=13)		Site-Level Administrators 1990-1992 (n=17)	
	Mean[2]	S.D.	Mean[2]	S.D.
ELEMENTS				
Physical Training	1.67 (12)	1.30	1.42 (17)	.84
Alcohol Treatment	1.60 (10)	.97	1.47 (13)	.99
Drug Treatment	1.60 (10)	.97	1.47 (13)	.85
Substance Abuse Education	1.61 (13)	.87	1.26 (17)	.45
Physical Labor	1.77 (13)	1.17	2.06 (16)	1.60
Drill/Ceremony	1.61 (13)	1.26	1.89 (17)	.99
Basic Education	2.00 (10)	1.41	2.00 (17)	1.49
Vocational Education	1.67 (3)	1.15	4.12 (6)	1.64
Pre-Release Programming	1.91 (12)	1.17	1.44 (17)	.70
Post-Release Service Delivery	3.10 (10)	1.52	1.61 (13)	.96

[1]Elements identified by respondents as not being a program element were excluded from calculations of mean scores.
[2]Element means are based on a scale of 1 (primary program element) to 6 (minor program element). Number of facilities with program elements are listed in parentheses.

higher priority by administrators of older facilities. However, slightly less than one-quarter (23 percent) of the older facilities had a vocational education component, whereas over one-third (35 percent) of the newer facilities included vocational education in their programming. Thus, although a slightly greater percentage of newer SI facilities offered vocational education, their administrators gave it less priority.

With regard to substance abuse programming, the percentage (about 77 percent) of older and newer facilities offering alcohol and drug treatment components has remained about the same. However, the administrators of newer SI facilities attached a somewhat greater priority to these two program elements than their counterparts from the older SI facilities (a mean of 1.47

for newer versus 1.60 for older). The same is true of substance abuse education. Although all administrators indicated the presence of substance abuse education in their programming, administrators from newer facilities again placed a slightly higher priority (a mean of 1.60 versus 1.46) on this program element than did administrators of older facilities.

Administrators of newer facilities also appear to attach greater significance to community reintegration programming. Newer facility administrators gave priority to prerelease programming (a mean of 1.44) while administrators of older facilities ranked that program element less highly (a mean of 1.91). Moreover, researchers found the greatest difference in administrators' responses in the priority they attached to postrelease services delivery. Administrators of new facilities gave this element a mean rating of 1.61, whereas administrators of older programs indicated a much lower priority with a mean rating of 3.1.

Summary and Conclusions

Generally, substance abuse programming in SI facilities is provided within a context in which positive offender change is widely articulated as a primary goal of the correctional experience. For the most part, officials responsible for the delivery of programs within a jurisdiction present programming goals and structures as a means of providing offenders with some of the basic skills, insights, and problem-solving behaviors logically associated with a drug- and crime-free reintegration into the community. Disparities and incongruities existed at some facilities. However, in general, the above data indicate that a strong potential existed for the implementation of bona fide substance abuse programs and an array of complementary services that could achieve some positive change in offender attitudes and behavior. It remains to be seen, however, if these apparently supportive contexts actually included substance abuse programs that were clinically relevant and psychologically informed.

Chapter Five: Substance Abuse Treatment and Aftercare Programming Associated with Shock Facilities Survey Results

As noted in chapter 3, individuals responsible for the delivery of substance abuse programming at each of the identified SI facilities were surveyed about the type of substance abuse programming offered at their facility. The bulk of this chapter contains an analysis of their responses. It is important to emphasize that 7 of the 29 facility-level respondents indicated that their facilities, while delivering substance abuse education to participants, lacked a formal substance abuse treatment program.

According to Brown (1992), there are five types of program models available for drug abusers in correctional settings: (1) incarceration without specialized services; (2) incarceration with drug education and/or drug abuse counseling; (3) incarceration with residential units dedicated to drug abuse treatment; (4) incarceration with client-initiated and/or client-maintained services; and (5) incarceration with specialized services that do not directly target users' drug abuse problems.

Using this taxonomy, and based on the responses of substance abuse treatment providers, the majority of SI programs operating at the time of this study would fall into the second category because they offered substance abuse education and/or treatment. Most of these programs followed an "outpatient" model in which only a small segment of an individual's daily routine is devoted to participation in substance abuse services. A minimal number of programs with well-integrated substance abuse elements along the lines of a therapeutic community might be placed in the third category—incarceration with residential units dedicated to drug abuse treatment. These programs could be characterized as following a residential treatment model.

Substance abuse treatment programs are also often categorized as reflecting one of three primary modes of treatment: (1) detoxification, used to withdraw addicts from illicit drugs and to reduce the physical and psychological effects of withdrawal; (2) medication maintenance programs which either involve medications that substitute for illicit drugs (e.g., methadone) or block the effects of illegal drugs (e.g., naltrexone); and (3) drug-free programs that promote abstinence as a core treatment goal and treat the psychological and behavioral aspects of drug dependence. Survey findings from this study indicate that of these three treatment modes, neither a pharmacological approach nor detoxification was used in SI programs at that time.

With regard to the use of pharmacological treatment interventions, SI substance abuse treatment appears to parallel intervention methods found in traditional institutional corrections rather than those found in free-world residential programs or some short-term correctional facilities (e.g., New York City's Key Extended Entry Program; see Peters, 1993). None of the responding programs indicated the use of chemical treatment, such as methadone, to reduce physical drug cravings, or the use of high vitamin therapy to counter some of the deleterious effects of drug use on the body. As mentioned before, detoxication is not a component of the treatment regimes provided in SI programs.

The Substance Abuse Survey did not explore why certain treatment interventions were not used by SI facilities, but based upon other information collected during the study, there appears to be four reasons why SI programs did not employ pharmacological interventions. First, as previously indicated, SI participants were likely to have spent time in jail or in another institution prior to their arrival at SI facilities, and physical withdrawal from drugs would likely have already occurred. Second, SI facilities typically have stringent physical requirements for participation in their programs, and these requirements would eliminate inmates whose drug use had resulted in serious health problems. Third, as a result of the typically young and healthy population targeted by SI programs, most facilities have limited medical staff capable of directing and monitoring such intervention. Fourth, interwoven with the other reasons, is perhaps the most important reason: an administrative reluctance to provide "drugs" to inmates due to concerns about compromising overall program integrity and institutional security. (For a discussion of similar problems with jail programs see Magura, Rosenblum and Joseph, 1992.)

The Mix of Substance Abuse Education and Treatment

There is some disagreement in the drug treatment literature on whether it is appropriate to consider drug education programming as a drug treatment modality. Many argue that substance abuse education/information programs do not constitute treatment (e.g., Lipton, Falkin and Wexler, 1992), and may, at best, provide basic support for treatment.

To assess how substance abuse program providers in boot camp facilities viewed this issue, a number of survey items investigated whether drug education was considered a separate program from drug treatment or a component of treatment. The responses, summarized in table 5-1, reveal three distinct program groupings with regard to the use of substance abuse education in boot camps. The first group are those that provide substance abuse education only, defined in the survey questionnaire as ". . . a separate, clearly

Table 5-1: Comparison of Program Elements and Goals by Facilities with Substance Abuse Education Only, Substance Abuse Treatment Only, and Both Education and Treatment

Program Elements	SA Education Only			SA Treatment Only			SA Education and Treatment		
	Mean	S.D.	(n=7)[a]	Mean	S.D.	(n=7)[a]	Mean	S.D.	(n=15)[a]
Physical Training	1.00	0	(7)	1.43	.79	(7)	1.21	.58	(14)
Alcohol Treatment	----	----	----	1.14	.38	(7)	1.60	1.12	(15)
Drug Treatment	----	----	----	1.14	.38	(7)	1.53	1.12	(15)
Substance Abuse Education	2.71	1.25	(6)	1.83	1.17	(6)	1.53	1.12	(15)
Physical Labor	1.67	1.21	(6)	2.86	1.68	(7)	1.67	1.17	(15)
Drill & Ceremony	1.43	.53	(7)	1.57	.79	(7)	1.47	.64	(15)
Basic Education	2.71	1.38	(7)	1.57	.98	(7)	2.33	1.63	(15)
Vocational Education	----	----	----	----	----	----	3.80	1.55	(10)
Pre-release Programs	3.14	1.21	(7)	1.43	.78	(7)	1.64	1.39	(14)
Post-release Programs	1.50	.71	(3)	1.67	1.03	(6)	2.33	1.77	(12)
Program Aims									
Deterrence	2.83	.98	(6)	3.00	1.00	(5)[b]	2.27	.70	(15)
Incapacitation	3.50	1.29	(7)	2.33	1.21	(6)[b]	3.14	.86	(14)
Retribution	3.50	1.29	(4)	3.50	1.29	(4)[b]	3.46	1.13	(13)
Rehabilitation	2.00	1.00	(7)	1.50	.84	(6)[b]	1.33	.62	(15)

[a]The numbers in these columns reflect the number of facilities indicating the area to be a program element or aim; means and S.D.s are based only on those indicating the program element or aim existed. Blanks (---) indicate that none of the reporting facilities identified the area as an element or aim.

[b] Number of reporting facilities also excludes one facility which did not report information on program aims.

identifiable substance abuse education program." Seven of the 29 responses (24 percent) indicated that this approach was used.

A second group of equal size (7) maintained that substance abuse treatment was provided, but indicated that it did not include a separate and

identifiable education component as defined above. For those programs, substance abuse education was intertwined with the substance abuse treatment component and not considered a separate program offering. Finally, a third, larger group of 15 facilities (52 percent) indicated that both an identifiable education program *and* a substance abuse treatment program were present. Behind these fairly crude distinctions lies an interesting finding. When those facilities having treatment programs were asked to identify the modalities used in their programs, all 22 programs identified substance abuse education. Thus it would seem that education plays an important role in substance abuse programming in boot camp facilities whether it is the only program component or integrated into a broader treatment paradigm. In effect all shock facilities provided some form of drug education.

Table 5-1 also presents the perceptions of substance abuse programming providers as to the priority their facilities attach to a variety of boot camp program components as well as their perceptions on the underlying aims of their boot camp programs. Responses are broken down by the type of drug treatment provided within each respondent's boot camp, as previously defined. Mean scores for priority ratings are based on a scale of one (highest priority) to six (lowest priority); scores for program aims are based on a scale of one (primary aim) to four (least important aim). Mean scores are based only on responses indicating that an aim or program element was present at the boot camp, with the figures in parenthesis indicating the number of boot camps indicating the presence of the aim or program element.

These data tend to indicate that providers' perceptions vary considerably by the nature of substance abuse programming provided to offenders in boot camps. Rehabilitation was ranked higher than the other correctional goals across all types of facilities. When both formal and separate substance abuse education and treatment programs were present, however, rehabilitation was rated more highly than when only substance abuse education was provided. In contrast, when substance abuse education was incorporated into treatment programs without being a distinct and separate program, the priority ratings for both alcohol and drug treatment were greater than when separate program components were present.

Furthermore, a greater proportion of boot camps that had substance abuse treatment programming indicated the presence of postrelease programming (6 of 7 and 12 of 15, respectively) than those that offered only substance abuse education (3 of 7). The presence of drug treatment programming and the mix of drug treatment and drug education programming appeared strongly related in very direct ways to the nature of rehabilitative programming found in boot camps. The presence of substance abuse treatment may be a defining characteristic of boot camps that most actively seek to rehabilitate offenders. In the eyes of substance abuse programming providers,

programs that merge treatment and education programming may witness the dilution of treatment programs.

An Overview of Substance Abuse Education

Of those 22 programs offering a separate and distinct education program in conjunction with treatment or alone, 20 (91 percent) mandated inmate participation. Instruction hours ranged from 6 to 358, with the average being just over 65 and the median being 21 hours. Facilities that provided both substance abuse education programs and treatment programs offered nearly 30 more hours of substance abuse education instruction (70 versus 42) on average than those programs that had only an education program, suggesting a more intensive program effort.

The means of delivering substance abuse education in SI appears fairly standardized across programs, with all programs using a class presentation format supplemented by movies and videos. Written materials were provided in handouts (77 percent) and through books and pamphlets (64 percent). Slightly less than one-third (27 percent) invited ex-addicts in recovery to address offenders, and a similar number (27 percent) brought in guest speakers and volunteers to make presentations.

Over one-half (54 percent) of programs providing a separate education program used inhouse staff to deliver the program. Eighteen percent of programs used external educators while about 9 percent contracted outside organizations. The remaining programs used multiple providers or other sources. The ratio of education staff to shock inmates ranged from about 1 to 10 at the low end to around 1 to 250 at the high end. The most common ratios of education staff to inmates were 1 to 20 (27 percent) and 1 to 30 (31 percent). Eight facilities (36 percent) required that their education staff be certified while 14 (64 percent) did not. Four facilities reported that one-half of their education staff were certified, 1 facility reported that 70 percent were certified, and 4 reported that all were certified. The remaining 13 facilities did not indicate staff certification. These numbers suggest that the determining factor as to whether an SI facility's substance abuse educators were certified rested principally upon whether or not such certification was required. In general, it appears that the majority of substance abuse educators in SI facilities are not certified and are not required to be certified.

The Nature of Substance Abuse Treatment Services

Many observers of correctional substance abuse treatment programs have evaluated programs on the basis of the existence and adequacy of three primary program components: an assessment phase including evaluation and development of a treatment plan, a treatment program, and an aftercare

component (c.f., Finn and Newlyn, 1993; Sherron, 1991; Weinman and Lockwood, 1993; Wexler and Lipton, 1993). The present analysis examines each of these components as they exist in SI substance abuse treatment programs.

Substance abuse assessment. Substance abuse treatment in the free-world community is generally premised on a clinical determination rather than on a legal one. The process initiating such treatment in the community usually is based upon an evaluation and determination that the individual is addicted to or suffers from a dysfunctional use of a substance. Using this free-world model as a point of reference to understand the nature of substance abuse treatment in SI programs, the following question was posed: Is substance abuse treatment in SI facilities based upon a clinical assessment of the offender's substance abuse problem?

Assessment of inmates' substance abuse problems was a fairly common practice in the shock incarceration programs surveyed. Of the 29 State and Federal programs responding to the substance abuse survey, 20 (69 percent) indicated that some type of substance abuse assessment was conducted, while 9 (31 percent) stated that no assessment took place. Those facilities assessing substance abuse indicated that it was a routine practice for all inmates entering the facility.

Assessment and treatment linkages. Despite the common use of substance abuse assessment in SI facilities, there appeared to be inadequate links between substance abuse assessment and subsequent treatment programming. Of the 29 programs responding, 22 reported substance abuse treatment, but only 18 conducted a substance abuse assessment; 4 did not. Further evidence of a lack of integration between assessment of substance abuse problems and subsequent treatment is revealed by the fact that of the 18 programs conducting assessments, only 9 indicated using assessment data to classify inmates for treatment programs. Some of those programs not using assessment data for treatment placement required all inmates to participate in treatment. In these situations, the assessment data was used to specify modifications in the delivery of treatment programs or classroom presentations to the inmate population.

Additional evidence of weak ties between substance abuse assessment and treatment placement is seen in the number of facilities that based mandatory substance abuse treatment on nonclinical decisions. Besides the four facilities mentioned above that placed offenders in treatment without substance abuse assessment, six facilities indicated that drug treatment was mandated by statute, two reported that a judge could mandate participation, and two indicated that other mechanisms mandated substance abuse treatment. One boot camp official commented that any inmate who meets general criteria for shock

incarceration receives substance abuse treatment, and this statement appeared to be widely generalizable to other facilities.

Interestingly, two States with assessment procedures did not provide substance abuse treatment at the facility level. One facility indicated that it had previously operated a treatment program but had moved to a program offering only substance abuse education; the facility continued the assessment process nonetheless. Another site indicated that it provided substance abuse education, but not treatment, and performed assessments for purposes of individualizing aftercare treatment plans.

In summary, it appeared that in most SI facilities legal factors, not clinical assessments of treatment needs, were the driving influences in defining substance abuse treatment programming.

Assessment tools. For those facilities conducting substance abuse assessments, there were a variety of tools, screening instruments, and classification systems available to identify individuals with alcohol and substance abuse problems. The survey of boot camp substance abuse providers asked respondents to identify the techniques used to determine if inmates had substance abuse problems. As seen in table 5–2, the majority of shock incarceration programs relied upon interviews extensively to determine offenders' substance abuse problems. All respondents except one (94 percent) stated that their program used face-to-face interviews. Slightly less than three-quarters (72 percent) reported using some form of a structured clinical interview.

The other common method used to assess inmates' substance abuse difficulties was reviewing case history information. The vast majority (83 percent) of facilities used case history information gleaned from sources such as presentence investigations, prior treatment records, and self-report information provided by offenders. A much smaller group (17 percent) confined their case history review to information related to present offenses.

Psychological/behavioral testing instruments were also popular methods of assessment. Over three-quarters (78 percent) of respondents conducting assessments indicated using these tools. However, there did not appear to be a clear favorite among the instruments identified on the survey. The most commonly used instruments were the Michigan Alcoholism Screen Test (MAST) and the Inventory of Drinking Situations, which were identified by slightly more than one-third (39 percent and 38 percent, respectively) of the facilities using such tests. The Alcohol Use Inventory was employed by more than one- quarter (28 percent) of those using tests. Six other scales were identified by less than 20 percent of this group. It should be noted that 56 percent of those indicating the use of such assessment instruments used tests

Table 5-2: Types of Substance Abuse Assessment[a] Provided in Shock Incarceration Facilities Providing Substance Abuse Treatment

Type of Assessment	Percentage of SI Facilities[b] With Assessment (n=18)	Type of Assessment	Percentage of SI Facilities[b] With Assessment (n=18)
Psychological/Behavioral Tests	**78**	**Face-to-Face Interviews**	**94**
Michigal Alcoholism Screen Test (MAST)	39	Clinical Structured Interview for (DSM-III-R)[b]	39
Inventory of Drinking Situations	38	Other Structured Interview	33
Alcohol Use Inventory	28		
MacAndrew Scale (MMPI subscale)	17	**Case History Beyond Offense**	**83**
Addiction Severity Index	17		
Alcohol Dependence Data Schedule	11	**Case History Confined to Drug Involvement in Offense Behavior**	**17**
Self-Administered Alcoholism Screening Test (SAAST)	11	**Biological Markers (e.g., blood/ urine tests)**	**33**
Substance Abuse Proclivity Index (SAPS)	06		
Mortimer-Filkens	06	**Use of Classification Systems[c]**	**44**
Adolescent Drinking Inventory	05	World Health Organization (ICD9)	06
Other	56	DSM-III-R	22
		Other	11

[a]Because respondents could indicate the utilization of more than one type of assessment procedure, tools do not equal 100 percent.
[b]Figures for two facilities that conduct substance abuse assessment for aftercare purposes but do not provide treatment are not included.
[c]Interview protocol based upon the Diagnostic and Statistical Manual (Rev. 3d. Ed.) American Psychiatric Association.
[d]Formal Treatment classification systems used to classify inmates for treatment.

other than the 14 listed on the survey instrument. Of these facilities, several indicated the use of a substance abuse screening instrument apparently developed as part of their admission and diagnostic screening process.

The use of biological markers, (i.e., urine and blood tests), was reported by only one-third (33 percent) of the respondents. The lack of such testing is surprising given their common use in community-based correctional treatment programs. The reason cited for their lack of use by SI treatment personnel was that most SI participants have spent time in jail or other correctional facilities before coming to SI facilities, and by the time they arrive the physical presence of drugs in their system is gone.

Summary of substance abuse assessment. In summary, about 69 percent of respondents indicated offender substance abuse assessment taking place within their facilities. For those facilities offering substance abuse treatment, this percentage increases to approximately 81 percent. The majority of these respondents indicated the use of multiple assessment techniques to identify substance abuse problems in their offender populations. The most common approach was the use of interviews, a review of case materials beyond the present offense, and the use of psychological or behavioral testing instruments. Despite these rather extensive efforts, however, survey results indicated that the predominant mechanism for placing SI offenders in substance abuse treatment was not a diagnostic process and clinically based evaluations of need, treatment amenability, and potential effectiveness, but rather through a legally mandated or nonclinical decision process. The issue to be considered here is probably not so much one of the mandatory nature of the treatment, but rather one of maximizing treatment resources and treatment appropriateness. Researchers have found that the threat of criminal justice sanctions motivates offenders to enter and remain in treatment for longer periods, enhancing the permanence of behavioral changes (Leukefeld and Tims, 1988).

Multiple Modalities and Interventions

In the Substance Abuse Treatment/Education Survey, respondents were asked to identify treatment modalities used in their programs from among six types commonly associated with correctional substance abuse programs: (1) substance abuse education; (2) the Alcoholics Anonymous/Narcotics Anonymous model; (3) individual counseling; (4) therapeutic communities; (5) group counseling; and (6) milieu therapy. In this context, the term "modality" was used to mean the general treatment delivery approach employed by the program. Additionally, respondents were requested to select the interventions they used from among 21 common therapeutic interventions. Space was also provided for the respondents to list two interventions not included in the listing. As used here, the term "intervention" denoted the specific type or style

of treatment offered. Information about the frequency of use for each of the modalities (excluding education) and the three most frequent interventions for each of the modalities is presented in table 5-3.

Table 5-3: Most Frequently Used Treatment Interventions for Five Primary Treatment Modalities in Shock Incarceration Facilities[a]

Modality	Number of Facilities Using (%)	Treatment	Number of Facilities Using (%)
Group Counseling	19 (86)	AA 12-Step	18 (95)
		Reality Therapy	16 (84)
		Stress Management	15 (79)
Alcoholics Anonymous Model (Self-help: AA/NA/CA)	17 (77)	AA 12-Step	17 (100)
		Reality Therapy	16 (94)
		Stress Management	13 (76)
Individual Counseling	14 (64)	AA 12-Step	13 (93)
		Reality Therapy	12 (86)
		Reentry	11 (79)
		Stress Management	11 (79)
Milieu Therapy	11 (50)	AA 12-Step	11 (100)
		Reality Therapy	10 (91)
		Stress Management	10 (91)
		Confrontation	9 (82)
Therapeutic Community	2 (9)	AA 12-Step	2 (100)
		Positive Peer Culture	2 (100)

[a]Responses of 22 facilities indicating that they provide substance abuse treatment.

As might be surmised from the information in table 5-3, all but one of the programs employed multiple modalities. Excluding education as a modality, Virginia had the only SI program reporting the use of a single-treatment modality (group counseling). Four facilities (18 percent) reported using 2 modalities, 10 facilities (45 percent) cited 3, and 6 facilities (27 percent) reported a combination of 4. This finding reflects a theme repeated

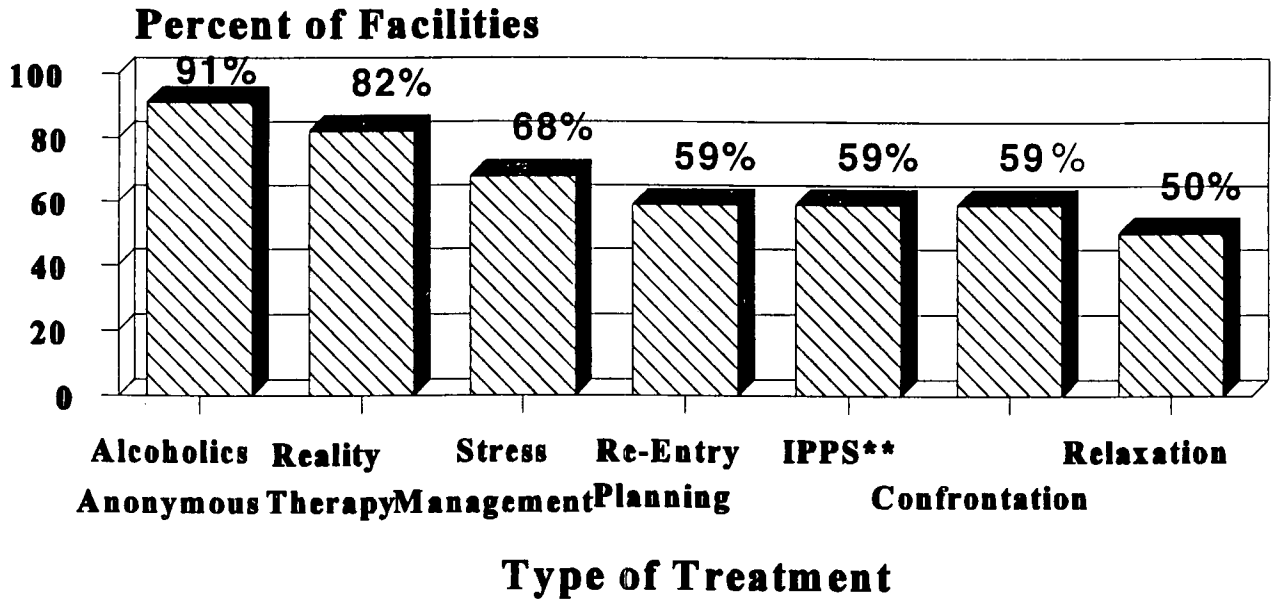
throughout this section—the eclectic nature of substance abuse treatment offered in SI programs. The majority of programs used multiple treatment approaches (e.g., education, group counseling, AA 12-step approaches, and individual counseling), and employed multiple treatment types.

Employing eclectic programs can have both positive and negative consequences for SI facilities. On one hand, facilities can provide multimodal treatment services covering a wide spectrum of problems underlying drug use and dependency. On the other hand, this approach can foster a lack of clarity and specificity as to the theoretical orientation or treatment approach being employed. A case for either of these two possibilities may be made by reviewing the most frequent treatment interventions associated with each of the modalities (see column 3 of table 5-3.) For each of the treatment modalities except the therapeutic community approach, three interventions—AA 12-step, Reality Therapy, and Stress Management—were ranked consistently as the most frequently used. (Because only two responding facilities indicated using a therapeutic community approach, an analysis of rankings for this intervention method holds little meaning.) The use of multimodalities and the predominance of the same interventions (slight variations are noted for milieu therapy and individual counseling) would seem to indicate a lack of strong differentiation between program approaches in SI substance abuse treatment programs, which is not surprising given the relative newness and rapid expansion of the SI movement. The few more established programs frequently served as models for new facilities. Treatment components found in programs with developed substance abuse approaches, such as the Alcohol and Substance Abuse Treatment model (ASAT) in New York, were replicated again and again.

The similarities in treatment across programs are further illustrated in figures 5-1 and 5-2, which detail the most and least employed therapeutic interventions. Most programs took a pragmatic, skill-building approach to helping offenders cope with problems they would face upon reintegration into the community. Traditional psychotherapeutic approaches, designed to uncover and deal with offenders' underlying psychological and emotional problems, were used much more infrequently.

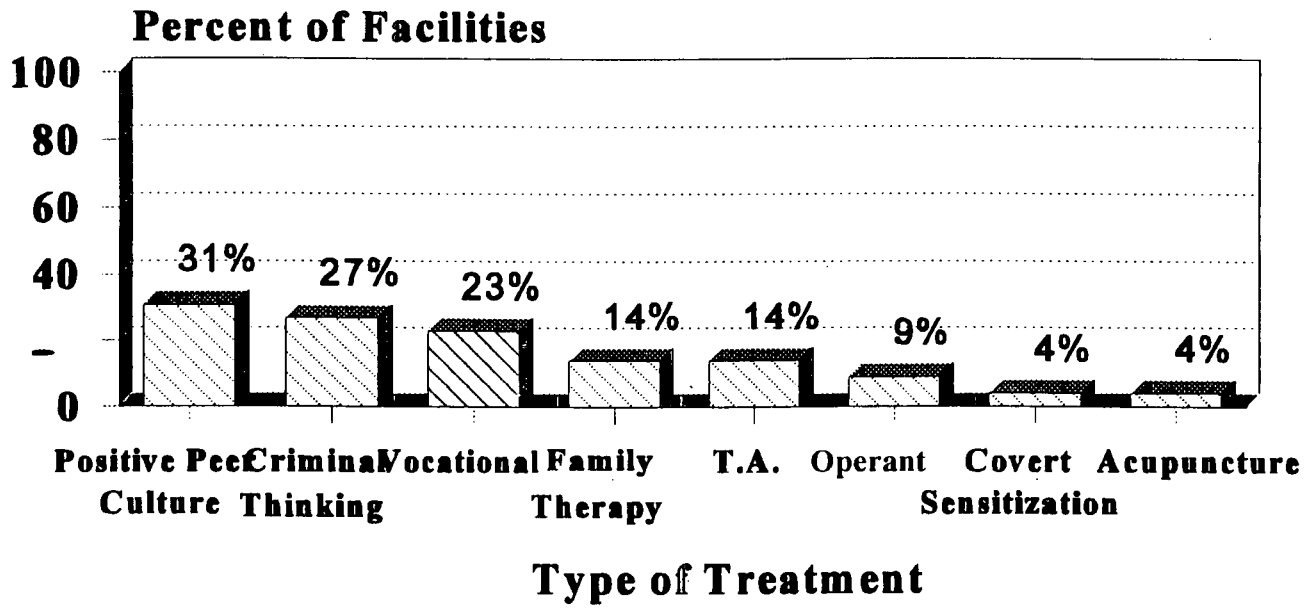
The "borrowing" of treatment approaches by a developing program from existing SI programs and from other correctional environments may result in a layering of interventions. This "everything but the kitchen sink" approach is evidenced by the number of interventions per facility revealed in the survey results. They ranged from 1 to 15, with 5, 7, and 11 being the most common (mode) number used. Furthermore, the type of modality used seemed to minimally affect the number of interventions employed. The average (mean) number of interventions ranged from 7.41 for therapeutic communities

Figure 5-1: Most Common Types of Treatment Offered in Shock Incarceration Facilities



*Provided by 50% or more of facilities offering treatment; n=22
**IPPS = Interpersonal Problem Solving

Figure 5-2: Less Used Types of Treatment Offered in Shock Incarceration Facilities*



*Provided by one third or fewer facilities offering treatment; n=22

(again caution should be used in interpretation as only two sites reported this modality) to 9.00 for milieu therapy.

The absence of therapeutic communities. The therapeutic community (TC) model has been identified as one of the most successful approaches to correctional substance abuse treatment (see Lipton et al., 1992; Pan et al., 1993). Somewhat surprising then is the fact that only two of the reporting facilities, those in Massachusetts and Wisconsin, specified the use of a therapeutic community model. It should also be noted that New York uses a TC approach in all five of its SI programs. Due to the lack of individual facility responses, however, they are not included in the aggregate responses presented throughout this report.

Many boot camp programs stress the need to develop an esprit de corps among participants that emphasizes reciprocal responsibility, the impact of individual action upon the larger group, and the use of peer pressure to reinforce positive behavior and eliminate negative behavior. Therefore, it would seem that the TC approach would blend well with SI program environments and philosophy. Because most shock incarceration programs espouse a multidimensional substance abuse approach emphasizing education, the use of peer support (i.e., AA 12-step approaches), and the use of pragmatic life skills-building interventions, the TC approach would appear to be compatible with extant treatment interventions employed in many of the SI facilities with substance abuse programs.

In summary, the substance abuse treatment approaches found in the majority of SI facilities throughout the Nation seemed to emphasize self-help (AA-type) programs and what Peters (1993) identified as psychoeducational approaches. These psychoeducational approaches are based on the assumption that substance abuse springs from multiple biophysical factors (e.g., individual predispositions and personal risk factors), and that treatment should focus on recognizing these factors and developing strategies to counteract individual deficits. According to Peters, these approaches focus on (1) development of motivation (to overcome dependencies) and commitment, (2) life skills development (e.g., fiscal management, communication skills, constructive use of time), (3) AIDS education and prevention, (4) relapse prevention strategies, and (5) development of aftercare plans to access community resources after release.

By contrast, absent for the most part in SI programs, were substance abuse treatment approaches emphasizing the "disease" model, medical treatment of addiction, including detoxification and pharmacological interventions and psychotherapeutic interventions (in particular individual counseling, family counseling, or psychiatric services). These approaches are designed to help offenders deal with intrapersonal problems and the psychological impacts of substance abuse.

Length of Treatment

Research over the years has consistently shown a relationship between time in treatment (TIP) and treatment outcomes (DeLeon, 1979; Simpson, 1981; Hubbard, Marsden, Rachal, Harwood, Cavanaugh, and Ginsburg, 1989; Wexler, Falkin, Lipton and Rosenblum, 1992). Although Wexler and his associates actually found a decline in positive outcomes for clients in a 12-month therapeutic community program, they attributed the decline to factors other than treatment duration. Two factors can affect the duration of an individual's stay in a treatment program: whether he or she completes the program or drops out, and the actual length of the program.

As mentioned earlier, for the majority of SI programs with substance abuse treatment programs, offenders' participation begins with legal and administrative procedures rather than assessment mechanisms. Of the 22 facilities reporting that they offered treatment programs, in only one was that treatment voluntary. In four programs treatment was required for certain inmates, such as those with drug offense convictions or those for whom the judge mandated participation. For the remaining 17 programs (77 percent), all inmates were required to participate. Overall, program lengths varied from 2 to 9 months for female SI programs, and from 3 months to 1 year for male programs. For both males and females, the most frequent program length was 6 months. Thus, general program length for SI facilities seems quite compatible with short-term residential drug treatment in the free world.

Due to the lack of clear boundaries between substance abuse treatment and the general program regimen found at most SI facilities, it was difficult to ascertain the precise time inmates spent in a particular treatment approach (also see the case studies discussed in chapters 2 and 6). Some facilities maintained, for example, that all of the time that offenders spent at a facility were days in "treatment." These programs might have listed the length of the treatment program as being the same length as the overall program (e.g., 90, 120 or 180 days), despite the fact that the time inmates actually spent in bona fide substance abuse treatment activities was much less.

Compounding this problem is the multimodal substance abuse treatment approach commonly seen at SI facilities. For example, an evening substance abuse treatment program might comprise a life skills exercise, a "confrontation" group designed to provide realistic peer feedback, and a self-revealing "go-around" session common to 12-step programs. This entire program frequently might be viewed and reported simply as group counseling by treatment staff. The lack of distinctions makes the quality of the data problematic regarding time in treatment for the various approaches.

Three coarser distinctions made, however, between programs on the basis of whether they provided education only, treatment only, or both education and treatment did reveal programmatic differences in both the length of time offenders spent in SI facilities and in the length of substance abuse programs. For female inmate programs having only a substance abuse education component, the mean SI program length was 4 months. For female programs with both an education and treatment component, however, the mean program length increased to 5.6 months; for those female programs with a singular treatment component the mean increased to 6 months. In male SI facilities the distinctions between program lengths among the three types of substance abuse programs were less apparent. Those male SI facilities with only an education component had a mean program length of 4.33 months. The length increased to 4.6 months for facilities that only provided a treatment component and increased slightly further to 4.78 months for programs that provided separate substance abuse treatment and education components.

The relatively small number of facilities falling into each of the three categories suggests that caution should be used when considering these differences because the length of one program could greatly influence the average length found for a category. This influence is particularly evident in the case of the female facilities. For male facilities, it appears that an education-only approach may be employed with SI programs of shorter duration because insufficient time exists to involve participants in a treatment regimen. On the other hand, providing separate education and treatment components may simply require more program time than providing either singularly, thus explaining the increased program length seen in facilities with both components. This line of thought suggests that the type of substance abuse program offered in SI facilities may be in part driven by larger structural considerations, such as statutory restrictions or administrative attempts to realize potentially greater cost savings.

Completion rates. With regard to completion rates there appeared to be few ways for an inmate to quit participating in a substance phase program without being removed from a shock incarceration facility. In 4 of the 22 facilities offering substance abuse treatment, inmates could be administratively removed from treatment and remain in the SI program. In only 2 of the facilities, however, could inmates voluntarily quit substance abuse treatment and remain in the program. Given this common requirement that inmates participate in substance abuse treatment to remain in the SI program, the possibility arises that adding the hurdle of a required substance abuse treatment program might reduce completion rates for SI programs. To explore this possibility, the study examined inmate completion rates for facilities providing only substance abuse education, for those providing only substance abuse treatment, and for those providing both. The results revealed that facilities

offering only an education program had the lowest completion rates at 70 percent. The completion rate improved to 78 percent for facilities providing both education and treatment programs, and further improved to 84 percent for facilities that focused solely on a treatment paradigm. Thus the presence of a treatment program appeared to facilitate rather than hinder inmates' ability to complete SI programs, despite the mandatory nature of such treatment and the association of treatment with longer SI programs. Jurisdictions thinking about incorporating a drug treatment component in the development of an SI program should consider these results.

Staffing

As Lipton et al. noted in their review of correctional drug treatment, "staffing is one of the keys to successful programming whatever the modality" (1992: 23). There are two predominant issues when considering treatment staff: (1) the quality of the staff, and (2) the size of the staff relative to the client population and to the type of treatment being offered.

The survey responses in this study revealed considerable diversity in the way treatment programs were staffed in SI programs around the Nation. Researchers found three models of staffing for substance abuse programs. In the first model, treatment programming was provided by full- or part-time agency staff—essentially an "inhouse" program delivery model. The second model was "mixed" in that individuals were contracted to supplement agency staff. The third model involved contracting all treatment services through individuals or an outside entity such as a community mental health agency or vendor.

The "inhouse" model was by far the most common approach to staffing SI treatment programs, with 15 (68 percent) facilities in the survey relying exclusively on agency staff. Only two facilities reported using contracted staff solely, and the remaining four facilities (18 percent) used the "mixed" model of both agency staff and contracted personnel. Table 5–4 presents characteristics of SI programs' contracted and agency staffing. As reflected in the table, contracted staff were more likely to be certified in substance abuse treatment, and full-time contracted staff were more likely to have also been formally trained in substance abuse treatment. Among the total treatment staff, 41 percent were certified and 73 percent had received formal training in substance abuse treatment.

SI programs also differed widely on their ratio of substance abuse treatment providers to client offenders. One program had a ratio of 4 clients for every 1 treatment provider staff. At the other end of the spectrum, another program surveyed had a ratio of 90 participants for every 1 treatment staff

member. The most commonly occurring inmate/staff ratios were 10 to 1, 30 to 1, 45 to 1, and 50 to 1. It is difficult to imagine that a substance abuse counselor could have much individualized interaction with offenders at ratios nearing 100 (or even 50) clients per staff member. Fortunately, inmate/staff ratios in boot camp treatment programs averaged in the range of 30 to 1 across types of modalities. (Data are not presented in tabular form.)

Table 5-4: Substance Abuse Treatment Staff at Facilities Providing Treatment (n=22)

Staff Type	Number of Facilities With (%)	Average Number of Staff	Range of Staff/Inmate Ratio	Percentage of Staff With Formal Training	Percentage of Staff Certified
Full-time Contracted	6 (27)	3.2	4–41:1	83	75
Full-time Agency	20 (91)	2.7	10–90:1	70	40
Part-time Contracted	7 (32)	3.7	10–33:1	71	33
Part-time Agency	1 (4)	5.0	15:1	0	100

Aftercare Programming

As previously discussed, aftercare is considered, for purposes of this study, any and all services and levels of offender supervision in the postrelease period that correctional officials regard as part of offenders' sanctions. This definition would exclude an offender's decision to voluntarily attend AA/NA meetings, but would include mandated participation as a parole condition. The distinction was based on whether offender use of community-based services was part of the continuum of services associated with their boot camp placement.

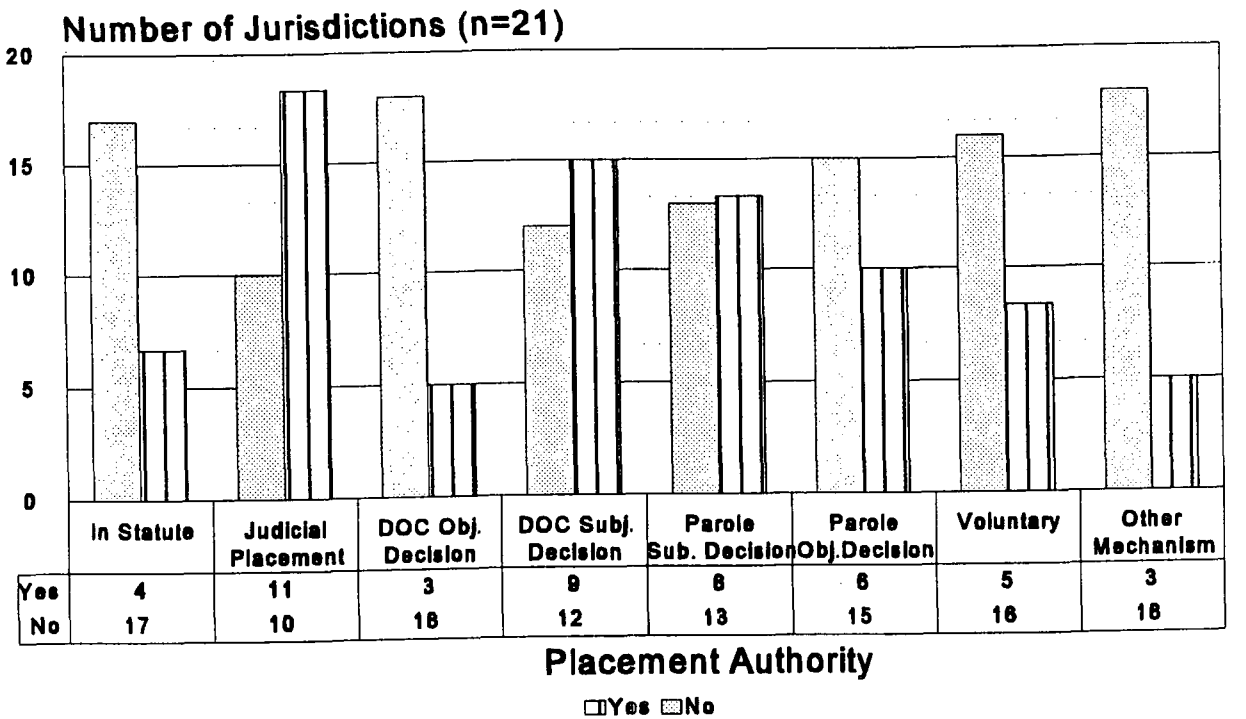
One difficulty in determining the extent of substance abuse aftercare in SI facilities centers in part on differences in perceptions as to what constitutes an aftercare program. Roughly 72 percent of treatment providers responded positively to the question, "Do inmates who participate in substance abuse treatment programs enter an aftercare substance abuse treatment program when released from your facility?"

Among administrators from the same facilities, a slightly smaller percentage (68 percent) responded in the affirmative to a somewhat more general question, "Is there an aftercare program for shock incarceration graduates after they are released from your program?" However, closer examination of these numbers reveals more pronounced differences. All substance abuse survey respondents indicating the existence of an aftercare program were at facilities providing substance abuse treatment. Yet three administrative responses indicating the existence of an aftercare program came from facilities with no substance abuse treatment program. Furthermore, five of the administrators from facilities with treatment indicated there was no aftercare program. Clearly, these responses suggest differences in perceptions regarding what constitutes "aftercare." As discussed later in this section, the aftercare services provided to SI releasees ranged from what is essentially traditional probation/parole supervision to highly structured programs with a clearly articulated substance abuse treatment component. The broad range of aftercare programming may account for some of the response discrepancies indicated above.

Aftercare placement. For those facilities offering aftercare, the mechanisms initiating placement of SI graduates in aftercare programs varied across jurisdictions. Much like substance abuse treatment in SI programs, however, aftercare appeared to be a mandated program element for the majority of respondents. Of the 21 SI facilities indicating aftercare services, over three-quarters (76 percent; $\underline{n}=16$) stated that participation was required. In four cases (19 percent) participation was mandated by statute. Less than one-quarter of the program providing aftercare (23 percent; $\underline{n}=5$) stated that offender participation was voluntary.

Furthermore, as displayed in figure 5-3, the decisionmaking authority for placement in aftercare appeared to be divided among various entities, and was most frequently determined subjectively rather than through a standardized or objective assessment of need. Thirteen facilities reported having multiple decisionmaking authorities, while eight vested the decisionmaking authority in one entity. Thus, for the 72 percent of respondents indicating the existence of a substance abuse treatment aftercare program at their facility, decisionmaking authority over offender placement seemed to rest, often simultaneously, among the judge, the facility, and the paroling authority.

Figure 5-3: Decision Authority* for Aftercare Placement



*Multiple decision authority exists in some jurisdictions; one facility missing

These findings lead to two conclusions. First, such division of decisionmaking authority suggests a legal rather than clinical orientation when treatment placement decisions are made. Second, while decisionmaking authority for aftercare placement may be defined somewhat by the statutory framework in which SI programs operate (i.e., probation or incarceration), the degree to which decisionmaking authority overlaps again reinforces the notion of generally inadequate mechanisms to ensure continuity between the inprogram portion of the sanction and the aftercare component.

Aftercare program models. Four strategies to provide aftercare services to SI graduates were apparent from survey responses. All of these approaches incorporate community supervision through probation or parole officers (depending on whether the SI program is established as a probation component or part of an incarceration sanction). With the exception of four facilities that reported providing no aftercare, virtually all survey respondents indicated some use of community supervision. Beyond the basic commonality of parole or probation supervision, however, there was wide variation in the scope and type of services provided to SI releasees, and especially to releasees in substance abuse programs. Inspection of these differences suggests that aftercare delivery may be categorized into four levels or program models, which are summarized in figure 5-4.

At the first level, aftercare closely resembles traditional parole or probation supervision, and officers refer SI releasees to available treatment programs in the community. In survey responses to the question of who provides aftercare services, this type of aftercare frequently was noted simply as "various probation/parole officers." This approach relies heavily on existing community programs, principally 12-step AA/NA programs, community mental health units, or city or county substance abuse clinics. At this level, links between the aftercare provider and the SI program are informal and loosely structured. Also, the inprogram substance abuse staff usually have little direct contact with or knowledge of offenders after they graduate, and the decisionmaking authority for aftercare substance abuse placement comes from the probation/parole agency or the courts rather than from the SI facility.

A second, more structured level of this approach, which uses an intensive supervision model, is employed in Georgia, Illinois, Louisiana, Maryland, and Virginia. At this level caseloads are intensively supervised using more frequent contact and such additional requirements as curfew, frequent urinalysis testing, and a structured substance abuse treatment referral process. This approach generally provides greater continuity of treatment because specialized probation/parole officers may be identified as part of the SI program and have more extensive contact with the institutional staff than

Figure 5-4: Shock Incarceration Substance Abuse Aftercare Program Models

Brokerage Model	Enhanced Brokerage Model
Traditional Parole/Probation Supervision Use of Existing SA Treatment Resources • AA/NA 12-step groups • Community mental health centers • City/county/private substance clinics Minimal Contact Between SI Facility Staff and Community Supervision Staff SA Treatment Placement Decision Rests With Parole/Probation Agency Rather Than With Facility	Intensive Parole/Probation • Specialized caseloads or intensivly supervised caseloads • Specialized requirement for SI releasees (e.g., curfew, frequent urinanalysis testing) Use of Existing Treatment Resources But With Structured Referral Process Parole/Probation Staff May Identify Themselves as Part of SI Program SA Treatment Placement Decision Continues to be Channelled Through Parole/Probation Agency
Contracted Vendors Model	**Comprehensive Model**
Intensive Probation/Parole Supervision Contracted SA Treatment Vendors Are Secured to Provide Services Direct Linkage Between SI Facility and Treatment Provider(s) • Formalized agreements exist stipulating treatment parameters (e.g., type, length, assessment costs) Formalized Mechanisms for Placement of SI Offenders in Treatment	Intensive Parole/Probation Supervision Integrated Program Developed and Formalized as Part of SI Program Continuum • Substance abuse treatment/relapse prevention • Job development/placement • Education/training • Housing assistance • Life-skills programming Established Linkages Between SI Facility/Program and Community Services

they would in a traditional parole/probation scenario. There may also be a concerted effort on the part of parent agencies to identify the SI program as a continuum of services with both institutional and release components. Also at this level, the provision of services continues to be channeled on an ad hoc basis, primarily through referrals by the supervising officer to existing community substance abuse programs.

At the third level, SI graduates receive, in addition to their community supervision, substance abuse treatment from contracted vendors. The difference between this approach and the brokerage or even enhanced brokerage strategy just described is the direct linkage between SI facilities/programs and aftercare providers. In the brokerage approach, supervising officers/agencies mediate interaction between the facilities and treatment providers. In this vendor model, formal agreements are developed between SI facilities/agencies and providers stipulating the parameters of treatment (such as treatment length and type, assessment, costs, etc.). In addition, the mechanisms for placing offenders into the treatment program are formalized. States specifying the use of vendors included Arkansas, Idaho, Massachusetts, Minnesota, Oklahoma, Tennessee, and Wisconsin.

The fourth and final level of aftercare services might be best characterized as a "comprehensive" model. In this approach, a structured mechanism for providing aftercare services to SI graduates is established that integrates multiple treatment elements addressing a range of issues beyond substance abuse treatment/relapse prevention and parole or probation supervision. These programs emphasize transitional services such as job development and placement, education, housing assistance, and life-skills programming.

Whereas the other three levels identified in this section may essentially achieve this level of programming, level-four comprehensive programs develop and formalize these program elements as part of the SI program continuum structure. At the time of this study, New York appeared to be the only State with SI aftercare services reaching this level; and even in New York, the aftercare program servicing offenders from the five boroughs of New York City was much more developed than it was in other areas of the State. It should also be noted that Massachusetts has made this type of aftercare available to SI graduates in the Boston area through a federally funded pilot project.

As might be expected, researchers found variants on these four approaches to providing substance abuse aftercare services. The Federal Bureau of Prisons, for example, provided aftercare through contracted vendors, but arranged delivery of the service through Regional Transitional Services Managers in the Transitional Programs section rather than through direct contact with the facilities.

Six of the responding facilities that stated they offered both a treatment and an aftercare program did not identify their aftercare treatment providers. Interpreting this omission is difficult, but again it may reflect a lack of coordination between the facility portion of the program and the community treatment/reintegration portion of the program. As one facility respondent

stated, "(Aftercare) placement (is) handled by courts after the inmate (is) released from our custody. No information is provided to us on who is in the program."

Responses of substance abuse aftercare service providers. As indicated in chapter 3, researchers identified 21 potential substance abuse aftercare providers through information furnished by facility respondents. Again, it should be noted that this group does not necessarily represent all aftercare providers, but only those identified by facility respondents. Survey responses were received from 16 of these providers, while 3 returned cards indicating that the agency/organization did not provide such aftercare services. Discussion of the nature of aftercare services in this section is based, therefore, upon the information provided by the 16 aftercare treatment providers responding to the survey.

Just as there appears to be four basic levels of aftercare services provision, two predominant models seem to reflect existing aftercare services for the survey population. The first type is chiefly operated by correctional agencies and reflects a general supervision or brokerage approach focused on SI offenders. At the second level, noncorrectional agencies focus exclusively on providing substance abuse treatment and direct programs at a more general clientele than just SI offenders. All of these latter programs identified themselves as nonprofit entities.

More than half (56 percent) of the nine aftercare providers responding to the survey appeared to fit in the first model; these respondents indicated they were part of a corrections department, or were a correctional agency but not a department of corrections. Of these "correctional" aftercare programs, seven (78 percent) had been initiated in conjunction with the start of the SI program. On the other hand, of the seven noncorrectional agency aftercare programs, only one had been inaugurated in conjunction with an SI program. Furthermore, over one-half (55 percent) of the aftercare providers affiliated with correctional agencies restricted their clientele to SI participants; and, as might be expected, all limited their clientele to offenders either from SI facilities, community programs, or other prison releasees. Only one of the noncorrectional aftercare providers limited its clientele exclusively to SI participants and an offender population.

With regard to the location of the substance abuse aftercare programs, slightly more than one-half (56 percent) provided treatment through a combination of residential and outpatient programming. In some cases the outpatient programming was provided by specific local programs; in others it was provided through statewide probation/parole "brokerage" services. In two

instances the residential portion of the program took place at a facility operated by a corrections department.

For the remaining programs, aftercare substance abuse programming was delivered exclusively in either a residential, outpatient, or correctional setting. Two of these programs were provided within a correctional facility. Interestingly, one program was delivered by a private nonprofit agency. Four of the substance abuse aftercare programs operated solely in an outpatient format (two operated by correctional agencies, and two operated by noncorrectional agencies). Finally, only one respondent indicated that the substance abuse aftercare program was provided solely in a residential drug treatment setting.

In general, correctional agencies tended to have statewide aftercare programs, whereas noncorrectional drug treatment providers tended to operate within one community or region. This difference may not so much suggest a differing program philosophy, but rather the existing differences in agency structure. Correctional agencies are likely to have agents/offices located throughout a State, whereas noncorrectional treatment agencies are likely to be located within a single locale and often provide services to a specified geographic region such as a city, county, or multicounty area.

Data regarding the number of participants for these programs were provided by only 14 respondents. Due to the small number of responses, the relationship between program size and other program features could not be explored in any depth. For those 14 agencies, a wide distribution in numbers of participants per month was seen, ranging from as few as 6 to as many as 280. One agency not reporting monthly totals indicated that it served over 25,000 clients each year. This respondent was likely a State probation/parole agency using the "brokerage" delivery approach.

Interestingly, this same respondent reported only 37 boot camp participants per year, the smallest number of boot camp offenders serviced by any of the responding agencies. Not surprisingly, this agency indicated that an aftercare program existed before the beginning of its SI program, and thus it likely represents an example of the provision of aftercare services simply being added to a group of extant supervision efforts. In contrast, the second largest number of yearly participants reported by a correctional agency was 2,196. In this instance the respondent indicated that all of the program's clients were SI participants and that it was initiated in conjunction with the development of the SI facility, both clearly indicating a major focus on aftercare programming for SI graduates.

There did not appear to be any relationship between provider type and program size. Both the second smallest number of monthly participants (10) and the largest number of monthly participants (280) were reported by noncorrectional agencies. Similarly, the program setting (i.e., correctional, residential, outpatient, or a combination thereof) did not appear to be related to program size. For example, three aftercare providers identified their programs as occurring in a correctional setting. One provider had 10 participants monthly, while the second had 183 participants. The third program, identified as a combination of a correctional setting and an outpatient program, had 93 offenders in the program. Outpatient programs ranged in size from 130 to 1,200 clients per year.

In summary, wide variation existed in the type and level of aftercare services available to offenders completing SI programs. For many programs aftercare was provided through fairly traditional probation/parole supervision—sometimes augmented by closer supervision, drug testing, and referrals to existing community substance abuse treatment resources. A small number of jurisdictions had developed more formalized linkages with drug treatment providers who generally also serviced noncorrectional populations. Even fewer jurisdictions had extended the continuum of treatment into the community in a substantial way. This lack of formal aftercare programming is especially troublesome due to the common recognition that it is perhaps essential for effective programs to plan for and have adequate resources to meet the post-discharge needs of inmates with substance abuse histories (Wexler and Williams, 1986; Hubbard et al., 1989).

Summary

This chapter has presented findings regarding the scope and nature of substance abuse programming within SI facilities and within the substance abuse aftercare programs associated with them. Several themes emerged from these findings that are worth noting. First, substance abuse programming seems to have been driven to a large extent by general structural and administrative concerns relating to SI facilities rather than by offender needs or therapeutic considerations. For example, although substance abuse assessments were commonly conducted in SI facilities, those assessments were rarely used to determine offender amenability to treatment or to tailor treatment to offender needs; treatment was generally mandated for all offenders by statute or policy and all offenders received the same treatment interventions.

Second, substance abuse programming in SI facilities seems to have been very eclectic, and there appeared to be vagueness on the part of respondents as to the exact composition of the treatment component. Generally substance abuse programming falls into one of three categories: (1) facilities

providing substance abuse education exclusively, (2) facilities providing only substance abuse treatment, and (3) those facilities providing both substance abuse education and treatment. The distinctions between these three categories were somewhat unclear, however, as the "treatment" provided sometimes included a strong education component. Treatment approaches typically were "multimodal" and employed a variety of specific treatment interventions. These interventions were heavily oriented toward pragmatic life skills, self-help, and cognitive development, rather than toward medical or psychotherapeutic interventions. Individual counseling by treatment staff was rare, and even group counseling was probably present more in name than reality. Operational concerns such as high inmate to staff ratios and total SI facility length of stay appeared instrumental in determining the contours of substance abuse programming offered.

Third, SI aftercare programming appeared to fall along a continuum composed of four basic levels or models: (1) the traditional probation/parole supervision model, (2) the enhanced probation/parole model, (3) the contracted model, and (4) the comprehensive model. These models vary according to the level of supervision given to SI offenders; the formalization of arrangements to provide specific substance abuse services after release; the degree of continuity and interaction between the incarceration and community release portions of SI programs; and the level of structured ancillary services, such as job placement, vocational training, family counseling, etc., assisting offenders' reintegration into the community. Generally, the majority of SI facility respondents seemed to fall within the first two models because of poorly articulated linkages between the inprogram portion of the program and the community release portion. A small number of facilities with well-defined linkages appear to fall within the third level. A minimal number of jurisdictions appear to have developed the well-integrated program identified by the comprehensive model.

Chapter Six:
Comparisons of Three Shock Facilities

This chapter presents a descriptive overview of three shock incarceration facilities with substance abuse treatment/education programs noteworthy for their extensiveness, the uniqueness of their treatment approach, or strong linkages between inprogram services and aftercare services. Programs were not selected to reflect the breadth of substance abuse programming in SI programs throughout the Nation, but rather to highlight effective program delivery strategies. If some mix of the program elements discussed here were adopted by other jurisdictions and tailored to their particular philosophical and structural contexts, the effectiveness of substance abuse treatment and aftercare programming associated with the SI experience would likely be enhanced.

The project team visited each site to obtain indepth information about the facility and its substance abuse programming, staff, and inmate clientele. This chapter presents a summary and comparison of the three programs based upon information collected through site-level surveys, site observations, interviews with selected staff and inmate participants, and additional program data provided by the facilities. As the chapter will illustrate, the three sites employed quite different substance abuse treatment/education approaches, a reflection of the fact that shock incarceration facilities are themselves quite distinct. Moreover, although each program exhibited desirable treatment features, each program also exhibited characteristics that are potentially problematic from both a policy and treatment perspective.

New York's Lakeview Shock Incarceration program, considered by many to be the flagship among New York's Shock Incarceration facilities, was chosen due to the maturity and breadth of its substance abuse program, and because the program has served as a model for many other jurisdictions implementing shock incarceration facilities. Additionally, New York has one of the strongest linkages between the incarceration phase of the program and aftercare phase for substance abusers.

The second site, the Massachusetts Shock Incarceration program in Bridgewater, Massachusetts, appeared to have an extensive substance abuse treatment component and was operated by a private vendor rather than by the State Department of Corrections. The private vendor model has potential advantages and disadvantages that may be of particular interest to jurisdictions lacking established frameworks for delivering substance abuse treatment and aftercare.

The third site, the Challenge Incarceration Program in Willow River, Minnesota, was particularly interesting due to the wide scope of treatment services it provided to offenders. Those services ranged from traditional one-on-one and group counseling to more avant garde approaches such as guided imagery/relaxation and acupuncture therapies. The program was quite small, permitting individualized instruction and intensive levels of inmate interaction with staff. Additionally, its aftercare component was based on a model featuring intensive field supervision and contracted vendors. At the time of the site visit, the aftercare component for this fairly new facility was just becoming operational, and relatively little can be said at this point about its functioning.

Program Environments

As discussed throughout this report, the delivery of substance abuse programming in shock incarceration is shaped by several key factors, including theoretical orientation, staffing, legal mandates, and the structural context in which a program operates. This context also includes attributes such as size, general program orientation (i.e., program goals and objectives), and the integration of the substance abuse treatment/education component into shock facilities' overall regimens. The three programs included in the site visits presented distinctly different program environments.

New York. New York, like many other States, experienced an enormous increase in drug-related arrests in the mid-1980's. The contract killing of a parole officer stemming from the parole revocation of a major drug dealer sharpened awareness and provided public support and financial resources to the State Department of Corrections (DOC) to develop new programs for the young, nonviolent, drug-oriented offenders pouring into the criminal justice system. New York's Corrections Commissioner visited boot camps in Georgia (then emphasizing hard work) and Oklahoma (emphasizing education) and felt that these programs were lacking in their treatment components. The Commissioner, a strong supporter of a pre-existing treatment program within the State, insisted that shock programming be based on the twin pillars of discipline and treatment. A joint task force of DOC and parole representatives was created to develop an SI model that incorporated both emphases. Elements of drill and ceremony, hard physical labor, and education were added to two existing program formats, Network and ASAT (described below), that emphasized life skills/decisionmaking and substance abuse treatment. From this framework, New York in 1987 opened its first shock incarceration program in Monterey, a pre-existing work camp with 250 beds. The Lakeview Shock Incarceration program (hereafter referred to as Lakeview) began operation in 1989 and became the flagship of the New York shock incarceration effort.

The Lakeview program is unlike most "boot camps" or shock incarceration programs in the country, largely because of its size. Housing over 1,000 inmates, including room for up to 160 female inmates, it is the largest shock incarceration facility in the country. The facility includes an annex that houses up to 250 inmates who have been disqualified from the program for medical reasons, inmates who have been voluntarily or involuntarily terminated, and inmates ineligible because they failed to meet admission criteria. Inmates at the annex are awaiting transfer to other institutions. The facility also serves as a 222-bed reception and screening center for all other shock incarceration facilities in the New York system. At the time of the site visit, the facility was filled to capacity and double-bunking some inmates.

The camp itself resembles a new medium-security facility with single-story brick buildings; the camps' housing units have a capacity of up to 128 inmates. Each of the two sides of the units holds a platoon of inmates comprising up to 54 individuals. The housing units are open dormitory style, with waist-high cubicles containing a single bunk and locker. There are guard towers and double-fences with razor ribbon both on the fence and in the space between the fences. An electronic motion detection system is also in place between the fences. Individuals enter the facility through a double sliding bar gate outside the control room and through other remote release gates on the fences. The facility gives the impression that it could rapidly be converted to a medium-security prison if the shock incarceration program were to fall into disfavor. Staff advised that the facility was based on a "cookie-cutter" or prototype design.

It is clear that the Lakeview program is designed to channel offenders away from other institutions and reduce offenders' time served, thus reducing institutional crowding and saving money. As the director of shock incarceration development for New York stated, "If the program wasn't cost-effective, we wouldn't be here." Although the facility offers participants very extensive programming (i.e., "idle" time is nonexistent), the form these programs take are heavily influenced by the volume of offenders passing through the facility. For example, there is no individual counseling except on an extremely limited and ad hoc basis and treatment groups are generally very large (platoons contain up to 54 inmates). This limitation on the nature of programming was recognized by staff and raised concerns subsequently addressed in this chapter.

Massachusetts. The process by which a boot camp was established in Massachusetts reflects the politicized nature of many of the SI efforts around the Nation. While not strongly favored by the Massachusetts State Department of Corrections, the idea of a boot camp program was strongly endorsed by the

Governor of Massachusetts as a "get tough" approach to crime. Given this support, it was clear that a boot camp would be implemented. It was not clear, however, what agency or agencies would operate it. County sheriffs in the State joined forces and created a proposal to develop and operate a boot camp program under their auspices. Sensing the potential political fallout from such a plan, the State Department of Corrections engaged in a tug-of-war with the sheriffs to ensure that this new correctional enterprise would be operated at the State level. With State funding behind the Department of Corrections, it was able to gain control of the boot camp initiative and subsequently opened the State's SI facility in late summer 1992.

In many ways, the Massachusetts Shock Incarceration Program appears to be a scaled-down version of the New York Lakeview facility, except that the Massachusetts facility has more of a "camp" atmosphere, meaning that it has a less permanent feeling due to the use of modular construction metal buildings. Like the New York facility, it is surrounded by a chain-link fence topped with razor ribbon. Unlike New York, a single sliding gate separates the inmates from the outside. The facility housed 105 male and 12 female inmates at the time of the research team's site visit, although it has a capacity of 256 individuals. Since its opening, it has not been close to operating at capacity. The housing style is again open-bay, dormitory-styled units, with each wing forming a platoon. Although the Massachusetts facility has its own administrator, it is administratively linked to the larger Bridgewater Correctional Complex and is dependent on a medium-security facility, which is within view of the camp, for certain institutional services such as medical care.

The offender population in the Massachusetts' program reflects a mixed jurisdictional influence as the facility holds both county and State inmates. In Massachusetts, offenders with sentences of up to 2.5 years are typically placed in county facilities under the control of the county sheriffs. Because legislative provisions restrict eligibility for the boot camp in such a manner that most State inmates are excluded, staff from the program regularly visit county facilities to solicit volunteers and screen potential applicants for the SI program. The initial rift between the State Department of Corrections and the county sheriffs may in part underlie the program's continuing problem of operating under capacity. As a result, despite being officially stated goals of the facility, the need to reduce overcrowding and divert offenders away from longer confinement was not as pronounced in Massachusetts as it was in many other States. Because the State pays for about 90 percent of the counties' jail costs, however, shorter sentence lengths (Massachusetts' program is 4 month) could ultimately mean cost savings to the State.

The major portion of the general program, including substance abuse programming, at the Massachusetts' facility is modeled after New York's program. Massachusetts' original program developers visited the New York facilities and adopted many of the program elements they saw, down to the slogans adorning many of the Massachusetts facility's buildings. One major difference between the two programs, however, was Massachusetts' decision to go with a private vendor to supply substance abuse treatment rather than to develop an inhouse program.

Minnesota. The last of the three facilities visited, the Willow River Challenge Incarceration Facility (hereafter referred to as Willow River) in Minnesota, was the smallest of the three facilities and more resembled a forestry camp than a prison. The facility opened with a capacity of 36 offenders, although in August 1993, it expanded its capacity to 72 offenders. During the research team's visit, the facility was preparing for the intake of its first female offender squad. The facility, which has no fences, gates, or motion detectors, is more open than either the New York or Massachusetts institutions. Although it tries to group offenders in squads of 12, Willow River apparently has had difficulty maintaining this squad size. One senior "squad" nearing the end of the program was observed with only four offenders remaining. Like the Massachusetts' program, the facility operates independently but is administratively attached to a larger correctional institution and is dependent upon the mother institution for certain services.

Willow River was created through a legislative mandate in 1992. Like other SI programs, it operates with a rather eclectic set of goals that reflect both a punitive aspect and a concern for offender change: (1) to punish and hold the offender accountable; (2) to protect public safety; (3) to treat offenders who are chemically dependent; and (4) to prepare offenders for successful reintegration into society. Programmatically, it resembles the New York and Massachusetts programs in many ways because the program's developers, like those in Massachusetts, visited New York's SI program and copied much of their programming. A major operational difference between the Minnesota and New York programs, however, and to a lesser degree, between the Minnesota and Massachusetts programs, is the Minnesota program's much smaller size. This difference in size affects not only the program's operational aspects, but also the program's orientation and philosophical approach. The Minnesota program operates on both a much more individualized and nonmilitaristic level. For example, during the site visit the research team observed the camp's top administrators talking knowledgeably about a specific inmate's situation and calling participants by their names. The program's small size and the fact that it, like New York's program, lasts for 6 months, permits a much more personalized approach and one-on-one interaction between staff and participants. In addition, staff-participant

interactions are less heavily imbued with a military-style flavor than those observed in New York and Massachusetts.

Substance Abuse Programming

During the site visits it became clear that overall program context has a major impact on the delivery of substance abuse programming in these facilities. New York's program size, Massachusetts' highly regimented and militaristic approach, and Minnesota's small, almost family atmosphere, are driving forces behind each program's approach to substance abuse treatment/education and delivery.

New York. New York's Lakeview facility provides to inmates the most mature substance abuse programming of the three sites visited. There are five major program components at Lakeview, all designed to complement each other in the development of a therapeutic community (TC) model. They include Alcohol and Substance Abuse Treatment (ASAT); Network (the teaching of community life skills, which is the foundation of the TC); mandatory education; drill and ceremony; and physical labor. The physical labor component relies heavily on community service projects for the region. Unlike many SI programs operating throughout the Nation, there is a fairly even balance in the time inmates spend within these various program elements. About 50 percent of inmates' time is devoted to labor, physical training, and drill and ceremony, and their remaining time is largely devoted to treatment and educational activities. Idle time is almost completely eliminated.

The therapeutic community model employed in New York is considered a holistic approach to offender behavioral change and includes abstinence from substances. It would therefore be erroneous to conclude that any single program component employed in New York is the program's sole mode of substance abuse treatment.

Network is the philosophical and operational foundation of the therapeutic community model employed in New York State's SI programming. The Network program was developed in 1979 because New York State prison inmates could not gain access to AA or NA programming while they were institutionalized. Network started as an alternative program designed to promote more effective life choices and decisionmaking among its clients. It employed a decisionmaking approach to substance abuse problems, but alcohol and substance abuse treatment was not its major focus. Rather, it was designed to establish within correctional facilities living/learning units that fostered involvement, self-direction, and responsibility among residents through group processes of control and change. The units, based on a control theory model of deviance, are supervised and operated by specially trained

corrections officers and supervisors. Under the original Network model, inmates volunteered for the program and officers working in these living units were trained as behavioral change agents to develop not only needed skills but also a sense of program ownership.

The ASAT (Alcohol and Substance Abuse Treatment) program was initiated by the New York State Department of Corrections during the 1980's. The program relies heavily on the AA 12-step model and emphasizes behavioral modification, drug education, and professional and peer group counseling.

These two treatment approaches—Network and ASAT—were adapted to the shock incarceration environment, and serve as the philosophical center of the New York program. One of the ASAT counselors indicated that through Network and ASAT the offenders were:

> shown the relationship between alcohol and substance abuse treatment and responsibility. We show the offenders they [lack of responsibility and substance abuse] go hand in hand. . . . We awaken their common sense—think before you act, choose responsibility.

Lakeview has 13 ASAT counselors and 3 Network administrators and although each program component is distinct, the components overlap greatly. Accordingly, the ASAT administrator also supervises Network administrators. Each dorm has a Network officer who is the drill instructor (DI) assigned to the 4 p.m. to midnight shift in each dorm. This DI facilitates daily communal meetings held at 4 p.m.

The ASAT counselors on staff are not required to be State-certified substance abuse counselors or to have a bachelor's degrees. All that is required is a General Education Diploma and 4 years of experience, or an associate's degree and 1 year of experience. Four to five of the ASAT counselors are in recovery themselves, and the mix of recovering and nonrecovering counselors is viewed as a way of presenting inmates with desirable counselor experiences. There are no Hispanic ASAT counselors on staff, which is unfortunate because a fairly significant percentage of inmates in the program speak Spanish only.

The third major program element at Lakeview is education. The primary focus of the education program is to provide Lakeview inmates with basic education skills, and it is viewed by program staff as integrated into the larger Network/ASAT approach. As the facility's education supervisor noted,

"If someone can't read the (AA) 12 steps, we try to focus our teaching on helping the inmate read and understand the 12 steps."

The program uses a team approach to combine these three program components, along with hard work, physical training, and drill and ceremony, into a "therapeutic community." A Network administrator and a senior-level counselor oversee programming for four platoons. Ideally, within each platoon (approximately 54 offenders) an ASAT counselor, a guidance counselor, a Network officer, and a drill instructor are equally involved in the program.

Interdisciplinary staff meetings are held every other week to discuss issues, develop planning, and modify program components. In addition, inmates are evaluated daily in all five program areas to monitor and encourage positive performance. Expected score ranges, which gradually increase as inmates' time in the program increases, serve as the baseline. If an inmate is consistently below expectations in three of the five areas, a hearing is scheduled to develop a learning experience that promotes more positive behavior. Thus, there is a strong communication network in place across program units, and much information is shared on the performance of each inmate. Gathering information on inmate performance does not serve an idle function—it is used in a very proactive management structure to guide programming decisions. This translates into a very proactive management structure in which inmates are being held consistently accountable for their behavior across all program components.

The New York program's administrative philosophy attempts to blur the distinctions between the traditional treatment and security staff members by making all staff responsible for conducting the program under the therapeutic community umbrella. Overall, it appeared that staff accepted this integrated approach although facility staff related individual examples of "weak" counselors and "disinterested" correctional officers. On the other hand, inmates with whom the researchers spoke seemed to question the commitment of some staff members to this total treatment environment concept. Most of the inmates with whom the team spoke were very positive about their interaction with the ASAT staff, but were less complimentary about other staff members. A statement by one inmate reflects this attitude:

> Some Network officers throw things at you to see if you can deal with it. This will hurt you because a drill (instructor) will bring it up (outside the meeting) and you become tense. . . . Your scores on the daily evaluations will drop. Some officers go out of their way to push an inmate's button.

Thus, to some degree, the ability of the program to achieve a truly therapeutic environment has been hindered by a lack of confidentiality about what was spoken during group meetings, the presence of some staff who have not adhered to the basic principles of a TC approach, and the blurring of interactions that although intended to be therapeutic were harassing or degrading in the eyes of some inmates. This situation was not isolated to Lakeview or New York, but appeared to be a common issue in SI facilities across the Nation that were attempting to develop therapeutic community approaches.

Most of Lakeview's program activities occur in the evening. Inmates have put in a hard day prior to these activities, and both staff and inmates noted the impact of fatigue on inmate attention in some classes. To accommodate the large number of individuals in these programs, platoons rotated through program activities in a 2-week cycle. Inmates received 3 hours of alcohol and substance abuse treatment (ASAT) per week and were involved two nights per week in school. One night per week was devoted to Network meetings. These meetings rotated biweekly between Choice Classes, which involved instruction and discussion on life choices and decisionmaking, and three-part meetings divided into sections on "affirmations," "concerns," and "teachings." On the fourth and fifth days of the week, inmates attended prerelease meetings covering areas such as community adjustment, self-esteem, and parenting skills, and meetings in which inmates confronted each other about problems and areas needing improvement. A typical 2-week schedule of evening programs is presented below:

Week 1		Week 2	
Monday:	School	Monday:	School
Tuesday:	School	Tuesday:	School
Wednesday:	Network Three-Part Class	Wednesday:	Network Choice Class
Thursday:	Prerelease	Thursday:	Confrontation
Friday:	Confrontation	Friday:	Prerelease

As can be inferred from the discussion of the Lakeview facility, the program has emphasized production and efficiency. Order and structure has permeated the program's treatment atmosphere, and at times has overridden therapeutic considerations. For instance, in New York's model, despite common pronouncements that individual counseling is a treatment component (see e.g., Parent, 1989), there was no structured form of individual counseling provided. An inmate's highly structured daily regimen did not include time for individual counseling, and there were simply not enough human resources available at Lakeview to engage in such efforts. Some counselors attempted to hold short counseling sessions with inmates perceived as having a need, but only on an ad hoc basis.

Furthermore, the large size of the platoons (up to 54 inmates) hindered the ability of group and community sessions—including confrontation and three-part meetings—to evolve into therapy groups that could meaningfully address the substance abuse issues and needs of each inmate. Treatment meetings observed during the site visit included so many participants that in some instances an inner and outer circle was needed to accommodate all participants. The group size, coupled with the presence of counselors and DI's, at times appeared to inhibit open responsiveness from the inmates.

It would be misrepresenting the nature of substance abuse programming in New York Shock facilities to say that proven and bona fide substance abuse therapies were in place. Rather, the establishment of SI facilities as an attempt to achieve cost savings and reduce prison populations in the State has resulted in some detriment to the program's treatment components. While there is little doubt that New York State has made very commendable efforts to develop and deliver a meaningful substance abuse treatment program to SI participants, there is also little doubt that a very limited focus has been placed on the individual offender and his/her treatment needs. Meeting group needs and those of the correctional system clearly were dominating goals in this SI facility. As acknowledged by New York's director of shock development, New York's substance abuse programming efforts have not been "treatment" per se, but rather concerted attempts to get shock inmates "ready for recovery."

Massachusetts. Massachusetts' substance abuse program strongly resembles the Network and ASAT approaches used in New York, for reasons discussed in the previous section. The Massachusetts program is centered on a programmatic theme called "GET REAL." Program elements consist of community meetings, confrontation groups, the clearing process, three-part meetings, steps in decisionmaking, and addiction workshops. Like the New York program, these elements are integrated into a broader program structure that includes basic education, life skills training, drill and ceremony, and physical labor.

One of the major differences between the New York and Massachusetts programs is the decision made in Massachusetts to contract treatment services to a private vendor, Right Turn Inc. This organization specializing in drug treatment programming was awarded a 3-year contract to provide substance abuse programming to the Massachusetts program. The contract represents about one-fifth of the boot camp's annual budget.

One potential problem facing the Massachusetts Boot Camp is that Right Turn could either pull out of its contract or lose it to another organization. Massachusetts' Department of Corrections recently solicited bids for a larger system-level contract to provide substance abuse programming throughout the State's correctional system. Right Turn submitted a bid for the contract, but another vendor was awarded the contract. At the time of the research team's site visit, Right Turn was in the second year of its 3-year contract with the camp, and staff at the SI facility were very concerned that the Right Turn program would not survive without having the larger corrections contract. If Right Turn did survive, there were fears that the Massachusetts program would not be able to continue to receive services from Right Turn since the contract award was given to another vendor. These concerns illustrate that not only did the boot camp correctional staff view the Right Turn staff and program very favorably, but that there were potential instabilities associated with the use of private vendors to deliver substance abuse treatment services.

A cornerstone of the Massachusetts program is termed "accountability training." This approach shapes a variety of traditional substance abuse treatment techniques, including the 12-step self-help model, reality therapy, and cognitive-behavioral counseling, to the mandated and coercive environment provided by the correctional facility. The accountability training approach uses the leverage available in the boot camp facility to motivate offenders:

> Accountability Training forges a direct link between chemical dependency and the consequences of use by applying leverage and coercion to facilitate positive behavior change. It is based on the assumption that punishment when combined with effective substance abuse treatment is better than punishment . . . or treatment . . . alone (Valle, 1991).

The traditional dichotomy between custody and treatment staff seemed nearly nonexistent at this facility. This might be due in part to the fact that Right Turn considered the Massachusetts State Department of Corrections

rather than SI offenders to be its primary client. This attitude was reflected in a statement made by the president of Right Turn's parent organization:

> An essential feature of all Right Turn programs is the recognition that the number one priority for treatment professionals in a criminal justice setting is public safety. Society at large and the contracting agencies of the criminal justice system are the principal clients, not the offender. Security, lines of authority, and the common good of the group must take precedence over individual offenders (Valle, 1991).

Certain features of traditional mental health therapies, such as therapist/client confidentiality, were therefore nonexistent in this setting. Drill instructors (DI's) were physically present in group sessions and information shared between treatment staff and offenders was not considered confidential, a situation that, according to inmate interviews, has led many inmates to be distrustful of the treatment staff.

The treatment staff, as a group, did not seem to view this situation as a problem. Their general feeling was that trust between inmates and themselves is slow in developing, taking 3 or 4 months to emerge, and that the inmates who expressed negative attitudes had not been in the program long enough to develop trusting relationships. Furthermore, some treatment staff indicated that even if positive staff-participant relations did not emerge, the notion of having distinct roles for treatment staff and DI's would be more harmful than beneficial. This facility's treatment staff earnestly believed that discipline (the military aspect) goes hand in hand with treatment, and that a highly regimented program minimizes distraction and energizes inmates. Little sentiment was displayed by the staff that inherent contradictions existed in the program because of its format.

Further blurring of treatment/custody roles may, in part, stem from the ambiguous and sometimes inconsistent roles some of the DI's adopted in the program. Some seemed to assume a paternalistic or mentor role, viewing their platoons as charges in need of guidance. One DI observed by the research team referred to a platoon of female boot camp participants as "his girls" and seemed genuinely concerned about their welfare and postrelease success. Others saw themselves in authoritarian or disciplinarian roles, particularly the younger DI's. They appeared to view the relationship between themselves and the inmates as more confrontational—that is, a contest for control. Inmates perceived this inconsistency among DI's as a problem. Because all DI action ideally should be consistent and oriented towards therapeutic ends, many inmates with whom we spoke believed that the variations in expectations,

wants, and behavior of DI's engendered distrustful and ambivalent attitudes toward the facility staff. In particular, the general climate of this facility was more coercive and militaristic in nature than those observed in the other facilities visited and seemed to compromise the therapeutic potential of the environment.

Although officials at the Massachusetts boot camp considered substance abuse programming to be "treatment," in actuality it is unclear whether the program falls more in line with substance abuse education or with treatment. Formal substance abuse programming takes place in a classroom and follows a detailed daily curriculum based on the 12-step model. The members of a platoon, usually no more than 30 inmates, go through the program together. An educational focus was emphasized, but as one counselor suggested, substance abuse education and treatment overlapped because group processes were emphasized throughout the boot camp as a key ingredient of the therapeutic community. Nevertheless, it is questionable whether these efforts fall in line with traditional group therapy modalities. As one Right Turn staff member stated, "This program is designed to be school, not to be experiential. We don't run therapy sessions."

Another major factor shaping the Massachusetts Boot Camp program is the prescribed role of the counselor:

> Unlike many treatment approaches, accountability training does not view the counselor as the primary agent of change. The role of the counselor is to facilitate and empower the offender's peer group to be the change agent (Valle, 1991).

In operational terms, this principle is consistent with the lack of individual counseling at the boot camp. The counselors did not see themselves as individual therapists and claimed they did not want this role. As one counselor stated, "Individual counseling in prisons is very difficult. It is very labor intensive and boundaries become unclear."

This approach, with the platoon serving as the primary agent of change, also helps explain why there is no AA or NA involvement in the boot camp program. A deliberate decision was made to have a "closed" community without outside volunteers involved in programming. It was thought that the presence of outsiders untrained in the total array of therapeutic community programming might dilute group processes of change.

This philosophical orientation of the treatment staff was consistent with the boot camp administration's view; Right Turn staff were not seen as mental

health clinicians. Participants' mental health problems were viewed as the domain of psychologists working at the adjacent prison, and these psychologists were called in when the need for "mental health" intervention arose. Accordingly, substance abuse was not operationalized as a mental health problem within the program.

Thus it is doubtful that a distinct substance abuse treatment program, based on traditional clinical interventions, can be said to exist at this facility. As one Right Turn staff member stated, however, "This is more all-encompassing and more holistic. There is no separate substance abuse programming experience here. It's your whole life here. Everything is so behavioral, all that matters is your actions."

Minnesota. The Minnesota program shared many elements with its counterparts in New York and Massachusetts, including an integration of substance abuse programming within a highly structured and regimented daily routine that included basic education, physical training, work, drill and ceremony, and expanded "life choices" (release planning). The major differences between the Minnesota program and the two other programs seemed to rest partly in its philosophical orientation and partly in its operationalization. Perhaps most importantly, there is the matter of the program's small size. Minnesota's small correctional system population did not seem to put as much pressure on the system to develop alternatives to longer term incarceration as was found in the New York system. Even when the program reaches its capacity of 72 inmates, it will remain a relatively small SI program; and its size and length (6 months) suggest that Minnesota has not viewed this program primarily as a mechanism to relieve overcrowding.

The program's small size has allowed considerably more individual attention for SI inmates than was observed for inmates in the other two programs. This individual attention began with an assessment consisting of interviews, reviews of case history materials, and four screening instruments. While neither this process nor the development of a treatment plan is unique, the program's Chemical Dependency Individual Treatment Plan was developed for each offender and used during one-on-one meetings between the offender and treatment staff in both the inprogram and the community supervision phases. The delivery of individualized programming, tailored to the unique needs of each inmate, was not nearly as pronounced in either New York or Massachusetts as it was in Minnesota.

Many of the treatment elements in the Willow River Program are commonly found in SI substance abuse programs. These elements include a multimodal approach employing several therapeutic interventions such as cognitive skills development, chemical dependency education, and counseling.

However, the personal level of interaction among the inmates—which tended to be negatively sanctioned elsewhere—and between the staff and inmates seemed far more extensive than that observed at either the Lakeview or Massachusetts facilities. In one of the cognitive skills classes, for example, the research team observed a considerable amount of give-and-take between the counselor-instructor and the inmates. Researchers also observed a significant amount of personal self-revelation by inmates on topics such as spouse/family relationships, self-image, and drug use.

Beyond the program's small size, however, two program elements—individual counseling and acupuncture—suggest a philosophical orientation more directed toward individualized treatment interventions than was seen in either New York or Massachusetts. But even the Minnesota program, with its small size and relatively good treatment staff-inmate ratio (a 1 to 15 ratio existed between substance abuse counselors and inmates at the time of the site visit), did not allocate specific time for individual counseling. Rather, inmates had to ask for an appointment with counselors, who worked in individual counseling sessions around their other activities. The fact that counselors at this facility were willing to make time to provide such individualized interaction, and that both the administrators and the substance abuse treatment providers indicated that they would like to provide more individual counseling to program participants, suggests a commitment to this approach not expressed at the other two facilities.

The acupuncture program at the Willow River facility even more clearly reflected this difference in orientation: it was the only acupuncture treatment in SI programs encountered in the course of this research, although it is used in other correctional drug treatment programs (e.g., in Miami's Drug Court; see Finn and Newlyn, 1993). The program was provided through a contracted vendor whose staff drove over an hour from the metropolitan Minneapolis-St. Paul area to the SI facility. Offenders began the acupuncture session with a period of relaxation and/or meditation in which they sat in a small group of 8 to 10 individuals. A therapist put on new-age music and dimmed the lights to help inmates relax. Relaxing inmates did not seem to be particularly difficult for therapists as the group had been up since 5:30 a.m., and the therapy session took place in the evening. In fact, during the session observed by the research team, two or three inmates seemed to be taking advantage of the opportunity to catch a nap!

During the group relaxation/meditation exercise, the therapist, with the assistance of an inmate clerk, called the participants one at a time to a separate office and briefly reviewed each offender's previous acupuncture session out loud, noting previous complaints and what type of treatment, if any, was given. The therapist then asked each offender what type of difficulties he had

been having, and if he wanted acupuncture treatment. Strictly speaking, not all treatment is acupuncture because the therapist might employ some massaging of offenders' nerve "points" or tape to their bodies small metal balls that could be used to massage an area of complaint during the following days until the next session. Sessions generally seemed to take about 5 to 7 minutes for each individual receiving treatment.

In the portion of the session observed by the researchers, all of the inmates received some type of treatment for individual complaints. For some the entire process seemed perfunctory, merely one more boot camp activity; for others there seemed to be a genuine acceptance and agreement that they were benefiting from the acupuncture treatment. Participation in acupuncture, although not required, was strongly encouraged and inmates were required to participate in at least one session. Discussions researchers had with inmates and staff after the session revealed mixed support among both groups for acupuncture therapy.

The use of this type of treatment reflects two distinctive philosophical elements in the Minnesota program. First, as with individual counseling, acupuncture is clearly an individualized treatment approach. The Minnesota State Department of Corrections has made a considerable investment to provide treatment at this level both in terms of program costs and willingness to approve a fairly invasive procedure for treatment. Second, while all three of the programs visited emphasized participants' physical well-being through physical fitness and classes on wellness and healthy lifestyles, only in the Minnesota program did the research team observe an attempt to couple instruction with physical intervention. This coupling of approaches seemed to emphasize a holistic wellness approach not seen at the other facilities.

Summary. Substance abuse programming offered at these three facilities reflected to a large degree the goals, objectives and philosophical underpinnings of the SI programs in which they operated. New York's Lakeview substance abuse program was built upon a well-structured, seasoned SI program and emphasized the SI program's larger themes of responsibility, self-discipline, and the development of decisionmaking skills. The substance abuse component was well integrated into the larger regime, strongly supported by the facility's administration, and carried out by an enthusiastic staff. While the program purported to be a "therapeutic community," the size of the Lakeview facility made the implementation of the community concept problematic.

The level of individual interaction between various participants and between participants and staff needed to develop trust and group identification has been difficult to accomplish given the facility's larger number of offender

participants. The program's size also seemed to push much of the program delivery into an instructional format, rather than into a therapeutic interaction mode. By necessity, individual counseling was virtually nonexistent. A pervasive feeling existed at the Lakeview facility of a clean, well-oiled machine, oriented more toward the goals of promoting efficiency and reducing system costs than toward the goal of offender rehabilitation. The research team did not have the opportunity to visit one of New York's smaller SI facilities, which, according to New York's SI administrator, operated the same substance abuse program as did Lakeview. It would have been interesting to see if this program, operating in a smaller environment, functioned differently.

Massachusetts' boot camp program appeared to have been developed hastily. The State Department of Correction's need to get a viable boot camp program up and running in a short period of time, may, in part, explain why a considerable amount of the program was copied from New York's program and why the boot camp has taken on a more "militaristic" approach than found at the other sites. Moreover, the speedy opening of the facility may also help explain why the State used the services of a contracted vendor to supply the substance abuse program rather than its own personnel.

Philosophically, the program operated a regime emphasizing structure and control. The vendor seemed well accepted by the facility, and traditionally common conflicts between treatment and custody staff appeared minimal. This positive relationship may in part have been due to the vendor's efforts to make the facility, not offenders, its client. Furthermore, the vendor's willingness to use the sanctions available within the boot camp environment as leverage to impose treatment fit within the larger program's need to provide discipline, build respect for authority, provide public safety, and promote prosocial values in offenders.

Although not hampered by the size problems seen in New York, the philosophical orientation of Massachusetts' substance abuse program moved away from an approach emphasizing individual and group counseling interventions that could potentially address the underlying problems of substance abusing behavior (e.g., sexual abuse, self-esteem and family dysfunctions) and toward an approach more educational and behavioral in nature (e.g., controlling anger, dealing with negative peer influences, and critical thinking skills). Staff members who seemed very committed to the program operated more in the role of facilitator or instructor than in the role of therapist; there was clearly more emphasis placed on behavioral change and upon the platoon being the major agent of that change than on the treatment provider.

In contrast to the other two programs, Minnesota's Challenge Incarceration Program seemed to have created a much more "family" environment, due in part to its much smaller size (the entire program was smaller than one platoon at the Lakeview facility) and to its philosophical orientation, which emphasized treating offenders individually. Treatment staff, who are State Department of Corrections employees, provided not only classroom instruction and group counseling, they also provided individual counseling. A contracted vendor provided acupuncture to help inmates deal with their physical addiction "cravings" and physiological problems.

The program's size has permitted greater familiarity between staff and inmates and among the inmates. The entire camp has become a "community" of staff and inmates, and although the Minnesota program has not identified itself as such, it probably comes closer to being a bona fide therapeutic community than either the New York or Massachusetts programs.

Inmate Reactions to the SI Experience

As part of the site visits to the three facilities, a group of inmates participating in the programs were asked to provide information about themselves and their perceptions of various aspects of the program, particularly substance abuse treatment. This information was collected through a self-administered questionnaire. Following the survey, the researchers held a brief open discussion with the participating inmates to solicit additional information they might be willing to share regarding the program and to clarify issues raised in the questionnaire. This survey effort was not intended to capture a representative group of inmates participating in SI programs, nor are the results necessarily generalizable to the larger inmate populations of these facilities. Rather, the purpose of this survey was to complement the researchers'observations and the perceptions of the program provided by the facilities' staff in order to obtain a more complete and accurate picture of these programs.

The inmates surveyed at the three facilities differed substantially with regard to race/ethnicity and education, but less so in terms of marital status, and differed minimally with regard to average age. In both Massachusetts and New York, however, male and female inmates took part in the survey. Only male inmates, however, were participating in the Minnesota program at the time of the site visits. One area that potentially could have affected survey results was the difference between the three survey groups in the length of time offenders had been incarcerated at their respective facilities. Massachusetts' inmates had been at their facility an average of 2½ months (10.5 weeks). Minnesota inmates had been involved in their program on average approximately 2 weeks longer (12.1 weeks), and New York's inmates

had been in their program on average just under 6 months (23.8 weeks). Due to the much shorter program in Massachusetts, both the Massachusetts and New York inmates had slightly over a month remaining in their programs at the time this survey was conducted, whereas offenders in Minnesota had, on average, nearly 3 months remaining.

Initial analyses indicated that, across all sites, inmates generally reported a favorable attitude toward their respective shock facilities. Surprisingly, inmates in Minnesota did not hold as positive a view of their program in providing help with their substance abuse problems as did inmates in either New York or Massachusetts. Inmates from Minnesota also perceived themselves as having changed less in their ability to deal with substance abuse than did inmates in Massachusetts or New York. Both of these findings run counter to the research teams' observations and general discussions with SI inmates.

Due to the relationship discussed earlier between the length of time spent in substance abuse treatment and treatment effectiveness, inmates' perceptions were examined in conjunction with the length of time those inmates had spent in their programs. Bivariate correlations (not displayed in tabular form) revealed a significant relationship between substance abuse program perceptions and the length of time inmates had been at a facility. Inmates who had been in their programs a short time, for instance, were more likely to disagree with the statement, "The program helps me in learning about my substance abuse problem," than those who had been in their program longer (r=-.26, p=.02). Further reinforcing the notion of a link between the length of time in an SI and the impact of its substance abuse program on offenders was a significant negative correlation (r=-.33, p=.004) between length of time and the level of agreement with the statement, "I have learned to deal with my substance abusing." These results would tend to indicate that the length of time offenders spend in the program does have an impact on their perceptions of program environments and benefits. However, length of time in treatment could not account for differences in response patterns across facilities.

Table 6-1 illustrates inmates' perceptions of SI program benefits and why inmates from Minnesota tended to display attitudes more negative than those of inmates from the other sites. The data are broken down by facility and the presence of an inmate self-reported substance abuse problem. This latter variable was included in the presentation because the presence of a self-reported drug problem was found to be strongly associated with inmate perceptions.

In the Minnesota program 18 (69 percent) offenders denied having a substance abuse problem, whereas only 8 (31 percent) reported having a problem. In Massachusetts, these proportions were reversed: 15 of 22 (68 percent) offenders acknowledged a substance abuse problem, whereas 4 (18 percent) maintained they did not have a problem (2 were uncertain, and 1 did not respond). In New York, the proportion of offenders acknowledging and not acknowledging substance abuse problems was more evenly divided. Fourteen offenders (56 percent) indicated that they had a problem, while 10 (40 percent) maintained that they did not (1 did not respond).

As displayed in table 6-1, noticeable differences were found in perceptions of program benefit and personal change for those offenders who admitted substance abuse problems and those who did not. While these results were expected on questions relating to the value of substance abuse programming, they were also found in responses to more generic program benefit statements such as "Nothing here will help me," and "Program elements will never help me." Although participants in both Massachusetts and New York who acknowledged a substance abuse problem generally gave more positive ratings to statements regarding program benefit and personal change than did those inmates not reporting a substance abuse problem, in Minnesota these differences were even more evident. Without exception, offenders with self-reported substance abuse problems in Minnesota gave more positive responses to every statement of program benefit and change than inmates who denied having a substance abuse problem. In essence, the large proportion of the Minnesota boot camp population who perceived themselves as not having a substance abuse problem appears to have resulted in their less favorable ratings for the Minnesota program compared to inmate ratings of programs in the other two States.

These findings are consistent with the earlier observation that, in actuality, the SI program in Minnesota may provide a more therapeutic substance abuse treatment environment than programs in New York or Massachusetts. The findings do suggest, however, that while Minnesota may be providing a good program, it may also be selecting the wrong group of inmates for participation (i.e., a group of inmates without acknowledged substance abuse problems, a group nonamenable to treatment, or a group in heavy denial).

Table 6-1: Program and Self-Perceptions of Inmates With and Without Self-Identified Substance Abuse Problems for Survey Groups at Site-Visit Locations

	Massachusetts (n=22)		Minnesota (n=27)		New York (n=27)	
	Substance Abuse Problem (mean)		Substance Abuse Problem (mean)		Substance Abuse Problem (mean)	
Program Perceptions	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**
Nothing Here Will Help Me	4.18	4.75	4.50	3.89	4.71	4.40
Program Elements Will Never Help Me	4.13	4.25	4.75	3.52	4.50	4.36
Program Helps Me in Learning About My Substance Abuse Problem	1.86	2.33	1.62	3.05	1.28	2.72
Not Enough Counselors	3.46	4.75	3.12	3.73	3.00	4.20
Counselors in the Program Are Informed	1.27	1.25	1.25	2.15	1.42	1.60
Too Large Groups	4.00	4.50	4.12	3.52	3.36	3.90
Staff and Inmate Contact Is Better Here Than In a Regular Prison	2.00	1.63	2.37	3.26	2.00	1.64
Self-Change Perceptions	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**
Program Will Not Change Me	4.60	4.75	4.50	3.55	4.14	4.50
I Am Becomming More Mature	1.40	2.00	1.50	2.89	1.64	1.36
Learned to Deal With My Substance Abusing	1.53	2.33	1.87	2.89	1.21	2.09
Treatment Has Helped Me	1.60	4.00	1.75	4.15	1.50	3.50
Helped Me Understand Myself	1.46	3.75	1.25	4.05	1.28	3.00

* Rated on a 5-point scale from 1 (strongly agree) to 5 (strongly disagree).
* Please note that scales are reversed due to wording of question.

Aftercare Programming

The aftercare programs of SI, like its institutional components, reflect the philosophy, organizational context, and maturity of the larger SI correctional program initiative. In the New York facility, for example, aftercare is a highly structured, distinct program with formal links to service providers. Massachusetts' aftercare program is in a state of development and evolution, and some of the political considerations affecting the program's incarceration phase were seen in its aftercare components. Program links were still being developed in the Massachusetts program and arrangements with service providers varied substantially depending on the area of the State. In Minnesota, the aftercare program appeared to be well designed, but at the time of the site visits it was just moving "off the drawing board"; agency officials indicated that they had just initiated relationships with service providers.

Administrators and staff at all three of the programs took the position that aftercare is an important and integral part of the SI experience; that is, they believed that their programs encompass a continuum of care that includes both incarceration and community release components. Furthermore, all advocate a comprehensive model of aftercare combining elements of intensive supervision, education and/or vocational training, job development and placement, some type of continuing program to maintain cognitive and behavior changes initiated in the inprogram phase, and continued substance abuse treatment or relapse prevention.

New York. In New York, the release portion of the program is initiated 2 to 3 months prior to an offender's release date. The institutional parole officer puts together a condensed parole summary that is reviewed by the Parole Board. Information regarding the offender's planned residence is forwarded to the field offices for investigation. In turn, the field offices report back to the institutional parole office on the suitability of the residence. The offender does not actually appear before the Parole Board, but the Board must approve the offender's release, which is done routinely.

SI releasees are placed into intensive supervision caseloads of about 40 offenders, supervised by a team of two officers. Supervision requirements include weekly home visits by the officers, a curfew, and weekly urinalysis testing. All New York City SI parolees are guaranteed a job upon release through an agreement with the Vera Institute's Neighbor Work Program. SI parolees work in neighborhood renovation projects that are part of a structured job development program; parolees spend 4 days a week on the job and on the fifth day visit a job developer. This program's eventual goal is to move the offender into stable, full-time employment.

Another contract with the New York City Episcopal Mission Society provides a continuation of the Network program emphasizing positive decisionmaking skills. Each week for 3 months after release, SI graduates participate in a community meeting, a "four-part" meeting, and a clearing meeting. Substance abuse and relapse prevention counseling is provided through Fellowship Center, and includes both group and individual counseling services offered during the first 6 months of release. Additionally, shock parolees are strongly encouraged to participate in AA/NA meetings. In fact, a typical AA slogan, "90 meetings in 90 days," was an offender directive in the institutional program.

Shock parolees found to be using drugs are confronted by their parole officers. The supervising officers have some discretion on how such violations are to be treated. A "mini" boot camp program is available at Rikers Island through which SI parolees can be "recycled," and residential commitment is also available at the Phoenix House. The Phoenix House option, however, has created some supervision problems for the parole officers due to the confidentiality restrictions that the facility has placed on information that can be provided to the supervising officer. After 6 months of intensive supervision, successful SI parolees are moved to regular supervision status. However, the Parole Board may still place special conditions on offenders.

As indicated in chapter 3, these program components have been the subject of internal evaluation, and while there is a lack of evidence suggesting that these efforts have reduced recidivism in the long term, it does appear that in the short term shock parolees do exhibit more successful community adjustments than comparable offenders released from other prison facilities to traditional parole supervision. This trend applies even to shock parolees residing in areas outside of New York City who have not had at their disposal the many resources made available to New York City shock parolees.

Massachusetts. In Massachusetts the program's parole release component was intended to resemble New York's, but two major impediments seriously altered its design. First, as originally conceived, State funding was to be made available for intensive aftercare services. This appropriation, however, was never passed by the State Legislature, which eliminated the possibility of vendors such as Right Turn (the vendor providing inprogram substance abuse treatment) contracting with the State to provide substance abuse aftercare services. This situation forced the State Parole Board to absorb SI releasees into its regular caseloads.

Second, three distinct entities, the county sheriffs, the Massachusetts State Department of Corrections and the State Parole Board, have differing jurisdictions for the supervision of boot camp inmates. The irregular

participation of county sheriffs in sending offenders to the boot camp also means that some counties in the State have no boot camp parolees. The Parole Board also has a policy of not guaranteeing parole release to SI offenders, a policy which has, in effect, left some offenders with no place to go after completing the incarceration phase of their sentence. Apparently, the State Department of Corrections has begun placing some of these individuals in community release centers, in an inmate status.

With the exception of parolees in a pilot program in the Boston area (discussed below), SI parolees are placed in intensive supervision caseloads of 60 to 65 individuals. The difference between regular parole and the intensive supervision provided to boot camp releasees includes more frequent contacts with the parole officer, two home visit contacts per month for 4 months, a curfew, no interstate travel, and a requirement to attend five AA/NA meetings a week. Like other parolees, boot camp releasees are subject to random urinalysis testing, and if unemployed, they must submit a weekly itinerary. The parole agency has been able to secure funding to place substance abuse coordinators in four of the nine existing parole offices to help offenders with substance abuse problems. The offices have also established contracts with vendors to provide boot camp graduates with a variety of services to ensure that graduates do not confront problems commonly encountered by parolees such as being denied acceptance into a program or being placed on long waiting lists.

In Boston, an intensive substance abuse parole program has been established through two Federal grant programs. Clients in this program include SI parolees and clients from a county House of Correction facility. This program resembles New York's aftercare program and includes contracted services from a job developer, a contracted substance abuse provider who maintains weekly case contact, and an intensive parole supervision unit consisting of 4 officers (2 teams) who supervise approximately 75 offenders.

Minnesota. Minnesota's aftercare program was designed as Phase II and III of its shock incarceration effort. Like both the New York and Massachusetts programs, the Minnesota program's release component begins with a prerelease conference with offenders in which a release plan is developed and an investigation of the prospective releasee's residential situation is conducted. Also like the other two programs, intensive supervision and surveillance of the offender's activities after release are emphasized, including frequent home and work site visits (at the time of the study, a day reporting center was also under development), and urinalysis testing. Probably reflecting the small size of the Minnesota program, the program's supervising agent only had 7 offenders under supervision at the time of the

research team's site visit, and the program was designed so that community release agents would have no more than 20 SI offenders in their caseloads.

The contracts for providing substance abuse treatment during aftercare were under development at the time of the site visit. Participation in AA/NA is required for offenders if recommended by the Chemical Dependency Counselor. The planned substance abuse release component also includes a continuation of offenders' acupuncture treatment begun in the facility. A supervising agent interviewed during the site visit indicated that staff has had difficulty linking up offenders to substance abuse providers, particularly with regard to acupuncture treatment. To help alleviate this problem, a day reporting center had been established to help facilitate contact between offenders and aftercare providers. Some released offenders were residing in halfway houses, but this aftercare program has not included residential substance abuse treatment.

One of the main thrusts of Minnesota's aftercare program is reinforcing positive changes initiated during the incarceration phase of the SI program. Weekly sessions reemphasizing "cognitive skills," (i.e., problem solving, social skills, negotiation skills, management of emotions, creative thinking, values enhancement, and critical reasoning) are required for releasees in the Phase II component. The responsibility model is also stressed. According to the supervising agent interviewed, much pressure is put on the offenders to succeed: Failure to remain drug free in Phase II, for example, results in a return to prison for the offender.

Much like the New York and Massachusetts programs, the Minnesota program is developing program elements such as job seeking and retention counseling, educational enhancement programming, and family, parenting, and domestic abuse counseling that are aimed at helping offenders readjust to the community environment. These program elements, combined with supervision and substance abuse treatment/relapse prevention efforts, provide the foundation for the Phase II program, which lasts for at least 6 months. After this period, offenders must meet four specific conditions to move to the next phase of the program: (1) evidence of job/educational stability for 30 days; (2) evidence of a positive adjustment to assigned programs and freedom from any program violation for 30 days; (3) completion of a pre-approved public service plan; and (4) release from a residential facility and/or restrictive electronic monitoring at least 60 days prior to completing Phase II.

Upon satisfactory accomplishment of these requirements, the offender moves into Phase III, a less restrictive supervision status, for the remainder of his or her sentence.

In summary, the aftercare components of these SI programs, although they differ in operational aspects, seem to have several program elements in common. Furthermore, these programs share some of the same problems regarding program implementation. These issues are summarized below:

1. There was an expressed need to have a multidimensional program approach in aftercare. This approach focuses upon four areas:

   - First, maintain the perceived positive changes made by the offender during incarceration. This is accomplished through sessions (in New York and Minnesota) emphasizing the cognitive development/critical thinking skills approaches developed in the institutional program.

   - Second, offer transitional programs aimed at helping the offender readjust to the realities of life in the community. Such programs include job development and placement, life skills, and family counseling.

   - Third, continue substance abuse support programming to prevent relapse and drug reinvolvement.

   - Fourth, operate a program of intensive supervision/surveillance consisting of frequent offender/supervisor contact and drug testing.

2. Despite the efforts made by each of these programs there still seems to be problems with the linkages between the incarceration and community portions of their SI endeavor. For instance, in Massachusetts the fact that two agencies, the State Department of Corrections and a separate parole authority, have jurisdiction over the incarceration and community segments of the larger SI program created impediments to a smooth transition of the offender from one portion of the program to the other.

   In Minnesota there was no separate parole authority, but the program was still in its infancy and it was difficult for researchers to determine if this model would result in improved linkages.

3. In each of the three States, a disparity exited between the level of aftercare services offered in urban areas (i.e., New York City, Boston, and Minneapolis-St. Paul), and the less populated areas. This disparity was due to the resource availability (i.e., existing programs that can be used are available in urban locations but not in rural locations) and resource allocations (i.e., the correctional agency placing the greatest level of resources into programs that would affect the greatest number of offenders.)

4. Respondents at each facility expressed concern that ideally a third component should be inserted into the SI program continuum between the incarceration and community aftercare programs. To ease the offender's adjustment from the intense, highly structured and regimented incarceration phase of the program to the relatively unstructured and self-disciplined environment to which the offender returns, many respondents indicated the desirability of transitional living arrangements (e.g., a halfway house or community correctional center). None of the sites studied had such a program phase, although a number of States including Maryland and California have been implementing such a program.

Summary

This chapter presented a descriptive overview of three shock incarceration facilities whose substance abuse treatment/education programs are particularly noteworthy. During site visits by researchers to New York's Lakeview facility, the Massachusetts Boot Camp, and the Willow River facility in Minnesota it became clear that the overall SI program context was having a sizeable impact on the delivery of substance abuse programming in these facilities. The size of New York's Lakeview program, Massachusetts' highly regimented and militaristic approach, and Minnesota's small, almost family atmosphere, shaped the substance abuse treatment/education approaches and program delivery at each site.

The substance abuse treatment program in New York's Lakeview facility was built upon a well-structured, seasoned SI program emphasizing responsibility, self-discipline and the development of decisionmaking skills. The program's substance abuse component was well integrated into the larger SI regime, strongly supported by administrative officials, and carried out by an enthusiastic staff. Although the program purported to be a therapeutic community, the size of the Lakeview facility made the implementation of the therapeutic community concept problematic. The program size seemed to push much of the program delivery into an instructional format, rather than into a

therapeutic interaction mode. By necessity, individual counseling was virtually nonexistent. The goal of offender rehabilitation appeared to be secondary to system-level goals.

Massachusetts' Boot Camp program appeared to have been rather hastily developed. Philosophically, the program was operating on a regimen emphasizing structure and control. The private vendor who supplied substance abuse services seemed well accepted by the facility and the common conflicts between treatment and custody staff appeared minimal. Although not hampered by the size problems seen in New York, the philosophical orientation reflected in Massachusetts substance abuse program moved away from an approach emphasizing individual and group counseling interventions that potentially could address underlying problems of substance abusing behavior (e.g., sexual abuse, self-esteem and family dysfunctions) and toward an approach more educational and behavioral in nature.

In contrast to the other two SI programs discussed, Minnesota's Challenge Incarceration Program seemed to have created a much more "family" environment due, in part, to its much smaller size (the entire program was smaller than one platoon at the Lakeview facility) and to its philosophical orientation, which emphasizes treating offenders individually. Treatment staff, who formerly were State Department of Corrections employees, provided not only classroom instruction and group counseling; they also provided individual counseling. The program's size permitted greater familiarity between staff and inmates and among inmates. Although the Minnesota program has not identified itself as such, it probably comes closer to being a bona fide therapeutic community than either the New York or Massachusetts programs.

All three of the programs emphasized the need for adequate aftercare programming, and while each program's aftercare component was in a different stage of development, treatment staff at every facility stated that aftercare is an important and integral part of an SI experience. That is, the SI program should encompass a continuum of care that includes both incarceration and community release components. Furthermore, all advocated a comprehensive model of aftercare combining elements of intensive supervision, education and/or vocational training, job development and placement, some type of continuing program to maintain cognitive and behavior changes initiated in the inprogram phase, and continued substance abuse or relapse prevention treatment. The major aftercare elements were highlighted in this chapter.

If bits and pieces of each of these program's institutional and aftercare components were consolidated into a structure compatible with the jurisdictional policies and program environment of the agency implementing a shock program, great strides could be made in the establishment of a correctional program that could make significant and positive effects on the substance abusing and recidivistic behavior of SI program participants. Short-term change, such as self-discipline, compliance with rules, positive work habits, and sobriety, can be initiated in an SI environment, and would gradually transfer and develop into long-term change if adequate mechanisms were in place to reinforce this behavior once offenders return to the community. These programs appeared, however, to face significant treatment and policy issues that likely have undermined each program's effort to achieve desired effects on inmate attitudes and behavior.

Chapter Seven:
Summary, Conclusions and Recommendations

The research goals of this project included (1) describing the nature of drug treatment interventions in both the inprogram and aftercare phases of the contemporary boot camp experience; (2) assessing the treatment validity of these programs in light of what is known about drug treatment efficacy; and (3) identifying treatment components that seem both best suited to boot camp environments and participants and that appear to have the greatest potential for reducing participants' undesirable behaviors.

As presented in chapter 1, two dimensions must be considered to achieve these goals. First, does a program's drug treatment paradigm have the ability to competently deal with offenders' drug problems? Second, does the drug treatment program fit within the context of the larger boot camp/aftercare effort? Essentially, the first of these questions is a treatment issue, and the second is a program/policy issue. This chapter is structured to address both the concepts of treatment competence and program/policy efficacy as they pertain to substance abuse and aftercare programming associated with adult SI facilities.

Despite long-standing beliefs that rehabilitative efforts aimed at substance abusing offenders are relatively ineffective (Lipton, Martinson, and Wilks, 1975; Carter and Klein, 1976), and more recent evidence that clients with extensive criminal involvement before treatment tend to exhibit poorer outcomes than persons without such a history (Simpson and Sells, 1982; Hubbard, Marsden, Rachal, Harwood, Cavanaugh, and Ginzburg, 1989: 129–130), "significant research results indicate that correctional drug treatment programs can have a substantial effect on the behavior of chronic drug-abusing offenders" (Anglin and Hser, 1990: 427).

Evaluations of substance abuse treatment programs, most of which until recently have been part of community-based programs, indicate that not all treatment programs are equally effective. Results vary widely, depending to a large extent on how programs are implemented. Factors associated with correctional drug treatment effectiveness tend to parallel those found to be related to treatment effectiveness in noncriminal justice settings.

Specific therapeutic strategies and program characteristics that produce efficacious results among substance abusing criminal offenders have been identified by researchers. For instance, Andrews and Keisling (1980), the National Task Force on Correctional Substance Abuse Strategies (1991), Wellisch, Anglin, and Pendergast (1993), and Peters (1993) have each

suggested principles of effective treatment that parallel principles espoused by other researchers. Moreover, many of these principles are similar to those associated with correctional treatment programs that researchers have found to result in reduced levels of offender recidivism (e.g., Gendreau and Ross, 1987; Andrews and Bonta, 1994). Some of these basic principles are listed below. Commentary is presented on how substance abuse programming in SI facilities does or does not comport with these principles, and implications for improving programming are provided.

1. Develop support within States' correctional systems to implement substance abuse and aftercare programming.

Although shock incarceration has been sold to the public largely on the basis of visceral appeal generated by media images of drill instructors barking commands at attentive and meek-looking young convicts, most of the adult boot camps surveyed appeared to be very positively oriented toward developing programs that change offender behavior. Survey results indicate strong agreement on the aims and goals of boot camps across system level officials, facility administrators, and officials in charge of delivering substance abuse treatment and education to SI participants. For instance, each group gave primacy to rehabilitation as a correctional aim of boot camps. Efforts to make positive changes in offender behavior—efforts not premised on fear or deterrent-based principles—were commonly articulated by SI correctional officials.

Researchers found some variation in responses to questions about the priority a shock facility placed on reducing offender drug use across types of SI personnel; facility-based staff placed greater emphasis on this goal than did system-level administrators. Nonetheless, most correctional officials surveyed indicated that reducing offender drug use was a goal of their SI facility.

Substance abuse programming in SI facilities is thus generally provided in a context in which positive offender change is widely articulated as a primary goal of the correctional experience. For the most part, officials responsible for the delivery of programs within a jurisdiction presented goal and programming structures as though the entire SI experience was designed to provide offenders with some of the basic skills, insights, and problem-solving behaviors that would logically be associated with a drug- and crime-free reintegration into the community. Some disparities and incongruities existed at some facilities, but in the main, the data indicate a strong potential for the implementation of bona fide substance abuse programs and an array of complementary services that may achieve some basic changes in offender attitudes and behavior.

Implication: Agencies involved in the funding, development, and implementation of SI facilities, including the Bureau of Justice Assistance, the National Institute of Corrections, the American Correctional Association, and the host of correctional agencies operating such programs should continue to articulate the necessity of developing program structures that are most likely to promote positive offender change. Political and correctional demands for programs oriented primarily toward hard work, physical training, and drill and ceremony must be countered by educational efforts that communicate adequately that such programming structures have not been found to produce the desired outcomes. While more treatment-oriented SI facilities have not yet been found to successfully affect recidivism rates, current theory and research suggest that these facilities are *most* likely to achieve such results.

2. Use a coordinated approach in the design and implementation of a substance abuse program, and involve both substance abuse and custody staff.

It appears that SI facilities have proliferated throughout the Nation, often without adequate conceptualization and planning processes being engaged in at the local level. In response to political demands, many jurisdictions have implemented SI programs without adequate input from treatment professionals (see, for example, chapter 6).

Substance abuse programming has often been introduced into a SI program only after a facility's major design parameters have already been established. In some instances, the programming introduced is too little and too late. Design inconsistencies are apparent in many facilities, and although reducing drug use may be one of their explicit goals, it is very difficult to reduce drug use if programs confine substance abuse programming to weekend and evening "off hours" and provide instruction to offenders over a relatively short period of time (i.e., 3 to 6 months). An exception to this pattern was found in New York State, which from the beginning of its program planned to equally emphasize treatment and discipline.

Many States have adopted the New York model, and sometimes with only minor modifications. But a model that may "work" in New York may not be applicable or appropriate in a different legal and program environment. Wholesale duplication of programs without adequate consideration of how the programs should be modified and/or tailored to best fit differing environments and offender populations has been an undesirable trend in the boot camp movement. Perhaps the greatest failure regarding program development has been lack of input from substance abuse treatment professionals when the initial designs of SI facilities and their aftercare components were created.

Implication: Stronger and comprehensive planning processes that include the input of substance abuse treatment professionals should be used before implementating of SI facilities.

3. Implement standardized and comprehensive assessment procedures and case management systems that match inmates to treatment services according to assessment results.

Almost 70 percent of the SI facilities surveyed indicated that offender substance abuse assessment occurred within their facility. For those facilities offering substance abuse treatment, this percentage increased to approximately 81 percent. A majority of facilities reported the use of multiple assessment techniques to identify substance abuse problems in their offender populations. The most common approach seemed to be the use of interviews, a review of case materials beyond inmates' present offenses, and the use of some type of psychological or behavioral testing instruments.

Despite these rather extensive efforts, however, the predominant mechanism for placement of SI offenders in substance abuse treatment came not through a diagnostic process and clinically based decision of need, treatment amenability, or potential effectiveness, but rather through a legally mandated or nonclinical decision process. The only study to examine the effects of boot camp experience on the lives of substance abusers indicated that mandated treatment interventions in the community based on legal—and not clinical—factors was not associated with reduced levels of offender recidivism. Moreover, the case study of the Minnesota program in chapter 6 indicated that forcing treatment on people who do not believe they need it may result in negative consequences for offender adjustments and attitudes during the institutional phase of SI programs.

Substance abuse programming seems to be driven to a large extent by general structural and administrative concerns relating to SI facilities, rather than by offender needs or therapeutic considerations. For example, although substance abuse assessment is commonly conducted in SI facilities, it is rarely used to determine offender amenability to treatment or to tailor treatment to offender needs because treatment is generally mandated for all offenders by statute or policy, and all offenders receive the same treatment interventions. In only a few jurisdictions (e.g., Illinois and Minnesota) were assessment processes used to match services to offender needs, and even in these cases results of the assessment process were not always used to develop treatment plans to guide interventions in the postrelease period.

Implication: All jurisdictions that have a substance abuse treatment component within their SI programs should use standardized assessment processes to place inmates in individualized treatment programs.

4. Provide multimodal treatment services that reflect a range of quality programs. Treatment activities should address the range of psychosocial problems and areas of deficit that may result in unsuccessful recovery.

In chapter 2, the great variability in the nature of substance abuse and aftercare programming provided across SI facilities was highlighted through a review of program documents.

The results of the survey buttress this finding. All system-level respondents indicated that alcohol and drug treatment services were provided to offenders in their SI facilities. However, 25 percent of site-level administrators and site-level substance abuse treatment/education providers reported not having alcohol or drug treatment programs in their facilities. There thus appears to be considerable confusion among some respondents as to whether a drug treatment program even existed at certain facilities. Prior surveys indicating that drug treatment programming was almost uniformly found in boot camps may have overrepresented the reality of the situation; these surveys tended to report findings derived from responses generated by system-level officials. It appears that these officials may have considered substance abuse education efforts to comprise treatment programming. Those individuals closest to the delivery of treatment programs, however, indicated that one-quarter of adult boot camps provided no substance abuse treatment programming.

A theme repeated throughout this report is the eclectic nature of substance abuse treatment offered in SI programs; the majority of programs use multiple treatment approaches (i.e., education, group counseling, AA 12-step approaches, and individual counseling) and employ multiple treatment interventions. This eclecticism in treatment methods appeared to reflect a lack of clarity and specificity as to the theoretical orientation or treatment approach employed by the SI programs.

Education has played an important role in substance abuse programming at boot camp facilities whether it is the only program component or integrated into a broader treatment paradigm. In effect, all shock facilities reported providing drug education in some form. The study findings indicate, however, that much more than simply providing classroom instruction should be done in those facilities to reduce substance abuse behavior.

The presence of drug treatment programming and the mix of drug treatment and drug education programming appeared to be directly related to the nature of rehabilitative programming found in boot camps. The presence of substance abuse treatment may be a defining characteristic of boot camps that most forcefully articulate it and seek the goal of offender rehabilitation. But programs merging treatment and education programming may witness the dilution of the former, at least in the eyes of substance abuse programming providers.

Those facilities that offered both substance abuse education programs and treatment programs provided nearly 30 more hours of substance abuse education instruction (70 versus 42) on average than those programs that only had an education program, suggesting a more intensive program effort in the former.

Examination of the most and least often used treatment interventions offered at SI facilities suggests that most programs have taken a pragmatic, skills-building orientation to help offenders cope with problems and stress they would encounter upon their return to their communities. This approach to treatment is what Peters (1993) has identified as psychoeducational. Psychoeducational approaches are based on the assumption that substance abuse springs from multiple biophysical and psychological factors (e.g., individual predispositions and personal risk factors), and treatment focuses upon recognizing these factors and developing strategies to counteract individual deficits. According to Peters, these approaches focus upon: (1) development of motivation (to overcome dependencies) and commitment; (2) life skills development including fiscal management, communication skills, and constructive use of time; (3) AIDS education and prevention; (4) relapse prevention strategies; and (5) development of a plan to access community resources after release.

Researchers found that detoxification and pharmacological interventions were completely absent in SI facilities and that traditional psychotherapeutic approaches, designed to uncover and deal with offenders' underlying psychological and emotional problems, were used much more infrequently. In particular, individual counseling, family counseling, and psychiatric services designed to help offenders deal with intrapersonal problems and the psychological impact of substance abuse were largely absent in SI facilities. The lack of programming addressing the psychosocial characteristics of the individual, either through individual or small group therapies, appears especially problematic from a treatment perspective.

Implication: Those SI facilities with only a substance abuse education component should consider expanding their services to include a substance abuse treatment component. All programs should consider introducing psychotherapeutic-based interventions, including individual and small group therapies for those individuals assessed to be in need of such interventions. The primary focus of treatment should be placed on developing multimodal approaches that are clinically relevant to the offender population.

5. Set up the treatment program to be independent (within security structures) of the prison administration. (The program should be autonomous with its own funding.) If this is not possible, provide a treatment unit that reduces the negative and corrosive influences of the general inmate population.

This principle is not as applicable to SI facilities as it is to traditional prison and jail environments because, as illustrated previously, in many SI facilities the entire incarcerative experience is designed to be therapeutic. Nonetheless, case studies have illustrated that even those facilities that are modeled as a therapeutic community have conflicts often confronted in traditional incarceration settings.

Summary punishments, for instance, are a common feature in boot camp environments and are often described not as "punishment," but as "learning experiences" (intended to be therapeutic in nature). Conversations the research staff had with SI inmates at a number of facilities and personal observations beyond those described in chapter 6 indicate that this distinction is often illusory, especially when a drill instructor (DI) fails to frame a sanction in appropriate therapeutic terms or when the DI is obviously acting as a security official rather than as a change agent. This discussion relates to a principle of effective drug treatment in correctional settings articulated by Wellisch, Anglin, and Pendergast. They wrote that "the kinds of infractions that are dealt with by prison authorities and the kinds that program personnel are empowered to deal with should be clearly defined and separated" (1993: 21). It seems that this principle is often violated in SI facilities.

Truly therapeutic environments are rarely found in boot camp facilities, and especially in those that insist that military bearing be rigorously adhered to at all times. A confrontation session or a group therapy session dominated by the presence of an overbearing DI who does not allow a spontaneous interchange of ideas and feelings and who administers negative consequences to inmates for such expressions is unlikely to produce desired results.

These issues are very significant in SI facilities not only because they occur commonly, but also because the inhouse model is by far the most common approach to staffing SI treatment programs. Almost 70 percent of the facilities surveyed relied exclusively on correctional agency staff to deliver substance abuse programming. Only two facilities reported using contracted staff solely, and the remaining four facilities used the mixed model of both agency staff and contracted personnel. As was illustrated in the case study of Massachusetts's program, even programs delivered by contractual staff confront significant issues related to confidentiality and desired staff-inmate interactions.

The major point of this discussion is that just because a facility is an SI program that espouses to be therapeutic community, it does not mean that traditional security/treatment conflicts do not arise.

Implication: Correctional officials and substance abuse providers in SI facilities must tackle much more directly the manifold issues surrounding the provision of treatment in a primarily custodial setting. "Defining" the issues out of existence is not adequate. Issues relating to confidentiality, sanctioning mechanisms, staff selection and monitoring, and "prisonization" processes in the SI setting must be addressed to nurture the establishment of truly therapeutic environments.

6. Enroll prisoners in treatment programs when their remaining period of incarceration is only as long as or slightly longer than the incustody portion of their treatment program. In doing so, encourage sustained inmate participation in substance abuse treatment and ensure that treatment lasts at least 3 months.

Due to the lack of clear boundaries between substance abuse treatment and the general program regimen found at most SI facilities, it was difficult to ascertain the precise amount of time inmates spent within a particular treatment approach (see the case studies discussed in chapter 6). Some facilities maintained, for example, that all of offenders' time spent at the facility was devoted to "treatment." These programs might list the length of the treatment program as being the same as the overall program length (e.g., 90, 120, or 180 days), but the time offenders actually spent in bona fide substance abuse treatment activities was much less. Compounding this problem is the multimodal substance abuse treatment approach commonly employed at SI facilities. For example, an evening substance abuse treatment program might comprise a life skills exercise, a confrontation group designed to provide realistic peer feedback, and a self-revelatory "go-around" session commonly used in 12-step programs. This program in its entirety frequently might be viewed and reported simply as group counseling by treatment staff. The lack

of distinctions between program components makes the quality of the data regarding time in treatment for the various approaches problematic to interpret.

In most instances, once offenders complete the SI program they are released to the community. Some SI programs, however, are not structured in such a manner, and once offenders complete their shock incarceration sentence they may be transferred to another prison setting. This policy likely undermines the potential effectiveness of the SI substance abuse treatment program.

There is some debate in the literature reviewed in this study as to whether individuals coerced into treatment are likely to benefit from the program. Most boot camp participants volunteer for SI correctional placement, but they are then often mandated to participate in substance abuse programming even if they do not feel that they have a substance abuse problem. What are the implications of forcing offenders into treatment for the programs' success?

More recent research data indicate that legal referral status is not a strong predictor of posttreatment outcomes (DeLeon, 1988); that is, offenders legally coerced into treatment do as well as voluntary clients. As indicated earlier, however, the legal coercion of offenders into treatment programming based on nonclinical assessments of need may have negative consequences for both inprogram and postprogram offender attitudes and performance.

Individuals who are legally coerced into treatment tend to remain in treatment longer than do individuals voluntarily admitted. Because length of time in treatment appears strongly related to outcomes, the motivation for treatment entry does not seem as salient a concern for criminal justice offenders as is commonly assumed. Thus the mandated nature of substance abuse treatment for boot camp participants is not likely, in and of itself, to undermine a treatment program's potential effectiveness.

What is of greater concern is the length of treatment commonly provided in SI facilities. Treatments lasting less than 90 days appear to be of limited value (Anglin and Hser, 1990: 439), but treatments in a prison-based therapeutic community lasting up to 1 year have been found to be monotonically and positively related to desired parole outcomes (Wexler, Falkin, and Lipton, 1990: 85–87). These findings raise concerns for boot camps, which typically house offenders for 90 to 180 days.

Implication: Inmates who successfully complete an SI program should be released to the community without prolonged intermediate stays in other correctional facilities. Substance abuse programming should be available throughout the SI experience and should be a sustained and clearly separate program activity. SI facilities that are primarily oriented toward the delivery of effective substance abuse programming but that are of relatively short duration should consider increasing the amount of time participants spend in treatment.

7. Select a high-quality professional staff, composed mainly of those who have professional skills and those who can function as role models for inmates.

This survey's findings indicated that contracted substance abuse treatment staff were more likely to be certified in substance abuse treatment than inhouse treatment staff, and that full-time contracted staff were also more likely to have formal training in substance abuse treatment. It appeared that the vast majority of substance abuse counselors and educators were not certified in their respective States.

SI programs also differed widely in their ratio of substance abuse treatment providers to client offenders. One program had a ratio of four clients for every one treatment provider staff member. At the other end of the spectrum, 1 program had a ratio of 90 participants for every 1 treatment staff member. Inmate/staff ratios in boot camp treatment programs averaged in the range of 30 to 1 across types of modalities.

Implication: SI facilities should make stronger attempts to ensure that substance abuse treatment providers are trained and qualified treatment professionals. Hiring contractual staff may be a desirable option. Qualifications for education and experience should be raised to ensure the quality of facilities' treatment staff. Moreover, those facilities that have relatively high inmate-treatment staff ratios should make all possible efforts to decrease those ratios.

7a. Program staff members should provide anti-criminal modeling that inmates can regard as behavior worth imitating. In addition, staff members should develop quality interpersonal relationships with inmates and demonstrate concern for their welfare.

A pervasive feature of many SI facilities, particularly in older facilities, is an overriding emphasis on discipline and military bearing. While this emphasis may not be inherently antithetical to the establishment of an effective treatment environment, the implementation of a militaristic model in SI facilities could result in the chronic and systematic degradation of the

inmates. In such contexts, anti-criminal role modeling processes and the emergence of quality, interpersonal relationships between staff and inmates can be compromised. These negative consequences can result even when only a minority of the staff, the facility's "cowboys," behave in a manner inconsistent with the establishment of a therapeutic environment.

Implication: Extensive cross-training (both preservice and inservice) of staff to promote staff-inmate interaction conducive to anti-criminal role modeling and the development of positive and nurturing relationships should be implemented. The reassignment or termination of staff who compromise the establishment of therapeutic environments should be an institutional priority.

8. Implement strategies that give participants a stake in the success of the program as a whole and in their rehabilitation.

The likelihood of effective interventions in correctional settings appears enhanced when treatment includes participation in bona fide therapeutic communities (e.g., Wexler, Lipton, and Johnson, 1988; Chaiken, 1989; Anglin and Hser, 1990; Wexler, Falkin, and Lipton, 1990). Participation in prison outpatient type programs (e.g., individual and group counseling and self-help groups) that are successfully integrated into more generalized prison activities and that require more of participants than merely meeting attendance requirements have also been suggested to promote desired outcomes (Collins and Allison, 1983; Chaiken, 1989). These activities would include involvement in group therapies.

Many boot camp programs stress the need to develop an esprit de corps among participants emphasizing reciprocal responsibility, the impact of individual action upon the larger group, and the use of peer pressure to reinforce positive behavior and eliminate negative behavior. The therapeutic community approach, therefore, would likely blend well with SI program environments and philosophy. Furthermore, since most shock incarceration programs espouse a multidimensional substance abuse approach that emphasizes education, the use of peer support (e.g., AA 12-step approaches) and the use of interventions to build pragmatic life skills, the therapeutic community approach would appear to be compatible with extant treatment interventions employed in many of the SI facilities with substance abuse programs. Nonetheless, researchers found that therapeutic community approaches were rarely used in SI facilities.

Implication: SI facilities should consider the explicit adoption of therapeutic community models and/or approaches to substance abuse treatment. Group processes of change that include some inmate role in the basic governance of their immediate living environments should be encouraged to

the fullest extent possible. Inmate input in the establishment of their individual treatment plans should also be encouraged.

9. Make continuing care and accountability during transition and return to the community as well as a lengthy period of supervision in the community integral parts of the treatment program.

The finding that self-reported criminality among active drug treatment clients receiving services in noncorrectional settings increased in the 3-month period immediately following treatment and before steady declines in criminal activity begin (Hubbard et al., 1989: 128) suggests the need for strong boot camp aftercare components during this crucial time period (see also Wexler and Williams, 1986). Graduated support and monitoring are considered critical to reintegrating the offender into the community.

Despite this common understanding, about one-quarter of the respondents reported that postrelease service delivery was not a program component associated with their boot camp facilities.

When aftercare services were provided, the nature of the authority structures that determined the aftercare services for specific SI graduates suggests that legal rather than clinical factors dominate the decisionmaking process. Decisionmaking authority for aftercare placement may be defined somewhat by the statutory framework in which an SI program operates (i.e., alternative to probation or incarceration); the degree of overlap in aftercare decisionmaking (e.g., sentencing judge, SI officials, parole or probation authorities), however, reinforces the notion that SI facilities generally have lacked adequate mechanisms to ensure continuity between the sanction's inprogram portion and aftercare component.

9a. Early in program development, plan for the transition of inmates into the community.

Officials from more recently opened SI facilities reported giving more priority to prerelease programming than did officials from facilities that opened before 1990. Overall, however, the research findings indicate a clear lack of linkage and coordination between inshock programming and aftercare programming efforts.

9b. Use community resources to provide services relevant to inmates' needs.

Beyond the basic commonality of parole or probation supervision in the aftercare period, researchers found a wide variation in the scope and type of services provided to SI releasees, particularly in the services related to

substance abuse programming. Only a minority of States operating SI facilities have contracted with substance abuse service providers to deliver treatment services to SI graduates, and only one State appeared to have a comprehensive aftercare model.

In this approach to aftercare programming, a structured mechanism for providing aftercare services to offenders is established to integrate multiple treatment elements that go beyond substance abuse treatment/relapse prevention and parole or probation supervision. These programs emphasize transitional services such as job development and placement, education, housing assistance, and life skills programming. While other States may essentially achieve this level of programming, the identifying characteristics of the comprehensive program is that these elements are developed and formalized as part of the SI continuum structure.

Thus, the type and level of aftercare services available to offenders completing an SI program varies widely. For many programs "aftercare" seems to be fairly traditional probation/parole supervision—sometimes augmented by closer supervision, drug testing, and referral to existing community substance abuse treatment resources. A small number of jurisdictions have developed more formalized linkages with drug treatment providers (who generally also service noncorrectional populations). Even fewer programs have extended the continuum of treatment back into the community in any substantial way.

The nature of aftercare programming provided to SI graduates is perhaps the most clearly deficient area of programming associated with the SI experience.

Implication: All possible efforts should be made to conceptualize and operationalize the SI experience as one that includes both an institutional and an aftercare phase. These efforts would include extensive enhancements to prerelease and postrelease programming efforts to ensure a continuity of care throughout the respective program phases. Legislative and organizational barriers to such efforts must be addressed and attenuated.

10. Teach coping skills that may enable inmates to deal with high-risk situations likely to precipitate their return to or involvement in illegal activity upon their release.

In general, successful correctional programs have been based on a social learning theory of behavior that assumes that prosocial behaviors must be learned in order to replace deviant behaviors. Programs should encourage the acquisition of prosocial skills that allow offenders to deal with

interpersonal problems, anger, stress, and frustration during recovery. Many of the SI programs surveyed appeared to be oriented toward equipping SI inmates with these skills, especially during institutional phases.

Implication: Both institutional and aftercare programming should emphasize the problem-solving and coping skills that will help offenders refrain from returning to criminal and substance abusing lifestyles. Greater emphasis should be placed on providing SI graduates with support mechanisms in the community that promote such decisions.

11. Build into the treatment program data collection and methodology for process and outcome evaluation.

Chapter 2 presented information on what is known about boot camps' impact on the lives of substance abusers. While some things are known about efficacious drug treatment in general and drug treatment within prison settings in particular, to date not a single study has been designed specifically to evaluate a drug treatment program offered to offenders as part of their boot camp experience. Studies from Louisiana suggest that the State's SI program has not been especially successful with substance abusers or problem drinkers, but Louisiana's boot camp has offered little in terms of a bona fide substance abuse program. We do not know at this time whether the boot camp experience results in improved offender adjustments to the community (see the comprehensive review of relevant evaluative research in chapter 2), and it is clearly time that a major infusion of resources be allocated to conduct significant process and impact evaluations of SI facilities. In particular, research should focus on those program elements likely to result in desired outcomes—most prominently, substance abuse and aftercare treatment programming.

Implication: Process and impact evaluations of all boot camps that receive Federal funding should be mandated. It is critically important that research be conducted to disentangle the effects of various program components—particularly substance abuse and aftercare programming—on the lives of SI participants.

12. Set up formal channels of communication with legislators, correctional officials, security personnel, parole officers, etc.

Because the boot camp movement has been highly politicized, political figures and correctional officials responsible for establishing and delivering SI programming have engaged in much dialogue. This dialogue has been especially evident in the past year or so as a result of pending Federal crime legislation and the release of research information showing that SI facilities

may not be generating their intended benefits. The Federal Government, and especially the Bureau of Justice Assistance, the National Institute of Justice, and the National Institute of Corrections, have disseminated information to a wide variety of involved parties that could benefit boot camp programming. Nonetheless, many difficult issues, especially those directly affecting substance abuse programming in SI facilities, have not been adequately addressed. Dialogue has not tended to confront potentially inherent contradictions that have been created in the attempt to provide meaningful substance abuse programming in boot camp structures.

Many SI programs attempt to achieve goals that may be inherently contradictory. The goal of reducing system costs, for instance, may be at odds with the goal of offender rehabilitation. Effective rehabilitation requires a significant investment of money and time. Designing successful substance abuse programming in SI facilities requires more than offering substance abuse classes for a few hours each week over a 3- to 6-month period. Yet it is often not possible to do more given the variety of constraints generated by political, legislative, and correctional system demands. Establishing effective treatment programs may not be possible at facilities that require inmates to work and/or march 8 hours a day to satisfy demands for deterrence and retribution.

Effective treatment programming may not be possible if clients, regardless of their individual situations and needs, are required by statute or policy to participate in a generic substance abuse program. Programs to change offender behavior that are based on role modeling and positive peer relations may be incompatible with correctional systems that rely almost exclusively on coercion to generate compliance, rather than on a broader mix of coercive, remunerative, and normative sanctions.

Until these and other fundamental issues are addressed directly by correctional theory and practice, it is unlikely that the formal channels of communication between key policymakers, program developers, and service delivery agents will result in substantial improvements in the ability of shock incarceration programs to change offender behavior patterns. Tinkering with the system (as evidenced by improvements in substance abuse programming within recently opened SI facilities and modifications to older, more established facilities; see chapter 3) may produce only marginal benefits given the broader and more fundamental issues that remain.

Implication: Correctional officials at all levels of government, a group of correctional treatment professionals, and policymakers should be brought together to discuss and attempt to resolve the fundamental policy, program, and treatment issues that have emerged as a consequence of the boot camp movement.

Final Thoughts

This study attempted to evaluate the effectiveness of boot camp programs along two dimensions: the competency of the drug treatment paradigm to deal with offenders' drug problems, and the role drug treatment plays within the larger boot camp/aftercare effort to change offender behavior.

Generally, this study's findings indicate a fairly high level of support across all levels of the correctional system for programs aimed at changing the behaviors of young offenders. Program aims and goals articulated across these levels seem to promote a rehabilitative orientation consistent with what has been termed "second generation" boot camps (Gransky et al., 1995).

However, the ability to actually support effective drug treatment within correctional boot camp environments begins to break down at the program delivery level. The process of translating program aims and goals into operational programs that actually can change individual behavior is complex. In the case of boot camp drug treatment, the ability to do so is frequently hampered by statutory and policy mandates that preclude matching individual needs with available treatment and by competing operational objectives. Further diminishing the capacity of boot camp drug treatment efforts to bring about offender change are a surprising lack of use of therapeutic community approaches, which have been identified as one of the more effective treatment models, and a lack of treatment continuity through postrelease aftercare.

In review of the findings, it appears that many of the problems associated with providing drug treatment to boot camp inmates can be explained by a lack of program integrity. Here, program integrity refers to the congruence of the underlying treatment philosophy, treatment elements, the capacity to implement the treatment, and the environment in which the treatment program operates. Current findings suggest that a lack of program integrity in many treatment efforts occurs when drug treatment paradigms are simply "force fit" into correctional boot camps. This situation is often seen when programs copy existing treatment approaches from other facilities without allowing for differences in areas such as facility environment, staffing, philosophical orientation and offender population.

Thus, it is not the lack of support for substance abuse programming nor the availability of potentially efficacious treatment approaches that hampers the effectiveness of substance abuse programs in correctional boot camps. It is rather the incomplete implementation of such approaches. To overcome this problem, program designers should concentrate on individual treatment needs, program integrity, and the continuity of boot camp programs from incarceration through postrelease aftercare.

REFERENCES

American Correctional Association. (1993). *Development of National Standards for Juvenile and Adult Boot Camps*. Laurel, MD: American Correctional Association. Unpublished report prepared for Advisory Board Meeting.

Andrews, D.A., and J. Bonta. (1994). *The Psychology of Criminal Conduct* Cincinnati, OH: Anderson Publishing Co., pp. 182-193.

Andrews, D.A. and J.J. Keisling. (1980). "Program Structure and Effective Correctional Practices: A Summary of the CAVIL Research." In R.R. Ross and P. Gendreau (eds.), *Effective Correctional Treatment*. Toronto: Butterworths.

Andrews, D.A., I. Zinger, R.D. Hoge, J. Bonta, P. Gendreau, and F.T. Cullen. (1990). "Does Correctional Treatment Work? A Clinically Relevant and Psychologically Informed Meta-analysis." *Criminology* 28 (3): 369-404.

Anglin, M.D., and Y. Hser. (1990). "Treatment of Drug Abuse." In M. Tonry and J.Q. Wilson (eds.), *Drugs and Crime*. Chicago, IL: University of Chicago Press, pp. 393-460.

Austin, J., M. Jones, and D. Bolyard. (1993). *The Growing Use of Jail Boot Camps: The Current State of the Art*. Washington, DC: National Institute of Justice Research Brief, U.S. Department of Justice. October.

Bell, J.C., and E. Corty (1988). "Basic Issues Pertaining to the Effectiveness of Methadone Maintenance Treatment." In C.G. Leukefeld and F.M. Tims (eds.), *Compulsory Treatment of Drug Abuse: Research and Clinic Practice*. National Institute on Drug Abuse, Research Monograph No. 86. Rockville, MD: U.S. Department of Health and Human Services, National Institute on Drug Abuse.

Brown, B.S. (1992). In C. Leukefeld & F. Tims (eds.), *Drug Abuse Treatment in Prisons and Jails*. National Institute on Drug Abuse, Research Monograph No. 118. Rockville, MD: U.S. Department of Health and Human Services, National Institute on Drug Abuse, pp. 31-37.

Burns, J.C. (1991). "A Comparative Evaluation of the Alabama Department of Corrections' Boot Camp Program." Paper presented at the Annual Meeting of the Academy of Criminal Justice Sciences, Nashville, TN. March 6, 1991.

Carter, R.M. and M.W. Klein, (eds.). (1976). *Back on the Street*. Englewood Cliffs, NJ: Prentice-Hall.

Castellano, T.C, and R. Beck (1991). "A Cross-classification of Prison Substance Abuse Program Models: The Relevance of Structural Fit." *Journal of Crime and Justice*.

Chaiken, M.R. (1989). *In-Prison Programs for Drug-Involved Offenders*. Washington, D.C.: National Institute of Justice.

Collins, J.J., and M. Allison. (1983). "Legal Coercion and Retention in Drug Abuse Treatment. *Hospital and Community Psychiatry* 34: 1145–1149.

Coyle, E.J. (1990). *Boot Camp Prisons*. Newark, NJ: Criminal Disposition Commission.

Cronin, R.C. (1994). *Boot Camps for Adult and Juvenile Offenders: Overview and Update*. Washington, D.C.: National Institute of Justice.

DeLeon, L.G., H.K. Wexler, and N. Jainchill. (1982). "The Therapeutic Community: Success and Improvement Rates 5 Years After Treatment. *Internation Journal of Addiction* 17 (4): 703–747.

Elis, L.A., D.L. MacKenzie, and C.C. Souryal. (1992). *Boot Camp Prisons: A Growing Trend in Corrections*. Unpublished paper.

Finn, P., and A.K. Newlyn. (1993). *Miami's "Drug Court": A Difference Approach*. Program Focus Report. Washington, D.C.: U.S. Department of Justice, National Institute of Justice.

Florida Department of Corrections. (1990). *Boot Camp: A Twenty-Five Month Review*, Tallahassee, FL: Unpublished report by the Bureau of Planning, Research, and Statistics, Florida Department of Corrections.

Flowers, G.T., T.S. Carr, and R.B. Ruback. (1991). *Special Alternative Incarceration Evaluation*. Atlanta, GA: Georgia Department of Corrections.

Gendreau, P., and R. Ross. (1987). "Revivification or Rehabilitation: Evidence from the 1980's." *Justice Quarterly* 4: 349–408.

Georgia Department of Corrections (1991). *Special Alternative Incarceration: Evaluation*. Atlanta, GA. Unpublished report.

Gransky, L.A., T.C. Castellano, and E.L. Cowles. (1995). "Is There a 'Second Generation' of Shock Incarceration Facilities? The Evolving Nature of Goals, Program Elements, and Drug Treatment Services in Boot Camp Programs." In J.O. Smykla and W.C. Selke (eds.), *Intermediate Sanctions: Sentencing in the 1990s*. Cincinnati, OH: Anderson, pp. 89-111.

Hall, S.M. (1984). "Clinical Trials in Drug Treatment Methodology." In *Drug Abuse Treatment Evaluation: Strategies, Progress and Prospects*, F.M. Tims and J.P. Ludford (eds.). National Institute on Drug Abuse, Research Monograph No. 51. Rockville, MD: U.S. Department of Health and Human Services, National Institute on Drug Abuse.

Hubbard, R.L., M.E. Marsden, J.V. Rachal, H.J. Harwood, E.R. Cavanaugh, and H.M. Ginsburg. (1989). *Drug Abuse Treatment: A National Study of Effectiveness*. Chapel Hill, NC: University of North Carolina Press, pp. 90-92.

Karr, S.P. and R.J. Jones. (1994). *Impact Incarceration Program: 1993 Annual Report to the Governor and General Assembly*. Springfield, IL: Illinois Department of Corrections.

Leukefeld, C.G., and F.M. Tims (eds.), (1988). *Compulsory Treatment of Drug Abuse: Research and Clinical Practice*. National Institute on Drug Abuse, Research Monograph No. 86. Rockville, MD: U.S. Department of Health and Human Services, National Institute on Drug Abuse.

Light, R.J., and R.V. Smith. (1971). "Accumulating Evidence: Procedures for Resolving Contradictions Among Different Research Studies." *Harvard Educational Review* 41: 429-471.

Lipton, D.S., G.P. Falkin, and H.K. Wexler. (1992). "Correctional Drug Abuse Treatment in the United States: An Overview." In C. Leukefled & F. Tims (eds.), *Drug Abuse Treatment in Prisons and Jails*. National Institute on Drug Abuse, Research Monograph No. 118. Rockville, MD: U.S. Department of Health and Human Services, National Institute on Drug Abuse, pp. 8-31.

Lipton, D.S., R. Martinson, and J. Wilks (1975). *The Effectiveness of Correctional Treatment: A Survey of Treatment Evaluation Studies*. New York: Praeger.

_____ (1990b). "Boot Camp Prisons: Components, Evaluations, and Empirical Issues. *Federal Probation*, September, pp. 44-52.

_____ (1991). "The Parole Performance of Offenders Released From Shock Incarceration (boot camp prisons): A Survival Time Analysis." *Journal of Quantitative Criminology* 7 (3): 213–235.

_____ (1993). "Shock Incarceration as an Alternative for Drug Offenders." In D.L. MacKenzie & C. Uchida (eds.), *Drugs and the Criminal Justice System: Evaluating Public Policy Initiatives*. Newbury Park, CA: Sage.

MacKenzie, D.L. and J.W. Shaw. (1990). "Inmate Adjustment and Change During Shock Incarceration: The Impact of Correctional Boot Camp Programs. *Justice Quarterly* 7 (1):125–150.

MacKenzie, D.L. and J.W. Shaw. (1993). "The Impact of Shock Incarceration on Technical Violations and New Criminal Activities." *Justice Quarterly 10* (3): 463–488.

MacKenzie, D.L., J.W. Shaw, and V.B. Gowdy. (1990). *An Evaluation of Shock Incarceration in Louisiana*. Unpublished final report submitted to the National Institute of Justice, August 1990.

MacKenzie, D.L., J.W. Shaw, and V.B. Gowdy. (1993). *An Evaluation of Shock Incarceration in Louisiana,* National Institute of Justice Research Brief. Washington, D.C.: U.S. Department of Justice, June 1993.

MacKenzie, D.L., J.W. Shaw, and C. Souryal. (1992). "Characteristics Associated with Successful Adjustment to Supervision: A Comparison of Parolees, Probationers, Shock Participants, and Shock Dropouts." *Criminal Justice and Behavior* 19 (4): 437–454.

Magura, S., A. Rosenblum, and H. Joseph. (1992). "Evaluation of In-jail Methadone Maintenance: Preliminary Results." In C. Leukefled & F. Tims (eds.), *Drug Abuse Treatment in Prisons and Jails*. National Institute on Drug Abuse, Research Monograph No. 118. Rockville, MD: U.S. Department of Health and Human Services, National Institute on Drug Abuse, pp. 192–210.

Mahtesian, C. (1991). "The March of Boot Camps." *Governing*. June 1991, pp. 21–22.

Marlette, M. (1991). "Boot Camp Prisons Thrive." *Corrections Compendium* 16 (1): 8–12.

Michigan Department of Corrections. (1991). *1991 Annual Report—Special Alternative Incarceration (SAI)*. Lansing, MI: Michigan Department of Corrections.

Miller, W. R. (1991). "Emergent Treatment Concepts and Techniques." *Annual Review of Addictions Research and Treatment* 1: 1–14.

Mississippi Department of Corrections. (1991). *1991 Regimented Inmate Discipline (RID) Annual Report*. Jackson, MS: Mississippi Department of Corrections.

Morash, M., and L. Rucker. (1990). "A Critical Look at the Idea of Boot Camps as Correctional Reform." *Crime and Delinquency* 36 (2): 204–22.

National Institute of Corrections. (1991). *Intervening With Substance-Abusing Offenders: A Framework for Action.* (The Report of the National Task Force on Correctional Substance Abuse Strategies). Washington, D.C.: U.S. Department of Justice.

National Institute on Drug Abuse. (1981). *Drug Abuse Treatment in Prisons.* Washington, D.C.: U.S. Department of Health and Human Services.

National Institute of Justice. (1991). *Evaluation Plan, 1991.* Washington, D.C.: U.S. Department of Justice.

National Task Force on Correctional Substance Abuse Strategies. (1991). *Intervening With Substance-Abusing Offenders: A Framework for Action.* Washington, DC: National Institute of Corrections, U.S. Department of Justice.

Nevada Department of Prisons. *Program of Regimental Discipline: Rules Handbook.* Carson City, NV: Nevada Department of Prisons. Undated.

New York State Department of Correctional Services and New York State Division of Parole. (1992). *The Fourth Annual Report to the Legislature: Shock Incarceration-Shock Parole Supervision*, Albany, NY: Division of Program Planning, Research and Evaluation, Department of Correctional Services and the Office of Policy Analysis and Information, Division of Parole. Unpublished report.

New York State Department of Correctional Services and New York State Division of Parole. (1991). *The Third Annual Report to the Legislature: Shock Incarceration in New York State*, Albany, NY: Unpublished report by the Division of Program Planning, Research and Evaluation, Department of Correctional Services and the Office of Policy Analysis and Information, Division of Parole.

New York State Division of Parole. (1989). *Shock Incarceration: One Year Out*. Albany, NY: Unpublished report by the Office of Policy Analysis and Information.

Nossiter, A. (1993). "As Boot Camps for Criminals Multiply, Skepticism Grows." *The New York Times*, December 18, 1993: A1.

Osler, M.W. (1991). "Shock Incarceration: Hard Realities and Real Possibilities." *Federal Probation,* March, pp. 34-42.

Pan, H., F.R. Scarpitti, J.A. Inciardi, and D. Lockwood. (1993). "Some Considerations of Therapeutic Communities in Corrections. In J. Inciardi (ed.), *Drug Treatment in Criminal Justice*. Newbury Park, CA: Sage, pp. 30-43.

Parent, D.G., (1989). *Shock Incarceration: An Overview of Existing Programs*. National Institute of Justice Research Monograph, U.S. Department of Justice. Washington, D.C.: U.S. Government Printing Office.

Peters, Roger. (1993). "Drug Treatment in Jails and Detention Settings." In J. Inciardi (ed.), *Drug Treatment in Criminal Justice*. Newbury Park, CA: Sage, pp. 44-80.

Pichens, R.W., and B.W. Fletcher. (1991). "Overview of Treatment Issues." In R.W. Pickens, C.G. Leukefled, and C.R. Schuster (eds.), *Improving Drug Abuse Treatment.* National Institute on Drug Abuse, Research Monograph Series, No. 106. Rockville, MD: U.S. Department of Health and Human Services, National Institute on Drug Abuse, pp. 1-19.

Sechrest, D.D. (1989). "Prison 'Boot Camps' Do Not Measure Up." *Federal Probation* 53: 15-20.

Shaw, J.W., and D.L. MacKenzie. (1991). "Shock Incarceration and Its Impact of the Lives of Problem Drinkers." *American Journal of Criminal Justice* 16 (1): 63-96.

_____ (1992). "The One-Year Community Supervision Performance of Drug Offenders and Louisiana DOC-Identified Substance Abusers Graduating From Shock Incarceration." *Journal of Criminal Justice* 20: 501-516.

Sherron, T. (1991). "Minimum Security and Chemical Dependency Treatment: A Functional Model for Corrections. *American Jails* 5 (5): 76.

Simpson, D.D. (1981). "Treatment For Drug Abuse: Followup Outcomes and Length of Time Spent." *Archives of General Psychiatry*, 136 (11): 1449–1453.

Simpson, D.D., and S.B. Sells. (1982). *Evaluation of Drug Treatment Effectiveness: Summary of the DARP Follow-up Research.* National Institute on Drug Abuse Treatment Report. Washington, D.C.: U.S. Government Printing Office.

Souryal, C., and D.L. MacKenzie. "Shock Incarceration and Recidivism: An Examination of Four State Programs." Unpublished paper.

Taricone, P., J. Benshoff, and J. Bordieri. (1991). *Illinois Department of Corrections Evaluation of Drug Education and Drug Treatment.* Unpublished report. Carbondale, IL: Rehabilitation Institute, Southern Illinois University at Carbondale.

Texas Criminal Justice Policy Council. (1990). *Special Alternative Incarceration Program Enhanced Substance Abuse Component.* Unpublished progress report to the National Institute of Justice on the multisite evaluation of shock incarceration programs.

Toby, J. and F.S. Pearson. (1992). *Boot Camps for Juvenile Offenders: Constructive Intervention and Early Support-Implementation Evaluation.* Institute for Criminological Research. New Brunswick, NJ: Rutgers University.

U.S. General Accounting Office. (1993). *Prison Boot Camps: Short-term Prison Costs Reduced, but Long-term Impact Uncertain.* Washington, DC: U.S. Government Printing Office.

Valle, S.K. (1991). "Accountability Training for Addicted Inmates." *The Counselor*, March-April. Reprint.

Warnock, K. M., and D. Hunzeker. (1991). "Prison Boot Camps: Policy Considerations and Options." *National Conference of State Legislatures State Legislative Report.* 16 (1): 1–10.

Weinman, B.A., and D. Lockwood. (1993). "Inmate Drug Treatment Programming in the Federal Bureau of Prisons." In J. Inciardi (ed.), *Drug Treatment in Criminal Justice.* Newbury Park, CA: Sage Publications, pp. 194–208.

Wellisch, J., M.D. Anglin, and M.L. Pendergast. (1993). "Treatment Strategies for Drug-Abusing Women Offenders." In J. Inciardi (ed.), *Drug Treatment in Criminal Justice*. Newbury Park, CA: Sage, pp. 5–29.

Wexler, H. K., G.P., Falkin, and D.S. Lipton. (1990). "Outcome Evaluation of a Prison Therapeutic Community for Substance Abuse Treatment. *Criminal Justice and Behavior* 17 (1): 71-92.

Wexler, H.K., G.P. Falkin, D.S. Lipton, and A.B. Rosenblum. (1992). "Outcome Evaluation of a Prison Therapeutic Community for Substance Abuse Treatment." In C. Leukefled & F. Tims (eds.), *Drug Abuse Treatment in Prisons and Jails*. National Institute on Drug Abuse, Research Monograph No. 118. Rockville, MD: U.S. Department of Health and Human Service, National Institute on Drug Abuse, pp. 156–175.

Wexler, H.K., and D.S. Lipton. (1993). "From Reform to Recovery: Advances in Prison Drug Treatment." In J. Inciardi (ed.), *Drug Treatment in Criminal Justice*. Newbury Park, CA: Sage Publications, pp. 209–227.

Wexler, H K., D.S. Lipton, and B.D. Johnson. (1988). *A Criminal Justice Strategy for Treating Cocaine-Heroin Abusing Offenders in Custody*. Washington D.C.: National Institute of Justice.

Wexler, H. K. and R. Williams. (1986). "The Stay 'N Out Therapeutic Community: Prison Treatment for Substance Abusers." *Journal of Psychoactive Drugs* 18 (3): 221-230.

Wolf, F.M. (1986). *Meta-analysis: Quantitative Methods for Research Synthesis*. Newbury Park, CA: Sage.

Yochelson, S., and S.E. Samenow. (1976). *The Criminal Personality, Volume 1: A Profile for Change*. Northvale, NJ: Jason Aronson.

APPENDIX A

SURVEY OF STATE CORRECTIONAL AGENCIES: ADULT BOOT CAMPS

Survey of State Correctional Agencies: Adult Boot Camps

State	System Response	Facility Administrative Survey Response	Facility SA Treatment Survey Response	SA Treatment Provided[b]	SA Education[a] Provided[b]
Alabama	Yes	Yes	Yes	Yes	No
Arizona	No	Yes	Yes	Yes	Yes
Arkansas	Yes	Yes	Yes	Yes	No
California	Yes	No	No		
Colorado	Yes	Yes	No	Yes	Yes
Florida	Yes	Yes	Yes	No	Yes
Georgia	Yes	---	---		
Al Buress		No	No	(yes)	(yes)
Dodge-IBC		Yes	Yes	Yes	Yes
Phillips		No	No	(yes)	(yes)
Putnam-PBC		Yes	Yes	Yes	Yes
Stone Mt.-PBC		No	No	(yes)	(yes)
Treutlen -PBC	Yes	Yes	Yes	Yes	Yes
Idaho	Yes	Yes	Yes	Yes	Yes
Illinois	Yes	Yes	Yes	Yes	Yes
Kansas	Yes	Yes	Yes	No	Yes
Louisiana	Yes	Yes	Yes	Yes	Yes
Maryland	No	Yes	Yes	No	Yes
Massachusetts	Yes	Yes	Yes	Yes	Yes
Michigan	Yes	Yes	Yes	No	Yes
Minnesota	Yes	Yes	Yes	Yes	Yes
Mississippi	Yes	Yes	Yes	Yes	Yes
Nevada	Yes	Yes	Yes	Yes	Yes
New Hampshire	No	No	No	Unk	Unk
New York	Yes	---	---		
-Butler	---	No	No	(yes)	(yes)
-Lakeview	---	No	No	(yes)	(yes)
-Moriah	---	No	No	(yes)	(yes)
-Monterey	---	No	No	(yes)	(yes)

-Summit	---	No	No	(yes)	(yes)
North Carolina	Yes	Yes	Yes	Yes	Yes
Ohio	Yes	Yes	Yes	Yes	Yes
Oklahoma	Yes				
-Eddie Warrior (women's)	---	Yes	Yes	Yes	Yes
-RID	---	No	No	(yes)	(yes)
-McAllister	---	No	No	(yes)	(yes)
-SIP	---	No	No	(yes)	(yes)
Pennsylvania	Yes	Yes	Yes	Yes	No
South Carolina	Yes				
-Thames SI (mens')	---	Yes	Yes	No	Yes
-Womens' SI	---	Yes	Yes	No	Yes
Tennessee	Yes	Yes	Yes	No	Yes
Texas	Yes	---	---	UA	UA
-Womens'	---	Yes	No	(yes)	(yes)
-Mens'	---	Yes	No	(yes)	(yes)
Virginia	Yes	Yes	Yes	Yes	Yes
Wisconsin	Yes	No	Yes	Yes	No
Wyoming	Yes	Yes	Yes	Yes	No
Federal Bureau of Prisons	Yes				
-Bryan, TX	---	Yes	Yes	Yes	Yes
-Lewisburg, PA	---	Yes	Yes	Yes	Yes

[a] Indicated a separate and distinct substance abuse education program.
[b] Yes responses presented in parentheses are those sites with substance abuse programs as reported by system level respondents. No facility responses were received from these sites, and these facilities are not included in the survey statistical analyses.

APPENDIX B

SURVEYS USED IN THIS REPORT: ADMINISTRATIVE, SUBSTANCE ABUSE TREATMENT AND EDUCATION, AFTERCARE, AND INMATE PARTICIPANT

ADULT SHOCK INCARCERATION
Administrative Survey

AGENCY: _____
(State & County if applicable)

NAME: _____
(of Shock Incarceration facility)

GENERAL INFORMATION

1. On what date did your Shock Incarceration facility open?

   _____

2. Please provide the relevant information requested regarding program capacities and populations. Additional space is provided at the end of the chart if an explanation is needed.

	MALE	FEMALE
Official Rated Capacity:		
Population as of September 1, 1992:		
Maximum Program Length (in months):		
Number of 1992 (as of September 1, 1992) program graduates:		
1992 program completion rate as of 9/1/92 (% of inmates who started program that finished):		

Explanations for above (if necessary):

_____

_____

_____

3. Please provide the information requested regarding program costs.

Average per diem costs for Shock Incarceration inmates: _____

Current Capital Budget: _____

Current Operating Budget: _____

4. Please indicate the percentage of your total Shock Incarceration populations which is represented by the following groups.

_____% probationers, with Shock as a condition of probation

_____% inmates directly sentenced from the courts in lieu of a prison sentence

_____% inmates directly sentenced from the courts in lieu of a jail sentence

_____% inmates sent directly to Shock by prison officials in lieu of a traditional prison sentence

_____% inmates assigned to Shock by prison officials after having served some prison time (i.e., they go to Shock with a certain amount of time left on their prison sentence).

_____% other _____

100 % TOTAL

5. Who makes the final decision to place someone in your Shock Incarceration facility? Please check all that apply.

[ ] sentencing judge
[ ] probation/parole authorities
[ ] Department of Corrections (or equivalent)
[ ] other _____
[ ] other _____

Please briefly describe this process:

_____

_____

_____

_____

6. Is placement into your program voluntary for the inmate?
[ ] yes [ ] no

7. Are there any eligibility restrictions for placement into your Shock Incarceration program? If so, please place a check on the blank to the left of the following possible eligibility restrictions. Additionally, please check the source of the restriction and describe the restriction.

_____ **Offender Age** _____ **By Policy** _____ **By Statute**

_____

_____

_____ **Offender Gender** _____ **By Policy** _____ **By Statute**

_____

_____

_____ **Type of Current Offense** _____ **By Policy** _____ **By Statute**

_____

_____

_____ **Prior Prison Sentences** _____ **By Policy** _____ **By Statute**

_____

_____

_____ **Current Sentence** _____ **By Policy** _____ **By Statute**

_____

_____

_____ **Physical/Mental Impairments** _____ **By Policy** _____ **By Statute**

_____

_____

_____ **Other (List and Describe)** _____ **By Policy** _____ **By Statute**

_____

_____

PROGRAM GOALS/PURPOSES

8. We would like to know the intended correctional goals of your Shock Incarceration program. The following are commonly described as reflecting the primary goals of the criminal sanction. Please rank each of the following goals as they relate to Shock Incarceration programming in your jurisdiction. That is, rank the most important goal as 1, placing the number 1 next to the appropriate statement. The second most important goal should be ranked as 2, the third as 3, the fourth as 4, and so on.

A. ____ Retribution - to pay offenders back for the harm they have caused society.

B. ____ Incapacitation - to protect society by putting criminals in jail so that they can't victimize anyone.

C. ____ Rehabilitation - to reform offenders so that they will return to society in a constructive rather than a destructive way.

D. ____ Deterrence - to teach criminals as well as other people contemplating going into crime that in America crime does not pay.

E. ____ Other - please describe: _____

_____

F. ____ Other - please describe: _____

_____

9. In addition to the above general goals of the criminal sanction, many correctional sanctions serve other objectives as well. For each of the following, what is the relative importance of that objective? Please circle the appropriate level according to the following scale.

		Very Important			Moderately Important		Not Important At All	
A.	Clean, Healthy, Secure Environment	1	2	3	4	5	6	7
B.	Instill Respect for Authority	1	2	3	4	5	6	7
C.	Reduce Crowding	1	2	3	4	5	6	7
D.	Improve Image of Corrections	1	2	3	4	5	6	7
E.	Offender Accountability	1	2	3	4	5	6	7
F.	Positive Offender/ Staff Contact	1	2	3	4	5	6	7
G.	Promote Discipline	1	2	3	4	5	6	7
H.	Public Safety	1	2	3	4	5	6	7
I.	Less Criminal Activity	1	2	3	4	5	6	7
J.	Environment Promoting Rehabilitation	1	2	3	4	5	6	7
K.	Alternative to Longer-Term Incarceration	1	2	3	4	5	6	7
L.	Improve Offender Confidence	1	2	3	4	5	6	7
M.	Less Cost	1	2	3	4	5	6	7

N.	Reduce Offender Drug Use	1	2	3	4	5	6	7
O.	Politically Acceptable Alternative	1	2	3	4	5	6	7
P.	Promote Positive Offender Social Behavior	1	2	3	4	5	6	7
Q.	Model for County Programs	1	2	3	4	5	6	7

9a. If these specific Shock Incarceration objectives have changed since the first program was introduced, please describe the nature of those changes.

_____

_____

_____

_____

_____

10. The following elements are commonly found in Shock Incarceration programs. Rank, according to the following scale, the primacy given to these program elements.

	Primary Program Element		**Secondary Program Element**		**Minor Program Element**		**Not a Program Element**
Physical Training	1	2	3	4	5	6	7
Alcohol Treatment	1	2	3	4	5	6	7
Drug Treatment	1	2	3	4	5	6	7
Substance Abuse Education	1	2	3	4	5	6	7
Physical Labor	1	2	3	4	5	6	7
Drill & Ceremony	1	2	3	4	5	6	7
Basic Education	1	2	3	4	5	6	7
Vocational Education	1	2	3	4	5	6	7
Pre-Release Program e.g. life-skills	1	2	3	4	5	6	7
Post-Release Services Delivery e.g. after-care components	1	2	3	4	5	6	7

10a. Have the emphases placed on specific program elements changed since the implementation of shock incarceration programming?

[ ] No [ ] Yes

If yes, please describe in some detail the nature, timing, and rationale related to these changes.

_____

_____

_____

_____

OFFENDER CHARACTERISTICS

11. By using the chart below, please report the approximate percentages of 1992 Shock inmates with the following characteristics:

CHARACTERISTICS	1992 PERCENTAGES
were first-time convicted offenders	%
were repeat incarcerated offenders	%
were convicted of a property offense	%
were convicted of a violent offense	%
were convicted of a drug related offense	%
have a substance abusing history	%
are 20 years old or under	%
are between 21-25 years old	%
are 26 years old or above	%
are male	%
are female	%
are Caucasian	%
are Hispanic	%
are African-American	%
have been enrolled in adult basic education program	%
have been enrolled in GED program	%
have been in facility drug treatment	%
have been in facility drug education	%

DAILY ROUTINES

12. Do you have a formal routine which determines the activities of inmates on a daily basis (excluding weekends)?

[ ] yes [ ] no

If yes, by using the following chart, please indicate how an inmate generally spends his/her weekdays at your Shock Incarceration facility.

	TIME	WHAT AN INMATE WOULD BE DOING AT THIS TIME ON A TYPICAL DAY
	5:00 a.m.	
	6:00 a.m.	
	7:00 a.m.	
	8:00 a.m.	
	9:00 a.m.	
	10:00 a.m.	
	11:00 a.m.	
noon	12:00 p.m.	
	1:00 p.m.	
	2:00 p.m.	
	3:00 p.m.	
	4:00 p.m.	
	5:00 p.m.	
	6:00 p.m.	
	7:00 p.m.	
	8:00 p.m.	
	9:00 p.m.	
	10:00 p.m.	
	11:00 p.m.	
	12:00 a.m.	
	1:00 a.m.	
	2:00 a.m.	
	3:00 a.m.	
	4:00 a.m.	

STAFFING ISSUES

13. What is the current total staff to inmate ratio at the Shock Incarceration facility?

_____

14. How many people work at the Shock Incarceration facility?

_____(full-time)--employed by the facility/State

_____(part-time)--employed by the facility/State

_____(full-time)--contracted from outside

_____(part-time)--contracted from outside

15. Is there pre-service training for staff?

[ ] yes--all staff
[ ] yes--certain staff
[ ] no

If only certain staff receive pre-service training, which job designations are chosen to receive it?

[ ] security [ ] administration [ ] _____
[ ] treatment [ ] _____ [ ] _____

If yes, what is the length of the training session(s)?

_____(hours)

If yes, can you briefly describe the content of the pre-service training program?

_____

_____

_____

_____

16. Is there an in-service training requirement for Shock Incarceration staff?

[ ] yes--all staff
[ ] yes--certain staff
[ ] no

If only certain staff receive in-service training, which job designations are chosen to receive it?

[ ] security [ ] administration [ ] _____
[ ] treatment [ ] medical staff eg. MD [ ] _____

If yes, can you briefly describe the content of the in-service training program. (If the content is similar to that of your pre-service training program, please comment accordingly.)

_____

_____

_____

_____

17. For each of the following areas, can you please estimate the approximate turnover rate at your facility during the past year?

___% administration ___% security

___% treatment

18. Is there an aftercare program for Shock Incarceration graduates after they are released from your program?

[ ] yes [ ] no

If yes, can you provide us with your understanding of what conditions and services are extended to shock incarceration graduates?

_____

_____

_____

_____

_____

_____

_____

Please provide the following information regarding the person whom you consider to be primarily responsible for the aftercare programming available in your jurisdiction:

Aftercare contact person _____

Mailing address _____

_____

Phone Number ( ) _____

FACILITY CHARACTERISTICS

19. What is the security classification of your facility?

[ ] maximum
[ ] medium
[ ] minimum
[ ] other _____

20. What is the custody classification of your inmates? Please describe in terms of the custody classification used in your jurisdiction. Please also describe reclassification decisions as it may exist:

_____

_____

_____

_____

21. Where is your Shock Incarceration program located?

[ ] on the grounds of a maximum security prison
[ ] on the grounds of a medium security prison
[ ] on the grounds of a minimum security prison
[ ] located at a separate facility

If your program is located on the grounds of another general population prison, do Shock Incarceration inmates come into contact with general population prisoners?

[ ] often
[ ] occasionally
[ ] rarely
[ ] never

If contact does occur, could you please briefly describe when, where, or how contact is made?

_____

_____

_____

_____

22. How are inmates housed at the Shock Incarceration facility?

[ ] open dormitories [ ] other _____

[ ] single-cell; one bed [ ] single-cell; two beds

23. On the basis of the following scale, how would rank the degree of overcrowding at your facility? Please check the statement that best applies.

_____ No overcrowding problem

_____ Slight overcrowding problem

_____ Moderate overcrowding problem

_____ Severe Overcrowding problem

PROGRAM EVALUATION

24. Are evaluations currently being conducted on the Shock Incarceration program(s) in your jurisdiction?

[ ] yes [ ] no

If yes, can you please identify the topic areas under study? (e.g., cost analysis, recidivism, treatment components).

_____

_____

_____

_____

_____

25. If yes to the above, What have been some of the more basic findings from these evaluations?

_____

_____

_____

_____

_____

26. We are very interested in reviewing whatever evaluative reports may be available on your shock incarceration program. If you can send us copies of these reports, please do so. If not, can you identify the person or source from whom or where we can request these reports.

_____

_____

_____

_____

27. Within the next three years, what do you think is likely to happen with the Shock Incarceration program(s).

[ ] expand in size [ ] remain the same

[ ] reduce in size [ ] have no idea

28. Person completing this survey:

Name_____

Title_____

# of Months/Years Employed at Shock facility_____

Phone # _____

Address _____

Thank you for your assistance.

If you have any thoughts you would like to share with us regarding this questionnaire or the Shock Incarceration program, please use the back of this page of write your comments.

We are also very interested in reviewing any evaluation or research reports that may be available on your Shock Incarceration program. If you can send us copies of these reports, please do so. If not, can you identify the person or source from whom or where we can request these reports?

_____

_____

_____

If you would like a copy of our results when this study is concluded, please check this box. [ ]

ADULT SHOCK INCARCERATION
SUBSTANCE ABUSE TREATMENT & EDUCATION SURVEY

AGENCY: _____
(State & County if applicable)

NAME: _____
(of Shock Incarceration facility)

ASSESSMENT & DIAGNOSIS

1. Is a substance abuse treatment program offered in your facility?

   [ ] yes [ ] no -- go to # 22

2. Is there an assessment process used to identify the substance abuse treatment needs of your offender clients?

   [ ] yes [ ] no -- go to # 7

   If yes, are all residents subject to the assessment?

   [ ] yes [ ] no

   If no, please describe the specific criteria used to determine which residents are assessed.

   _____

   _____

   _____

   _____

3. Below are a list of tools often used in the assessment process. Please check all of those utilized in your facility. Additionally, please estimate the approximate percent of offenders who are assessed with that particular tool at your facility.

   [ ] _____% face-to-face client interview

   [ ] _____% case history reviews which go beyond drug involvement offense history information

   [ ] _____% case history reviews confined to drug involvement in offending behavior

   [ ] _____% biological markers (e.g. urine & blood tests)

   [ ] _____% behavioral or psychological tests

4. Below are a list of addictions screening instruments used to assess substance abuse. Please check all those used at your facility.

TESTS

____ Michigan Alcoholism Screening Test (MAST)

____ Self-Administered Alcoholism Screening Test (SAAST)

____ Mortimer-Filkins

____ MacAndrew Alcoholism Scale (MMPI sub-scale)

____ Substance Abuse Proclivity Scale (SAPS) (MMPI sub-scale)

____ Adolescent Drinking Index (ADI)

____ Addiction Severity Index (ASI)

____ Inventory of Drinking Situations

____ Severity of Alcohol Dependence Questionnaire

____ Edinburgh Alcohol Dependence Schedule

____ Rand Dependence Scale

____ Alcohol Dependence Data Schedule

____ Alcohol Use Inventory

____ Alcohol Use Disorders Identification Test (AUDIT-World Health Organization)

____ Other (please specify) _____

STRUCTURED INTERVIEWS

____ Structured Clinical Interview for DSM-III-R

____ Composite International Diagnostic Interview (CIDI)

____ Schedules for Clinical Assessment in Neuropsychiatry (SCAN)

____ Other (please specify) _____

CLASSIFICATION SYSTEMS

____ World Health Organization: IDC-9 (International Classification of Diseases)

____ American Psychiatric Association: DSM-III-R

____ Other (please specify) _____

5. Are the data collected from assessment used to classify inmates for treatment programs?

[ ] yes [ ] no

If yes, do you use a standard treatment classification scheme? Please check the ones you use.

[ ] DSM III 3R
[ ] Int. Classification of Drug Abuse - ICD9
[ ] other, please specify:_____

_____

6. Please briefly describe how the assessment processes used at your facility are utilized to direct offenders into substance abuse treatment.

_____

_____

_____

_____

SUBSTANCE ABUSE TREATMENT

7. Is substance abuse <u>treatment</u> required for Shock Incarceration inmates?

[ ] yes - all inmates [ ] yes - certain inmates [ ] no - voluntary

If substance abuse treatment is mandated, who makes the final decision to place someone in the treatment program?

[ ] statutory requirement

[ ] sentencing judge

[ ] your facility -- mandated treatment not based on assessment procedures discussed above. Please describe:

_____

_____

_____

[ ] your facility -- staff decision based on substance abuse assessment

[ ] other _____

8. What substances are commonly used prior to incarceration by Shock Incarceration inmates? Indicate the approximate percentage of current offenders who have been identified as abusing the following substances: (Note: Due to multiple drug use, column may sum to more than 100%)

____ % Narcotics -- for example: opiates, including heroin and related analgesics

____ % Stimulants -- for example: amphetamines

____ % Stimulants -- for example: crack, cocaine

____ % PCP

____ % Alcohol

____ % Sedative-Hypnotics -- for example: barbiturates, non-barbiturate sedatives, and minor tranquilizes

____ % Inhalants -- for example: glue, gasoline, paint-thinner

____ % Hallucinogens -- for example: LSD, mushrooms

____ % Cannabis

____ % Other _____

____ % Other _____

9. Generally, what type of substance abuse treatment modalitie(s) is\are used in your Shock Incarceration facility? Please check all that are in use.

[ ] substance abuse education

[ ] AA/NA/CA

[ ] individual counseling
e.g., traditional psychotherapy
reality therapy
behavior modification

[ ] therapeutic communities
e.g., Cornerstone & Stay'n Out

[ ] group counseling

[ ] milieu therapy
may include individual/ group counseling, mildly confrontive groups & peer interaction in isolated drug-free environment

10. Specifically, what type of substance abuse treatment interventions are offered in your Shock Incarceration program? Please check all that apply.

[ ] AA/12 Step	[ ] Vocational
[ ] Chemical e.g., methadone	[ ] Recreational
[ ] Confrontation Therapy	[ ] Positive Peer Culture
[ ] Reality Therapy	[ ] Moral Development Training
[ ] Non-directive/Client Centered Counseling	[ ] Family Therapy
[ ] Re-Entry Planning	[ ] Operant Strategies
[ ] Psychodynamic Therapy	[ ] Stress Management
[ ] Relaxation Therapy	[ ] Covert Sensitization
[ ] Interpersonal problem solving training e.g., Platt	[ ] Criminal Thinking Strategies e.g., Yochelson & Samenow
[ ] Transactional Analysis	[ ] Behavior Modification

[ ] other _____

[ ] other _____

10a. Since your program first began operation, have the specific substance abuse interventions changed in a notable manner?

[ ] yes [ ] no

If yes, please describe:

_____

_____

_____

11. Is the length of substance abuse treatment the same (uniform) for all offenders?

[ ] yes [ ] no

If yes, please specify the length of the substance abuse treatment program. _____

_____

If no, please describe the variation. _____

_____

_____

12. Are outside vendors employed for the substance abuse treatment component at the Shock Incarceration facility?

[ ] yes -- total program
[ ] yes -- part of program
[ ] no

12a. What is/are the name(s) & address(es) of the outside vendor(s)?

Name _____

Address _____

_____

Phone ( ) _____ - _____

Name _____

Address _____

_____

Phone ( ) _____ - _____

13. Can offenders be administratively removed from substance abuse treatment programs but remain at the Shock Incarceration facility?

[ ] yes [ ] no

If yes, please explain what would cause an inmate to be removed from the treatment program but be allowed to remain at the Shock Incarceration facility.

_____

_____

_____

_____

14. Can offenders voluntarily quit the substance abuse treatment program without being removed from the Shock Incarceration program?

[ ] yes [ ] no

If yes, are there any repercussions to the offender for quitting the program?

[ ] yes [ ] no

If yes, please describe:

_____

_____

_____

15. Do inmates who participate in substance abuse treatment programs enter an after-care substance abuse treatment program when released from your facility?

[ ] yes [ ] no [ ] don't know

15a. If yes, who makes the decision to refer/place an inmate in after-care substance abuse programming? Please check all that apply.

[ ] voluntary, decided by the offender

[ ] statutory

[ ] sentencing judge

[ ] your facility -- objective classification assessment

[ ] your facility -- subjective decision by personnel

[ ] parole/probation authority -- subjective decision

[ ] parole/probation authority -- objective decision

[ ] other (please specify) _____

_____

16. Can you please identify the name(s) and address(es) of the aftercare providers?

Name: _____

Address: _____

_____

Phone: ( ) _____ - _____

Name: _____

Address: _____

_____

Phone: ( ) _____ - _____

17. Are there any treatment elements that you would like to implement but cannot due to security requirements or concerns?

[ ] yes [ ] no

If yes, please explain:

_____

_____

_____

18. Are there any treatment elements that you would like to implement but cannot due to budgetary constraints?

[ ] yes [ ] no

If yes, please explain:

_____

_____

_____

_____

19. Are any substance abuse monitoring methods used while the offender is at the Shock Incarceration facility? (e.g. urinalysis)

[ ] yes [ ] no

If yes, please briefly describe how substance use is monitored.

_____

_____

_____

_____

20. Is there a waiting list to enter the substance abuse treatment component at your facility?

[ ] yes [ ] no

If yes, approximately what percent (%) of inmates who are wait-listed do not receive substance abuse treatment before their release from Shock Incarceration?

_____ %

21. Within the next three years, what do you think is likely to happen with the Shock Incarceration substance abuse treatment program offered at your facility?

[ ] expand in size

[ ] reduce in size

[ ] remain the same

[ ] have no idea

SUBSTANCE ABUSE EDUCATION

22. Is a separate, clearly identifiable substance abuse <u>education</u> program offered in your Shock Incarceration program?

[ ] no--go to question 28 [ ] yes

22a. If yes, is participation in the substance abuse education program mandated?

[ ] yes [ ] no

22b. If yes, what criteria are used to mandate offender participation in substance abuse education?

_____

_____

_____

23. Is there a waiting list to enter in the substance abuse education component at your facility?

[ ] yes [ ] no

If yes, approximately what percent (%) of inmates who were wait-listed do not receive substance abuse education before their release from Shock Incarceration?

_____ %

24. Who teaches the substance abuse education program?

[ ] correctional staff
[ ] contracted community based substance abuse educators
[ ] contract with external organization/institution
[ ] other (please specify) _____

25. How many total hours of education does the curriculum entail?

_____ (in hours)

26. In what form is the substance abuse educational material presented? Please check all that apply.

[ ] class presentation/discussion [ ] books, pamphlets

[ ] movie/videotapes [ ] guest speakers, volunteers

[ ] hand-outs [ ] other _____

[ ] ex-addicts/people in recovery [ ] other _____

26a. Can you briefly describe the topics/curriculum modules that are presented in your substance abuse education program?

_____

_____

_____

_____

27. Within the next three years, what do you think is likely to happen with the Shock Incarceration substance abuse education program offered at your facility?

[ ] expand in size [ ] reduce in size

[ ] remain the same [ ] have no idea

STAFFING

28. Please list the various job staffing titles for substance abuse treatment and substance abuse education oriented positions. Additionally, please list the number of persons employed in the various positions, whether the positions are full or part-time and if they are filled by correctional staff or contracted outside the institution.

TITLE	FULL OR PART TIME	# OF POSITIONS	CONTRACTED or INSTITUTION STAFF
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

29. Approximately what is the substance abuse treatment and substance abuse education staff to inmate ratio?

Treatment Education

_____ : _____ _____ : _____

30. Are education and treatment personnel required to meet or work towards a state certification?

Treatment Education

[ ] yes [ ] no [ ] yes [ ] no

If yes, what percent (%) of your treatment and education staff are currently state certified?

Treatment Staff Education Staff

_____ % _____ %

If certification is required, please describe both the educational and experiencial requirements.

For Substance Abuse Treatment Personnel: _____

_____

_____

For Substance Abuse Education Personnel: _____

_____

_____

** THE FOLLOWING QUESTIONS CONCERN THE GOALS, OBJECTIVES, AND ELEMENTS OF THE ENTIRE SHOCK INCARCERATION PROGRAM. PLEASE ANSWER ACCORDINGLY.

TOTAL PROGRAM GOALS/PURPOSES

31. We would like to know the intended correctional goals of your Shock Incarceration program. Please rank each of the following goals as they relate to Shock Incarceration programming in your jurisdiction. That is, rank the most important goal as 1, placing the number 1 next to the appropriate statement. The second most important goal should be ranked as 2, the third as 3, and so on.

A. ____ Retribution - to pay offenders back for the harm they have caused society.

B. ____ Incapacitation - to protect society by putting criminals in jail so that they can't victimize anyone.

C. ____ Rehabilitation - to reform offenders so that they will return to society in a constructive rather than a destructive way.

D. ____ Deterrence - to teach criminals as well as other people contemplating going into crime that in America crime does not pay.

E. ____ Other (please specify) _____

_____

_____

32. In addition to the above general goals of the criminal sanction, many correctional sanctions serve other objectives as well. For each of the following, what is the importance of that objective being achieved? Please circle the appropriate level according to the following scale.

		Very Important			Moderately Important			Not Important at All
A.	Clean, Healthy, Secure Environment	1	2	3	4	5	6	7
B.	Instill Respect for Authority	1	2	3	4	5	6	7
C.	Reduce Crowding	1	2	3	4	5	6	7
D.	Improve Image of Corrections	1	2	3	4	5	6	7
E.	Offender Accountability	1	2	3	4	5	6	7
F.	Positive Offender/ Staff Contact	1	2	3	4	5	6	7
G.	Promote Discipline	1	2	3	4	5	6	7
H.	Public Safety	1	2	3	4	5	6	7
I.	Less Criminal Activity	1	2	3	4	5	6	7
J.	Environment Promoting Rehabilitation	1	2	3	4	5	6	7
K.	Alternative to Longer-Term Incarceration	1	2	3	4	5	6	7
L.	Improve Offender Confidence	1	2	3	4	5	6	7
M.	Less Cost	1	2	3	4	5	6	7
N.	Reduce Offender Drug Use	1	2	3	4	5	6	7
O.	Politically Acceptable Alternative	1	2	3	4	5	6	7
P.	Promote Positive Offender Social Behavior	1	2	3	4	5	6	7
Q.	Model for County Programs	1	2	3	4	5	6	7

32a. If these specific Shock Incarceration objectives have changed since the first program was introduced, please describe the nature of those changes.

_____
_____
_____
_____

33. The following elements are commonly found in Shock Incarceration programs. Rank, according to the following scale, the primacy given to these program elements.

	Primary Program Element		**Secondary Program Element**		**Minor Program Element**		**Not a Program Element**
Physical Training	1	2	3	4	5	6	7
Alcohol Treatment	1	2	3	4	5	6	7
Drug Treatment	1	2	3	4	5	6	7
Substance Abuse Education	1	2	3	4	5	6	7
Physical Labor	1	2	3	4	5	6	7
Drill & Ceremony	1	2	3	4	5	6	7
Basic Education	1	2	3	4	5	6	7
Vocational Education	1	2	3	4	5	6	7
Pre-Release Program (e.g. life-skills)	1	2	3	4	5	6	7
Post-Release Services Delivery (e.g. after-care components)	1	2	3	4	5	6	7

33a. Have the emphases placed on specific program elements in your jurisdiction changed since the implementation of shock incarceration programming?

[ ] yes [ ] no

If yes, please describe in as much detail as possible the nature, timing, and rationale related to these changes.

_____
_____
_____
_____

34. The following are some statements having to deal with drug abuse. Please indicate whether you strongly agree, agree, disagree, with each of the following statements (or have no opinion). Please use the following scale to record your responses. (e.g., 1=strongly agree, 5= strongly disagree)

Strongly Agree	Agree	No Opinion	Disagree	Strongly Disagree
+++++1+++++++++2+++++++++3+++++++++4+++++++++5+++++				

_____ Drug abusers are not inherently different from non-abusers; what differs is how they have learned to cope with life.

_____ Drug abusers have such character defects that any attempt to educate or treat them for substance abuse problems is doomed.

_____ Drug abusers and alcoholics tend to be weak-willed people.

_____ A drug abuser or alcoholic should be viewed and treated as a person who is ill.

_____ A person should not be held responsible for being an alcoholic or drug abuser.

_____ The Shock Incarceration facility at which I work is treatment oriented.

_____ Most Shock Incarceration offender clients receiving substance abuse treatment are receptive.

PERSONAL INFORMATION

35. Person completing this survey:

Name_____

Title_____

Phone # ( )_____

Address _____

Length of Employment at this Facility _____ Years _____ Months

36. Can you please specify your highest educational level attained?

[ ] high school graduate

[ ] some college, no degree

[ ] Associate's Degree

[ ] Bachelor's Degree

[ ] Master's Degree

[ ] Ph.D.

Please specify the specific academic degrees that you hold or are working towards (e.g., B.A. in psychology, M.S. in rehabilitation, etc.)

_____

_____

_____

_____

37. In your academic background, do you have any formal educational training in drug/substance abuse education or treatment?

[ ] yes [ ] no

If yes, please specify the type and extent:

_____

_____

_____

_____

Thank you for your assistance.

If you have any thoughts you would like to share with us regarding this questionnaire or the Shock Incarceration program, please use the back of this page to write your comments.

We are also very interested in reviewing any evaluation or research reports that may be available on your substance abuse program. If you can send us copies of these reports, please do so. If not, can you identify the person or source from whom or where we can request these reports?

_____

_____

_____

_____

If your would like a copy of our results when this study is concluded, please check this box. [ ]

BOOT CAMP DRUG TREATMENT AND AFTERCARE:
AN EVALUATION REVIEW AND
AFTERCARE INFORMATION SURVEY

Date: _____

Name of Person Completing This Survey:

_____

Title: _____

Name of agency or organization: _____

Address: _____
_____

Phone: _____

Section I. Program Information

1. Please identify the shock incarceration/boot camp program(s) for which you provide aftercare services:

_____
_____
_____

2. Please indicate the client population that your agency services.

_____ Adult Male Offenders
_____ Adult Female Offenders
_____ Adult Male and Female Offenders
_____ Youthful Offenders
_____ Only Drug-Dependent Offenders

3. Are your services provided only to boot camp releasees?

_____ yes
_____ no

(if no, please indicate the percentage of individuals in your program in the various categories:

_____% boot camp offenders
_____% other prison releasees
_____% offenders on probation or other types of community supervision
_____% individuals from non-criminal referral sources

4. Was your program started as a separate initiative for those completing a shock incarceration/boot camp program?

_____ yes
_____ no

4a. If no, was yours an ongoing program which began accepting shock incarceration/boot camp offenders after that program was developed?

_____ yes
_____ no

5. Which of the following best describes your agency/organization?

_____ part of a state department of corrections
_____ a state corrections agency other than a department of corrections
_____ a non-correctional state agency (such as a department of mental heath)
_____ a county/municipal correctional agency
_____ a non-correctional county/municipal agency
_____ a private not-for-profit organization
_____ a private for-profit corporation
_____ other (please describe below)

_____

6. Which of the following best describes the setting of your aftercare program?

_____ a correctional setting
_____ a hospital setting
_____ a residential setting
_____ an outpatient setting
_____ a combination of residential and outpatient
_____ a statewide program

7. Please indicate the total number of individuals in your program in each of the following categories for CY 1992.

_____ average number of participants per month
_____ total number of participants for year
_____ number of participants from boot camp programs for year

8. Please indicate which of the following are requirements for offenders participating in your program. Check all that apply.

_____ maintain regular contact with a probation/parole officer
_____ seek/hold regular outside employment or be enrolled as a full time student
_____ have an ongoing curfew
_____ be on an electronic monitor
_____ support dependents
_____ participate in community service requirements
_____ pay restitution
_____ pay court cost of treatment/supervision fees
_____ other (please identify)

_____
_____

9. Is there an assessment process used to identify the substance abuse treatment needs of your offender clients?

_____ yes
_____ no (skip to question #11)

9a. Below are a list of tools often used in the assessment process. Please check all of those utilized in your facility. Additionally, please estimate the approximate percent of offenders who are assessed with that particular tool at your facility.

[ ] _____% face-to-face client interview
[ ] _____% case history reviews which go beyond drug involvement offense history information
[ ] _____% case history reviews confined to drug involvement in offending behavior
[ ] _____% biological markers (e.g. urine & blood tests)
[ ] _____% behavioral or psychological tests

10. Please list addictions screening instruments your agency uses to assess substance abuse problems of boot camp releasees.

_____
_____
_____
_____

11. Are any substance abuse monitoring methods used while the offender is at in your program? (e.g. urinalysis)

_____ yes
_____ no

If yes, please briefly describe how substance use is monitored

_____
_____
_____

11a. If an offender is found to be using drugs while in your program which of the following would occur:

[ ] mandatory removal from the program and return to a correctional facility
[ ] discretionary removal from the program and return to a correctional facility

[ ] mandatory removal from the program but the offender would likely be permitted to remain in the community
[ ] discretionary removal from the program but the offender would likely be permitted to remain in the community
[ ] other (please explain)

_____
_____

Section II. Substance Abuse Treatment Information

12. Are individuals with identified substance abuse problems placed in a substance abuse treatment program?

_____ yes, a separate and distinct program
_____ yes, it is part of the overall aftercare program
_____ no, there is no program available

If no, please skip to question 24.

13. Is there a waiting list to enter the substance abuse treatment program?
_____ yes
_____ no

13a. If yes, approximately what percent (%) of offenders who are wait-listed do not receive substance abuse treatment? _____ %

14. Do you know who makes the decision to refer/place an offender released from a boot camp facility into aftercare substance abuse programming? Please check all that apply.

[ ] voluntary, decided by the offender
[ ] statutory
[ ] sentencing judge
[ ] the boot camp facility
[ ] your program -- objective classification assessment
[ ] your program -- subjective decision by personnel
[ ] parole/probation authority -- subjective decision
[ ] parole/probation authority -- objective decision
[ ] other (please specify) _____

15. Is this a treatment or education program?
_____ treatment
_____ education
_____ combination
_____ unknown

16. Is the offender's participation in this program voluntary or mandatory?
_____ voluntary
_____ mandatory
_____ unknown

17. Can an individual be returned to incarceration if he/she fails to successfully complete the substance abuse treatment program?
_____ yes (describe if possible)
_____
_____
_____ no
_____ uncertain

18. Which of the following predominant treatment strategies does your program use?

[ ] detoxification (e.g., Medical, Non-Medical, Methadone)

[ ] pharmacological (e.g., Methadone, Naltrexone)

[ ] monitoring (i.g., drug and alcohol testing, electronic)

[ ] community supervision (e.g, Parole, Intensive Probation)

[ ] counseling, thearpy, education (e.g, individual, group, AA/NA/CA, drug education)

[ ] auxiliary services (e.g., vocational, employment, academic instruction, social services)

[ ] other (please identify) _____

19. Specifically, which of the following treatment <u>modalitie(s)</u> is\are used in your program? Please check all that are in use.

[ ] substance abuse education

[ ] AA/NA/CA

[ ] individual counseling
e.g., traditional psychotherapy
reality therapy
behavior modification

[ ] therapeutic communities
e.g., Cornerstone & Stay'n Out

[ ] group counseling

[ ] milieu therap
may include individual/ group counseling, mildly confrontive groups & peer interaction in isolated drug-free environment

20. Specifically, what type of substance abuse treatment <u>interventions</u> are offered in your program? Please check all that apply.

[ ] AA/12 Step

[ ] Chemical
e.g., Methdone

[ ] Confrontation Therapy

[ ] Reality Therapy

[ ] Non-directive/Client Centered Counseling

[ ] Re-Entry Planning

[ ] Psychodynamic Therapy

[ ] Relaxation Therapy

[ ] Interpersonal problem solving training
e.g., Platt

[ ] Transactional Analysis

[ ] Vocational

[ ] Recreational

[ ] Positive Peer Culture

[ ] Moral Development Training

[ ] Family Therapy

[ ] Operant Strategies

[ ] Stress Management

[ ] Covert Sensitization

[ ] Criminal Thinking Strategies
e.g., Yochelson & Samenow

[ ] Behavior Modification

[ ] other _____

[ ] other _____

21. Is the length of substance abuse treatment the same (uniform) for all offenders?

_____ yes
_____ no

21a. If yes, please specify the length of the substance abuse treatment program. _____
_____

If no, please describe the variation. _____
_____
_____
_____

22. Can offenders be removed from the substance abuse treatment program for other than a new offense or drug use but remain in the community?

_____ yes
_____ no

22a. If yes, please explain what would cause an inmate to be removed from the treatment program but be allowed to remain in the community.

_____
_____

23. Can offenders voluntarily quit the substance abuse treatment program without being removed from the aftercare program?

_____ yes
_____ no

23a. If yes, are there any repercussions to the offender for quitting the program?

_____ yes
_____ no

If yes, please describe:

_____
_____
_____
_____

24. In your jurisdiction, approximately what percentage of the following offender groups are reincarcerated within 1 year of their release?

_____% of prison releasees

_____% of boot camp releasees

25. Do you believe that offenders who have successfully completed a boot camp program differ significantly from other offenders who participate in your program?

_____ yes
_____ no

25a. If yes please describe the differences:

_____
_____
_____

26. Have there been any formal evaluations completed on your program?

_____ yes
_____ no

If yes would it be possible for you to send a copy of the evaluation to the address listed at the beginning of this survey.

Thank you very much for your time and assistance!
If you have any thoughts you would like to share with us regarding this questionnaire or the boot camp/shock incarceration program, please use the back of this page to write your comments.
If you would like a copy of our results when the study is concluded, please check this box. [ ]

BOOT CAMP DRUG TREATMENT EVALUATION
INMATE PARTICIPANT SURVEY

_____ Control Number

1. Name of Facility _____

2. State _____

3. Sex: [ ] Male [ ] Female

4. Race\Ethnicity [ ] White [ ] Black [ ] Hispanic

[ ] Other, please specify

_____

5. Age _____

6. What is the highest level grade you have achieved?

[ ] less than 8th grade
[ ] 9 or 10th grade
[ ] 11th or 12th grade (but didn't graduate)
[ ] GED
[ ] H.S. graduate
[ ] Some college

7. Are you married?

[ ] Yes [ ] No

If yes, for how long? _____ years

7a. If no, do you have someone outside who's like a wife or husband to you?

[ ] yes [ ] no

8. How long have you been at this facility _____ (months)____

9. How long before you are released _____(months)

10. What is your current conviction offense?

_____

(If more than one charge please list the others below)

_____

_____

_____

_____

11. How long was your original sentence? _____

12. How did you end up coming to a boot camp? (please check the one below which best applies to your situation)

_____ I did not volunteer but the judge decided/sentenced me to the boot camp

_____ I didn't volunteer but the Department of Corrections officials placed me in the boot camp

_____ I volunteered because it reduced my sentence

_____ I volunteered because it meant I wouldn't have to go to a regular institution

_____ None of the above

13. Please check the status below which best applies to your release situation:

_____ When I am released I will have completed my sentence and will not be under any type of supervision.

_____ When I am released I will be under regular parole supervision.

_____ When I am released I will be under regular probation supervision.

_____ When I am released I will live in a regular half-way house or community center.

_____ When I am released I will live in a special alcohol or drug treatment facility

_____ Other (please describe below)

_____

_____

14. Please check all of the following that apply to your prior criminal involvement:

_____ In trouble as a juvenile

_____ Have prior misdemeanor convictions as an adult
If so, number _____

_____ Have prior felony convictions as an adult

If so, number _____

If so have you ever been on probation

[ ] yes [ ] no

If so have you even been in prison

[ ] yes [ ] no

_____ Never had any prior convictions as an adult (excluding traffic violations)

15. We would like to ask some questions about your use of drugs/alcohol.

A. Think about the last six months you were on the street before you were sent to the boot camp program. If you drank alcohol, how much did you usually drink?

[ ] did not drink at all

[ ] not enough to get drunk

[ ] enough to get drunk

[ ] enough to pass out.

B. How often did you use alcohol in your last six months on the street before you were sent to the boot camp?

[ ] every day [ ] few times each month

[ ] almost every day [ ] once a month

[ ] few times each day [ ] once or a few times

[ ] once a week [ ] never

C. In your opinion, did you have an alcohol problem prior to being placed in the boot camp program?

[ ] no [ ] yes [ ] don't know

D. In the six months your were on the streets before being sent to the boot camp program, did you use drugs other than those required for medical reasons?

[ ] no [ ] yes

If yes, please answer the following questions:

1. Check the type of drug(s) that you used in that six month period:

_____ marijuana (pot, THC)
_____ stimulants (speed, meth)
_____ depressants (downers)
_____ hallucinogens (LSD, mescaline)
_____ opiates (heroin)
_____ cocaine
_____ crack
_____ inhalants (nitrous, glue)
_____ other, please specify_____

2. Did you use more than one drug at the same time?

[ ] no [ ] yes

3. How often did you use drugs?

[ ] every day [ ] few times each month
[ ] almost every day [ ] once a month
[ ] few times each week [ ] once/a few times
[ ] once a week

E. In your opinion, did you have a drug problem prior to being placed in the boot camp program?

[ ] no [ ] yes [ ] don't know

F. I consider my level of alcohol consumption (when not in the boot camp) as:

[ ] light [ ] moderate [ ] heavy

[ ] excessive [ ] do not drink

G. I consider my level of drug use (when not in the boot camp) as:

[ ] light [ ] moderate [ ] heavy

[ ] excessive [ ] do not use drugs

H. Do you consider the offense for which you were sent to the boot camp to be related to your use of alcohol or drugs?

[ ] no [ ] yes

1. If yes, please explain: _____
_____
_____
_____

16. Since you entered the boot camp program, have you participated in a substance abuse treatment program?

[ ] yes [ ] no

16a. If yes, did/do you participate in group or individual substance abuse counseling?

[ ] group [ ] individual [ ] both

16b. If yes, how many hours per day did/do you spend in the treatment program?

_____ hours of individual counseling

_____ hours of group counseling

16c. If no, will you be participating in such a program prior to release? (go to Q #23)

[ ] yes [ ] no [ ] don't know

17. We would like to ask you a few specific questions on how you feel about your experience in the <u>substance abuse treatment program</u>. Please indicate whether you strongly agree, agree, disagree, or strongly disagree with each of the following statements (or have no opinion). Please use the following scale to record your responses (e.g., 1 = strongly agree, 5 = strongly disagree, 6 = doesn't apply).

Strongly Agree	**Agree**	**No Opinion**	**Disagree**	**Strongly Disagree**	**Doesn't Apply**
1	2	3	4	5	6

a. _____ The substance abuse counselors at the boot camp know what they are talking about.

b. _____ As a result of the treatment program, I do not believe that I will have a drug problem after I am released from the boot camp.

c. _____ The treatment program has helped my deal with my substance abuse problem.

d. _____ There are not enough treatment counselors in the boot camp.

e. _____ The treatment groups are too large.

f. _____ I really do not get a chance to discuss my substance abuse problem while in the treatment program.

g. _____ The treatment program has helped my understand my substance abuse problem.

h. _____ As a result of the treatment program, I do not believe that I will have an alcohol problem after I am released from the boot camp.

18. What are the areas that were/are being covered in the treatment program that are most helpful to you.

_____

_____

_____

_____

19. What are the areas that were/are being covered in the treatment program that are least helpful to you.

_____

_____

_____

_____

20. Had you ever been through a substance abuse treatment program before you came to this boot camp program?

[ ] yes [ ] no

If yes, how long did the program last?

_____

If yes, was this an in-patient/residential program?

[ ] yes [ ] no

21. If you have been through an other treatment program, how does the boot camp treatment program differ from what happened then? That is, "Compared to other programs I have been in, the boot camp substance abuse treatment program has been": (note: if you have not been in prior treatment, skip this question)

Much More Helpful	Somewhat More Helpful	No Different	Less Helpful	Much Less Helpful
2	1	0	-1	-2

22. Do you believe you will need to continue treatment for substance abuse after you are released from the boot camp?

[ ] yes [ ] no [ ] uncertain

23. We would like to ask you a few general questions on how you feel about your experience in the **overall boot camp program**. Please indicate whether you strongly agree, agree, disagree, or strongly disagree with each of the following statements (or have no opinion). Please use the following scale to record your responses (e.g., 1 = strongly agree, 5 = strongly disagree).

Strongly Agree	**Agree**	**No Opinion**	**Disagree**	**Strongly Disagree**
1	2	3	4	5

a. _____ There is nothing in this place that has/will help me.

b. _____ This experience has not/will not change me.

c. _____ This place has/will help me learn self-respect.

d. _____ This guards put on a big show, but that is all it is.

e. _____ This place has/will never help me in any way.

f. _____ I have learned things about myself here.

g. _____ I am becoming a better person here.

h. _____ The programs in this place (e.g. drug treatment) have/will never help me in any way.

i. _____ I have learned about my substance abuse problem while being here at the boot camp.

j. _____ I am becoming more mature here.

k. _____ Because of my experience here, I will probably not get in trouble again.

l. _____ I feel confident about my ability to stay out of trouble after I'm released from the boot camp program.

m. _____ I feel more safe here than I would feel had I been incarcerated in a regular prison.

n. _____ I have learned to deal with my substance abusing behavior while in the boot camp program.

o. _____ The contact between inmates and staff is better than I thought it was going to be.

p. _____ I believe that I will be more able to get the things I want out of life as a result of completing the boot camp program.

24. Below are a list of inmate activities which are commonly found in boot camp programs. Please review the list below and indicate those activities in which you have been involved in by placing a check in the appropriate column. Please also indicate how beneficial this activity has been for you by checking the appropriate space. (That is, have you gained something by performing or taking part in this activity?)

involved in activity	activity	no help	some help	very helpful	no opinion/ don't know
___ yes ___ no	Physical Training	___	___	___	___
___ yes ___ no	Drug/Alcohol Treatment	___	___	___	___
___ yes ___ no	Substance Abuse Education	___	___	___	___
___ yes ___ no	Physical Labor	___	___	___	___
___ yes ___ no	Drill & Ceremony	___	___	___	___
___ yes ___ no	Basic Education	___	___	___	___
___ yes ___ no	Vocational Education	___	___	___	___
___ yes ___ no	Pre-Release Programming	___	___	___	___

25. What suggestions would you make to officials for improving inmate boot camp programs for people such as yourself?

_____

_____

_____

_____

_____

_____

26. Specifically, what suggestions would you make to officials for improving the **substance abuse treatment component** found in boot camp programs for people such as yourself?

_____

_____

_____

_____

_____

_____

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