DRAFT FINAL REPORT

Process Evaluation of Tier IV Connecticut Department of Correction

Residential Substance Abuse Treatment Programs

Susan E. Pease, Ph.D.

Raymond Chip Tafrate, Ph.D.

Stephen M. Cox, Ph.D.

Department of Criminology and Criminal Justice
Central Connecticut State University

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INTRODUCTION

The Department of Criminology and Criminal Justice of Central Connecticut State University (CCSU) formed a research partnership with the Office of Addiction Services of the Connecticut Department of Correction (CDOC) for the purpose of conducting a process evaluation of three residential substance abuse treatment (RSAT) programs, CDOC's highest level of treatment, on the basis of consistency and effectiveness. The evaluation attempts to identify those programmatic factors which contribute to inmate success and failure so that recommendations can be made regarding the implementation of these programs.

The evaluation consists of the *Time Program* at the Carl Robinson Correctional Institution (Robinson C.I.), the *New Horizons Program* at the Osborn Correctional Institution (Osborn C.I.), and the *Marilyn Baker House* at the York Correctional Institution (York C.I.). We had originally intended to include the residential substance abuse program at the Mansion Youth Institution; however, the program was disbanded and redesigned during our study period. Therefore, we will attempt to include outcome data for Mansion in the Outcome Evaluation.

The present evaluation is concerned with looking within and across institutions to determine what kinds of differences may exist with regard to program content, characteristics of program participants, institutional administrative support, staff retention and stability, program philosophy and delivery, program completion rates, and inmate satisfaction with the program. This evaluation is the first component of a larger

outcome study also funded by the National Institute of Justice. Future components will more directly address the effects of residential substance abuse programs on recidivism.

The present report will first describe the structure of the programs, as outlined by the CDOC. A description of the researchers' qualitative assessment will then be provided for each program. The next section presents the quantitative analyses regarding participant characteristics, selected psycho-social measures of change, prediction of program completion, and summaries of inmates' satisfaction for each program. The final section highlights several critical issues in residential substance abuse treatment, summarizes the overall findings of the process evaluation, and provides recommendations for program improvement.

CDOC Program Outline and Overview

CDOC internal research has determined that large proportions of their inmates (84%) are substance abuse involved when committing their instant offenses. Their observations are consistent with the literature concerning the relationship between substance abuse and crime (Ball, Rosen, Flueck, & Nurco, 1981; Ball, Schaffer, & Nurco, 1983; Inciardi, 1981; 1986; Inciardi, Lockwood, & Pottieger, 1993; Johnson & Wish, 1986; McBride, 1981; Nurco, Hanlon, & Kinlock, 1991). It follows that one prerequisite to reducing recidivism in the CDOC system is to reduce offender involvement in substance abuse. Therefore, treatment is a key factor in the CDOC effort to reduce the number of inmates who return to prison.

The CDOC Office of Addiction Services offers four tiers or levels of substance abuse treatment. Tier I is comprised of six substance abuse education sessions, Tier II is a two to three month outpatient program with two or more weekly components. Tier III

is a four to six month program that meets five days a week. The highest level of treatment offered by the CDOC is the Tier IV program. The Tier IV program is a six month full-time residential treatment program located in a separate housing unit.

Program Philosophy and Goals

The Tier IV program philosophy is contained in the Addictions Services Unit Tier IV Program Standards (1998). CDOC states that the program is based on cognitive behavioral principles. Programs addressing the development of cognitive problem solving skills and social skills (Hawkins, Catalano & Wells, 1996; Hayes & Schimmel, 1993; Husband & Platte, 1993; Walters, Heffron, Whitaker, & Dial, 1992) such as stress and anger management skills (Yen, Peyrot & Prino, 1989) are considered to be more effective than programs that focus only on knowledge about the negative effects of drug and alcohol use (Botvin, 1983). The focus of the CDOC intervention is to train inmates to respond to situations differently so that they end up in positive situations rather than criminogenic circumstances involving substance use.

The community environments of the three CDOC programs are designed to promote positive interaction and personal growth through socialization in a therapeutic community, group and individual counseling, and peer mentoring. Emphasis is placed on promoting positive changes in inmate attitudes and behaviors that can be observed and rewarded. CDOC does not tolerate violence or antisocial behavior, in that, such actions result in dismissal from the programs. Inmates are encouraged to develop personal responsibility, discipline, and pro-social attitudes. Inmates are also encouraged to support one another in recovery, serve as positive role models, and develop positive peer relationships (DeLeon, 1995;1996). The peer mentor program is specifically designed to

recognize and utilize inmates who demonstrate motivation, constructive conflict resolution, and honest communication.

As outlined by the CDOC, the criteria for entering a Tier IV program is to have a documented need for substance abuse treatment, personal desire for treatment, and completion of a Tier II or III program. The goals of the Tier II and Tier III programs are to provide inmates with basic recovery skills and concepts. Tier IV programs are designed to provide inmates with the opportunity to learn advanced recovery skills and reinforce what they have learned in Tiers II and/or III.

The primary residential treatment goals across all three institutions are to provide inmates with the foundation for recovery to prevent substance abuse relapse. While stressing cognitive behavioral skills, admittedly, the treatment focus is eclectic. Treatment components include: education, cognitive restructuring, recovery concepts, understanding the link between substance abuse and crime, anger management, conflict resolution, parenting, stress management, team building, and elective modules (e.g., cultural awareness, dealing with past traumas and victimizations). Participants completing these programs should have obtained the skills needed to prevent relapse, to successfully complete aftercare, and to demonstrate positive behaviors and pro-social values.

Tier IV Program Structure and Procedures

All inmates are assessed twice before entering the Tier IV program. The first assessment occurs when an inmate enters the CDOC. This assessment identifies individual risks and needs of the inmates, including substance abuse treatment need. A second, more focused, assessment is conducted by an Addictions Services Counselor

prior to entry into a Tier IV program. This assessment provides a more in-depth understanding of the inmates' substance abuse history, record of previous treatments, community functioning, family and social relationships, and current motivation for treatment. The information collected is used to devise an individualized treatment plan that includes specific actions to be taken in preparation for release, job placement, family counseling referrals, and homework assignments that address each inmate's own triggers for relapse. The treatment plan is reviewed regularly by the inmate in conjunction with his/her counselor. The review is used to monitor the inmate's progress in completing assignments, identifies additional needs, and determines whether any changes in the plan are needed.

The six-month programs are designed to be highly structured and standardized. They follow the therapeutic community model, which allows program participants to live and interact with each other, with minimal contact with the general prison population. Because of the therapeutic community model, participants are immersed in programming activities for over forty hours, five days each week. Homework is often assigned in treatment groups, which is to be completed in between activities. In addition, inmates are expected to maintain employment inside the institution or attend school while not attending groups. Thus, the overall structure leaves inmates with little "down time." Mandatory requirements related to treatment are to keep a journal focusing on the recovery process, to attend two fellowship (12-Step) meetings per week, and attend two group meetings per week.

Program participants are required to participate in three phases of treatment that range from providing educational information to developing new skills. Phase I is

viewed as an orientation period providing basic educational modules on addiction. Phase II offers specific topic groups (e.g., building life skills, parenting, conflict resolution) and emphasizes positive interaction with group participants. Phase III provides intensive relapse skills allowing inmates the opportunities to fine tune and utilize the skills obtained in Phases I and II. Aftercare plans are developed during Phase III and inmates are referred to community aftercare programs. Aftercare within the institution is offered for residents who have graduated the in-patient portion of the program and are not immediately released. They may elect to remain in the treatment housing unit, hold a full-time job, and still attend weekly program groups and fellowship meetings.

Pilot Evaluation Findings

Pease and Love (1996) completed a pilot outcome evaluation of the Marilyn Baker Program at the York Correctional Institution for female inmates. Their findings indicated that inmates successfully completing the Marilyn Baker Program were less likely to be readmitted (31%) to the Department of Correction after one year following release when compared to inmates who failed to complete the program (55% return), inmates who completed a less intensive non-residential program (47% return), and inmates did not participate in any treatment program (64% return). These findings provide tentative support for the effectiveness of the RSAT programs.

The present evaluation seeks to better understand the delivery of the RSAT programs and their immediate outcomes (i.e., program completion), building upon the pilot study of the Marilyn Baker Program by including two male institutions. The following section provides a description of each program along with researcher

observations and information provided through focus groups with program staff and participants.

RSAT PROGRAM DESCRIPTIONS AND QUALITATIVE OBSERVATIONS

Qualitative observations and structured focus groups were conducted in order to obtain clear and detailed understanding of the implementation of the RSAT programs. The observations were centered on the physical structure housing the program (e.g., treatment space, offices, and living space) and the implementation of group treatment sessions (number of participants attending each group, counselor's skills, collaboration between participants and counselors, and content of the group session). Focus groups were conducted with program staff, current participants, and inmates who did not complete the programs. The focus groups were conducted to obtain a first-hand account of the actual functioning of the programs, identify strengths and problem areas, and also solicit recommendations for program improvement.

Time Program at Carl Robinson Correctional Institution

The Time Program is housed in the Carl Robinson Correctional Institution, a 1141-bed medium security facility for males age twenty and older. Ninety-two (92) percent of the inmates at this facility have been identified by the CDOC as having a significant need for substance abuse treatment. The racial/ethnic composition of the inmates is 24% white, 50% African American, and 27% Latino.

The Time Program began in 1992 with 50 inmate participants. Program participants are partially separated from the rest of the general prison population with regard to program activities and housing (see details below). As of September 1999, the program has 90-beds with 10 full-time staff and one secretary.

Facilities and Living Conditions

The Time Program is housed in two separate buildings. Program participants are assigned to half of a dormitory building. The other half of the dormitory contains non-program inmates. While there is separation between program and non-program inmates, they frequently mix with each other. In addition, during recreation and movement in and out of the dining facilities, program and non-program inmates interact. This has been a source of frustration for the staff because the program participants are frequently harassed by the general population.

The second building, about 1/8 of a mile from the dormitory, is primarily devoted to programming and counseling activities and contains staff and administrative offices. Participants have to move between the dormitory building and the program building several times a day. This, of course, allows for further interactions with the general population. The other drawback of having the living space separate from the treatment space is that the counseling staff only observes a participant's behaviors during treatment activities (e.g., groups) and not during most of the individual's daily routine. Thus, treatment is not fully integrated into daily living.

In terms of office space, each counselor has a private office where individual counseling sessions may be conducted. There is also a common area that serves as a meeting area and waiting room for participants. Two large rooms are devoted to group therapy activities. Unfortunately, some of the private offices are located off of the group therapy rooms, thus having staff members frequently disrupt group activities when moving in and out of their offices. Overall, the programming space appears to be small for such a large program. In addition, the programming area appears run down and

outdated. For example, chairs are old and falling apart, carpeting is stained and has tears, and walls are dirty and dark.

Selection and Recruitment of Participants

Inmates are recruited into the Time Program through a variety of methods: classification screenings, orientation, recommendations from other inmates, encouragement from peer counselors, participating in Tier II programming (non-residential), participating in narcotics or alcoholics anonymous meetings, attorney or prison consultant recommendations, or parole board recommendations. An inmate expresses interest in the program by submitting a written request. A program counselor then screens each potential participant and makes decisions on admittance into the program. Apparently few individuals are rejected. One potential problem in the admissions procedure is that inmates who are removed from a Tier II program, due to lack of compliance or motivation, sometimes apply and are accepted into the Tier IV (Time) program.

The Time Program operates on a rolling admissions basis. As individuals graduate and beds become available, new participants are admitted. The rolling admissions policy ensures that space is utilized efficiently. However, this also disrupts cohesion among participants in that individuals are constantly rotating in and out. Thus, new members need to be continually socialized into the therapeutic community. There also exists administrative pressure to keep beds filled. This tends to result in accepting individuals who are not likely to be motivated to fully participate in treatment. In addition, if beds are not filled they will be assigned to non-program inmates. It is

reported that individuals that are not part of the program, but who are housed in the therapeutic community tend to have a disruptive influence on the goals of the program.

Program Structure

Curriculum model. The Time Program consists of two phases and lasts for a total of six months. Overall, the curriculum is standardized in that each participant receives the same programming. However, due to the variability in counselors' education, skills, and treatment orientation, material may be presented or covered differently by individual counselors. Phase I lasts for three months and is focused on creating client awareness, introducing the *disease* concept, and building trust. Group meetings cover a variety of topics: basics of addiction, fellowship information, honesty, image, ego, introduction to spirituality, feelings, and criminal thinking. During Phase I, participants attend four group meetings per week. They also attend two individual counseling sessions per month. Surprisingly, additional individual sessions are not granted to participants who may be experiencing increased emotional or behavioral problems.

Phase II of the program also lasts three months and emphasizes interaction among program participants. Group topics include the following: cultural sensitivity, violence, anger and resentment, team building, fear, grief and loss, family, parenting, shame, relapse prevention. Again, participants attend four group meetings per week and two individual counseling sessions per month.

At the time this evaluation began there was very little in the way of aftercare. Participants who completed the six months of programming were moved back into the general population. Aftercare consisted of one meeting per week for all program graduates. In the Winter of 2001, a 30-bed aftercare program was implemented.

Although aftercare participants live together in a dormitory they are housed with non-program graduates. Aftercare participants attend one group meeting per week and two 12-step meetings per month. Another option for those graduating the program is to apply for positions as peer mentors. Staff vote on whether to accept an individual as a peer mentor. Peer mentors continue to live in the Time Program dormitory and assist in running groups and providing additional support to new participants. At the time of the current evaluation there were thirteen peer mentors. The number seems to fluctuate and there have been as many as twenty at one time. Peer mentors generally keep the position for about one-year. Again, because of the separate housing and programming space, peer mentors frequently are the ones who attempt to maintain the integrity of the program in the dormitories. They are frequently the ones who will report rule violations and disruptive behaviors to the staff. Some participants have reported that complaints may be somewhat politically motivated in that those who are friendly with the peer mentors are granted greater latitude in their daily actions.

Rules for participants. The program is extremely structured and inmates are required to follow group rules and house rules. In regard to daily living, participants are required to maintain good personal hygiene, wear pants around the waist (as opposed to hanging down), and not engage in smoking, gambling, fighting, stealing, or derogatory comments. Other rules include flushing the toilets after use, no displays of pornography, and no reserving phones or television.

Group rules include being on time, maintaining confidentiality, showing respect for other residents and staff, not engaging in "side" conversations while the group is in

session, and using "I" statements as mechanism for taking responsibility for one's own problems. Participants may amend program rules through group votes.

Staff Characteristics

As noted earlier, the staff consists of nine counselors, one administrator, and one secretary. Staff are evenly divided in terms of gender (6 females and 5 males). In regard to minority representation, there is one African American counselor and two Latino counselors. Only one counselor speaks Spanish. The educational background of the counselors is extremely varied. Three earned masters degrees, two have Bachelors degrees, one has an Associates degree, and two have high school diplomas. Five counselors are certified alcohol and drug counselors (CADC). Four counselors have been successfully treated for their own substance use problems. The wide variability in education sometimes creates communication problems regarding treatment conceptualization and can be a source of staff tension.

Those counselors with certification are required to attend continuing education trainings. There does not appear to be any additional incentives for pursuing continuing education skill development. In addition, there are no financial incentives for earning an advanced degree.

Correctional officers are not specifically assigned to the Time Program but instead to the dormitory building itself. Thus, they do not possess any special training or sensitivity regarding the goals of treatment. Correctional officers who oversee the dormitory rotate every few months. Thus, custody staff are sometimes viewed as not being supportive of the treatment mission.

Researcher Observations

Focus groups with participants. Focus groups were held with current participants and program non-completers. Although a number of factors influenced individuals to pursue the program, the primary motivation was that it would be helpful in subsequent parole hearings. Overall, the Time Program seems to enjoy a good reputation among counselors and inmates in the general prison population.

Comments from current participants were overwhelmingly positive. Participants reported that they developed close relationships with the staff and other members of the program (e.g., "inmates help each other;" "there is community involvement"). In addition, it was reported that relationships among participants were easily formed across racial lines. Another common comment was that the programming assisted inmates in developing skills that they could use in the future. Comments from participants regarding the treatment staff were also positive (e.g., "the counselors are great;" "they care about you;" "they are responsive and take the time to help you;" "they make you face things"). The majority of the participants see the staff as caring and focused on treatment goals. Remarks regarding the peer mentors were more variable. Some of the peer mentors are seen as helpful and as an asset to the program. Other peer mentors were viewed as having selfish motives for taking on the roles (e.g., "in it just to live in the Time Program dormitory;" "on a power trip").

Current participants also reported that they saw indicators of progress and change such as being able to share their emotional experiences with others and being more considerate in their daily behaviors. There seemed to be consensus among the participants that six months was not long enough for programming. It was pointed out

that around the six month point is where many people are just starting to see change and then they are sent back to the general prison population. Many appeared anxious that their treatment improvements would not be maintained once returned to the general population. Since only a few individuals can go on to become peer mentors, few opportunities exist for staying connected to the program.

Several of the non-completers also had positive comments about the staff (e.g., "the staff is good;" "they will try to help you"). Non-completers saw the peer mentors as a negative influence and in at least two instances they were blamed for people being dismissed from the program. Among the non-completers, the peer mentors are viewed as people who look for problems and report them. It should be noted that during the course of the focus group, the non-completers appeared significantly more emotionally disturbed than those who were successfully engaged in the program. Some sample reasons for dismissal included out of place tickets, an altercation with other participants, and lack of motivation.

Focus groups with staff. As a group, the staff comes across as cohesive and professional. As noted earlier, the majority of the staff are certified substance abuse counselors and most continue to develop their counseling skills. Staff members identified several areas of concern: (a) need for more treatment staff to adequately serve all program participants, (b) lack of adequate treatment space, (c) lack of a formal aftercare program, (d) custody staff that is not sensitive to treatment issues, (e) need for more minority counselors, (f) high degree of variability in psychological awareness among new participants, and (g) little input into the screening and selection process of new counselors. In terms of support from the custody personnel, counselors reported a

great deal of variability in the attitudes of correctional officers. Overall, there is the perception among the counseling staff that treatment issues are peripheral. Thus, counselors feel undervalued and sometimes cynical about their potential impact. In terms of the variability of new participants, some arrive having completed the Tier II program while others have never experienced any type of counseling services. One suggestion was to make sure that Tier II is a prerequisite for all new participants. The problem of too few counselors is sometimes compounded by the assignment of Time staff to other duties throughout the facility. For example, counselors have been assigned to run 12-step groups and domestic violence groups for general population inmates.

Clinical observations of treatment. The evaluators selected a representative sample of groups for observation. Counselors appeared prepared, organized, goal directed, and managed time efficiently. Goals of each group were communicated to participants. In addition, all counselors observed demonstrated good basic counseling skills (good attending skills, expressed appropriate empathy, encouraged participation). One area where counselors did not consistently achieve high ratings was in the use of paraphrasing and summarizing participants' thoughts and emotions. In addition, counselors in general were not attentive to the emotional shifts of participants and did not ask questions that would reveal more relevant information. Since participants were not probed sufficiently regarding their inner experiences, group sessions, although very well organized, appeared to lack depth. One possible reason for the lack of a more in-depth focus, might be that some of the groups observed were rather large ($n < 25$). Thus, counselors had to make a choice between allowing everyone to contribute versus exploring a specific individual's feelings and thoughts in a more extensive manner.

Sample group session (Building Community). Since the initial group was rather large (n=32) they were divided into three smaller groups. Peer mentors were helpful in keeping things organized. Each group was given a series of statements which they had to complete (e.g., I know it is silly, but I'm afraid of...; when I was a child...; ten years from now...). Each person would respond to the statement and someone would record each members' responses. Each group then presented the responses and discussed areas that people had in common. This exercise seem especially useful to get everybody talking to each other and to realize that they share much in common. They also verbalized many reasons why they were motivated to change. On the downside, this exercise did not allow for follow-up and more in-depth exploration of thinking styles or associated emotions.

Another exercise that was used during this session involved each group creating a skit that expressed some type of community issue that they all had in common. For example, one group presented a skit around an inmate looking for work after release. It illustrated the difficulties and challenges that can arise. First, a released inmate went for a series of interviews with potential employers, and received feedback ranging from cool to hostile when the interviewer found out the person had spent time in prison. Second, the same person feeling deflated from the interviews is walking home in the old neighborhood and was approached by old acquaintances who wanted to know if he needed a job that involved selling drugs. The person uncomfortably refused the offer. The larger group then provided feedback on each of the skits.

New Horizons Program at Osborn Correctional Institution

Direct observations of ongoing treatment, focus groups with inmates and staff, and data collection from individual program participants, were more difficult to obtain from the New Horizon Program compared to the other adult Tier IV programs. The evaluation of the New Horizon Program was plagued with scheduling difficulties, limited access to the facilities and inmate participants. Thus, the following is presented based on limited information. In many cases there is a lack of clarity regarding certain program procedures. Nonetheless, the following overview is presented based on the findings obtained.

The New Horizons Program is housed at the Osborn Correctional Institution, a 1441-bed medium security facility for males age twenty and older. The racial/ethnic mix of the general prison population is 28% white, 43% African American, and 28% Latino. Ninety (90) percent of the inmates at this facility have been identified by CDOC as having a significant need for substance abuse treatment. There are currently approximately 50 inmates participating in the Tier IV program.

Facilities and Living Conditions

The New Horizons Program is housed on separate floors of one building. Participants live in a dormitory located in the basement and treatment staff offices are on a separate floor. Inmate participants live in dorm style conditions with 20 individuals to a room. We did not view the living areas. General population inmates are also housed within the same building. Although there is separation between program participants and the general population inmates, interactions occur sporadically during transitions and movement (e.g., to meet with treatment staff, in the cafeteria, and during recreation).

The New Horizons program staff consists of one administrator and five counselors. There is currently no administrative assistant or secretary for the program. The lack of support staff may have contributed to scheduling difficulties and organizational problems experienced during the present evaluation. The administrator of the Tier IV program also oversees the Tier II program. Regarding office space there is a very small-designated area for the New Horizons Program, which consists of several private offices. Some treatment staff are separated only by soft walls about six feet high. Non-private offices are not appropriate for individual sessions and counselors must share the limited private office space available. There is a small area for file cabinets, a copy machine, and inmates appear to be used as clerical staff. Group meetings occur in an area of the basement, which has a small break out room with a door so two groups can be run at the same time.

Selection and Recruitment of Participants

Inmates generally complete a Tier II (a two and a half month program) before entering the Tier IV program. There are currently two types of Tier II programs. One is residential and the other is considered outpatient (inmates are housed with the general population). Thus, while the majority of inmates have had some prior treatment, many have not been socialized into an inpatient therapeutic community model. Occasionally an inmate will be admitted without having completed any prior treatment.

In terms of gaining admittance to the program, inmates write to express interest. Staff examines the disciplinary record of the individual (must have a minimum of 120 days free from disciplinary problems), length of time left on sentence (there must be at

least 18-months remaining), and motivation (assessed through an interview). The New Horizons Program admits new participants in groups of 25 at a time. However, there is some administrative pressure to keep beds filled when spaces become available. Thus, non-program inmates are sometimes assigned to the program dormitories. However, they are usually relocated after several days.

Program Structure

Curriculum model. The New Horizons Program consists of two phases and lasts for a total of six months (each phase is three months). However, as noted above the vast majority of individuals have had two and a half months of Tier II programming. Thus, total time in treatment is eight and a half months. Overall, the curriculum is standardized, consisting of core modules and electives. Examples of core modules include 12-step education, thinking errors, social skills training, and team building. Sample electives include family violence, fatherhood, GED education, and investing. Individual counselors may present materials differently due to the variability in counselor experience, education, and treatment orientation. During the two phases of the program, participants receive weekly group sessions and two individual counseling sessions per month. Additional individual sessions are granted to participants who may be experiencing increased emotional difficulties.

Aftercare for those individuals who complete the program is limited due to the small number of staff. There is currently one aftercare group meeting per week and one 12-step oriented group. The groups may at times be quite large and include as many as 45 inmates. The aftercare component is described as lacking in structure. Program graduates may attend the aftercare program for the period of one year. Another option

for those graduating from the program is to apply to become peer mentors. Peer mentors help co-facilitate groups sessions and keep the integrity of the program intact in the living areas. Peer mentors also receive supervision and feedback from the counseling staff. Currently, there are 18 peer mentors in the New Horizons Program. Although there is presently no limit on the amount of time one may serve as a peer mentor, a one-year term limit is being considered.

Rules for participants. As part of the program structure, inmates are expected to adhere to both house rules and group rules. Sample rules include not being late for meetings, doing homework assignments, and not using foul language in groups. In addition, participants are assigned a variety of cleaning tasks. Three rule violations result in dismissal from the program.

Staff Characteristics

As already mentioned five counselors and one administrator make up the staff. The staff is racially diverse consisting of three African Americans and three Caucasians. The staff is also evenly divided in terms of gender. The educational background of the counselors is varied and ranges from completion of high school to a Masters degree. Two of the staff have received certifications as alcohol and drug counselors (CDAC). There does not appear to be much incentive or motivation for pursuing additional education or skill development. While the counselors' diversity in terms education and experience can be positive (counselors from differing perspectives may connect with different inmates) the lack of minimum educational standards may also, at times, hamper staff cohesiveness and communication.

Correctional officers are not specifically assigned to the New Horizons Program. Thus, they do not receive any special training regarding the therapeutic community. There appears to be a great deal of variability regarding the custody staff's support of treatment. A frequent complaint is that a non-sensitive correctional officer can often undermine the cohesiveness and supportive environment desired for the program.

Researcher Observations

Focus groups with participants. Focus groups were held with current participants and program non-completers. Current participants reported that they initially found out about the program from discussions with inmates, through an inmate newspaper, or were encouraged by the courts to participate in programming. Although participants reported that the program was generally helpful, several expressed concern that there was not enough attention from the counseling staff. Several stated that the staff did not seem caring or committed to their needs. A related concern was that there was an over-reliance on peer mentors to run groups and deliver treatment. Another area of participant concern was the large amount of "down-time" that could be better utilized with program activities. For example, there was no programming available during the weekends.

Inmates also reported that they were deterred from asking for additional mental health services because they felt their security level would be raised. They expressed hostility toward drug dealers who were directed to the program, but not necessarily substance abusers. Those with substance use difficulties felt that drug dealers should not be allowed in the program.

Program non-completers reported that that they were dismissed from the program for violating rules or regulations. In most cases the inmate believed that his infraction

was minor and did not warrant dismissal. For example, one inmate stated he was perceived as belligerent in the group. He also slept a lot. He complained that he was HIV positive and suffered from depression and took several drugs, which affected his behavior. Two other inmates were dismissed for "out of place" tickets. A fourth was discharged from the program because he did not wear a shirt on route to the shower. Apparently, he had been warned but continued to do this. All the inmates complained the program had too many petty rules. Program non-completers also had a negative view of the counselors, describing them as not interested and unsupportive. In spite of these complaints, all of the non-completers reported that they have re-applied to the program. Their reasons for re-applying were that it looked good for parole, the living environment is better, and they wished to receive any treatment that was available.

Focus groups with staff. One of the main concerns of the staff was that they did not receive the same respect within the institution and from the central office as custody staff. There is no parity in rank. They did not believe that treatment was viewed as a priority by the Department of Correction. The staff expressed a low moral, but felt that they supported each other, stuck together and kept a good sense of humor. Another concern was that custody staff should receive some cross training regarding treatment issues and that only custody staff who understood treatment objectives should be assigned to the program.

Although staff expressed interest in developing their counseling skills and increasing their level of education, there were no institutional incentives for them to put in the effort. Staff also believed that there was not enough emphasis in the treatment program on dealing with grief due to loss (e.g., freedom, friends, & family).

Clinical observations of treatment. There often appeared to be disorganization in terms of getting the groups together. Among the groups that were observed most started late. Once a group began, however, the counselors appeared to be well organized and goal directed. Many of the groups were large (over 20 participants), and counselors did a good job managing the time efficiently. Counselors demonstrated good basic skills (e.g., attending, empathy, and encouragement), but did not take advantage of opportunities to explore the emotions of participants in any depth (see example below). One possible reason for not focusing on emotional shifts of participants was the desire to have everyone contribute in the time allocated.

Sample group session (Super Victims Group). The goal of the Super Victims Group was to develop a change in thinking where the inmate does not view himself as the victim and continue to pass blame for his current situation to others. Thus, one stops blaming parents, the judge, or the correctional staff, and takes responsibility for one's own behavior. The inmates participated in this group with a great deal of enthusiasm, spontaneity, and openness. They clearly respected and liked the peer mentor who was leading the group.

Sample group session (Steps). Participants were split into two groups of ten after the "Feelings Check." Each group of ten then began with an "Ice Breaker" exercise, "What have you done for someone in recovery?" This was followed by a discussion of the homework, which consisted of writing answers for the following questions posed during a previous session: (1) List three things you think are the very best things you

have done in your life? (2) List three things you think are the worse things you've done which have caused shame, fear, anger, embarrassment, regret, and/or guilt? (3) How can you change your outlook to become a more open-minded sharing, caring person? (4) What are your long-term goals? A majority of individuals appeared to be prepared to answer and discuss the questions. Counselors attempted to engage as many members of the group as possible when it came answering each item. In several instances, inmates had tears in their eyes as they grappled with some of the statements. As noted above, counselors did not further explore feelings or the meaning of the situation for the individual. Participants answered the questions and the counselor moved the focus to the next person.

Marilyn Baker House Program at York Correctional Institution

York Correctional Institution is a 1166-bed maximum security facility for females 16 and older. It currently houses the Tier IV Marilyn Baker Program, which is six months in duration and serves a total of 85 inmates. The inmate racial/ethnic mix is 31% white, 47% African American and 22% Latino. Eighty-seven percent (87%) of the inmates at this facility have been identified by CDOC staff as having a significant need for substance abuse treatment.

The Marilyn Baker Program began September 29, 1992 with 32 inmates. The participants are isolated from the rest of the general prison population with regard to program activities and housing. Two major housing moves occurred (one during January 1995 and the other July 1998) which caused some disruption to the program. However, the moves were considered positive and the new housing arrangements were an

improvement in terms of providing increased privacy for inmates, better offices for staff, and additional room for program activities

Facilities and Living Conditions

The Marilyn Baker program is housed in one building. No other general population inmates are housed with the program participants. There are two floors comprised of both dorm rooms and activity rooms. Most inmates (60) live on the second floor, however about 22 residents live on the first floor. It is considered a privilege to live on the first floor because it is quiet and less congested. First floor room assignments are most often reserved for peer mentors or an inmate with special health needs (e.g. pregnancy) that make walking up and down stairs difficult. There are generally two residents to a room. There is enough space for a library, common activities room, a large multi-purpose room, and smaller group rooms. Staff have individual offices and there is a common area that serves as a kitchen and meeting area. Inmates have also decorated the facility in a pleasing manner. Overall, there appears to be adequate space and the facilities meet the needs of a therapeutic community.

Selection and Recruitment of Participants

York inmates apply to the program by writing a letter requesting permission to be admitted to the program. A member of the interview team meets with the applicant and assesses her treatment needs. The materials are presented to the clinical team and a decision is made regarding admission. If the inmate is considered suitable for the program, she is placed on a waiting list and allowed to enter the program as soon as space

is available. The wait is usually less than 30 days. In some cases, the clinical team feels the inmate is either not yet ready for the program or does not meet the criteria for admission. Recommendations for alternative treatment programs are made at this time. The Marilyn Baker Program operates on a rolling admissions basis.

During the inmates' orientation to York, information concerning the Marilyn Baker Program is presented and a written flyer is included in all inmates' orientation packet. There is no systematic attempt to identify potential clients by the Marilyn Baker staff for recruitment purposes. Interestingly, most inmates we spoke with during focus groups stated that they heard about the program from other inmates or from treatment staff when they participated in other programs.

Program Structure

Curriculum model. The Marilyn Baker Program consists of three phases for a total of 22 weeks. Upon completion of the program inmates may choose to remain in the aftercare program and live in the Marilyn Baker Housing Unit. Phase I lasts for three weeks and is the inmate's orientation to the program. Upon admission to the program, the inmate meets with her counselor who answers questions and discusses the program. The inmate signs a contract agreeing to stay for at least three weeks. The class sessions are designed to cover such topics as "Addiction as a Disease," "Introduction to the 12 Steps," and "Powerlessness." Inmates are allowed to withdraw after the three week period without prejudice and return to the general population.

Phase II of the program lasts fifteen weeks. During this period the inmate develops a treatment plan in consultation with her counselor. In addition, the inmate participates in groups that address recovery, decision-making, spirituality, women's

issues, and family relations. There is a written curriculum and the Phase II meetings occur twice a week for 90-minutes each. Participants also select elective courses that are consistent with the inmate's treatment plan. The elective courses run for six weeks and have staggered start and stop dates. Although electives may change, the following are examples of the types of elective courses offered: aerobics, anger management, art therapy, beyond fear, bible study, business, choir, communication skills, domestic violence awareness group, fun in recovery, GED, grief and loss, health support group, leisure education, parenting, project F.I.T. (a course dealing with exercise, nutrition, and holistic healing), self esteem, spirituality in recovery, survivor's group, thresholds, typing, and a victim awareness program. Participants must complete two electives and are allowed to participate in electives offered to the general population. For example, if the parenting elective is not offered, the inmate is allowed to enroll in the elective offered in the general prison community. Participants are encouraged to offer suggestions for additional electives.

Phase III lasts for four weeks with two 90-minute sessions per week. During this period, inmates develop a relapse prevention plan and make decisions regarding aftercare. Participants may also apply to be a peer mentor during this time. During Phase III, inmates continue to attend at least three 12-step meetings per week and attend scheduled activities. They continue to participate in groups and elective courses. Participants receive written assessments regarding their attendance and active participation in the groups and are evaluated on the degree to which they exhibit initiative, positive risk-taking, independent study, and the ability to work as a member of team for the enhancement of the therapeutic community.

During this phase, an inmate may choose to apply to become a peer mentor. Although there is a formal application process and interview, most who apply are accepted to the program. In order to apply, an inmate must already have achieved a certain status in the program ("blue status") and achievement of this status is consistent with the criteria necessary to become a peer mentor. An inmate who completes Phase III might be denied peer mentorship status because the staff felt she needed to continue to focus on herself and her own recovery and should not take on more responsibility or she might not possess the necessary leadership skills.

Phase IV is the aftercare portion of the program. Inmates may choose to continue to live in Marilyn Baker housing, or return to the general population. There are generally about 25 inmates in aftercare. Participants are assigned to work a full-time job either in the housing unit or elsewhere in the facility. They are also required to participate in scheduled program activities. These activities include fellowship meetings, the Big Sister/Little Sister Program, Community Elder Program, in-house committee assignments and process groups. Phase IV allows inmates to practice life management skills in a safe and structured environment. Most inmates remain in aftercare for three to four months and some inmates have stayed for as long as one year. However, if the beds are needed, aftercare participants are encouraged to leave the program.

Rules for participants. The program is highly structured and inmates are required to follow group rules and house rules. Group rules include being on time, maintaining confidentiality, showing respect for other inmates and staff, not engaging in "side" conversations while the group is in session, and using "I" statements as mechanism for taking responsibility for one's own problems. If inmates are unable to attend a group

they are required to notify both the group leader and their individual counselor before the group. Failure to attend three groups in one week adds an additional week to the program. Once an inmate enrolls in a group, she cannot drop the activity without permission from the counseling staff. No one is allowed to "just stop attending or drop out."

House rules address proper attire, physical maintenance of the housing facility, and proper conduct in the housing facility, personal hygiene, dining etiquette, scheduling, laundry, and safety. Participants are expected to serve as role models throughout the prison facility and must abide by the Marilyn Baker rules of conduct even when engaged in activities outside of the program.

Staff Characteristics

The program currently has eight correctional counselors, one correctional treatment officer (one step above correctional officer), one classification counselor, two correctional service aides, one unit manager and program coordinator, one secretary, and three correctional officers per shift.

The program director has both treatment and custody responsibilities. Therefore, she has a good understanding of the treatment needs of participants and security needs of the institution. Unlike many other prison-based programs there appears to be little conflict and tension between treatment and custody staff. However, it did appear to the researchers that the custody demands of her job left little time for her to address treatment concerns. Upon questioning by the researchers, it was learned that she is often called away from the program to attend to custody-related activities such as training or meetings. Although we were certainly impressed with the hard work and dedication of

the treatment staff, we had reservations about whether the program director could provide the necessary leadership and supervision to treatment staff, when the custody demands on her time were so great.

When possible, custody staff are selected who are sensitive to the treatment needs of individuals in the program. Occasionally, a custody person is put in who does not understand treatment issues and this can be disruptive to the program. However, it does not seem to happen often enough to compromise the treatment and the program director does appear to have control over those situations.

The educational background of the counselors is varied and ranges from completion from high school to a Master's degree. Two of the counselors have received certification as alcohol and drug counselors (CDAC). Although it appears to be coincidental rather than planned, several staff have overcome their own substance use problems. The diversity of educational backgrounds appears to be viewed positively by the program director and participants. Nonetheless, several staff are enrolled in educational programs and seeking M.S. degrees in counseling. Staff members would like to see incentives for furthering education and obtaining new skills.

Researcher Observations

Focus groups with participants. Focus groups were held with current participants, wait-list inmates, and program non-completers. For inmates across all focus groups, the primary motivation for seeking admission to the program was the belief that it would be helpful in subsequent parole hearings. Another factor influencing motivation was the belief that completing the program would increase one's eligibility for placement in a halfway house. Apparently, the program has a good reputation with a number of

community-based facilities. In many cases, treatment staff in other programs encouraged inmates to apply. There did not seem to be a difference in terms of reasons to seek admission to the program between current participants, wait-list inmates, and non-completers.

Several inmates who were on the wait-list had previously failed to complete the program and were seeking readmission. Staff was responsive to their requests to return. One non-completer stated that she did not really want to be in the program but was encouraged to participate by someone else. Those on the wait-list also admitted that they were very focused on avoiding any type of disciplinary reports because these would jeopardize their spot in the program. Generally, individuals on the wait-list were optimistic that they would soon be admitted. The longest wait that they were aware of was 45 days.

The inmates had a number of positive comments. Surprisingly, even non-completers reported positive aspects of the program (e.g., "well structured program," "I liked the program a lot," "it is a very good program," "It helped a lot," "I learned a lot," and "I liked the counselors"). Those currently participating in the program described the counselors as caring, supportive (e.g., "it has a family feel") and hardworking. Another comment was that the custody staff are well integrated into the program (e.g., "they treat us like human beings"). Based on our observations there does seem to be cooperation and sensitivity among the custody staff and on several occasions we have witnessed custody staff answering inmate questions and discussing the positive aspects of a treatment focus.

Non-completers provided several reasons why they believed they were dismissed. A common reason for being removed was a verbal or physical altercation with another participant. Also, several individuals were reportedly removed from the program due to suspicion of being romantically involved with another participant. There was a concern that rumors about romantic relationships could get one thrown out of the program. Non-completers did acknowledge, compared to conditions in the general prison environment, the program had better housing and the structure and rules made it a nicer place to live. Non-completers also had a number of negative comments concerning the staff. Among the criticisms were that the counselors were not skilled or well trained, counselors showed blatant favoritism, and that peer mentors were unhelpful.

Current participants expressed some concern about the need for more extensive aftercare, more individual treatment, and better training for counselors. There was the observation that counselors may be overburdened with large numbers of cases. It was also reported that no treatment exists for those in the maximum security part of the York institution.

Focus groups with staff. The treatment staff appeared to be particularly enthusiastic about the program. They felt there were few institutional barriers to treatment although they would like to see a more comprehensive assessment on inmates coming into the program. The staff would also like to see more pre-and post-testing of inmates. There appeared to be cohesiveness among the staff and cooperation among treatment and custody staff.

Sample group (Community Issues). The meeting began with a brief summary of the rules and procedures for the session. There were two counselors present (one to run

the meeting and one to take notes) with a group of 40 inmates. The first part of the meeting addressed any problems in the community such as needed physical repairs or group requests for permission to watch a special television show or to have a party. The facilitator recognized the participant as she stood and stated the issue. Some examples of community issues raised at this meeting were: showers not working, leaking radiator, and a request for a Christmas party.

The next part of the meeting involved "pull ups". A pull-up is negative feedback offered to a participant by another participant or staff regarding her behavior during the week. The participant receiving the pull up is not allowed to respond or argue. She must say "thank you" and sit down. If she feels the pull-up is unfair, she is told discuss it with her counselor. During this meeting the inmates began by directing pull ups to themselves (the counselor felt this occurred because the residents did not want other inmates to direct pull ups at them while the evaluator was observing). Some examples of the self pull-ups included apologizing for talking in the hallway and being impatient and irritable. Pull-ups of other inmates included complaints about participants being loud and rowdy, talking loudly in the hallway, and gossiping.

The next part of the meeting involved offering "push ups" to inmates for something positive they may have done during the week. For example, a push up was given to an inmate for helping someone who was feeling withdrawn, thanking someone for helping clean the bathroom, and thanking someone for offering support. The participants then asked if they could push up Mr._____, a correctional officer assigned to the Marilyn Baker House Program. The correctional officer (CO) was called to the meeting and residents told him he was kind and caring CO who helped them with their

problems and supported them. There was much applause and the inmates stood to honor him.

Sample group session (Self-Esteem). The group began with inmates (n=30) being asked to define self-esteem. Some of the answers included feeling positive about yourself, not depending on anyone else, feeling highly (sic) about yourself, inner perception of self, self concept, how you feel about the way you look and contrasted with confidence which is about the things you do.

At one point the group was interrupted for count. However, the presence of the officer did not appear to impact group interaction. He tried to be non-intrusive and the inmates appeared comfortable with his presence. We have witnessed this positive interaction among participants and correctional staff repeatedly. The inmates view the program director and the officers as supportive and caring. The inmates say they feel comfortable approaching the director with their problems and feel that she is receptive.

The inmates then watched a video on self-esteem, which was stopped periodically for the purpose of having participants answer questions on a work sheet. Examples of the work sheet questions were: "I can't love myself because...," "I get so mad at myself because...," "Others are ahead of me when it comes to...," "I should be better at...." The facilitator was allowed some talking and spontaneity while participants completed the questionnaire. Inmates then discussed how a person could develop positive self-esteem. Some suggestions were affirmations, attend meetings, change attitudes, seek help from your higher power, and change negative people, places, or things.

The facilitator ended the session by making the point that if an inmate does not like herself it will be more difficult to stay sober. She encouraged them to make a choice to believe in themselves and seek support.

The above descriptions are a representative sample of the groups we observed. In several groups, researcher observations were consistent with the literature indicating a high prevalence of early sexual abuse and recurrant sexual victimization among women particpating in substance abuse treatment (Briere & Runtz, 1987; Brown, Stout, & Mueller, 1996; Janikowski, Bordieri, & Glover, 1997; Root, 1989; Simmons, Sack, & Miller, 1996; Teets, 1995; 1997; Wadsworth, Spampneto & Halbrook, 1995). We observed incest victims supporting one another during a process group. Although we did not ask women to reveal whether they were victims of incest or early child sexual vitimization in any of the paper and pencil questionnaires, in one process group, 11 of 17 shared similar experiences of early childhood sexual victimization. The Marilyn Baker Program seems particularly sensitive to helping the program participants deal with these issues. A program elective, Survivors, is offered for any woman who was a victim of incest or other type of sexual assault or victimization. This elective consists of a six week education component and a six week process group component (although women are allowed to stay in the process group as long as they feel the need for treatment). Program staff feel strongly that these women, in particular, require longer treatment than the six months duration of the RSAT. Many women cannot begin to substantively address their addiction recovery until they have made significant progress dealing with past sexual victimization.

Summary of Observations and Focus Groups

The qualitative component of the process evaluation assessed the implementation of the three RSAT programs in terms of consistency with the CDOC documented structure for these programs, strengths and weaknesses of each program, and staff and participant recommendations for program improvement.

Physical Structure

The Marilyn Baker Program was the only RSAT that housed both the program activities and living areas in one location separate from the general population. Because of this physical structure, Marilyn Baker inmates did not appear to have interference from non-program inmates, as was the case at the Time and New Horizons Programs. For this reason, we believe that inmates at Marilyn Baker felt a stronger sense of community.

The movement of inmates from living areas to program activities at both the Time and New Horizons Programs created two separate problems. First, it increased interaction with non-program inmates. Program participants often complained of being harassed by other inmates. The second problem was that the movement afforded opportunities for custody staff to effect the implementation of program activities. For example, we observed several instances where miscommunications between custody staff and treatment staff resulted in participants not showing up for meetings and group sessions.

Furthermore, having programming and living situations together allow for counseling staff to be more fully integrated into the living of participants. Counselors have the ability to observe inmate behaviors outside of group and individual sessions. At the Time and the New Horizons Programs it appeared that the custody staff and peer mentors had more frequent contact with program participants than the counselors. In

contrast, counselors at the Marilyn Baker Program appeared to have a stronger connection to program participants.

Collaborations with Custody Staff

Sensitivity to treatment issues by custody staff was consistently identified as important for maintaining a therapeutic community by inmates and counseling staff. The Marilyn Baker Program appears to have the benefit of correctional officers who supported the treatment mission of the program. A frequent concern at both the Time and New Horizons Programs was that custody staff occasionally were insensitive and undermined treatment objectives. For example, a specific complaint was that correctional officers would sometimes interact in an unnecessarily provocative manner with a program participant resulting in a disciplinary infraction. Another related concern was that prison administrators would assign counseling staff to handle tasks outside the treatment program. This would result in a disruption of treatment activities for Tier IV participants.

Lack of Aftercare

All of the programs appear to be struggling with the lack of consistent or available aftercare. Counseling staff and participants alike were concerned about maintaining gains made during the Tier IV treatment. While the programs attempted to provide some form of aftercare, it appeared that these efforts were inconsistent and not well developed.

Counseling Staff Education and Skills

Counseling staff at the three RSAT programs had a wide range of educational backgrounds, skill levels, and treatment philosophies. These differences can foster a

more diverse array of treatment interventions and enhance the ability of the staff to respond to the varying treatment needs of participants. However, it was reported that these differences, at times, resulted in a lack of communication and inconsistent delivery of treatment. Thus, even standardized treatment modules are likely to be presented differently by individual counselors. It is unclear to what degree the CDOC employs integrity checks to ensure that treatment is delivered in a consistent manner.

While it is desirable to have a well-educated and skilled counseling staff, a consistent complaint was a lack of incentives for pursuing advanced degrees or certifications. This negatively effected staff morale, as it was perceived to demonstrate a lack of commitment by the CDOC to treatment issues.

Inmate Perceptions of Counseling Staff

Overall, the inmates reported that counseling staff was supportive and helpful at the Marilyn Baker and the Time Programs. While participants at the New Horizons Program viewed the staff as having the potential to be helpful, they were seen as less concerned and involved in addressing the inmates' needs.

A frequent finding was that inmates, across all three programs, desired to have more individual attention in the form of scheduled sessions from counseling staff.

Prerequisites for Treatment

The CDOC Tier IV program structure strongly suggests that inmates who enter these programs have completed a less intense substance abuse treatment program. However, participants entering these Tier IV programs had varying levels of socialization into substance abuse treatment. Some inmates had completed Tier II while others had no prior treatment upon entering a Tier IV program. This seems to be less of a problem at

New Horizons, where the vast majority of inmates have had some Tier II programming. Counseling staff believed that the lack of a consistent prior treatment background hindered group cohesion and slowed delivery of treatment modules in a group format.

QUANTITATIVE ANALYSIS AND RESULTS

Data were collected for 173 inmates across the three institutions. These data consisted of official records from CDOC, paper and pencil instruments completed by the inmates, and the Tier IV treatment data provided by the individual programs. The paper and pencil instruments were administered to inmates shortly after being admitted to the program. These instruments consisted of the Addiction Severity Index (a partial version), Rosenberg Scale of Self-Esteem, Spirituality, Locus of Control, Self-Efficacy, the Millon Multiaxial Inventory-III, and the Trait Anger Scale. Following program completion, inmates were readministered the Rosenberg Scale of Self-Esteem, Spirituality scale, Locus of Control, Self-Efficacy, and the Trait Anger Scale. Upon completion they were also asked to complete the Client Evaluation of Treatment.

Official Connecticut Department of Correction Records

Data gleaned from the CDOC database consisted of date of birth, length of prison sentence, overall risk score, mental health score, residence score, vocational score, and educational score. Within thirty days of being admitted to prison, CDOC staff assess inmates to determine their overall risk levels, mental health, education, and substance abuse needs, vocational training/work skills, and family/residence/community resource needs.

An inmate's Overall Risk Level signifies the amount of external and internal security needed to safely incarcerate the inmate. There are seven factors that are used to determine an inmate's level of risk. These are: escape profile, severity/violence of current offense, history of violence, length of sentence, presence of pending charges

and/or detainers, discipline history, and security risk group membership. Each inmate is given a "1" to "5" rating for each factor, with higher scores indicating greater risk. The inmate's overall risk level is based upon the highest rating of any factor, with the exception that the CDOC Director of Offender Classification and Population Management has to approve the assignment of a Level 5 overall risk level.

The Mental Health Need Score was created to determine behavioral, cognitive, emotional, and/or interpersonal problems that could effect adjustment in an institutional or community correction environment. Each inmate is assessed by a mental health professional and assigned a "1" to "5" mental health needs score. Inmates rated "1" have no mental health history or current need. Inmates rated "5" are severely impaired with an acute psychiatric condition (e.g., major psychosis, affective disorder, major depression, or acute anxiety).

The Educational Need Score is used by CDOC staff to understand the educational level of the inmate. This score is based on a "1" to "5" rating, with "1" representing individuals having advanced to or completed post-secondary education. A rating of "5" indicates that the inmate is deficient and has minimal skills. These inmates may be functionally illiterate or need specialized programs such as educational counseling.

The Substance Abuse Need Score describes the nature and pattern of inmates' alcohol or drug use related to general life functioning. CDOC Addiction Services staff makes these assessments and use a "1" to "4" rating scale. A rating of "4" indicates the inmate has at least three of the following problems: a long history of substance abuse, has habitually abused alcohol or drugs for more than two years, has been in medical detox at least twice, has been unable to complete a treatment program on at least one occasion, or

has had substance abuse disrupt his/her life in two major life areas (e.g., family, employment, legal). A score of "1" indicates that the inmate has no or minimal history of substance abuse. All inmates in the Tier IV programs have a substance abuse rating of "3" or "4".

The Vocational Training/Work Skills Evaluation measures inmates' abilities and interests. Classification/educational/vocational specialists determine individual interest in a vocational program. This rating score is based on a "1" to "5" scale. A rating of "1" indicates the inmate is either certified or qualified for certification in a technical field and is capable of learning other technical/professional trades. A rating of "5" is given to inmates with no skills or training in any field. These inmates have no employment history and most likely do not meet minimum requirements for any occupations.

The Family/Residence/Community Resource Needs score suggests how much priority be placed on locating the inmate in close proximity to his/her residence, significant others, family members, or community resources. This needs score is used to develop program placement recommendations such as a family assistance program, pre-release counseling, or other types of counseling. Inmates are assigned a rating of "1", "3", or "5". A rating of "1" indicates there is no need to place the inmate in a correctional institution near the community of residence. A rating of "5" recommends placement closest to the community of residence due to extreme hardships of immediate family members of the inmate.

Treatment Records

The Tier IV program staff provided a list of entry and exit dates for all inmates participating in the Tier IV programs. In addition, staff noted whether an inmate

successfully completed the program and, if not, the reason the inmate did not complete the program (voluntarily left the program, asked to leave the program, or discharged from prison before completing the program).

Paper and Pencil Tests

Addition Severity Index (ASI). A partial version of the Addition Severity Index (MecLellan, Cacciola, Kushner, Peters, Smith, & Pettinati, 1992) was used to assess alcohol and drug problem severity. Participants were provided with a list of fourteen drugs and asked to report the number of years that they used each drug, age of first use, and route of administration. In addition, participants were asked to indicate which substance they viewed as the major problem and what substance is usually associated with relapse.

Million Clinical Multiaxial Inventory -III. The Millon Clinical Multiaxial Inventory – III (Millon, Davis, & Millon, 1997; MCMI-III) consists of 175 true-false items. The MCMI-III provides scores that closely conform to the Diagnostic and Statistical Manual of Mental Disorders – 4th edition (American Psychiatric Association, 1994; DSM-IV) and thus provides information on 10 acute clinical disorders (Axis I) and 14 personality profiles (Axis II). The clinical scales of the MCMI-III have been shown to have good internal consistency and test retest reliability, and correlate positively with other measures of psychopathology and clinician-judged evaluations (Millon et al., 1997). The MCMI has been used in over 400-hundred research studies.

Trait anger. The *Trait Anger Scale* (Spielberger, 1988) is designed to measure an individual's propensity to experience and express anger. This scale consists of ten statements that describe subjective feelings of anger. In response to the sentence stem,

"How I generally feel," participants rated on a 4-point Likert type scale (1=almost never to 4=almost always) how characteristic each item was for them. Higher scores indicate greater feelings of anger. The scale reliability for the Trait Anger Scale in the present sample was 0.88.

University of Rhode Island Change Assessment Questionnaire (URICA). The URICA is based upon transtheoretical constructs of stages and processes of change (Prochaska & DiClemente, 1982). Prochaska, DiClemente, & Norcross (1992) identify five stages of change through which the individual will progress who seeks to modify addictive behaviors: precontemplation, contemplation, preparation, action, and maintenance. During precontemplation the individual displays no intention to change his or her behavior and may not be aware of any problem that needs changing. The contemplation stage indicates that the individual thinks change is a good idea but too difficult. Individuals in the preparation stage have decided to make the change and have already taken some action. The action stage occurs when the individual is fully involved in changing his/her behavior and learning new behaviors. The maintenance stage occurs when the individual has remained sober for about 6 months and consciously works to prevent relapse. If the individual stops working on maintaining the changes he/she has made, the chances of relapse increase and the individual is considered to be in the termination stage. The URICA is based on theory and research suggesting that addictive behavior cannot be successfully changed unless the individual has the suitable attitude toward change (Willoughby & Edens, 1996). A key to substance abuse treatment is to identify those individuals seeking treatment with the appropriate attitudinal stage of change. There is also a common belief that the stage of change is often related to the

drug a person to which a person is addicted (Abellanas & McLellan, 1993). Here, we assess the URICA stages of change in the RSAT sample to determine if there are differences in motivation across the three programs and differences related to the types of drugs used. Four subscales of the URICA were analyzed in this study. The Cronbach alpha for the current sample for these subscales were 0.68 for precontemplation, 0.78 for contemplation, 0.77 for action, and 0.54 for maintenance.

Self-efficacy of relapse. Self-efficacy related to avoiding relapse was measured using a twenty-five item self-report instrument (Annis, 1990). In this measure, inmates were given statements regarding drug use and asked to rate on a 1 (extremely confident) to 4 (not at all confident) Likert type scale how confident they would be in avoiding drug use in various situations. The Cronbach alpha for this measure for the current sample was 0.96.

Locus of control. Locus of control was measured using the Rotter Internal-External Locus of Control scale (Rotter, 1966). This measure is a twenty-nine item index that explores the extent to which respondents feel they exercise control over their lives (internal) or the extent to which they cannot control their own lives due to fate, destiny, chance, or other forces (external). The instrument provides two statements related to perceived control over life situations (e.g., work success, school success, others reactions). Respondents are asked to select the statement that best describes their position. A high score on this measure indicates a high level of external locus of control while lower scores indicate a more internal locus of control. The Cronbach alpha for the locus of control scale in the present sample was 0.59.

Spirituality. Many 12-Step programs emphasize a spirituality component. Thus, spirituality using a fourteen-item scale which provided statements related to spiritual attitudes. Respondents rated on a five point (1=never; 5=nearly always) Likert format the degree to which each item described their beliefs. A high score indicated a high level of spirituality. The Cronbach alpha for this measure in the present sample was 0.75.

Self-esteem. Items pertaining to perception of self were operationalized through the Rosenberg-Bachman Measure of Self-Esteem (Bachman, 1970). This measure contains ten items related to self-perceptions. Participants rate on a four point Likert type scale (1=strongly agree; 4=strongly disagree) how strongly they agree or disagree with each item. The alpha for the self-esteem scale in the present sample was 0.77.

Post-program measure. A client evaluation of the treatment program was adapted from the instrument developed by Wanberg and Milkman (1998) to measure the client's assessment of and attitude toward their counselors and the treatment. We added questions asking about the peer mentors since they played an important role in the delivery of the treatment.

Participant Characteristics

This study included both male and female samples from three institutions. Table 1 presents the CDOC descriptive data by institution. Overall, the average age of the inmates in the Tier IV programs was 33 years old. The overall risk scores were relatively low for the Time and Marilyn Baker Programs and moderate for the New Horizons Program. The mental health needs scores, and the residential needs scores were also consistently low across all three programs. Additionally, the vocational needs and educational needs scores were moderate. The program participants were similar on age

at time of program entry, vocational score, and educational score. Statistical differences were found for prison sentences (the Marilyn Baker group served a much shorter prison term), overall risk score (the Marilyn Baker group had a lower mean risk score), mental health score (the Marilyn Baker group was rated higher for mental health problems), and residential score (York is the only women's correctional facility in Connecticut, therefore, every female inmate is given a 1 for this score). Differences across the three programs appear to be mostly a result of the Marilyn Baker Program, which consist of only women participants.

Table 1. Descriptive Data by Institution

	Time (n=61)	New Horizon (n=35)	Marilyn Baker (n=77)
Age (Years old)	33.4	32.2	33.6
Prison Sentence (Years)*	7.2	8.8	3.2
Overall Risk Score*	1.96	2.45	1.59
Mental Health Need Score *	1.52	1.64	1.91
Residence Need Score*	2.26	2.70	1.00
Vocational Need Score	3.28	3.06	2.88
Educational Need Score	2.35	2.52	2.34

*Means are statistically different at p.<.05.

Table 2 displays the inmate's drug of choice across the three programs. The treatment group at the Time Program had a higher percentage of alcoholics and marijuana users compared to participants in the New Horizons and Marilyn Baker Programs. The majority of the inmates in the New Horizons Program used either cocaine (41%) or heroin (30%). The Marilyn Baker group showed a fairly even distribution for heroin (28%), crack (24%), and cocaine (24%).

Table 2. Inmates' Drug of Choice by Institution

	Time (n=54)	New Horizons (n=27)	Marilyn Baker (n=51)
Alcohol	14 (26%)	3 (11%)	7 (14%)
Marijuana	12 (22%)	3 (11%)	6 (12%)
Cocaine	8 (15%)	11 (41%)	12 (24%)
Crack	7 (13%)	2 (7%)	12 (24%)
Heroin	12 (22%)	8 (30%)	14 (28%)
Other	0	1 (2%)	0

Note: Chi-Square value is not statistically significant at p. < .05.

Substance use and comorbidity. The co-occurrence of substance use with a variety of other emotional and behavioral disorders is a well-known phenomenon in criminal justice drug treatment programs (Fishbein & Reuland, 1994; Hiller, Knight, & Simpson, 1996) that can affect retention and success in treatment programs (Lang & Belenko, 2000). Comorbidity patterns for the present adult Tier IV participants are presented for both Axis I clinical syndromes and Axis II personality disorders.

Table 3 presents the frequencies of individuals who met the criteria for each clinical syndrome across the three adult programs. As expected, both drug dependence and alcohol dependence were among the most common disorders identified among participants. Only five percent (n=7) of participants failed to meet the criteria for either drug dependence or alcohol dependence on the MCMI-III. These seven participants were equally distributed across the three programs. Thus, all three programs appear equally effective in recruiting participants with significant substance abuse problems. One difference among the programs did emerge in terms of the type of substance use problem. The Time Program had significantly more participants with alcohol problems than either the New Horizons or Marilyn Baker Programs.

Anxiety was the most commonly reported co-occurring problem with 85% of male participants and 52% of female participants reporting significant anxiety symptoms. Thus, difficulties with tension, somatic discomfort, apprehension, and worry were widespread across program participants. A significant gender difference was also noted indicating that men reported significantly more anxiety than women.

Table 3. % of Tier IV Participants Meeting Criteria for MCMI-III Axis I Disorders

BR >=75	Marilyn Baker (n=50)	Time (n=53)	New Horizons (n=27)	Totals (n=130)
Drug Dependence	86%	87%	78%	85%
Anxiety Disorder*	52%	85%	85%	72%
Alcohol Dependence*	46%	70%	56%	58%
Dysthymic Disorder	14%	28%	19%	16%
Bipolar: manic	16%	13%	22%	16%
Delusional Disorder	11%	9%	24%	15%
Posttraumatic Stress Disorder*	12%	6%	30%	13%
Major Depression	14%	2%	7%	8%
Thought Disorder*	4%	0%	11%	4%
Somatoform Disorder	4%	2%	7%	4%

*Chi-square is statistically significant at p.<.05

There were several additional differences across programs related to Axis I comorbidity patterns. The New Horizons Program had significantly more participants (30% vs. 12%, and 6%) who met the criteria for posttraumatic stress disorder (PTSD) and thought disorder (11% vs. 4%, and 0%). While not reaching statistical significance, the New Horizons Program also had more individuals with bipolar disorder and delusional disorder. The overall pattern of results indicates that the New Horizons Program recruits more participants with serious additional psychopathology compared to the other two programs.

Table 4 presents the frequencies of individuals who met the criteria for each Axis II personality disorder. All the personality disorders were represented in the sample with

the exception of histrionic and compulsive, which did not appear for any of the male participants. There was a high rate of comorbid personality patterns with each participant meeting the criteria for an average of four personality disorder diagnoses. The most frequently indicated personality disorder was antisocial which was present in 74% to 79% of individuals across the three programs. Men and women were equally likely to receive an antisocial personality disorder diagnosis. Other frequent personality disorders were dependent, depressive, and negativistic. The MCMI-III measures several personality patterns (negativistic, depressive) that are not officially part of the current diagnostic system but appear in the DSM-IV under criteria sets provided for further study. Individuals with a negativistic personality pattern display a pattern of negative attitudes, experience frequent disappointments, vacillate between deference and defiance, and have periods of explosive anger or stubbornness intermingled with periods of guilt or shame (Millon et al., 1997). Individuals with depressive personality pattern experience pessimism, lack of joy, and a hopeless orientation regarding the future (Millon et al., 1997).

Several significant differences emerged across programs regarding Axis II personality patterns. Participants at the Time Program showed greater frequencies of negativistic (57% vs. 37% & 18%), avoidant (42% vs. 15% & 12%), and schizotypal (38% vs. 11% &14%) personality disorders. Thus, individuals at the Time Program consistently experience greater pessimism, anxious anticipation of life's negative events, and prefer social isolation and interpersonal detachment.

Table 4. % of Tier IV Participants Meeting Criteria for MCMI-III Axis II Disorders

BR >=75	Marilyn Baker (n=50)	Time (n=53)	New Horizons (n=27)	Total (n=130)
Antisocial	76%	79%	74%	77%
Dependent	32%	43%	52%	41%
Depressive	32%	43%	52%	41%
Negativistic*	18%	57%	37%	38%
Masochistic*	48%	26%	11%	32%
Paranoid	34%	25%	30%	29%
Narcissistic	34%	19%	33%	28%
Borderline	36%	42%	30%	28%
Avoidant*	12%	42%	15%	25%
Schizoid	14%	38%	11%	23%
Sadistic	22%	26%	22%	18%
Schizotypal*	14%	38%	11%	12%
Histrionic*	18%	0%	0%	7%
Compulsive	2%	0%	0%	0.8%

*Chi-square is statistically significant at p.<.05

Female participants also displayed significantly more histrionic (18% vs. 0% & 0%) and masochistic (48% vs. 26% & 11%) personality patterns than male inmates. Thus female participants with histrionic personality disorder are more prone to seek signs of acceptance and approval from others and display a greater desire for stimulation and affection. Although deleted from the DSM-IV, masochistic personality disorder corresponds to the DSM-III-R self-defeating personality disorder. Masochistic individuals allow and perhaps encourage others to exploit or take advantage of them, intensify their own deficits, and repetitively recall past misfortunes (Millon et al., 1997). Since approximately half of female program participants experience the masochistic pattern, modifying such behaviors may be an important treatment goal for female inmates.

Stages of change. Table 5 presents the means and F values for the analysis of variance tests across programs for the four stages of change. Examination of the mean

scores across all three programs indicated that participants generally endorsed items related to the contemplative and action stages of change in comparison to the precontemplative stage of change. This indicates that, overall, participants had an acceptable level of self-motivation. The one difference across the three programs was that the inmates at the Marilyn Baker Program (M=36.23) had a higher contemplative score than the inmates at the New Horizons Program (M=34.17). This indicated a slightly lower level of awareness and motivation among New Horizons' participants.

Table 5. URICA Stages of Change by Program

	Marilyn Baker (n=55)	Time (n=57)	New Horizons (n=31)	F Value
Precontemplative	13.82	13.86	15.61	1.73
Contemplative	36.23	36.09	34.17	3.47*
Action	35.86	35.02	34.84	1.13
Maintenance	30.99	31.79	30.29	1.22

(*F value is statistically significant at p.<.05)

Table 6 shows the URICA subscale means by inmate's drug of choice. There were no statistically significant differences across these mean scores. This indicated that the drug of choice had little effect on the motivational levels of participants in the current sample.

Table 6. URICA Subscale Means by Inmates' Drug of Choice

	Precontemplative	Contemplative	Action	Maintenance
Alcohol (n=24)	13.50	36.42	35.04	30.48
Marijuana (n=21)	15.76	35.14	35.05	31.05
Cocaine (n=30)	13.13	36.97	36.60	31.97
Crack (n=19)	14.89	35.60	35.66	31.85
Heroin (n=34)	13.71	35.53	35.02	31.00

Note: F values are not statistically significant at p. < .05.

Program Completion

Table 7 presents the treatment outcomes by program. The Time and New Horizons Programs had higher completion rates than the Marilyn Baker Program. The

inmates at the New Horizons Program are in the program for a significantly longer period of time (between two to three months longer) than the Time or Marilyn Baker Programs.

Table 7. Treatment Outcome by Institution

	Time	New Horizons	Marilyn Baker	Total
Completed*	44 (80%)	30 (93%)	50 (66%)	124 (75%)
Did not Complete	11 (20%)	3 (7%)	26 (34%)	40 (25%)
Average Length of Treatment (Days)**	199	272	178	228

*Chi-Square is statistically significant at p.<.05.
**Means are statistically different at p.<.05.

Table 8 summarizes the reasons given by Tier IV treatment staff as to why inmates did not complete the program. The majority of noncompleters (65%) were asked to leave the program followed by a variety of other reasons (e.g., transferred to other institutions, transferred to a hospital). Thus, participants were more than twice as likely to be asked to leave a program than for other reasons.

Table 8. Reasons for Leaving the Program

Reason	Number	Percentage
Voluntarily left program	2	5%
Asked to leave program	26	65%
Discharged from prison	2	5%
Other reason	10	25%

Predicting program completion. Logistic regression analysis was employed to predict program completion using CDOC official records and the paper and pencil instruments as predictors. Tables 9-11 present the results of these regressions. Due to the gender differences between the Marilyn Baker Program versus the Time and New Horizons Programs, separate logistic regression analyses were conducted for males and females.

For males and females, sentence length positively predicted completion of the Tier IV program (Table 9). The longer the prison sentence, the more likely the inmate

would be successful in the program. Males having early substance use onset were also more likely to complete the program. This was not found for females. For female participants, those having a lower vocational/work skills score were more likely to finish the program compared to women with higher vocational/work skills scores. It appears that women with the least amount of job skills were more successful.

Table 9. Logistic Regression Predicting Program Completion with Official Records Data (Bold and italics indicate statistical significance)

	Males		Females	
Variable	B	Standard Error	B	Standard Error
Age	.1103	.0791	-.0290	.0608
Sentence Length	***.5505***	***.2347***	***.7976***	***.2901***
Overall Risk Score	-1.091	.5694	-.3855	.7192
Education Score	.9326	.6267	.3488	.5334
Mental Health Score	-1.286	.7282	.9399	.6890
Vocational Score	-.1601	.8281	***-.9968***	***.6890***
Age of Onset	***-.2511***	***.1259***	-.0080	.0817
Used Injection	-.4653	1.108	2.336	1.407
-2 Log Likelihood	64.881		-2 Log Likelihood	67.417
Goodness of Fit	63.193		Goodness of Fit	49.290
Model Chi-square (p.=.01), df=8	20.488		Model Chi-square (p.=.01), df=8	21.889

Table 10 presents the logistic regression analysis for program completion using the paper and pencil instruments as predictors. None of these constructs statistically predicted successful program completion.

Table 10. Logistic Regression Predicting Program Completion with Paper and Pencil Instruments
(Bold and italics indicate statistical significance)

	Males		Females	
Variable	B	Standard Error	B	Standard Error
Trait Anger	.0404	.0664	-.1479	.1002
Self-Efficacy	.4746	.7502	.3575	.6448
Self-Esteem	-.0003	1.368	-.7655	1.333
Locus of Control	5.658	3.354	1.485	3.450
Spirituality	1.175	.7113	-1.929	1.157
-2 Log Likelihood	44.805		-2 Log Likelihood	37.989
Goodness of Fit	63.906		Goodness of Fit	30.306
Model Chi-square (p.=.06), df=5	10.670		Model Chi-square (p.=.50), df=5	4.351

In assessing the predictive ability of the MCMI-III on program success, we calculated the number of clinical syndromes (Axis I) and personality disorders (Axis II) for each participant. The logistic regression equation attempted to predict program completion from the number of Axis I and Axis II disorders (Table 11). The models were not statistically significant for either male or female participants.

Table 11. Logistic Regression Predicting Program Completion with Axis II Disorders on the MCMI-III (Bold and italics indicate statistical significance)

	Males		Females	
Variable	B	Standard Error	B	Standard Error
Axis I	-.2394	.2327	-.0893	.2135
Axis II	.0149	.1547	-.1537	.2040
-2 Log Likelihood	64.232		-2 Log Likelihood	66.475
Goodness of Fit	74.280		Goodness of Fit	50.172
Model Chi-square (p.=.60), df=2	1.011		Model Chi-square (p.=.46), df=2	1.554

The final analysis of program completion looked at the number and percentage of completers and noncompleters by the inmates' self-reported drug of choice (Table 12). The highest percentage of completers were marijuana users (85%) and the lowest

percentage were crack users (57%). These differences, however, were not statistically significant.

Table 12. Inmates' Drug of Choice by Program Completion

	Complete	Did Not Complete
Alcohol	17 (81%)	4 (19%)
Marijuana	17 (85%)	3 (15%)
Cocaine	22 (73%)	8 (27%)
Crack	12 (57%)	9 (43%)
Heroin	22 (67%)	11 (33%)
Other	0	1 (100%)

Note: Chi-Square value is not statistically significant at p. < .05.

Program Changes Over Time

After leaving the program, inmates were asked to complete the Rosenberg scale of Self-Esteem, Spirituality, Locus of Control, Self-Efficacy, and the Trait Anger Scale. Table 13 presents the pre and post means by program. As noted earlier, we were unable to collect program completion data from the New Horizons Program due to scheduling problems. We also found that Marilyn Baker inmates who successfully completed the program were often released or transferred to a halfway house before we could collect program completion data.

Table 13. Pre to Post Means by Institution

	Time (n=44)		Marilyn Baker (n=17)	
	Pre	Post	Pre	Post
Trait Anger	20.84	21.11	***20.67***	***17.18***
Spirituality	3.62	3.70	***3.78***	***4.14***
Self-Esteem	***2.41***	***2.25***	***2.31***	***2.07***
Self-Efficacy	***3.12***	***3.34***	3.33	3.50
Locus of Control	10.72	10.19	9.92	10.00

*Italics indicate that means are statistically different at p.<.05

Statistically significant differences were found for self-esteem and self-efficacy for the male inmates at the Time Program. The post-treatment mean for self-efficacy increased indicating that inmates had greater confidence in their abilities to resist a

variety of relapse triggers. Scores on self-esteem decreased indicating that inmates had a less positive view of themselves. Female participants at the Marilyn Baker Program reported significant anger reduction and increased spirituality. Similar to the male inmates, Marilyn Baker participants also showed decreases in self-esteem. These treatment programs may foster a greater awareness of personal deficits resulting in lower self-esteem scores.

Among inmate participants, especially men, anger emerged as a clinically relevant co-occurring problem. The mean pre-test score for all female program participants was 19.70 (SD=5.47) and for all male program participants 21.13 (SD=6.47). The level of anger reported by women in the program indicated that this sample was angrier than 64% of normal adults, while men were angrier than 76% of normal adults. Subjects scoring in the upper 25th percentile on the Trait Anger Scale report serious anger related consequences (Tafrate & Kassinove, 1998), greater intensity and frequency of anger experiences in contrast to a less angry comparison group (Deffenbacher, 1993), and are prone to engage in negative expressions of angry feelings (Tescher, Conger, Edmondson, & Conger, 1999).

The magnitude of anger reduction across the programs was disappointing. Pre-to-post-test effect sizes (*d*) were calculated by the authors with the D-STAT program (Johnson, 1989), which also provides an adjustment for sample size. The current programs effect sizes ranged from low (Time; d=.05) to moderate (Marilyn Baker; d=.48) on the variable of trait anger. Men showed almost no improvement on anger, while women indicated some improvement. However, treatment gains, even for women, were far below what has been achieved by other programs. Readers are referred to Tafrate

(1995) and Bowman-Edmondson and Cohen-Conger (1996) for meta-analytic reviews of the adult treatment outcome literature and to Sukhodolsky and Kassinove (1997) for a review of the child and adolescent literature.

A second component of this analysis looked at the number of individuals that actually changed during the program across the scale constructs (Table 14). These findings reflect the mean pre-post tests. That is, more than 50% of the inmates attending the Time Program showed improvement in self-efficacy. However, more than 50% did not show improvement for trait anger, spirituality, and locus of control. At the Marilyn Baker Program, over 50% of program participants improved on trait anger, spirituality, self-efficacy, and locus of control. The Marilyn Baker Program seems to have a greater impact on a variety of identified treatment goals.

Table 14. Pre to Post Changes in the Number of Program Participants

	Time		Marilyn Baker	
	Improved	No Improvement	Improved	No Improvement
Trait Anger	20 (46%)	24 (54%)	12 (75%)	4 (25%)
Spirituality	20 (46%)	24 (54%)	12 (76%)	5 (24%)
Self-Esteem	11 (27%)	30 (73%)	3 (17%)	15 (83%)
Self-Efficacy	28 (67%)	14 (33%)	10 (59%)	7 (41%)
Locus of Control	15 (42%)	21 (58%)	7 (58%)	5 (42%)

Participant Evaluations

Inmate evaluations regarding program helpfulness were overwhelmingly positive. These findings were consistent with the observations presented earlier. Tables 15-20 summarize inmate perceptions of the program.

Table 15. Perceived helpfulness of the Tier IV program at the Time Program

	Rating		
	Not at all	Somewhat	Helpful
Helpfulness of program	0	3 (7%)	41 (83%)
Helpfulness of peer mentor	1 (3%)	7 (22%)	24 (75%)
Helpfulness of Addiction Services Counselor	1 (3%)	1 (3%)	30 (94%)
Helpfulness of sessions on anger/aggression	2 (4%)	8 (18%)	35 (78%)

Table 16. Perception of peer mentors and addiction services counselors at the Time Program

	Rating		
	No	Yes, Somewhat	Yes, For Sure
Feel comfortable with peer mentor	4 (9%)	19 (43%)	22 (50%)
Was peer mentor understanding of your situation	3 (7%)	19 (43%)	22 (50%)
Did peer mentor respect your cultural values	5 (11%)	19 (42%)	21 (47%)
Was peer mentor there when you needed him/her	4 (12%)	12 (35%)	19 (52%)
Feel comfortable with the AS counselor	2 (6%)	4 (13%)	26 (81%)
Was the AS counselor understanding of your situation	3 (9%)	3 (9%)	26 (81%)
Did the AS counselor respect your cultural values	1 (3%)	9 (28%)	22 (69%)
Was AS counselor there when you needed him/her	4 (13%)	6 (19%)	22 (68%)

Table 17. Inmate's program satisfaction at the Time Program

	Rating		
	No	Sometimes	Most or all of the time
Were you satisfied with the program	0	4 (9%)	40 (91%)
Were you satisfied with peer mentor	1 (3%)	7 (22%)	24 (75%)
Were you satisfied with the AS counselor	1 (3%)	3 (9%)	28 (88%)

Table 18. Perceived helpfulness of the Tier IV program at the Marilyn Baker Program

	Rating		
	Not at all	Somewhat	Helpful
Helpfulness of program	0	1 (3%)	32 (97%)
Helpfulness of peer mentor	2 (6%)	7 (22%)	23 (72%)
Helpfulness of Addiction Services Counselor	0	1 (3%)	32 (97%)
Helpfulness of sessions on anger/aggression	0	3 (9%)	29 (91%)

Table 19. Perception of peer mentors and addiction services counselors at Marilyn Baker Program

	Rating		
	No	Yes, Somewhat	Yes, For Sure
Feel comfortable with peer mentor	3 (10%)	12 (40%)	15 (50%)
Was peer mentor understanding of your situation	2 (7%)	12 (41%)	15 (52%)
Did peer mentor respect your cultural values	2 (7%)	12 (40%)	16 (53%)
Was peer mentor there when you needed him/her	0	15 (47%)	17 (53%)
Feel comfortable with the AS counselor	0	4 (13%)	28 (87%)
Was the AS counselor understanding of your situation	0	3 (9%)	30 (91%)
Did the AS counselor respect your cultural values	0	2 (6%)	30 (94%)
Was AS counselor there when you needed him/her	0	9 (27%)	24 (73%)

Table 20. Inmate's program satisfaction at Marilyn Baker Program

	Rating		
	No	Sometimes	Most or all of the time
Were you satisfied with the program	0	16 (50%)	16 (50%)
Were you satisfied with peer mentor	1 (3%)	9 (28%)	22 (69%)
Were you satisfied with the AS counselor	0	1 (3%)	31 (97%)

Participants in both programs rated their satisfaction as generally high. Counselors also received positive ratings in terms of comfort, helpfulness, respect of cultural values, and availability. Peer mentors generally received positive ratings, but they were not as consistently high as the counselors. Participant evaluations seem consistent with the results from the focus groups reported earlier for Marilyn Baker and the Time Programs. Unfortunately, high participant satisfaction cannot be assumed for the New Horizons Program given the lack of data and concerns raised in the focus groups.

Summary of Quantitative Analyses

The quantitative analyses used data collected from CDOC records, pre- and post-program paper and pencil tests, and program completion records. The purpose of these

analyses was to assess pre-program characteristics of the participants, program completion rates, pre- to post-test changes, and participants' satisfaction of the Tier IV programs.

Participant Characteristics

Assessment of selection criteria. Based on results from the CDOC risk and needs scores, the MCMI-III, and the URICA scores, it appeared that selection procedures among all three programs accurately identified and recruited individuals with clinically relevant drug or alcohol problems, who also possessed sufficient motivation for change. The findings from the MCMI-III and the URICA scales validate the CDOC selection process. Drug and alcohol dependence were among the most common disorders reported by participants on the MCMI-III. For the URICA scales, participants more consistently identified items related to contemplative and action stages of change, and appeared to be sufficiently motivated for treatment. The program participants were selected for the three RSAT programs based on the identification of drug and alcohol treatment needs. These procedures appeared to be appropriate for selecting inmates for Tier IV programming.

Presence of comorbid disorders. Anxiety emerged as the most frequently reported co-occuring problem with men reporting significantly more anxiety symptoms than women. For the sample as a whole, 72% of participants (85% of men and 52% of women) met the criteria for an anxiety disorder on the MCMI-III. Thus, participants were likely to experience high levels of physical arousal, difficulties with worry and somatic discomfort. In contrast to the MCMI-III results, the CDOC mental health needs scores reflected low levels of additional psychopathology. Anxiety related problems may

not be detected or may not be considered significant in the CDOC's mental health screening procedures.

In terms of difference across programs, participants in the New Horizons Program had a significantly higher rate of Axis I disorders. New Horizons' participants appeared to have more emotional problems (e.g., post-traumatic stress disorder and thought disorder) compared to inmates in the other two programs. The higher rate of psychopathology among New Horizons' participants did not appear to effect program completion rates. However, it will be important to determine during the outcome phase of the evaluation whethr psychopathology affects success in the community following release from prison.

There was also a high rate of Axis II personality disorders, on the MCMI-III, among program participants across all three programs. This indicated that participants were likely to lack awareness of their dysfunctional behavior patterns and had significant difficulties in interpersonal relationships. Of particular concern, was the high rate of antisocial personality disorder among both men and women participants (77% of the entire sample met the criteria for an antisocial personality disorder). In terms of differences across programs, Marilyn Baker (female) inmates were significantly different on two personality patterns. First, 18 % reported symptoms related to excessive emotionality and attention seeking behavior. The second pattern indicated 48 % were likely to place themselves in situations and relationships where they could be taken advantage of, and to subsequently discuss repeatedly these past misfortunes.

Program Completion

All three programs had a high completion rate (75%). New Horizons had the highest (93%) followed by the Time Program (80%) and Marilyn Baker (66%). Marilyn Baker participants had a significantly lower completion rate than participants in the other two programs. As noted earlier, the Marilyn Baker Program has a different physical structure than both the New Horizons and the Time Programs that afforded treatment staff more contact with program participants. Overall, program completion rates for the CDOC RSATs compared favorably to other therapeutic community programs (Hiller, Knight, & Simpson, 1999b; Lang & Belenko, 2000; Wexler, Cuadrado, & Stevens, 1998).

Additional analyses were conducted to identify predictors of program completion. These possible predictors were taken from official CDOC records, MCMI-III scales, paper and pencil tests, and inmates' reported drug of choice. There were very few predictors of program completion. This may due to the high completion rates across the three programs, creating limited variability to predict completion outcomes. Sentence length predicted program completion for both men and women. That is, the longer the sentence the higher likelihood an inmate would complete the RSAT program. For men, age of onset for drug use negatively predicted completion (earlier onset indicated more program completion). For women, vocation skills negatively predicted outcome (women with low vocational skills were more likely to complete the Marilyn Baker Program). Significant predictors did not emerge for any of the MCMI-III scales, paper and pencil tests, or inmates' preferred drug of choice.

Program Changes Over Time

As noted earlier, pre- to post-program change measures were collected only for the Marilyn Baker and Time Programs. Across the five process measures, significant pre- to post-program changes were found for trait anger, spirituality, self-esteem, and self-efficacy. Both men and women participants reported significant decreases in self-esteem. It is possible that the RSAT programs contributed to a greater awareness of participants' problems and interpersonal functioning. Decreases on trait anger were found for women but not men. Thus, the Marilyn Baker Program was effective in producing significant decreases on inmates' anger. Marilyn Baker inmates also reported a significant increase in attitudes related to spirituality. In contrast, Time program participants reported increased self-efficacy related to resisting relapse triggers.

Participants' Perceptions of the Programs

Program completers were asked a variety of questions about their experiences in the RSAT programs concerning the relationship with counselors, peer mentors, and overall helpfulness of the program. Both male and female participants rated their overall program satisfaction as high, and counselors consistently received higher ratings than peer mentors. These perceptions were limited to the Time and Marilyn Baker programs.

CONCLUSIONS AND RECOMMEDATIONS

This purpose of the present evaluation was to examine the various components of three RSAT programs within the Connecticut Department of Correction. Both qualitative and quantitative methods of evaluation were used to explore program structure, staffing, selection of participants, program content, and preliminary outcomes. The results of this study have established baseline measures for the NIJ-funded outcome evaluation of these programs. The following section presents an overview and discussion of the process evaluation findings, program strengths, recommendations for future program implementation, and summarizes key components of the subsequent outcome study.

Summary and Discussion of Findings

There were several consistent observations across the qualitative and quantitative measures. These observations will be discussed in terms of program structure, staffing, participant selection, program content, time in program (TIP), and aftercare.

Program structure. While all three programs followed a modified therapeutic community model (DeLeon, 1995), housing locations were separate from counseling and treatment activities in two of the three programs (Time and New Horizons). The Marilyn Baker Program fully integrated both living quarters and program activities. The differences in physical structure appeared to be related to a number of implementation issues. First, Marilyn Baker participants had less interaction with the general prison population. A key component of a therapeutic community model is that inmates live and work together and support each other to achieve common goals. Thus, in the Marilyn Baker Program, there appeared to be a stronger sense of community and participant

support compared to the other two programs. Second, by integrating daily living with ongoing treatment activities, counseling staff had more overall contact with program participants. There appeared to be a stronger connection between counselors and inmates at the Marilyn Baker Program. Third, the separation of counseling and living quarters required greater coordination between custody and program staff regarding inmate movement. Therefore, having separate locations increased the likelihood of miscommunication resulting in inmates missing treatment activities.

The differences in physical structure may also have affected program outcomes. For example, Marilyn Baker participants demonstrated more consistent improvements on pre- to post-test program measures such as anger, spirituality, and self-efficacy. The Marilyn Baker Program also had a lower program completion rate than the Time and New Horizons Programs. These findings may, in fact, be due to the higher level of supervision received from the counseling staff.

Staffing. Another consistent finding was the importance of cooperation and sensitivity from custody staff in supporting treatment goals. While many of the interactions between custody and counseling staff were positive, the rotation of custody staff in and out of the therapeutic communities resulted in inconsistent rewards and punishments of participant behaviors. These problems were minimized at the Marilyn Baker Program primarily due to having an administrator who had both custody and counseling responsibilities, and correctional officers who were specifically trained in treatment issues. However, it should be noted that the program director may have difficulty balancing both treatment and custody responsibilities particularly since custody demands must always take precedence even to the detriment of treatment demands.

Additionally, there was a great deal of variability in the educational backgrounds, skill levels, and treatment philosophies of the counseling staff within and across all three programs. These differences may have enhanced program flexibility and responsiveness to a variety of inmates' needs. On the other hand, these differences may also have hampered communication between counselors, and resulted in inconsistent delivery of treatment components. Even though paraprofessionals can be as effective as professionals (Brown, 1997), such differences in the present study appeared to result in a substantial variability in the manner in which educational and therapeutic materials were presented. For example, some counselors preferred a more didactic presentation while others relied on Socratic questioning as a means of delivering program content.

Counseling staff among all three programs expressed a desire to continue their education and skill development. However, the lack of incentives provided by the CDOC was viewed as an obstacle in developing a more professional staff. The lack of incentives also appeared to have an influence on job satisfaction and morale, as counselors questioned the commitment of the CDOC to substance abuse treatment.

Selection of treatment participants. Before being accepted in an RSAT program, inmates must have scored high on the CDOC intake needs assessment for substance abuse treatment and volunteer for treatment. We assessed the validity of the selection procedures by evaluating the presence of drug and alcohol problems (using the MCMI-III) and motivation for change (using the URICA instrument). Selection procedures among all three programs accurately selected and recruited inmates with clinically relevant drug and/or alcohol problems. These inmates also possessed sufficient motivation for change.

Even though selection procedures were successful in identifying motivated individuals with clinically relevant drug and alcohol problems, a significant percentage of participants reported serious additional mental health problems. We believe that these mental health issues were severe enough to limit individual treatment gains and have the potential to trigger relapse once outside a highly structured environment. Moreover, individuals suffering from non-substance abuse issues may disrupt the treatment process for others.

Based on the data we collected and analyzed, anxiety emerged as the most common co-occurring emotional problem. Assessment for anxiety disorders may be warranted prior to program admission. If detected, treatment should be provided by a mental health professional separate from the substance abuse treatment. Making a distinction between stress as a side effect of incarceration, sobriety, and other substance abuse treatment issues versus a clinically debilhitating anxiety disorders is important. Whereas the current curriculum addresses the former, substance abuse treatment staff should not be expected to treat the later within the RSAT structure. The treatment for clinical anxiety should occur before entering the RSAT or be concurrent with (but separate from) the substance abuse treatment.

Second, we were not surprised to find a high rate of antisocial personality disorder among men and women participants. Antisocial personality disorder has been well documented among substance abuse populations (Knop, Jensen, & Mortensen, 1998; Vaglum, 1998). In the current programs, some antisocial personality characteristics were addressed through modules such as criminal thinking, emphasizing responsibility in daily

living, and creating a sense of empathy for others. However, it may be more beneficial if serious cases of antisocial personality disorder are identified and addressed separately.

Women emerged as having several characteristics that may require special consideration. Women reported a greater tendency toward excessive emotionality and attention seeking behaviors. Also, they were more prone to put themselves in situations where they could be taken advantaged of, and to subsequently discuss past mistreatment and situations where they had been victimized. One might expect women to report greater rates of post-traumatic stress disorder (PTSD) than male participants. However, in the current sample, while some women reported past victimization, they did not as a group report anxious arousal and avoidance behaviors related to these specific past events. Rather, past mistreatment appeared to reinforce self-perceptions of inferiority. Prior research, as well as the observations noted earlier, indicate the need to address early sexual abuse and recurrent sexual victimization (Briere & Runtz, 1987; Brown, Stout, & Mueller, 1996; Janikowski, Bordieri, & Glover, 1992). Sobriety often allows the old memories of sexual victimization to surface which then increases a woman's likelihood of relapse (Brown, Stout, & Mueller, 1996; Evans & Schaefer, 1987; Rohsenow, Corbett, & Devine, 1988; Young, 1990).

The Marilyn Baker Program does offer an elective that covers issues dealing with sexual assault or sexual victimization, but it is questionable whether the duration and intensity of this program component is adequate. Experiences related to victimization and abuse need to be more carefully assessed and treated by counselors with expertise regarding these issues.

Treating addiction and early childhood sexual victimization in female substance abusers would be extremely cost effective since there is strong evidence that such treatment would reduce the likelihood of relapse. Female substance abusers, who put themselves at risk for HIV and sexually transmitted diseases, not only burden the health care system with their own needs, but give birth to HIV positive and/or drug addicted babies. Moreover, the children of incarcerated drug addicted mothers are often sent to foster care placing an even greater burden on the Department of Children and Families. These children are also more likely to become enmeshed in the juvenile justice system and are at greater risk for substance abuse thereby perpetuating the childhood victimization, substance abuse, incarceration, cycle.

Program content. In terms of treatment content, we observed the RSAT programs to be eclectic in nature, focusing on a variety of issues such as education regarding substance use, 12-step recovery skills, skill development around several important life issues (e.g., parenting, stress management, conflict resolution), and cognitive restructuring. The eclectic nature of these programs seemed to vary from the primarily cognitive-behavioral program philosophy outlined by the Addiction Services Unit Tier IV Program Standards (1998). Nonetheless, the eclectic program content allowed counseling staff to emphasize their own areas of expertise.

Since anger is reportedly addressed in all three programs and the overlap between anger and substance use has been consistently documented in the scientific literature (Deffenbacher, 1993; DeMoja & Spielberger, 1997; Tafrate, Kassinove, & Dundin, 2001; Walfish, Massey, & Krone, 1990), anger reduction is an important treatment goal. However, changes in trait anger scores in the present sample were minimal. There are

two primary explanations why the magnitude of change was low for anger. One, most programs in the treatment outcome literature are about six to nine sessions in length. It is possible that the current anger modules, which are covered in approximately three group sessions, were not of sufficient duration to have a meaningful impact. Two, treatments with empirical support for anger reduction are predominantly behavioral, cognitive, or cognitive behavioral in nature. It appears that only a small portion of the anger modules in the current programs target the thinking and behavior patterns most associated with anger. To achieve increases in effectiveness, programs may need to expand the anger module to six sessions and emphasize cognitive and behavioral skills.

Time in Program (TIP). The CDOC Tier IV programs consist of three phases for a total time in the program of six months. The inmates in the New Horizons Program had the highest average time in the program (272 days; due primarily to the prerequisite of Tier II treatment) followed by the Time Program (199 days) and the Marilyn Baker Program (178 days). The amount of time in program for these Tier IV programs was shorter than the optimal program length of nine to twelve months (Wexler, Falkin, & Rosenblum, 1992).

Research evaluating program effectiveness has strongly indicated that time in program (TIP) is the strongest predictor of positive treatment outcome (Condelli & Hubbard, 1994; DeLeon, 1984; Wexler, Falkin, Lipton, & Rosenblum, 1992) with nine to twelve months representing the optimal TIP (Wexler et al., 1992). The findings with regard to a female population of substance abusers also indicated that TIP was related to positive treatment outcomes (Wexler, Cuadrado, & Stevens, 1998). The Kyle New Vision program, a corrections based substance abuse treatment program in Texas,

consists of nine months of treatment while the offender is still in prison with three months of mandated post release treatment in a transitional therapeutic community **and** supervised outpatient aftercare lasting up to one year (Hiller, Knight, & Simpson, 1999). Other well known programs such as Amity in the Donovan Prison in San Diego, CA is 12 months (Wexler, DeLeon, Thomas, Kressel, & Peters, 1999), Cornerstone is nine months (Fields, 1989), and Stay'n Out, a prison based TC in New York State, is nine to twelve months (Wexler, 1988).

When the treatment is delivered can also impact its effectiveness in terms of relapse and reincarceration. For example, the Kyle New Vision program is delivered during the last nine months of an inmate's sentence (Hiller, Knight, & Simpson, 1999). In contrast, CDOC inmates are allowed to enroll in programs without regard to the time remaining on their sentence. As a result, some inmates are unable to complete the program whereas other inmates might have years to serve before being released to the community .

Aftercare. A reoccurring finding from the focus group interviews was the need for aftercare, before and after an inmate leaves prison. Although some inmates successfully completing the RSAT program were eligible to continue living in the therapeutic community as peer mentors or successful graduates, there was no formal structured aftercare program in place at the Time or New Horizons Programs, and no formal community based post-release aftercare plan.

The literature strongly supports the need for aftercare following release from prison (Hiller, Knight, & Simpson, 1999; Price, 1997; Wexler et al., 1999) and following residential substance abuse treatment in lieu of incarceration of criminal offenders

(Hiller, Knight, Devereux, & Hathcoat, 1996; Knight & Hiller, 1997). Hiller et al., (1999) reported that those inmates who successfully completed both the in-prison therapeutic community and the transitional therapeutic community were the least likely to be rearrested following release from prison.

Wexler et al., (1999) reported that twelve months following release from prison, 40.2% of those who successfully complete the Amity prison TC return to prison compared with 8.2% of those inmates who not only successfully completed the TC but also completed the aftercare program. Recognizing that the argument could be made that the aftercare participants really had less risk during the twelve months following release from prison than those completers who were released directly to the community, Wexler et al., (1999) provided reincarcerations for 24 months following release, thereby allowing at least 12 months of community risk time for the aftercare completers. The differences between these two groups remained strong. Whereas 14.0% of those who completed aftercare returned to prison after 24 months, 48.8 percent of those who successfully completed the program but did not participate in aftercare returned to prison.

Similar findings are reported (Wexler et. al., 1999) with regard to number of days to reincarceration. At the 24 month post prison follow-up, the average number of days to reincarceration for those who successfully completed the TC but did not participate in the aftercare program was 253.74 compared with 391.17 days for those who successfully completed the aftercare program.

It has also been reported that inmates who completed the TC without aftercare still had more positive outcomes than inmates who did not participate in any treatment (48.8% compared with 67.1% return to prison following 24 months at risk in the

community). However, the most positive outcomes were related to the successful completion of both the TC and the aftercare (with only 14% returning to prison after 24 months). Those inmates who appeared to be highly motivated to enter the prison based TCs were also found to volunteer for and successfully complete aftercare (DeLeon, Melnick, Thomas, Kressel, & Wexler, 2000).

We believe the findings of previous researchers strongly support the need for an aftercare program in Connecticut for offenders who successfully complete the Tier IV program in prison in order to maintain the positive gains made in prison. Not only do the inmates in the present study appear to be highly motivated to receive the prison based treatment, but expressed to us in focus groups their desire to participate in community based aftercare programs.

Program Strengths

The three RSAT programs that were evaluated had a number of strengths. They all adhered to the therapeutic community model, utilized effective screening and selection procedures, followed an organized structure, and were perceived by inmate participants as helpful in the treatment of addictive behaviors and related issues. We were particularly impressed with the dedication of the administrators and program staff who deliver treatment to a challenging and difficult population under somewhat chaotic conditions.

Program Recommendations

The results of the current evaluation have led us to make the following recommendations to further enhance the effectiveness of the RSAT programs:

(1) CDOC should evaluate the feasibility of combining housing and program activities for the Time and New Horizons Programs. A better integration of treatment into daily living would strengthen the sense of community and further reinforce important treatment lessons. In a related issue, the CDOC should also assess the potential problem of assigning inmates from the general population into RSAT beds. Administrators who use program space to house non-treatment inmates will undermine program effectiveness and the morale of staff and participants (Lipton, Falkin, & Wexler, 1992). Treatment staff should not feel compelled to admit an inmate for treatment who does not really qualify in order to prevent the assignment of a general population inmate to a treatment housing unit.

(2) Time in program should be increased to be consistent with best practice models which indicate 9 – 12 months as optimal.

(3) Custody staff can have an important impact on program implementation. Thus, training of custody staff in the goals of treatment should be provided to correctional officers who work with inmates in the Time and New Horizons Programs. As pointed out by Wexler, Blackmore, & Lipton (1991), "Cross-training of correctional and treatment staff helps sensitize treatment personnel to the rules and regulations of a corrections facility and assists them in gaining acceptance among all levels of corrections staff, while orienting security staff to treatment objectives and methods." This training might be educational in nature (e.g., providing information about the positive impact of treatment on recidivism, reviewing unique custody issues related to dealing with inmates in

treatment) or experiential (having correctional officers spend time observing or co-facilitating groups). Having fewer correctional officers rotated in and out of the therapeutic communities could also reduce the potential for negative effects of custody staff.

(4) CDOC can enhance treatment integrity while preventing staff burnout and turnover by providing opportunities for professional development and incentives for further education and credentialing of substance abuse treatment staff (Anglin et al., 1996, cited by Lurigio, 2000; Lipton, Falkin, & Wexler, 1992). Best practice models and empirically supported interventions in the area of substance abuse treatment are continually evolving. Supporting staff in obtaining advanced degrees or in maintaining certifications helps to professionalize staff, ensures treatment integrity, and prevents staff burnout and turnover.

(5) Given the great variability in counselor education, skill, and treatment orientation, there is the potential for a lack of adherence to a specific treatment model. We recommend the development of a system of integrity checks to ensure that treatment is delivered in a consistent manner across and within programs. Integrity checks might take the form of supervision sessions, observations, and/or written documentation of procedures followed.

(6) Based on the high prevalence of several co-morbid disorders among program participants we strongly recommend the addition of mental health staff to specifically assess and treat serious mental health issues such as anxiety disorders, antisocial personality disorder, and early sexual victimization and

abuse. One full-time psychologist working cooperatively with staff from all three programs could have a substantial impact on long term treatment success

(7) Treatment modules that address anger should be strengthened by increasing the number of sessions to six and adhering to cognitive behavioral treatment programs with empirical support.

(8) The CDOC should strengthen the in-prison aftercare programs for inmates who after completing the RSAT program, will continue to serve the remainder of their sentences in prison. Inmates appear to be highly motivated to receive continued prison-based treatment. On the other hand, if treatment were delivered at the end of the inmate's sentence, he/she would receive community based aftercare.

(9) Finally, the CDOC should incorporate community based aftercare with transitional supervision. Inmates who successfully complete the in-prison RSATs should have the opportunity or be required to participate in community -based aftercare programs for three to six months in order to maintain the positive treatment gains made in prison. Moreover, the inmates themselves recognized the need for post-release aftercare.

Components of the RSAT Outcome Evaluation

The goals of this process evaluation were to summarize the various components of the three CDOC programs and to collect baseline data for the subsequent outcome evaluation. The Marilyn Baker, Time, and New Horizons Programs were successful in selecting appropriate inmates needing treatment and provided a high level of substance abuse treatment in accordance with the modified therapeutic community model. While

the current evaluation was important in enabling us to identify key similarities and differences across the three programs, the outcome evaluation will allow us to determine the long-term utility of the therapeutic community model for substance abuse treatment as well as the individual successes of each of the three RSAT programs.

The outcome evaluation will focus on three major areas. These areas will be: collection and analysis of one-year follow-up data, creation of a comparison group, and identification of predictors of long-term program success. The first area of focus will be the collection of one year follow-up data on all inmates attending the three programs. Follow-up data will be collected for all inmates attending the RSAT programs, including those that did not complete the program and inmates unavailable for post-program paper and pencil tests. Data to be collected will consist of official CDOC records (e.g., disciplinary reports since program completion, prison release date, and whether the inmate was returned to prison and for what type of offense), limited paper and pencil tests (Trait Anger, Self-Esteem, Self-Efficacy, Spirituality, Locus of Control, and the URICA), and perceptions of program helpfulness in remaining free of relapse.

The second primary focus of the RSAT outcome evaluation will be the creation of a comparison group. CDOC data have already been collected for inmates eligible for treatment but not selected. Out of these inmates, a smaller sample will be randomly selected and asked to participant in the study by completing paper and pencil tests (MCMI-III, Addiction Severity Index, Trait Anger, Self-Esteem, Self-Efficacy, Spirituality, Locus of Control, and the URICA). These data will allow us the opportunity to compare recidivism rates of program participants to nonprogram participants.

The third aspect of the outcome evaluation will explore potential predictors of program failure (failure will be defined as returned to prison and substance use relapse). Results from the process evaluation indicated that sentence length, early onset of drug and alcohol use (for men), and low vocational needs scores (for women) were predictive of program completion. We will employ similar analyses to determine which factors are important to inmates' long-term success in avoiding substance use and behavior that could cause them to be returned to prison.

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