"AN EVALUATION OF THE STANDARDS IMPLEMENTATION PROGRAM FOR DRUG AND ALCOHOL ABUSE OFFENDERS IN GEORGIA CORRECTIONAL INSTITUTIONS"

PREPARED BY:

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SENIOR OPERATIONS ANALYST

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INTRODUCTION

The Georgia Department of Offender Rehabilitation's (DOR) drug and alcohol treatment project entitled The Standards Implementation Program for Drug and Alcohol Abuse Offenders was supported for twenty-one months by a federal discretionary grant from the Law Enforcement Assistance Administration (LEAA). The grant award became effective on July 1, 1979 and was initially scheduled to end on December 31, 1980. The Department had not anticipated this early award date, and had therefore planned program start-up for late September 1979.

In an effort to compensate for lost time and to allow for a full eighteen months of active project operation, DOR requested and received a grant extension. LEAA approved an additional three months of operation, allowing expenditure of program funds through March 31, 1981.

Federal grant contract obligations require the submission of a final project evaluation no later than ninety days after the close of the grant period. A final project report on the drug and alcohol grant program was completed in June 1981 and the assessment was sent to the funding agency as required.

The final report for the grant focused upon the overall progress toward program goal attainment. The report presented here is an out-growth of the grant evaluation; however, the purpose and audience differ. The purpose of this evaluation report is to provide both descriptive and program impact information to Department decision-makers.

This evaluation is formatted into eight sections. The first section provides a brief history of the drug and alcohol treatment program. Section Two presents the methodology used for data collection and analysis. The third division presents the program components common to each of the four institutions operating the treatment communities such as intake procedures, screening processes, and treatment approaches. The fourth chapter of the report describes the central office administrative involvement in the program's development and in the monitoring of the program's progress.

The fifth section of the evaluation report reviews each of the four treatment communities, highlighting the unique difference among them. The subdivisions could stand alone as independent evaluations of each individual therapeutic treatment community. The sub-sections describe the strengths and weaknesses of each program's operation, focusing upon the unique aspects while also capturing the basics. Recommendations are provided at the conclusion of each program assessment and they correspond to identified weaknesses and/or program components with the potential for improvement/refinement. Section Six presents the quantifiable outcomes such as the number of disciplinaries associated with program members and the comparison cohort group. The final two sections (7 and 8) present the comprehensive evaluation's conclusions and recommendations related to improvement and expansion of the therapeutic communities.

1.0 PROGRAM HISTORY

The original drug and alcohol community treatment program was initiated at Georgia Industrial Institute in November 1970. This program operated until July 1978 when new dormitory construction prohibited the continuation of the therapeutic community.

In 1973 through a block grant from the Law Enforcement Assistance Administration (LEAA), drug and alcohol treatment programs were initiated throughout the Department of Corrections. Counseling staffs at each state facility were expanded to include a position specifically for drug abuse counseling. Sixteen counselor positions were provided through the 1973 block grant award and, when the grant funding for the counselors ended in 1975, the sixteen positions were subsumed under the state budget.

The actual programs initiated through the block grant, however, fell short of expectations. Only two correctional institutions--Georgia Industrial Institute and Georgia Earned Release Center--continued operating the drug treatment projects. (Georgia Industrial Institute had been operating approximately two years prior to the federal funds.)

Although the provision of drug and alcohol treatment services was a focus of the 1973 grant, little formal program activity directed toward substance abuse was operating in Georgia prisons by the middle of the nineteen seventies. The absence of treatment services was documented in an LEAA report of July 1978 which assessed Part E Programs. The Region IV Area Office of Audit and Program Review found that DOR "was not placing sufficient emphasis on providing drug treatment to incarcerated offenders within the prison system". The audit report appeared at a time when preceding experiences had already begun to stimulate activity in this area of program development.

Several events coalesced and influenced the decision both to develop a program and to request grant funds for improving treatment services for inmates with drug and/or alcohol abuse problems. One such event was the Final Judgement, Section of Civil Action Number 3068, Guthrie vs. Caldwell, U.S. District Court, Southern District of Georgia, Savannah. The judgement cited that rehabilitation services should be available, programs should be standardized, and qualified staff should be provided to conduct educational, vocational and rehabilitative programs. Drug and alcohol treatment programs, while not specifically listed in the final order, were considered to be part of the overall rehabilitative program of any institution.

A crucial issue in the years before the Guthrie ruling, however, was the acceptance of counseling services as an integral component of the correctional setting. The 1973 effort to institute drug and alcohol treatment counselors and programs may have preceded counseling's total integration into the correctional environment. Substantive support for counseling was demonstrated in 1976 through the passage of legislation creating the Earned Time System. The legislation mandated that counseling services occur on a regular basis for all offenders.

A third important factor was the availability of federal funds to standardize and upgrade drug and alcohol programs. The Department was

contacted and invited to apply for LEAA discretionary funds aimed toward improving substance abuse programs.

Because of the continued need for drug and alcohol treatment services, along with the LEAA audit report citing deficiencies in substance abuse services and the invitation to apply for grant money to address and correct these problems; the Department of Offender Rehabilitation developed the Standard Implementation Program for Drug and Alcohol Abuse Offenders in Georgia Correctional Institutions. The grant, as the title suggests, was developed to upgrade, improve, and expand drug and alcohol treatment services and was not designed as a demonstration project. The grant approach was based primarily upon the drug and alcohol program then operating at the Georgia Earned Release Center (GERC), now known as the Middle Georgia Correctional Institution, Youthful Offender Unit.

The program combined an in-house structured living environment with an eclectic approach to therapy. The GERC program was three-phased:

1) orientation,
2) problem identification and confrontation, and
3) preparation of post-release plans.

The basic program philosophy stated that "drugs and alcohol are not the problem, only the result of an individual's inability to cope with other problems, sociological, psychological and/or environmental".

Effective July 1, 1979, LEAA awarded $107,153 to the Georgia Department of Offender Rehabilitation. Grant 79ED-AX-0056 was officially sanctioned on this date, though program activities did not become fully operational until the second quarter of the grant award. The official termination of the discretionary grant occurred in March of 1981; however, drug and alcohol treatment programs at three of the four program sites continue to operate. The Youthful Offender Unit, Georgia Industrial Institute and Metro Correctional Institution all are continuing their therapeutic communities for inmates with drug and/or alcohol abuse problems. The Women's Unit suspended their program at the end of March, but plans are underway to reinstate the program.

2.0 EVALUATION METHODOLOGY

The Standards Implementation Program for Drug and Alcohol Abusers in Georgia Correctional Institutions was evaluated through a combination of objective and subjective analysis techniques. The assessment effort was directed toward acquiring information to describe the development of each in-house drug and alcohol treatment community, to determine the extent of compliance with Law Enforcement Assistance Administration (LEAA) "Part E" Treatment Standards, and to provide decision-makers with some information regarding program effect. Steps toward a future impact assessment were also begun. However, since behavior changes sought by the drug and alcohol treatment programs and the efforts of the trained counselors working throughout the state system are directed toward bettering response choices to "free-world" situations, the effects upon releasees can best be determined after three to five years.

2.1 Staff and Participant Interviews

The evaluation in general was process oriented. The methodology depended largely upon interviews with program staff, consultants, and participants, supplemented by extensive file reviews. Standard interview questionnaires were designed for program counselors and consultants, correctional officers, and inmates who were members of the drug and alcohol in-house treatment communities. These interview forms are provided as Appendices 1, 2 and 3, respectively. The interview format for the counselors, consultants and inmates focused upon the drug and alcohol program's processes and the program role of the individual interviewed. These interviews also included questions about participation and involvement of support services such as academic and vocational education, medical services and recreational activities. This type of inquiry was directed toward assessing "Part E" Standards. The inquiry made of correctional officers was directed toward discerning their understanding and perceptions about the programs.

2.2 Record-keeping Assessment

Policy and procedures for the Drug and Alcohol Program clinical records were described in an August 1980 memorandum from the Director of Counseling Services to program staff. (Excerpts from that memo are included as Appendix 4 to this evaluation report.) Policies outlined in the memo were translated into specific criteria to be used in evaluating program record-keeping.

In order to assess and determine adherence to the required record-keeping policy for the drug and alcohol programs, three separate data collection instruments were developed. Prior to the review of files, interviews with program staff established what client information should be included in clinical records and what should be found in the inmate's institutional file. The Uniformity of File Content (See Appendix 5) checklist was used for this process. If, for example, a counselor indicated that personal history information should be found in both clinical and permanent records, a check would be placed on the form under both columns. After each type of information was identified with a particular file, then the evaluators used the completed Uniformity of File Content form as a standard to gauge completeness of records.

The second data collection instrument used to acquire knowledge of the program's record-keeping system was entitled Record-keeping System Overview (See Appendix 6). This sheet was completed by interviewing program staff and recording their responses. After filling out the Uniformity of File Content and Record-keeping System Overview forms, assessors were prepared to investigate clinical and institutional files (using Appendix 7 to record their information.)

2.3 Impact Assessment

A monthly report form initiated mid-way through the grant funding of the project was used as a source for identifying the specific inmates coming into contact with the program. The form, Appendix 8, provided space to identify (1) inmates screened for program membership, (2) those accepted after screening and (3) those not accepted or personally refusing participation. Space to explain the reason for rejection was included. The form provided information from which to develop a list of program members. A separate list of inmates who were screened but for reasons outside their control (e.g., inappropriate sentence length) could not or chose not to participate was developed for comparison. The cumulative results of these monthly reports are found in Section 6 of this report. Comparisons are made between program and non-program members in terms of disciplinary rates, time-out data and return-to-prison rates.

3.0 PROGRAM DESCRIPTIONS--COMMON FEATURES

The Standards Implementation grant program was aimed toward upgrading the program at the Georgia Earned Release Center--now known as the Middle Georgia Correctional Institution, Youthful Offender Unit, re-establishing the Georgia Industrial Institute therapeutic community and establishing treatment programs at the Middle Georgia Correctional Institution, Women's Unit and at Stone Mountain Correctional Institution. (The Stone Mountain Program was eventually moved to Metro Correctional Institution. Because of this transfer and because the evaluation was conducted at Metro Correctional Institution, program discussion throughout this report will focus on Metro Correctional Institution.)

In addition to the improvement and expansion of the drug and alcohol therapeutic communities, counseling staff at all other state facilities were to become equipped to identify, refer, and to counsel inmates with drug and/or alcohol abuse problems. One counselor per institution was to be appointed as the drug and alcohol counselor and was to receive training.

The four in-house therapeutic communities were the central focus of the grant program and overall efforts. These four projects focused upon improving existing operations and expanding services. Each project was predicated upon the in-house community at the Georgia Earned Release Center--Youthful Offender Unit; however, freedom to explore alternate approaches to drug/alcohol treatment in an in-house therapeutic community was permitted the programs. As the grant period progressed and the programs evolved into more static and defined operations, several common components emerged. The elements common to the four treatment projects are described in the following subsections. Separate and individual program qualities are highlighted in Section 5.0 where each of the four therapeutic communities is reviewed in terms of what is unique to each particular program's operation.

3.1 Intake

Intake for male offenders occurs at the Georgia Diagnostic and Classification Center (GDCC) in Jackson, Georgia. Female offenders follow the same diagnostic process as their male counterparts except for the location; intake for female offenders is handled on-site at the Middle Georgia Correctional Complex, Women's Unit. Appendix 9 lists the twelve steps of the diagnostic process conducted by GDCC and the Women's Unit in conjunction with Central Office Offender Administration.

The information compiled and collected during the six-week diagnostic process remains an integral part of the identification of a sub-population of drug and alcohol abusers--a population that is later screened by each of the in-house therapeutic community programs. Most of the drug/alcohol information that can be obtained during or through the intake process at GDCC or the Women's Unit is acquired through self-reporting or self disclosure. Inmates answer questions about their life styles, habits, problems, and criminal activity during intake interview sessions with counselors. The results of these sessions are combined with test results from the Sixteen Personality Factor (16 PF) and the Clinical Analysis Questionnaire (CAQ). These test results identify personality characteristics and behaviors such as drug/alcohol problems.

An additional step in the diagnostic procedure used for both male and female inmates that may identify a drug or alcohol problem is the medical examination. This procedure is common to all persons incarcerated and thus common to members of each of the four drug/alcohol programs. During the medical examination, inmates are asked about their history of illness, allergies, operations, hospitalizations and current problems. Through discussion between the client and the medical staff, drug/alcohol use or dependency may be disclosed. More direct diagnosis of substance abuse may be made during the physical examination or through laboratory results. Evidence such as "needle track marks" or cirrhosis of the liver, for example, may be obtained from the medical examination and noted on the inmate's medical records. Preliminary physical examinations are usually provided within the first two hours of a male inmate's arrival at GDCC.

Further confirmation of an inmate's history of drug or alcohol abuse problems may be received from records/information provided by "free world" medical facilities. After inmates are asked about previous illnesses and hospitalizations, there is an attempt to verify the information by contacting the specified hospital(s)/physician(s). Documentation of services occasionally provides an indication of substance abuse. For example, an emergency room experience reported by the offender as a hospitalizaton may after verification be discovered to have been the result of an "overdose". Documented reasons for medical treatment such as described in the example not only confirm self-reported medical histories but also may identify treatment needs.

The final diagnostic step taken by GDCC is the recommendation made by the behavioral specialists regarding institutional assignment for each male offender. Female offenders have no choice of institution; they arrive and are diagnosed at their assigned facility. Final assignment for male offenders is made by the Central Office Offender Administration Division. Although none of the four selection of institutions with drug/alcohol programs have control over

the inmates assigned to their facility, they do have diagnostic data available from intake from which to identify the sub-group of substance abusers--a group from which program members can be screened and selected.

3.2 Screening Procedure

Once an offender arrives at any of the four pilot institutions, he/she is generally assigned to a counselor, oriented to the facility and may undergo additional diagnostic work. An extended assessment is routinely prepared.

If there is evidence of drug and alcohol abuse, an appropriate counseling group may be identified as a part of the individual's treatment plan. In the four institutions where pilot programs operated, actual admission into the pilot treatment program may be months or years away from the initial recommendation. Time of program admission depends upon the inmate's sentence length. This time factor is a result of each pilot program's establishing a specific number of months a potential participant must have available in order to be a viable candidate for program admission. The prescribed time frame is a preliminary screening device.

Each pilot program established a limitation on the time an individual must have available for participation in the treatment project. The women's project, for example, established a 24-month time period between program entrance and an inmate's tentative release date. "This was done so that she would have ample time to complete all phases of the program (6 months) before she was eligible for a pre-release program."[1] Metro Correctional Institution established a 12-month time span between program entrance and tentative parole or pre-release dates for the group members. "An effort was made to assign a person to the program so that program completion would coincide with movement to a pre-release center."[2] The Georgia Industrial Institute pilot project prescribed that "an inmate must be within one year of parole eligibility and/or discharge date."[3] The Youthful Offender drug and alcohol treatment program initially accepted members four months prior to conditional release consideration. The Youthful Offender project subsequently increased the length of the program to six months; the admission criteria changed also.

Compliance with time limitations, however, was not the only consideration as to who would be an eligible program member. A specific screening process was set in place at each pilot program. The process uniformly included interviews between prospective members and project counselors. Intake information from the diagnostic packages identified the "pool" of potential program members for screening. Programs also received potential participants through referrals from institution counselors. Discovering inmates with alcohol and drug problems after intake, and through additional assessments conducted on-site at the "home" facility was not unusual. These individuals were also referred for consideration.

Screening inmates for potential placement in any of the four therapeutic communities is largely dependent upon interviews. Individual interviews are conducted with inmates who have been identified through diagnostics as substance users/abusers or referred by counselors for consideration. Interviews with potential program members are conducted by the senior counselor of each drug/alcohol project. An optional or additional interview resource available to each program is the use of their assigned psychologist/consultants. (Each program was provided a part-time psychologist through the grant and the services have continued through the Department's budget.)

Inmates may be screened by the psychologist either through individual interviews or a combined meeting between the consultant, program counselor and inmate. In any case, the final recommendation for inclusion/exclusion in the program is made by the project's senior counselor. He or she forwards the approved candidate's name to the institution's Classification Committee for final approval. Program entry ultimately depends upon the Classification Committee's sanction.

The common criteria for evaluating and identifying candidates to be recommended for inclusion in the drug and alcohol therapeutic communities include:

1) reliable information confirming drug/alcohol problems,

2) available space-group size,

3) length of sentence or compliance with time limitations,

4) inmate's motivation to deal with the problem(s), and

5) for male offender programs, the absence of major disciplinary reports prior to the possible program entry date. (For example, the Youthful Offender Unit will not allow an inmate to participate if he has more than 3 major disciplinaries within the 12 months preceding his entry date.)

3.3 Treatment Approaches

Four specific treatment features were found to be standard or common among the pilot programs. These common factors were (1) group counseling sessions held at a minimum of once a week, (2) individual counseling, (3) an identified therapeutic community housing only program members, and (4) program rules and regulations in addition to the general institution guidelines.

3.3.1 Group Counseling. Group and individual counseling sessions were found to be an integral part of each pilot treatment program. Group counseling sessions supported through the therapeutic group living experience were the specific change modes through which drug and alcohol abuse problems were confronted and alternatives identified. Among the four programs, the group counseling sessions were conducted and scheduled differently. The size, frequency, and duration of each group counseling session varied as is evident in the program designs, in the program handbooks, and from observations. Interviews with program staff, consultants and participants confirmed each program's reliance upon the group treatment approach.

3.3.2 Individual Counseling. Individual counseling is a requirement common to all institutions. One-to-one counseling sessions were integrated as a component of all four pilot drug and alcohol programs. Individual counseling was scheduled more easily and occurred more regularly at some of the four pilot facilities than at others. All programs, however, provided at least one scheduled individual counseling session per month; program members at the Youthful Offender Unit were seen individually on a scheduled basis twice a month.

In addition to the scheduled individual sessions, counselors for all pilot programs were reported to have an "open-door" policy allowing inmates counseling time upon request. In cases where counselors were unable to take time out when requested, a specific counseling time was arranged for the inmate.

3.3.3 In-house Therapeutic Communities. Living units vary in physical structure and capacity, but in each pilot program, members are grouped together in a homogenous environment based on need and purpose. The Women's Unit Program was housed in J Building quadrant three, when it was operating. This location had a capacity of 24 inmates. The Youthful Offender project is provided space in the Holly Building, F-Hall. The capacity of the dormitory is approximately sixty-five inmates. At Metro Correctional Institution, members are housed on one "range" of a single building; a range contains fourteen bedspaces. The program at Georgia Industrial Institute is housed in the newest building at the institution. The building is similar in design to those at Metro Correctional Institution--four ranges per building with a correctional officer station located center front. The correctional officer station has a view of the entire building. The Georgia Industrial Institute program is assigned to the two top ranges of B Building, allowing a total of 28 bedspaces.

TABLE 1
CAPACITIES OF PILOT DRUG AND ALCOHOL PROGRAMS

Institution	Number of Spaces Available
Women's Unit	24
Youthful Offender Unit	65
Metro Correctional Institution	14
Georgia Industrial Institute	28

Regardless of the number of beds or the physical configuration, each program housed group members together in one area, and each depended upon a 24-hour therapeutic environment. All pilot communities specified that in the absence of a counselor, inmates were expected to behave in accordance with program rules and philosophy; the communal living arrangements provided the vehicle for compliance. Thus the group experience, whether on a quadrant, dormitory or range, is the reinforcing change agent.

3.3.4 Rules and Regulations. The fourth standard program treatment feature is a set of behavioral rules specific to the program. Some of these program rules mirror institutional regulations while others are unique to the program. Although institutional rules remain applicable, stronger emphasis is placed on certain rules/regulations in order to enforce expected conduct of program members. The house rules/program rules for each project are listed in Appendix 10. Rules common to each of the in-house communities include:

1) no violence or threats of violence,

2) no drugs, and

3) no stealing.

3.4 Case Management

The results of the file review conducted at each program site were generally favorable for institutional records, but the outcome was poor for the clinical system. For example, as prescribed by policy "the program screening results were to become a part of the inmate's clinical file;" in no case were screening results included in clinical records. Each and every program was deficient in this area. Some programs did have a log book or separate file detailing screening of individual inmates; however, information was not incorporated in the files as prescribed.

Individual programs had particular problems with files. At the Women's Unit, each clinical record contained different types of information, with no identifiable standard or minimum recording requirement. Some clinical files had questionnaires and tests, program participation summary sheets, signed consent forms, clinical notes and treatment plans; others contained only brief clinical notes. Of the eight active program member files reviewed, only one clinical file had any information other than clinical notes. This finding suggests that as the program grew older, less attention was given to maintaining complete clinical records.

Another aspect of the record-keeping process that was flagged during the file reviews, was the different styles of clinical documentation. For the Youthful Offender program, clinical notes and other personal history and performance information were available either through the clinical file or from institutional records. Each counselor had developed an independent system of recording individual and group counseling session information. Both counselors were meeting the policy outlined by the Director of Counseling Services, but their methods were unique to the counselor.

Georgia Industrial Institute's clinical system was satisfactory in most areas, except for their exclusion of the screening results. Clinical notes describing individual performance at each group session were contained in each file. These performance notes were written by the counselor or by the therapy consultant. Institutional files contained the diagnostic data, personal history information, and treatment plans necessary to support clinical records.

Institutional records at Metro Correctional Institution were in satisfactory order, containing the client information as prescribed by policy and as indicated during the interview with program staff concerning file content. However, clinical records were not only deficient in screening results information as were records at the other pilot projects; four of the nine "active" files reviewed did not include signed "consent to participate" forms.

3.5 Support Services

Support services were found to be available at each institution operating a drug and alcohol community. Services such as educational programs and medical care were adjunct operations to the therapeutic treatment. These services common to the programs are described in the following paragraphs.

3.5.1 Educational Programs. Inmates at each of the four institutions operating drug and alcohol therapeutic communities had access to academic and vocational training. These services were peripheral program components.

To determine availability and participation in academic and vocational classes, interviews with program participants included an inquiry into their scheduled weekly activities. Through describing their typical daily/weekly routines, academic and vocational class participation was evidenced. Information was also available from computer profiles. Of the program members interviewed, 11% were participating in Adult Basic Education, 36% in the Georgia Equivalency Diploma (GED) program, 32% in college courses, and 21% were not actively involved in any academic courses. Thirty-two percent of those interviewed participated in vocational education classes, and 68% had no involvement with vocational classes. The types of vocational class experiences included: 1) drafting, 2) woodworking, 3) welding, 4) plumbing, 5) mechanics, 6) solar energy and 7) clerical classes.

Forty-eight percent (48%) of all program participants interviewed were participating in academic courses (including college) compared to 38% of the combined general population of the project institutions. Percent participation in vocational training programs was greater for program members, too. Thirty-two percent (32%) of all program members interviewed participated in vocational training. Only 19% of the combined general populations of the four pilot institutions were involved in vocational courses. Using the percentages comparison, both academic and vocational program participation was better for program members than for the general population from facilities housing drug and alcohol projects.

The following list (Table 2) presents the type of vocational programs available at each of the four pilot institutions. The total number of training slots available to the facillity is also provided. There is obviously a derth of programs at Metro Correctional Institution. Inmates at Metro complained of the lack of vocational opportunities. This situation, however, is supposed to be remedied as the new institution matures.

TABLE 2

VOCATIONAL TRAINING COURSES AND NUMBER OF AVAILABLE SLOTS AT PILOT INSTITUTIONS

Institution/Program	Number of Available Slots
Georgia Industrial Institute	
Electrical	15
Automotive I	15
Automotive II	15
Masonry	15
Welding	15
Auto Paint	15
Barbering	15
Upholstery	15
Woodworking	15
Heating & Air Conditioning	15
Small Engines	15
Plumbing	15
Food Service	15
Auto Body	15
Visual Advertising	15
Electrical Motor Repair	15
Youthful Offender Unit	
Carpentry	15
Electrical	15
Drafting	15
Plumbing	15
Automotive	15
Meatcutting	15
Heating & Air Conditioning	15
Welding	15
Masonry	15
Women's Unit*	
Clerical	15
Cosmetology	15
Dental Lab Technician	(to be available 10-1-81)
Metro Correctional Institution	
Custodial Maintenance	15

*Women have access to the vocational training courses provided at the Youthful Offender Unit; 32 slots are available. One slot for welding, three for drafting and two for each of the other courses excluding meatcutting where an apprenticeship approach is being used for training the female offenders.

3.5.2 Medical Services. Medical services at each of the pilot institutions include routine sick call and emergency care. Staffing of the health care sections of each facility differs according to population need and size. Interview questions asked of program staff and participants were directed at determining sick call and emergency medical procedures as well as arriving at their perceptions of the quality of medical services.

Questionnaires administered to staff asked if health care services were provided and also asked for a brief description of these services. Counselors confirmed the availability of health care services at each of the pilot institutions; their descriptions of those services were broad and general. They generally avoided assessments concerning the quality of health care. Two counselors commented that they had little contact with medical staff and rarely knew when a client was on medication. A stronger link between the counseling and medical staffs was discussed as a necessary adjunct for total program services. More routine and consistent sharing of information between the counseling and medical staffs seems to be needed at all four institutions.

When staff were asked how medication was dispensed and if this method differed from that used for the general population, their responses were the same. The process appears to be uniform from facility to facility. Medical staff prepare the medications and send them in a locked container to the correctional officers. The officer gives the medication as dispensed by the medical staff to the appropriate inmate. Dispensing and administering drugs to the general population and the drug treatment program members occurs in the same way.

Inmates were asked if they received any different medical services from non-program members. One hundred percent of those interviewed agreed "they treat us all the same." One program member who was interviewed explained that the medical staff did not know who was in the drug program and who was not a member.

3.6 Training Drug and Alcohol Counselors

Drug and alcohol counselor training was provided to the staff of the four pilot programs as well as to representatives from each of the other facilities throughout the state correctional system. The training assisted in upgrading services by providing a skilled drug/alcohol counselor at each correctional facility. Counselors throughout the system were afforded these training opportunities by (1) the DeKalb Addiction Clinic, (2) the U.S. Bureau of Prisons drug program at the Atlanta Federal Penitentiary, and (3) quarterly group sessions with psychologist/psychiatrist consultants having expertise in treatment of drug and alcohol problem cases. Counselors who were not directly involved in the four therapeutic communities but who did receive training established groups at their own institutions. Services were thus enhanced through better skilled counselors system-wide.

4.0 ADMINISTRATION

The grant program by design identified the State Director of Counseling Services as the overall project director. In addition to noting his role, other administrative levels were identified. Each of the four therapeutic community programs were subject to similar lines of authority. Specifically, the communities fell within the direct control and jurisdiction of their respective institution's warden and deputy warden for care and treatment and the chief counselor. Daily operations and direct services administration were ultimately the responsibility of the senior counselor in charge of the drug and alcohol program.

An organization chart excerpted from the grant document and revised for this report is provided on the next page. The display demonstrates the multi-level administrative complex involved in the operation of the drug programs.

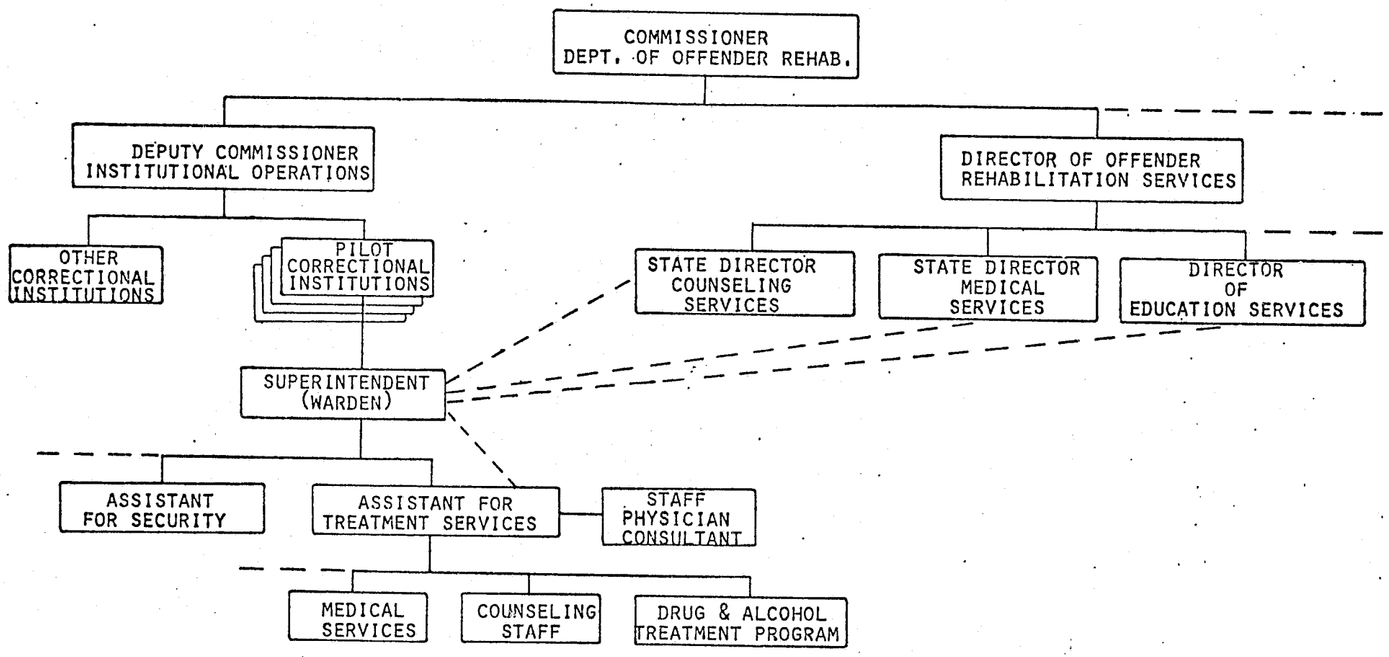
4.1 Counseling Services

The Director and Assistant Director of Counseling Services were both involved in the initial decision to apply for LEAA discretionary funds directed toward upgrading and expanding the drug and alcohol treatment services available to offenders within Georgia's penal system. Cooperating with the agency's Grants Section, Counseling Services developed the program idea, pursued funding and received the grant award to support the enhancement of treatment opportunities for drug and alcohol abusers.

Originally, the Director of Counseling Services had wanted to incorporate a coordinator's position into the grant--realizing the need to link field services closely with upper echelon program administration. He was discouraged from pursuing this request, because the Department was trying to avoid any new obligations or commitments to fund with state money those positions originating with federal funds. The coordinator position was therefore not pursued, but the need for system-level program coordination remained. Consequently, the Director and the Assistant Director of Counseling Services were required to act as coordinators, handling many of the tasks they had intended to delegate to project staff.

After the grant was prepared, submitted, and the award received, the Director of Counseling Services and the Assistant Director conducted an orientation session with institutional Chief Counselors. The four institutions initiating or expanding the therapeutic communities participated in this orientation. The grant program's goals and purpose were discussed and reviewed with the Chief Counselors attending the meeting. The Director of Counseling Services reports that Chief Counselors at the orientation meeting were given the responsibility of communicating the information they had received to their staff. Interviews with program staff indicated that this communication either failed to happen or--because of turn-over in program personnel--failed to be passed along, leaving new staff uninformed.

FIGURE I.
ORGANIZATION CHART
SHOWING RELATIONSHIPS BETWEEN
STAFF SECTIONS AND CORRECTIONAL INSTITUTIONS



In addition to the orientation meeting held between Counseling Services administration and the Chief Counselors, training conferences designed especially for identified drug and alcohol counselors were held periodically throughout the life of the grant. These were initiated by Central Office. The first two training conferences focused upon administrative issues such as the program's purpose and operating strategies designed to meet objectives. For example, during one such conference, each senior program counselor shared his/her operational design, processes and selected success stories with fellow project counselors throughout the State. The project director expected the training conferences, especially the early sessions, to provide a forum for formal and informal communications, questions and problem-solving for program staff.

The Director of Counseling Services was directly involved in the administration of the Drug and Alcohol grant, working closely with the three psychologist/consultants who provided assistance to staff from the four treatment programs. As project director he recruited these consultants searching for the best individuals to provide the support services he had conceptualized. The consultants were to be a link between Central Office Administration and the four drug and alcohol programs, a link not directly available through the Department's organizational structure. The consultants' weekly contact with each program and the required written monthly reports provided an information network that allowed for an outside objective assessment of program progress, process and outcomes as well as providing quality assistance to improve counselor skills.

Further evidence of the attempt to integrate the operations of the four programs with the expectations of the project director is found in the role played by the Assistant Director of Counseling Services. During the twenty-one month period of grant program operation the Assistant Director acted in many different capacities. He was a monitor for the four pilot projects, visiting each site approximately once a quarter. He was a "troubleshooter" fielding questions and problems from institutional administrators and line staff. He also scheduled and coordinated training. These activities associated with the drug and alcohol program were in addition to his other duties as the Assistant Director for Counseling Services.

In many cases, routine monitoring served as an effective quality control over particular program components. For example, in late Summer 1980, the Assistant Director conducted an intensive on-site monitoring designed to identify critical problem areas regarding program performance and record-keeping. The monitoring resulted in memoranda to the Director citing specific program problems and weaknesses. The Director subsequently forwarded memoranda to each project's warden identifying a date when a follow-up visit would be conducted to review progress made in correcting the situations. These problems were primarily related to files and record-keeping. When the follow-up visit occurred, the Assistant Director found the record-keeping system much improved.

Notwithstanding these many attempts to provide sustained program coordination from Central Office, direct service delivery staff expressed an absence of understanding about the overall goals and purpose of the drug and alcohol program. During interviews conducted as part of this evaluation, project staff evidenced knowledge only of their own treatment community. Although there had been an effort both to provide orientation and to keep counselors informed through periodic training conferences, a communication problem was apparent. Interviews with administrators from Central Office and from institutions revealed that oral communication was indeed the method most frequently used. Staff were told of the program's goals, and they were told of their colleagues' experiences.

This method of information transmittal seems to be the core of the difficulty. Program staff continually complained about the absence of written information, guidelines, and statements of purpose. They expressed frustration over what they perceived to be a lack of direction provided by the uppper echelons. Specifically, there were complaints that they had never received copies of the grant document and that the program goals as designed were not communicated. They were unsure regarding what program counselors were expected to achieve--what results were sought.

For their part, both Counseling Services and Grants Administration were reluctant to send the entire grant package, including the budget to line staff. A previous similar experience had resulted in project staff ordering supplies without prior Central Office approval. Providing copies of sections from the grant such as the Problem Statement, and Goals, however, would have given program staff what they said they needed and kept budget information contained at Central Office.

Future programs should combine written and oral communication, to ensure that staff who do not receive the information from their supervisors do receive copies of guidelines and procedures. Reliance upon oral communication also jeopardizes standardization of processes and prohibits documenting experiences to benefit others in the future. The difficulty of replicating programs is compounded without a guide to follow.

In addition to the absence of written grant information, other documented procedures were few in number and late in distribution. Staff complaints focused upon the tardiness of written procedures for maintaining clinical files. Clinical record-keeping instructions were disseminated in August 1980, a year after official grant initiation. The procedures were provided in response to a federal audit. What should also be pointed out, however, is that the clinical record-keeping procedure was developed from the Department's Practices and Procedures Manual Chapter 7020. Copies of this publication were available at each institution operating the drug and alcohol program. The Alcohol and Drug Program Clinical Records process was modeled after existing policies, though it is true, that the refined written procedures were not distributed until August 1980.

Written program procedures and an operations manual for each drug and alcohol program are still needed. Program manuals, in addition to participant orientation handbooks, are necessary to provide continuity of program operations especially when personnel change. Program guidelines and procedures allow project replication based upon sound workable processes and the documented

experiences of others. The development of this type of handbook/guideline should be supported by Central Office administrators. Each of the four community programs' orientation manuals and other documentation should be compiled to produce a standard operating procedure manual for drug and alcohol programs--a basic guide explaining how to initiate and operate an in-house therapeutic community. Support for this effort must come not only from the Director of Counseling Services but from upper echelon Central Office managers as well. The need for this type of handbook must be expressed by institutional administrators and service delivery staff.

The grant provided added administrative leverage to the Director of Counseling Services and the Assistant Director during the first twenty-one months to accomplish upgrading of treatment services. This added administrative dimension afforded to the Director during the grant period has now ceased. There is no longer an outside factor requiring commitment to drug and alcohol treatment services. In order to insure (1) that the programs that currently are operating improve, (2) that expansion based upon the best treatment approaches occurs, and (3) that qualified staff continue to be available, a renewed explicit commitment to serving drug and alcohol abusers must come not only from line service delivery staff, institutional administrators, and program administrators, but also from the Department's Deputy Commissioner level. Without support from upper level managers, potential for expanding the program is eliminated and sustaining current levels of services is questionable. Administration holds the key to the direction the program will take.

4.2 Research and Evaluation

Three basic functions were prescribed for the Evaluation section in terms of administration and support for the Drug and Alcohol grant. These included: (1) on-site monitoring, (2) interim progress reports and (3) the final project evaluation. These activities were prescribed in the grant document, although the narrative explanation was difficult to understand. The execution of these three activities was not in strict compliance with the grant design. For example, no in-house evaluation staff visited any of the four pilot projects during the grant period. Consequently, written monitoring reports based upon information acquired during these visits were not prepared. Institution staff and Central Office administrators were not provided formative evaluation reports.

Quarterly progress reports, however, were provided by evaluation staff. These reports were written in compliance with discretionary grant guidelines and regulations, not as an integral part of the self-assessment strategy. To prepare the quarterly reports, the Director and Assistant Director of Counseling Services were interviewed, and monthly progress reports from the consultants were reviewed. The evaluator thus functioned as an information collector and not as a true program monitor.

A part-time data consultant position, operating out of the Office of Research and Evaluation was provided through the grant contract. The data consultant visited each program, interviewed staff and inmates, and subsequently designed a data collection form. This form was initiated in June 1980. Staff were requested to "back-track," if possible, and complete forms for the preceding program months. After these monthly reports were initiated, data provided from them became an additional resource for completing the quarterly progress reports.

The part-time data consultant also compiled an interim assessment report with program recommendations per project and a checklist on the status of each program in relation to Part E Standards. This report was completed in December 1980, the expiration date for the data consultant's contract. The information was shared with the Director and the Assistant Director of Counseling Serices, but was not released as a formal document.

The third and final support activity associated with the Office of Research and Evaluation was the final project evaluation. This effort included on-site assessment of each program, interviews with staff and inmates and file reviews. The evaluation was conducted during April and May, 1981. The final grant report was completed and submitted to LEAA on time. The methodology and focus of the evaluation, however, did not comport with the self-assessment design in the grant document. The focus upon return-to-prison data was changed to a more descriptive assessment of the program.

Failure to meet the full extent of the self-assessment design and monitoring obligations defined in the grant was due in part to staff turnover within the Office of Research and Evaluation. The individual who wrote the self-assessment design and the staff assigned to conduct the evaluation were different. The self-assessment plan was written in general terms, allowing for fluid interpretations and freedom for creativity. However, the very freedom and fluidness of the design which was intended to promote creativity, failed to provide direction. So much was left to the discretion and interpretation of the evaluator that the design created frustration and confusion. Future evaluation designs should be developed in detail and, whenever possible, carried through by the same staff member who conceived the design. Only in unusual circumstances should a program evaluation strategy be executed by someone other than the originator of the design. To ensure the continuity of the evaluative effort in the event of staff turnover, designs must be developed in the fullest detail and described in terms easily understood by another staff member.

In addition, data collection provisions need to be implemented at the start of a program. Data collection consultation should be an integral part of the early planning stages, with form designs and implementation strategies developed prior to program initiation. To expect project staff to reconstruct program history mid-way through the project, as was requested with the June 1980 initiation of the data collection form, is to increase the potential for data error and misrepresentation of program performance.

4.3 Training

As previously described through the administrative efforts of the Assistant Director of Counseling Services and the financial support of the grant, counselors throughout the State's correctional system were afforded the opportunity to attend specialized drug and alcohol counseling training. The training was provided by three separate sources: (1) U. S. Bureau of Prisons, Atlanta Penitentiary, (2) the DeKalb Addiction Clinic, and (3) through the purchase of consultant services.

The U. S. Bureau of Prisons presented a two-day program to non-pilot institutional counselors and a three-day more intensive course to pilot project personnel. During the grant period, a model Drug and Alcohol treatment project was operating at the Atlanta Penitentiary. Their experiences provided a reality-based framework for the delivery of the specialized training to DOR counseling staff.

Thirteen of the total eighteen correctional facilities in operation during the grant period identified one counselor to receive drug and alcohol training. The four pilot programs sent both project counselors to training. A combined total of twenty-one counselors attended the U. S. Bureau of Prisons training session. The scheduling of these individuals was handled through the central office Division of Counseling Services.

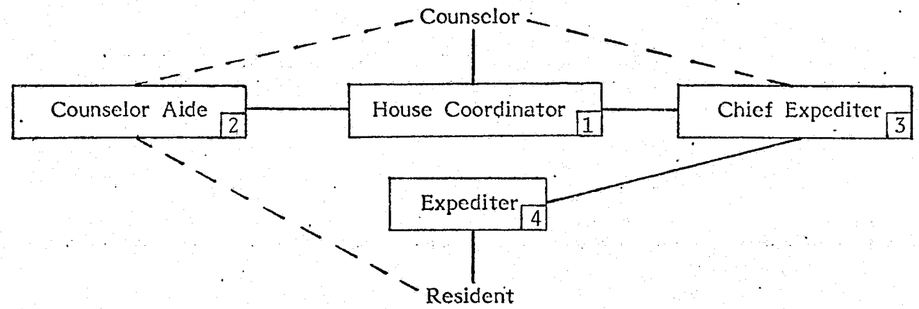
A one-week course was presented to the pilot and non-pilot drug/ alcohol counselors by the DeKalb Addiction Clinic. Seventeen separate sessions were conducted from November 1979 through March 1980, providing training to twenty-one state correctional institution counselors. Transitional center counselors were also given the opportunity to attend the DeKalb Addiction Clinic program. Five counselors from five separate transitional centers completed the one-week course. All total, 26 counselors attended the one-week DeKalb Addiction Clinic course; 21 from institutions and five from transitional centers. The sessions were arranged by the Assistant Director of Counseling Services, who also coordinated scheduling the participants.

Additional training was arranged and coordinated by the Department of Offender Rehabilitation's Staff Development Division. Four two-day conferences were held between April 1980 and February 1981. Consultants with expertise in drug and alcohol treatment provided the training.

5.0 DISTINGUISHING CHARACTERISTICS OF THE FOUR IN-HOUSE THERAPEUTIC COMMUNITIES

5.1 Middle Georgia Correctional Institution - Women's Unit

The in-house therapeutic drug and alcohol program (DAP) operated at the Women's Unit during the course of the grant funding, but was suspended at the end of March 1981. The DAP Unit was designed as an in-house therapeutic program focusing upon problem identification, self-awareness, and education. Peer influence supported by group and individual counseling sessions combined as the vehicles for change. A well defined program hierarchy as demonstrated by the organizational chart below was utilized during the early and mid-points of the program operation.



The duties and responsibilities of each of these positions are capsulized in the following lists. The lists are not exhaustive but highlight the activities of each structure position.

1) House Coordinator

- directly responsible to staff counselor
- schedules community meetings
- holds "pull-up" meetings
- calls dorm meeting
- trains and supervises expediter

2) Counselor Aide

- general helper
- works with problems regarding visitation
- direct line to counselor
- monitors PER privileges

3) Chief Expediter

- keeps dorm log
- acts as sounding board for residents
- schedules "one-to-ones" with residents

4) Expediter

- responsible for guest staff speaker
- logs "pull-ups"
- coordinates orientation activities

Community meetings called by the house coordinator were planned to be held once a week on Monday afternoons at 4:30; the entire group was expected to attend. The program handbook identified the community meeting procedure as follows:

1) Opening--call meeting to order
2) Presentation--five-minute talk on a relevant topic to promote conversation
3) Reaction Panel Report--three members assigned to take notes on presentation and react affirmatively/negatively to information, notes are passed along to recorder
5) Guest Staff Speaker
6) Old Business
7) New Business
8) Group Report on Contract Status
9) Know Your Neighbor Report
10) Recorder Report
11) Closing

The House Coordinator is also responsible for "pull-ups". A "pull-up" is a program activity that involves a direct confrontation by one program member of another program member to point out a negative attitude. A resident is made aware that she is displaying a negative attitude, and she is to respond to the "pull-up" by saying "I accept." A "pull-up" is intended to help a program member recognize her negative behavior, understand the problem, and identify why she reacted negatively. At the same time some alternative, more positive, reactions to the same situation are discussed. The "pull-up" is a helping hand.

Another program component is the "one-to-one". The Chief Expediter is responsible for scheduling "one-to-ones". This activity is different from a "pull-up" because it is a means of working out differences between two residents. During the "one-to-one," the Chief Expediter is present, acting as a mediator and trying to provide an objective view of the problem. If the Chief Expediter observes that emotions are flaring and that tempers are preventing progress, she may end the session. The process will be continued when talk can be resumed and handled more constructively. The "one-to-one" is designed as a means for resolving conflict and promoting unity and understanding.

Program structure members are involved in designed orientation activities. A pre-test was scheduled prior to program entry. The test was given by the Expediter. The orientation phase as planned was a six-week period during which

time a Substance Abuse Summary Test and a Drug Abuse Summary Test were administered; again this activity was handled by the Expediter. After the six-week period, a test over the program policies, philosophies, and rules was given. Specifically, group members were required to know and abide by all institution rules; however, selected rules were combined with therapeutic rules to develop what was called Cardinal Rules. The Expediter was responsible for administering tests, conveying rules and regulations, answering all questions concerning the program for new members involved in orientation, and for administering tests.

Through the formal structure meetings and informal house meetings, peer influence and peer support provided pathways for each program member to discover herself and her own potential.

5.1.1 Intake. The intake process for women as described briefly in an earlier section paralleled that used for the male offender, with the exception being the facility. Women have only one institution and all intake processes occur at this one location.

5.1.2 Screening. Selection and screening for the women's program are more difficult to discern and appear more fluid than at the other pilot projects. Interviews with the counselors, the consultant and program members provided information regarding perceptions about criteria for admission and personal experiences with screening procedures.

The only documented or written screening or selection criteria available come from the program handbook. The handbook prescribed the time a woman must have remaining in order to become a program member and identified a peer evaluation committee. Entrance into the program usually took place when an individual was 24 months from a tentative release date. The description of a peer evaluation committee stated the purpose of the committee to be "to evaluate new members in the program as to their reasons for wanting to participate and their sincerity in wanting to keep the program going." The handbook further described the committee as a precaution against abuse of the program. Information from the peer committee was to be confidential and reported only to the counselor. This process although documented in the DAP handbook was not affirmed by any of the interviews.

Discussions with staff and participants determined that program screening consisted primarily of an interview. The senior counselor generally conducted the interviews although some individuals were also interviewed by the psychologist/consultant. Interview questions included why an individual was interested in participating in the program and if there were prior drug treatment experiences.

In trying to discern whether certain criteria influenced admission decisions, the results were varied. For example, when asked if age was a criterion affecting admission, one counselor said age had no effect, the other counselor explained that women sentenced as Youthful Offenders had to be outpatients because of the legal constraints against living with felons. The consultant pointed out that some older persons had misgivings about the program. Therefore, age may or may not have had an effect depending upon who is queried. (The actual age range of participants was from 19-39 years.) The program counselors made the final decision as to who was eligible. If they disagreed, the senior counselor decided.

When asked if the type of drug and if the duration of usage had an impact on admission, both counselors responded "no". The consultant, however, suggested that the duration of drug usage may affect admission because the worse the problem the more likely a person was to participate. Regarding the type of drug as a criterion affecting admission, the consultant believed there was a tendency to discount alcoholism. The counselors believed the type of drug had no effect on admission.

The criterion "history of emotional illness" was said not to affect admission to the program. On this point, there was no disagreement. The staff and consultant also agreed that the size of the group affected admission because without an available bed no one could be added to J-3 quad.

Other criteria indicated by the staff that could result in the rejection of an inmate included: (1) no confirmation of drug abuse from a pre-sentence investigation or diagnostic intake data, (2) denial by the classification committee, and (3) lack of interest on the part of the potential group member. Another factor which might exclude a person from the program was the determination of an ulterior motive for participation. For example, if an individual was considered to only want to live with friends and had contrived and self-reported a drug/alcohol problem(s) in order to accomplish inclusion in the program, the individual would be rejected.

5.1.3 Treatment Programs. The treatment program at the Women's Unit included both group and individual counseling. Each of these components is described below.

5.1.3.1 Group Counseling. The Drug and Alcohol Program (DAP) at the Women's Unit was designed to accept new members 24 months prior to their tentative release date. After completing the orientation phase (6 weeks) the program member was to be involved in one of the two primary group counseling activities. The two group counseling activities were: (1) Crime Group and (2) Drug Education Group. Before completing the program, the participant should have been involved in each counseling group. The defined goal of the Crime Group was "to recognize and take personal responsibility for the decision to commit a crime and to practice new ways of dealing with such situations."[4] The philosophy of the group was that if drugs had not been a part of the members' lives, many would not have become involved in criminal activities. The group process was aimed toward identifying alternative ways of dealing with the situations in lieu of drugs. The sessions used a method of placing one member at a time on the "hot seat". The individual told about her crime, about her decision to commit the crime and if drugs contributed to her decision. The group discussed the situation to determine and provide feedback regarding other ways to have handled the problem.

The second group, Drug Education, focused upon changing attitudes about drugs and imparting information so that informed decisions could be made. The group process included discussion of drug laws, defining drug abuse, learning drug classifications and their effects, and identifying alternatives to drug use.

The program handbook identified the level of group performance expected of each member, the expected contribution to the community living arrangement and the requirements of each group. The group counseling experiences coupled with the living environment and structure constituted the basic treatment program processes at the Women's Unit Drug and Alcohol Program.

5.1.3.2 Individual Counseling. Individual counseling as previously described occurred either through pre-arrangement between counselor and inmate, at the request of the counselor, or on an inmate drop-in basis. (The opportunity for individual counseling sessions is required by the Earned Time System.) The one-to-one sessions provided an additional treatment opportunity for program counselors, primarily because program members were assigned to the drug and alcohol counselors' individual caseloads.

The women's program had additional individual counseling or treatment possibilities. Both the program's "pull-up" and "one-to-one" procedures may be considered individual treatment approaches; these were defined above in Section 5.1. However, individual counseling by qualified counselors should be the primary means of individual treatment. At the Women's Unit, individual sessions with counselors were occurring primarily on an ad-hoc basis. Although there was an expressed "open-door" policy for inmates needing access to their counselor, there was no routinely scheduled individual counseling session. Inmates indicated that they grew dependent upon their peers to fill this vacuum and that counselors grew dependent upon the group session to satisfy necessary contact with their caseload; neither of which was satisfactory.

The entire treatment process whether group or individual was capsuled by the 24-hour therapeutic living arrangement, an arrangement that had no time or schedule barriers. Problems and issues could be addressed by "family" members as they arose. The house structure helped to facilitate this process.

5.1.4 Support Service. Program membership did not affect access to general support services that are available to female offenders. Access to educational and vocational programs continued even after an inmate moved to the DAP Unit. Although active involvement in academic and vocational education programs was not a structured requirement, program members were encouraged to be involved in such activities.

In addition to vocational academic programs, health care and recreational services were also available to the women in the female Drug and Alcohol Program. These services did not differ either in accessibility or in treatment of program or non-program female offenders.

5.1.4.1 Educational Programs. Of the eight program members interviewed, four were attending college classes through Georgia Military Institute, two were enrolled in the GED program and two were not involved in academic classes.

Only two participants were involved in vocational training. One was active in a drafting course, the other in a clerical program.

5.1.4.2 Recreation. Recreational activity was provided to program members just as it was to other inmates. Yard call was daily, and recreational call occurred in the evenings. In addition to softball and volleyball games, the group made their own special events. They initiated a monthly birthday party for all members born within the month. At Halloween, they also celebrated the season with a party. These were independent activities attended and developed by program members.

5.1.4.3 Medical Services. Each cottage at the Women's Unit has an assigned clinic day; this doesn't vary. There were no different services provided program members or non-program inmates. If a woman required an appointment for medical services, she signed the list and an appointment was scheduled and a notice of the time returned to her. At the appointed time, the inmate visited the clinic.

Very little comment was made by inmates or staff on medical services. However, the consultant was disturbed about several aspects of the health care system. He expressed concern about the use of medication and the lack of follow-up to determine if indeed the dosage or the prescription were correct or effective. There are no routine interim health checks as a follow-up to initial diagnosis; the consultant believed there should be. In addition he believed there to be an under-prescribing of medication or prescribing medication that was not the most suitable to the problem. Prescribing valium for a depressed client was cited as an example of inappropriate matching of problem and prescription. The consultant was also disturbed that the potential to store medication existed. Checking a client to verify that she swallowed the prescription was encouraged.

5.1.5 Follow-Through Continuity of Service. There are three basic types of activities associated with the follow-through of services:

1) activities occurring within the prison for graduate or unsuccessful terminations,

2) preparations for release either in-house or through a transitional setting, and

3) post-release services and assistance, such as parole recommendations or knowledge of community resources.

The Women's Unit provided no follow-through of services to drug/alcohol clients who were removed from the program as a punitive action. If their individual counselors provided drug and alcohol counseling that would be the only possible assistance. If a client were returned to general population in closing days before release, even without a negative action, no follow-up counseling would occur. Some graduate members were permitted to remain in the quadrant, continuing to receive community support prior to leaving the institution, but no graduate sessions were conducted.

The Women's Unit drug and alcohol program sent 50% of their members through a transitional center prior to completing the exit to freedom. This transfer allowed the women an opportunity to gradually adjust to a slightly more independent situation prior to release. Counseling services were available through the transitional process.

Post-release plans are to be prepared on all clients ready to leave the institution on parole. These plans are the primary responsibility of the parole officer, except in Youthful Offender cases. For the two female parole cases that were reviewed by contacting parole officers both had pre-release plans. Follow-through with those plans was difficult. One individual was living in a community that did not have a drug/alcohol counseling program available. The

Parole Officer was providing counseling. The other parolee was required through her contract to participate in drug/alcohol counseling. At the point the Parole Officer was contacted, the individual was actively attending her scheduled counseling appointment.

For cases where a client leaves the institution and goes directly to a transitional center or is paroled, there is a high probability that some drug/alcohol counseling services will be continued for the client. However, for individuals released from prison--those not paroled but whose sentence expired or through mass-release left the institution--little follow-through of services is available. If a counselor has time, he or she is supposed to provide pre-release preparation; but what happens to the woman after her release? Resources and assistance programs for people with drug and alcohol problems are available in many communities. However, when staff at the women's facility were asked about their knowledge of community services and contacts to facilitate the pre-release process or to provide information to the offender leaving the system, counselors were only sure of Department of Labor contacts. They had little knowledge of community resources designed to provide support for these women. The lack of resource information and ready references was acknowledged as affecting both the thoroughness with which counselors were able to execute pre-release services and to prepare clients for post-release problems that are sure to arise.

5.1.6 Issues/Problem Identification. The actual program operation at the Women's Unit varied in the extent to which the design was followed and prescribed program operations were carried through. Review of files and interviews with program staff found a more intense tightly structured and operated program during the first half of the grant period with a gradual decline of the program until the project was suspended in March. For example, clinical file reviews of early program members demonstrated the use of tests during the orientation period. A Substance Involvement Summary Test, Drug Abuse Summary Tests and tests about the DAP rules and philosophies were filed in individual records. Additionally, written reports on particular drug classes were contained in the files, thereby demonstrating the full implementation of the Drug Education group design. Evidence such as this was not included in later client files.

Interviews both with counselors and inmates identified program strengths and weaknesses. In the first half of program operation, clients' progress was measured and recorded. Records of group participations as well as periodic summary sheets were found in client files. However, the senior counselor who left the program completed the progress reports, and the program counselor remaining was never introduced to the system or the forms. Group and individual progress were documented in the form of clinical notes in the last months of project operation. A peer rating system also in place at one time was not operational in the later quarter of program operation. The paper flow generally demonstrated the decline in the program.

Inquiry of participants and staff as to "what determines successful program completion" revealed the absence of clearly defined processes. One counselor explained that there was no formal completion time, some women were in the program for over a year. According to the consultant, success criteria were

"foggy". The second counselor suggested that successful program completion was based upon compliance with rules and participation in program groups. She pointed out, however, that before a woman could actually complete the program she was generally sent to a transitional center.

During eight interviews conducted with program participants, responses to the question regarding successful program completion were as follows:

Question:

> How is it determined that a participant has successfully completed the program? What is defined as success and who determines the successful completion?

Responses:

- Nobody really finished program
- I'm not sure, individual would be best able to tell... self-assessment
- Complete both groups (Drug Education and Crime Groups)
- After 30-day trial period, group decides if you stay; six months after that if you need more help you stay otherwise you're gone
- Only one program member was returned from the "House" the others return like hot cakes
- Don't know
- Periodic evaluations, opinions of peers and counselors
- Individual decides what she wants to do after six months.

There appears to be no uniformly accepted successful completion or program termination process.

Group meetings did not occur with regularity. Although efforts were made for weekly group sessions, participants reported that groups were often cancelled for other events. Softball games pre-empted group counseling sessions at one period in the program's history. The intended pattern of three months in the Crime Group with subsequent movement to the Drug Education group was not routinely practiced.

Interviews with program members presented a feeling that there was a lack of commitment on the part of counselors. The example of infrequently held group sessions was used to illustrate the point. For example, one individual who had been a program member in excess of one year explained it should take no more than six months to finish the program. She had not yet completed both the Crime and Drug Education groups, primarily because the groups were not held. There was a feeling too that the "old" counselors cared, new staff were strictly "nine-to-five." One inmate pointed out that in the last five months before the program closed the consultant provided at least one meeting every two weeks and often this was all that occurred. Even before there was no staff counselor to provide services, group sessions were sporadic and often ignored.

The correctional officer most familar with the drug and alcohol program was interviewed. Her general observations and comments reinforced the positive effect of the in-house therapeutic community upon the residents and their problems. She noted that the inmates were encouraged to solve their own problems and discouraged from going to Correctional Officers and that there was a group feeling and group attitude to protect one another. She also discussed the lack of stealing and lying among group members.

Several problems were also identified by the Officer: the absence of permanently assigned correctional staff to the unit, the need for correctional officers to be trained to identify and work with substance abusers, the need for more rewards or privileges for program members who follow rules and regulations and renewal of the program topped her list of concerns. In addition, she pointed out that the coordinator position had too much power over other members and could prevent a phone call or show favoritism. This observation was also supported through interviews with program members. It was suggested that group members vote on house structure rather than having the leaders appointed by staff. The correctional officer supported inmate complaints that the rigid pyramid ruling structure was too political and not a healthly component of the support living situation.

When inmates were asked "if you could make changes to improve the program, what would you change or add", responses included the following:

- design a screening committee to identify potential members with inmate representation;
- allow an inmate to lead groups, with counselors for support;
- provide sessions in body language and communication skills to help you when you're afraid in group encounters;
- evaluate a program candidate more closely prior to entering program to ensure that she had drug problems;
- do not allow people without drug-related problems into the program;
- provide a way to earn more privileges to be rewarded for extra efforts;
- allow a separate meeting of house structure weekly;
- increase responsibility as an individual grows to demonstrate increased worth;
- remove the top heavy h ouse structure, too many chiefs;

- increase supervision by administration of counseling staff so that program doesn't fail to operate;
- provide committed counselors.

The counselors/consultants responded to the question as follows:

- have a designated officer assigned to that cottage who has special training in drug/alcohol problem areas;
- assign security permanently;
- restrict program participation to six months;
- continue the in-house living environment quad arrangement;
- have available more audio-visual materials, e.g., educational films;
- provide clearer definition of lines of authority between administration and counselors.

5.1.7 Recommendations

* Re-open the program with extensive pre-planning directed at implementing a therapeutic support community.
* Refine the screening process to ensure drug and/or alcohol abuse tendencies/behavior exists. Documentation such as PSI and medical reports in addition to self-disclosure should be required.
* Allow program members to identify leaders for the in-house structure. These candidates if not voted on by members should be sanctioned by the group prior to placement as a Coordinator, Expediter, Counselor Aide, etc.
* Define, establish, and maintain a consistent schedule for group meetings.
* Establish criteria for progression through the drug program, identifying selection criteria, required performance activities and levels, and a time frame and exit criteria.
* Recognize and reward the program for achievement and members for individual progress. An extra telephone call or an "E" may be sufficient or extra TV time.

* Assign two full-time counselors to the program, screening counselors for commitment to the program.
* Divide program members equally between counselors or at least use some manageable distribution of client caseload.
* Maintain consistent records. Files should include the same basic information per program client and such information should be linked with program performance and personal growth.
* Coordinate the handbook written program description with the actual operations of the program; the program should follow the design as a guide. If changes occur, update the information.
* Link individual counseling more closely to program design and establish a process for routine individual sessions.
* Clearly define the chain of command in terms of program responsibility.
* Provide counseling staff at the Women's Unit with information on community drug/alcohol programs and other assistance groups provided by local-state-federal governments, religious and other non-profit organizations.

5.2 Middle Georgia Correctional Institution Youthful Offender Unit

The Youthful Offender Unit program design was the base from which other programs were to be developed. The in-house therapeutic community was the focus of the grant program design. The Youthful Offender Unit drug and alcohol program that survived the 1973 federal block grant project was to be used as the model for developing new drug and alcohol programs. The grant program emphasis for the Youthful Offender Unit was to upgrade and improve the program's operations.

Changes were indeed made in the program's processes. Prior to August 1980, the project was a phased program; thereafter, the emphasis shifted to that of group themes. This approach was similar to the program at the Women's Unit. Some of this similarity was a result of both institutions receiving guidance from the same psychologist/consultant.

In addition to changing from a phased process to a group topic focus, staff expectations of what clients should accomplish for program completion changed. Residents were initially expected to attend fifteen group sessions in four months; the time frame has now expanded to six months. Group counseling was divided into two major categories: Drug Education Group and Crime Group.

Approximately nine different topics are carried out under the Drug Education Group category, and clients are expected to participate in sessions and do outside projects. The Crime Group uses the same "hot seat" approach used in the women's program where a client discusses his crime and its relationship to drug/alcohol use. Group members discuss and rate the presentation. The assessment scale for this group is provided on the following page.

How does a Youthful Offender inmate with drug and alcohol problems become involved with this therapeutic community? After the general diagnostic process, what intake and screening procedures are used to identify and select program members?

5.2.1. Intake. The initial intake for male Youthful Offenders occurs at Georgia Diagnostic and Classification Center (GDCC) where the diagnostic steps outlined in Appendix 9 are used for each new admission. The intake process is to be decentralized in the near future; as part of this plan, Youthful Offenders will be sent directly to the Youthful Offender Unit for diagnostics and intake.

5.2.2 Screening. The initial screening report from the Youthful Offender institution Assessment Unit documents information regarding an inmate's drug/alcohol usage. The unit makes the initial recommendations for program involvement; this may include participation in the drug/alcohol program. During the orientation interviews at the facility, the Youthful Offender is informed of the availability of a drug/alcohol counseling program.

Counselors make program/treatment recommendations on individual performance plans, and this may include participation in the drug/alcohol program. These plans are routed from the intake counselor to the treatment team for processing. It is at this stage that the actual pilot program counselors interview potential program candidates. The file review checklist (Figure 2) is also prepared at this stage. The interviews with program counselors and a file check for documentation of actual drug/alcohol problems generally suffice in making the final decision. On occasions the psychologist/ consultant intervenes for additional screening of an applicant.

The interview and file review processes consider the following entry criteria:

- Inmates with Culture Fair IQ below 70 will be subject to denial depending upon whether they can perform adequately within the program.
- No current disciplinary reports in the previous 60 days.
- No more than three major disciplinary reports during the 12 months.
- Voluntary signed statement by the inmate of willingness to participate in the program before official acceptance into the program will be completed.
- Reliable information of drug history from at least two of the following sources:

Person Rated _____

Date _____

Total Score _____

CRIME GROUP
OBJECTIVES AND ASSESSMENT SCALES

1. To describe the crime in a voice and with the body language that others see as "regretful".

1	2	3	4	5
Consistently not regretful		Moderately regretful, inconsistent		Consistently appropriately regretful

2. To acknowledge the possibility of choosing whether or not to commit a crime.

1	2	3	4	5
Sees crime as exclusively the result of other people and other outside factors		Sees self and others as equally responsible for decision to commit crime		Sees self as a primarily responsible for decision to commit crime

3. To acknowledge the role of drug use (if any) in the decision to commit a crime.

1	2	3	4	5
Denies role of drug use		Partially sees roles of drug use		Realistically sees role of drug use

[] Drug use did not influence decision to commit a crime and this is recognized. Circle "5" above.

4. To describe an appropriate plan for dealing with difficult situations that previously occurred when the decision to commit a crime was made.

1	2	3	4	5
No realistic plans		Some realistic plans		Extensive realistic plans

FIGURE 2

DRUG/ALCOHOL HISTORY CHECKLIST

NAME: _____ Number _____

This subject's file has been screened by the counseling staff of the MGCI Drug Program for possible placement in the Drug Counseling Program. Available data in subject's file regarding drug/alcohol history is outlined below:

1) Subject has medical history of drug/alcohol abuse.
Yes _____ No_____

2) Family letter reports use of _____.

3) Subject's self report is that he uses _____.

4) Subject was under influence of drugs/alcohol when present offense was committed. Yes _____ No _____

5) Subject's offense was VGCSA Yes _____ No _____

6) Subject has history of drug related offenses. Yes ____ No ____

7) Subject admits to theft or drug sales to obtain funds to purchase drugs. Yes _____ No _____

8) Psychological report includes following factors indicative of drug abuse:

FACTOR	STEN SCORE
A. Q1	_____
B. Q4	_____
C. PP	_____
D. D6	_____

9) Subject has history of previous treatment for drug/alcohol abuse.
Yes _____ No _____

10) Other: _____

_____

RECOMMENDATIONS: _____

_____

_____

--drug-related offense, Pre-Sentence Investigation;

--family letter;

--poly-drug usage;

--previous drug program participation;

--self-disclosure;

--letter from inmate explaining why he wishes to participate.

Recommendations for program participation are documented and presented to the Classification Committee in the form of a proposed Youthful Offender contract. The Parole Board then receives this proposed contract for approval. If approved, the individual enters the drug and alcohol program four to six months prior to his conditional release. If approval is not granted, a revised contract is executed.

Interviews were conducted with program counselors, the consultant and participants to discuss screening and admission. The counselors and consultant were asked if any of the following six criteria affected admission: (1) age, (2) duration of drug usage, (3) type of drug, (4) history of emotional illness, (5) length of sentence and (6) size of group. These criteria are the same asked of counselors/consultants at each of the pilot programs. Only two of the six criteria were affirmed by the counselors as having impact upon admission: length of sentence and group size. Other factors cited included IQ scores; Culture Fair scores are listed in the documented screening criteria.

The consultant responded differently to the question about relevant criteria. He reported that the duration of drug use did affect program admission because the worse the problem, the more likely an individual was to participate. The "type of drug" was also indicated to affect program admission. This response differed from the counselors' responses. The consultant's other responses were in line with the counselors'.

The program counselors do have final say on who is admitted; however, the consultant may recommend clients based on his interview and using his criteria. Ten of the sixty program members were interviewed about their experiences with the screening and selection process. Three questions were asked inmates regarding selection. When asked "what type of selection process was involved in becoming a program member," each of the respondents provided a variation of the same process. They first described the initial identification of their problems. Some inmates indicated that the intake/diagnostic process at Georgia Diagnostic and Classification Center and the Kemper Building at the Youthful Offender Unit had identified them for screening; others noted their participation in clinics on the street identified them for the program. One individual suggested that his juvenile record identified him for screening.

The inmates explained that the next step in the selection process was interviews with counselors where they discussed their participation in the drug/alcohol program and their Youthful Offender contracts. Youthful Offenders

identified as substance abusers often have to participate in the drug/alcohol program as a provision of their contract. Contract components must be followed. Nine of the ten inmates interviewed stated they did not volunteer to participate in the program. Statements were made such as "I didn't come up here because I wanted to but because they put me" and "I wasn't asked, it was part of my contract." However, further inquiry concerning the perceived involuntary selection process revealed that although a program member felt he was pushed into participating because of his contract, once involved, he no longer resented the assignment.

When asked, "would you change the selection process, if you could," six said "no" and four responded "yes". Those who would like to change the process suggested:

- look at past closer to make sure non-drug problems aren't put on hall--hall gets overcrowded;
- give communication skills test -- some people haven't ability to talk with others;
- they don't tell you a lot about the program so that you'll know ahead of time (orientation);
- let A-Hall people visit to get a look at program before they are sent up as members.

No one suggested changing the involuntary selection factor.

5.2.3 Treatment. Each counselor is responsible for conducting group counseling sessions every week. There are two types of groups: Drug Education Group and the Crime Group. These group counseling processes are supported by the in-house therapeutic community structure. The 24-hour therapeutic community is based upon using peer influence as a motivational change and support factor. The in-house community has additional house rules, a hierarchical structure, and a token economy system. House rules have already been identified and are listed in Appendix 3 of this report. These rules emphasize institutional regulations but add program specific regulations as well, such as learning the "word of the day" (identified on the bulletin board) by a specific time each morning.

Rules have been discussed but the house structure has not. The hierarchical organization of the in-house community is structured similarly to the women's program. There is a House Coordinator position that is responsible for providing counselors with information regarding the atmosphere of the dorm, conducting community meetings, maintaining a list of people qualified for rooms, supervising activities, and assisting other structure members such as the Orientation Coordinator. This position is to assist new residents during orientation in learning hall policies, rules and procedures; to assemble clinical folders with all proper blank forms in place; and to meet with new residents twice a week to review rules and regulations and to help those having difficulty. Two additional positions are the Chief Expediter and the Senior Expediter who supervise and coordinate the activities of the six Expediters. These two

positions make schedules for Expediters, meet with counseling staff at structure meetings and deal with Expediters having or causing problems. The six Expediters keep order in the dorm and enforce rules and regulations pertaining to dorm conduct and use of facilities as well as offer support to other structure members. There are two Section Head Coordinators and six Section Heads. The Coordinators each supervise one Section Head in F-1 Hall and three on F-2.

Fifty percent of the inmates interviewed commented on the need to improve the selection of structure members. When asked "if you could make changes or improve the program, what would you change or add", the responses included such statements as:

- Evaluate structure members better before appointing them.
- The Orientation Coordinator needs to do a better job with the new group.
- The structure should be chosen by members--the counselors don't have to live with 'em.
- Between Expediters and Orientation people there's a big war, try to watch the guy to see if he does bad.

Qualifications for each of the structure positions are listed as Appendix II.

The merit/demerit system in place at the Youthful Offender Unit drug and alcohol program is unique to that program; no other drug or alcohol community in the institutions has such a system in place. Merits are awarded for doing something productive; demerits are awarded for counterproductive behavior. For example, a PN (E) equals 1 merit, a PER (monthly) equals 5 merits, a positive daily inspection rating equals 2 merits and a negative equals 1 demerit. A disciplinary report equals 10 demerits. Merits can be used to purchase program privileges such as described in the following list directly excerpted from Youthful Offender Unit material.

- Five merits entitle you to see a movie.
- One merit entitles you to use tapes.
- 20 merits saved places your name on semi-private room waiting list.
- PER (E)'s = 5 merits. For this you can see a movie or listen to five hours of taped music or you can still use them for "special visits" or extra phone calls if you request them from counselor.
- Demerits may be worked off at a rate of one hour per demerit or a suitable condition of one hour per demerit. This must be approved by staff.

- For room rent - one (1) merit per week collected at the end of each month. Failure to pay room rent means room removal at the end of that month.

- A total of 25 demerits will bring about placement of the resident on probation with the possibility of program removal.

- One merit entitles subject to three games of his choice on any of the recreation equipment available in game room. (At the point of the evaluation visit new equipment was in but had not as yet been placed in the game room.)

The merit/demerit system was seen by the counselors as an innovative feature of their program. Inmates considered the system to be a privilege or at least a way in which to earn privileges. For example, when asked if there were any special privileges or rewards available to program members not available to others, 80% of the program members interviewed responded "yes." Examples of the privileges included: movies, tapes, phone calls, merit system to buy a semi-private room, game tables, respect, and no fear of theft of personal items. Five of the seven examples were directly attributable to the merit/demerit system.

5.2.3.1 Group Counseling. Each program counselor is responsible for conducting group sessions each week. However, the day and time are fluid. In order for a client to successfully complete the drug/alcohol program, he must attend at least four crime groups, six drug education groups and two additional group sessions such as AA or an audio-visual education group. It is up to the program counselors to provide the clients with enough opportunities during their six-month timeframe to allow them to successfully finish the drug/alcohol program. There were approximately 75 drug/alcohol members who exited the institution during the grant period, and 100% were successful program completions; therefore, it is assumed that group sessions occur often enough for the opportunity to attend 12 sessions to be provided. A firm schedule, however, is absent. For example, during the on-site evaluation, one counselor announced to the dorm that a group would meet that evening; the news traveled by word of mouth quickly.

The spontaneous and unscheduled meeting of groups does not seem to be the most appropriate method of handling counselors' time nor effecting good habits in the Youthful Offenders. It is understood that with a program population often climbing as high as eighty clients and averaging 65, each client with his own daily routines; it is difficult for two counselors to arrange a schedule for group meetings. But a schedule at least a week in advance would allow inmates an opportunity to program time and to anticipate when groups are to meet. This could be accomplished in the weekly goal setting practiced by counselors and the psychologist/ consultant. As a part of their goals each week a defined schedule for conducting group counseling could be established and communicated to the dorm through the bulletin board or by word of mouth. This goal setting would set a positive example and help to improve the situation.

5.2.3.2 Individual Counseling. Individual counseling sessions are held twice per month per client, although, the method of scheduling varies between counselors. One counselor schedules two days per month per client, the other counselor uses an ad-hoc method of seeing clients. Though no one complained

about lack of attention and/or failure to receive individual sessions, clients on the more fluid schedule did express dissatisfaction regarding the uncertainty of when they would meet with their counselor. There was also a question as to whether they were receiving the counselor's fullest attention when they were able to "grab" some of his time. There were no complaints about schedules or individual attention from inmates assigned two days per month for individual counseling.

5.2.4 Support Services. Educational, recreational and medical services are available to all inmates at the Youthful Offender Unit, therefore, they are accessible to program members as well. Involvement in these support services is described in the following sections.

5.2.4.1 Education. Of the inmates interviewed, 70% were active in academic education courses and 70% were active in vocational training. Thirty percent (30%) were not involved in either vocational or academic education. One inmate was not involved in any type of educational activity.

5.2.4.2 Recreation. Recreational services, though being upgraded with the addition of a new pool table, were described as minimal. Yard call was held twice a week and gym once a week. "If you're working on a detail you miss yard call, unless it happens to come on a weekend," one Youthful Offender stated during his interview. Staff and inmates also felt that there was no effort either to organize team activities or to provide hand crafts and musical opportunities. These types of activities were discussed as needed recreation and as having a therapeutic content as well.

Television was often the only recreational outlet for inmates. They commented that, unlike the problems and arguments centered around the television in other dorms, F-Hall did not have problems associated with the use of the TV. The program schedule was controlled by the counselors. If there was a program that an inmate wished to view, he would request the time slot and the show would be placed on the schedule if the time and day were open. The TV room was quiet. Inmates reported they were comfortable with the scheduling and that they could hear the television when programs were on. They attributed the quieter, more organized operation of television time not only to the scheduling procedure but to the respect for each other fostered by the program.

5.2.4.3 Medical Services. Medical services were considered by some inmates to be "poor to mediocre" and by others to be "pretty good". In general, the inmates interviewed found no difference between treatment of program members and inmates not in the program.

Counselors commented on the need to work more closely with the medical staff. They considered communications between both staffs to be poor and in critical need of improvement. For example, they wanted to establish a routine way of informing staff of which clients were on certain medication and who might have epilepsy. Lack of information regarding medicated inmates and inmates with conditions such as epilepsy was considered to endanger the safety of the client and his peers. Counselors harbored an additional concern regarding the potential for inmates to save up prescriptions; staff perceived that supervision of the consumption of medication was a problem. The psychologist/consultant expressed the same concern when he was interviewed.

Implementing methods to facilitate a stronger link between medical services and counselors in the drug and alcohol program is encouraged. Correctional staff should be apprised of the counselors' concerns regarding the saving of prescriptions.

5.2.4.4 Correctional Staff. While the on-site evaluation was in progress, an effort was initiated to have correctional officers permanently assigned to the drug/alcohol unit. The warden requested a list of correctional officers who in the estimation of counseling staff would best facilitate the in-house therapeutic program. One correctional officer on duty during the program assessment was interviewed and, coincidently, he was later recommended as an officer who should be assigned to the drug/alcohol unit. Correctional staff were considered to be another avenue of support for the community program but only if the security personnel were interested in rehabilitative approaches in lieu of punitive.

During the interview with the Correctional Officer, he was asked to define the purpose of the drug/alcohol program; he defined the program in rehabilitative terms. When identifying changes he would like to make, he cited a reduction in the dorm population to an average of 50. In addition, he emphasized the need for a more thorough screening of inmates to ensure that those in the program really wanted to improve. Not only did he recommend that inmates be more thoroughly screened but that security staff assigned to the dorm also be screened. He believed that officers who were prone to criticize and punish would not be suitable candidates for security on F-Hall. The security officer stressed the link between security staff and counselors and a closer relationship between counselors and inmates in order for the program to be successful.

The support of security staff was a tangential issue at the time of the on-site assessment. However, assigning Correctional Officers with desires and attitudes comparable to those of the correctional officer interviewed, the potential for security to become a valuable adjunct to the program is real.

5.2.5. Continuity of Services. Unique to the Youthful Offender program, DOR counselors must prepare a post-release plan on each Youthful Offender client. These preliminary release packages are requirements of the Youthful Offender Act. The post release plans link programs such as the drug/alcohol unit begun in the institution to "free world" parole requirements.

Post-release plans prepared for Youthful Offenders include: (1) planned residence upon release, (2) planned employment, (3) notation of skills acquired while incarcerated, and (4) enumeration of treatment program involvement. Recommendations and/or Special Conditions such as "AA participation--Narcotics Anonymous participation--drug screening tests periodically--Mental Health counseling" etc. may be indicated on the post-release plans. Follow-through with drug and alcohol counseling for Youthful Offenders can be recommended via the plan, but cannot be enforced by those recommending the activity.

Youthful Offenders from the drug/alcohol program rarely go through transitional centers. During the course of the grant program and according to monthly report data only 7% of the Youthful Offenders leaving went through a transitional center. There is an in-house pre-release program, however, that is a part of the drug/alcohol program. The pre-release program includes six films accompanied by a workbook. The inmate proceeds through these films and accompanying materials as he prepares to leave. The tape/film series includes:

1) A reality overview

2) Habits + Attitudes = Outside Performance

3) Making the Transition

4) Motivation and Personal Accountability

5) Half Step Process to Change, and

6) Release Goals and Imprinting.

After the inmate completes this pre-release series, he is sent to interview with the Department of Labor contact.

Resource materials to aid counselors in preparing pre-release/post-release packages were scarce. The senior counselor had spent extra time and effort trying to locate information on community treatment programs throughout the state. The one valuable tool he had received in April 1981 was a copy of the DHR guide on drug/alcohol programs indexed by community. This handbook was the only real resource guide accessible. Both counselors were frustrated at the absence of information regarding available programs and opportunities, since they could not apprise their clients of services and provide telephone numbers and names of persons to contact as they wished to do. Parole officers were acknowledged to have access to many of these services and to be familiar with individual communities, but often the client needs some immediate contact and link--a need that exists before the Parole Officer is familiar enough with the person or case to recognize the need. There is also the issue of trust. Information provided by an institution program counselor who has already formed some bond with the client may be more acceptable than information from a relative stranger. The client also may not be trusting enough in the early stages of release to express his need for counseling and support to a Parole Officer. But he may be willing to contact a community resource that provides the service he is seeking.

5.2.6 Recommendations.

* Correct fluidness in counseling schedules. Group counseling schedules need to be defined and routinized. Individual counseling should be scheduled for all drug/alcohol clients. Both counselors need to follow a bi-monthly schedule of individual sessions per client.

* Maintain the population of the program down around sixty. Managing a therapeutic community of 75 to 80 clients and providing group sessions that will benefit members become too difficult with a population this size.

* Review the selection process for in-house structure members. If program members can play a part in identifying potential structure members, they should be allowed input. An assessment of the job performance of each structure member by his peers may reduce the tendency to over-react and wield power and position.

* Continue to develop the use of security staff as an adjunct to the program. Assigning interested officers to F-Hall is applauded and recommended.

* Implement a formal communication system between counseling and medical services.

* Advise correctional officers to increase their scrutiny of the consumption of medication.

5.3 Metro Correctional Institution

In the beginning months of the grant funded program, Stone Mountain Correctional Institution housed the second of the two new drug and alcohol programs. The original plan called for a drug and alcohol therapeutic community to be housed in an institution in the metropolitan area, and Stone Mountain Correctional Institution met this qualification. When Metro Correctional Institution opened, the program was transferred to the new facility. Screening candidates for the drug and alcohol program began the first couple of months that Metro Correctional Institution was operational. During this same time the program continued at Stone Mountain Correctional Institution until each member had an opportunity to complete the program. The psychologist/ consultant served both facilities during the transfer, screening clients at Metro Correctional Institution and running group sessions at Stone Mountain Correctional Institution.

When the actual on-site evaluation was conducted, there was no longer a program operating at Stone Mountain Correctional Institution. Staff had been transferred to Metro CI and program records had been forwarded. Because of this complete transfer of operations, Metro Correctional Institution will be the focus of this report, not Stone Mountain Correctional Institution. The two programs are similar, and there is some continuity in staff. The Senior Counselor at the Metro Correctional Institution drug and alcohol program was involved in the Stone Mountain project and the psychologist/ consultant was involved with both projects as well.

The drug and alcohol program at Metro Correctional Institution uses an in-house 24-hour therapeutic community approach, relying upon peer influence as the primary change vehicle. The men occupy one range of H-Building which has a design capacity of 14 beds. The program had 13 members at the time of the on-site assessment. The program members are distributed between each counselor's caseload for individual counseling. Each counselor has between 40 to 50 additional clients on his caseload.

The community living arrangement is seen as the principal change agent for the program, in that it allows inmates the opportunity to informally deal with their own deficits while receiving support from peers. There is a commonality of issues in the group, so personal deficiencies are not unique.

The program as designed is to last six months; the participants spend the first three months identifying personal issues which are then formed into a behavior contract. The remaining three months are directed toward contract completion.

5.3.1 Intake. The intake process for men at Metro Correctional Institution is the same as that for men in the remainder of the system. Each inmate goes through Georgia Diagnostic and Classification Center (GDCC) where he is tested, counseled and receives a physical examination. Recommendations are then made for assignment to an institution; Central Office Offender Administration makes the final assignment decision and cuts transfer orders.

It is from the group received at Metro Correctional Institution that a sub-population of potential group members is identified for screening. When reviewing who will be screened three major areas are considered: (1) dependency, (2) program suitability, and (3) motivation. The Metro Correctional Institution drug and alcohol program handbook states the pre-screening factors as follows:

1. Salient factors in recognizing dependence will be:
   (a) The period of time over which drugs have been abused.
   (b) The quantity and type of drug abused. Occasional drug use and experimentation will not be considered as indications of drug dependence which will require special intervention.
   (c) The impact of drug use on an individual's level of functioning.
2. Documentation to determine suitability for program participation.
   (a) Utilization of Jackson Diagnostic Center materials in regards to personal interviews and social histories.
   (b) Referral from Counselor or Institutional Psychologists.
   (c) Through interviews, the individual shows there is a need present which should be addressed.
3. Essential skills which are necessary to determine an individual's motivation for changes.
   (a) An adequate level of intellectual functioning which would be an IQ of 70 or higher.
   (b) An individual must have an awareness of his surroundings, his deficits and limitations, as well as his goals of the future. He must have good reality contact.

5.3.2 Screening. Information describing the screening process was acquired from the program handbook and through interviews with staff. Screening can be initiated through referrals from the institution's counselors or by direct request from inmates. The candidates referred to or requesting admission are interviewed by the program psychologist/consultant and then interviewed by one of the program counselors. The Counselor (OR) does all the screening. Names of individuals recommended for group membership are forwarded to the Classification Committee after a consensus is reached on the suitability of the

inmate's participation. Approval from the Classification Committee sanctions the inmate's assignment and movement to the drug and alcohol program/unit at the appropriate time.

Specific qualifications considered during the screening interviews at Metro Correctional Institution include all the ten points provided in the following list. The information is excerpted from the program handbook.

Issues and Qualifications Which Should Be Addressed
During the Screening Process

1) Significant history of drug or alcohol abuse.
2) Suitable motivations to deal with problems.
3) Capacity of individual for self-disclosure, insight, openness, and the ability to handle confrontation.
4) Ability to deal with fear that often results from confrontation (in a constructive sense).
5) Family background of the individual.
6) Tendency towards self-destructive behavior.
7) Ability of individual to deal with self-destructive behaviors and bring them up when they are noticeable.
8) If the individual were to sabotage his progress in the program, how would he do it?
9) Ability to deal with racial issues and racial balance of the program.
10) Make individuals aware of policies at the Metro Drug and Alcohol Program.

Interviews with the program counselors and the consultant concerning factors affecting admission resulted in a unanimous "no effect" regarding the criteria of age and type of drug. Length of sentence and group size were affirmed as criteria affecting admission. The psychologist/consultant differed slightly with the counselors in the responses she gave regarding what criteria could affect admission to the program. For example, the consultant indicated that duration of drug usage could affect admission, if the usage indicated an experimenter; that is, an experimenter would not be a likely program candidate. Other factors which would affect admission according to the consultant included very low IQ's, and/or brain damage. In addition, the consultant recommended that the screening interviews probe for conflict in persons. "If a person doesn't have conflict, they're less eager to deal with and admit problems." Therefore, the consultant uses "conflict" as an admission criterion.

Disciplinary infractions were reported as an additional or miscellaneous factor affecting admission. This element was particularly associated with the program during its operation at Stone Mountain Correctional Institution. Disciplinaries could affect an individual's admission to the Stone Mountain program by prohibiting him from participating in the counseling program.

Again, the screening process and final acceptance are based on available space in the program. When the counselors and the consultant were queried as to whether the group size affected admission, the responses were affirmative. The capacity of the living unit for the Metro program is 14; the size automatically limits group membership.

When program participants at Metro Correctional Institution were interviewed about the selection process, they were asked what type of process was involved in becoming a member. Responses varied in detail and in the presentation of the sequence of events; however, everyone was screened through an interview. Some participants stated they were interviewed by the program counselors, some were interviewed by the psychologist and others were interviewed by both. When asked if they would change the selection process, no one was in favor of changing or adding to the selection process he experienced. (Inmates who were screened and rejected were not interviewed.)

5.3.3 Treatment Programs. The treatment program at Metro CI included both group and individual counseling. Each of these components is described below.

5.3.3.1 Group Counseling. The drug and alcohol treatment program at Metro Correctional Institution has an established schedule for group counseling sessions and activities. Group counseling and other group activities occur on Tuesdays and Wednesdays of each week. Specifically, every Tuesday morning from 10:00 a.m. to 11:00 or 11:30 a.m. the counselors and group members play basketball; following basketball they have group meetings. Group meetings are held both on Tuesday mornings and Tuesday afternoons. One counselor co-leads each session with the psychologist/consultant. The group counseling sessions last approximately one hour. On Wednesday evenings community meetings are held. They are run primarily by inmates although counselors are involved. Issues regarding room assignments/changes and other house problems are aired at these Wednesday night meetings.

The group counseling sessions vary in format depending upon how the clients react and if the discussion requires prompting from the counselor/consultant. Some inmates expressed a feeling of uneasiness and intimidation regarding the consultant, because of her method of putting inmates on the "spot" and making them feel "small". "Her questions are hard to handle," reported one inmate. No matter how uncomfortable the clients said they were initially, each completed his discussion of the consultant indicating his increased ability to handle the situation and her questions.

How is it determined that a participant has successfully completed the drug and alcohol program? This question was asked inmates, counselors and correctional staff alike. In addition to the six-month time factor, the most frequent response was "self-assessment;" that is, there appears to be no quantified or objective termination criteria, only a subjective assessment. A more formal progress rating was done during the Stone Mountain Correctional Institution operation but has not been replicated at the Metro Correctional Institution project. The baseline is that success is based on completing Phases I & II in six months.

The inmates and the consultant interviewed all expressed the need for more group counseling activity; the one- to one-and-a-half hours per week (Tuesday a.m. or p.m.) was considered insufficient for handling problems. The consultant suggested that as a minimum their group time should be doubled. In addition to the recommendation to increase group session time, the consultant also recommended defining topics or themes for at least one group per week. Suggested group ideas included:

1) meditation/relaxation exercises;
2) assertiveness training;
3) child rearing;
4) communication skills;
5) drug education; and
6) how to use leisure time.

The group counseling sessions could continue using the same therapeutic approach, but could be improved by adding educational sessions on topics such as those previously identified. Realizing budget constraints, the consultant suggested using volunteers to provide evening courses on these topics.

5.3.3.2 Individual Counseling. Individual counseling is available to each program inmate. The inmate can set up a scheduled time, drop in if convenient and sometimes the counselor will request a meeting. Both project counselors stay late two evenings a week. This allows an opportunity for individual sessions to clients who have school and other daily routines that preclude them from seeing their counselor during the day. It also helps in scheduling a counselor to oversee Wednesday evening community meetings. There is no counselor on-site during weekends, although there is a designated staff member on-call in case of emergency.

5.3.4 Support Services. Metro CI has not fully implemented all their support services. For example, there is an absence of vocational training opportunities. Academic education is, however, fully operational. Medical services and recreational activities also are provided. These are available to program members just as they are to the general population.

5.3.4.1 Education. Five of the thirteen program members were interviewed. All were participating in academic courses. Three program members were enrolled in GED courses and two in college courses. Mercer University in Atlanta provides college courses during the evening. No one was involved in vocational training. Vocational training or the absence of opportunities was an issue raised by several program members. They expressed a desire to participate in vocational instruction but complained that there were no courses available.

5.3.4.2 Recreation. The major recreational activity for those individuals interviewed was the weekly ball game held on Tuesday mornings. Outside of this activity one individual spent time singing in the institution band, another was involved in drama and was soon to present a play at the women's prison and a third lifted weights when he had the chance. Television was the most commonly used means of recreation. It was emphasized that there were no problems with the TV, unlike on other "ranges". The community cooperated and members were quiet while the TV programs were on.

5.3.4.3 Medical Services. Although medical services are accessible to the program members and members are treated the same as the remainder of the population, the greatest complaints regarding medical services at any of the four pilot programs came from the five inmates interviewed at Metro CI. The most negative reactions were associated with the attitudes of medical staff. Inmates described the medical services as follows:

- "poor--prove you're dead before you can get an aspirin"
- "no sick call on Wednesday, Saturday or Sunday"
- "inadequate, my ankle was swollen and he told me I was faking"
- "they don't believe you unless you're cut or something"
- "said they'd check my blood pressure cause I've hypertension . . . haven't yet and I've been here since January"

Medication is dispensed in the same way that it is at the other institutions. There was no concern expressed by the staff or the consultant regarding the handling or the distribution of prescriptions and medication to inmates.

5.3.4.4 Security. Security staff were neither informed about nor involved in the drug and alcohol program. During the period of time the unit had been operating at Metro CI, correctional officers assigned to H-Building had changed almost with each shift. There was no integration of security staff into the therapeutic community and no core of security staff assigned to H-Building.

Through interviewing the CO on duty during the time the assessment was conducted, it was found that he had no orientation regarding the purpose of the program. He, therefore, felt unprepared to respond to an inquiry, as to whether the purpose of the program was being accomplished. However, the CO did point out that it was easier to work with the inmates in H-Building, since "they woke up without problems and they looked out for one another." He also commented that the program members acted like a family and this affected the behavior of the non-program inmates living in H-Building. Without being aware of the program's intent or purpose, the security officer had witnessed a difference in program members' behavior--a positive difference.

5.3.5 Continuity of Services. Continuity of services was a concern not just for those leaving the institution but for program members who would complete their six months and remain at Metro Correctional Institution. Out-patient or graduate client services had not been determined when the evaluation was conducted. Inmates brought up their concern for returning to "general population" during their interviews. There was an acute awareness of the difference in behavior, trust, and safety associated with the in-house community and a reluctance to leave the group after completing six months.

Most inmates completing the program will be close to discharge, and will be referred to community agencies directly by the counselor or by parole officers. However, counselors at Metro Correctional Institution were only slightly more equipped to provide contacts and telephone numbers of community treatment/service organizations than those previously described. This was primarily because of the familiarity with programs in and around the metro Atlanta community. A copy of the drug and alcohol handbook provided by DHR and on-hand at the Youthful Offender Unit was not available at Metro Correctional Institution. Resources and contacts were self-obtained.

Because the program at Metro Correctional Institution had just been initiated, the percent of clients sent through a transitional center as part of the follow through of services is unknown. Stone Mountain CI sent approximately 10% to transitional centers during its period of program operation, perhaps this can also be assumed for Metro. In any event a small number is likely because of the large male prison population and the small number of transitional center bed-spaces. Probability alone dictates that few will go through a center. Consequently, it is important that post-release plans for potential parolees consider the drug/alcohol issue and provide continued treatment and support. For those exiting without a period on parole it is more important that counselors in the facility have information available to provide those leaving in case continued counseling is desired.

5.3.6 Recommendations.

* Increase program time by adding educational group sessions on an ad hoc basis once monthly. This can expand the scope of the program. Use volunteers or interns to eliminate additional work on staff.

* In lieu of weekly group co-leadership with the psychologist alternate so that an extra group session can be added. For example: Week 1 group A meets Tuesday morning with only the consultant and group B meets with counselor and consultant in the afternoon. Group A meets with counselor Thursday afternoon. Week 2: reverse schedule for group B. This will add one extra group session every other week for each group and still not impact on counselor/consultant work schedule.

* Increase the available vocational training opportunities. Survey inmates to determine interests as well as institutional need.

* Integrate Security staff into the drug and alcohol program. At a minimum all security staff should have a general knowledge of the purpose and design of the program. A brief orientation should be delivered to inform Correctional Officers. Assign a selected cadre of security personnel interested in rehabilitative programs to H-Building.

5.4 Georgia Industrial Institute

Georgia Industrial Institute's drug and alcohol program was reinstated with the 1979 grant funding. The program which had operated since the 1973 grant had closed due to facility construction. The program was relocated to newly constructed quarters in Building B. The architectural design of this structure is like that of many new institutions: a security station is flanked on both sides by upper and lower ranges. The drug and alcohol program occupies two ranges with a capacity of 28 individuals.

Once an individual is admitted to the drug and alcohol program at Georgia Industrial Institute, he remains there until he is paroled, his sentence expires, or he is sent to a transitional center. To be eligible for the program an inmate must have at least 12 months remaining before his parole eligibility or discharge date. Of the five program members interviewed, length of time in the program varied from 3 to 18 months.

Program members recognized that once in the group, barring any rule violations, they would remain members until their release. This aspect of the Georgia Industrial Institute program differs significantly from the other three programs that by design identify four to six months of program membership; although in practice there is often more similarity to the Georgia Industrial Institute program than to their own designs.

5.4.1 Intake. Intake does not differ any for the inmates at Georgia Industrial Institute; they also are sent through Georgia Diagnostic & Classification Center. The evaluation assessment did not discover any intake procedures unique to Georgia Industrial Institute.

5.4.2 Screening. Screening inmates for potential placement in the drug/alcohol group is largely dependent upon interviews. Individual interviews are conducted with inmates who have been identified through diagnostics as drug abusers or as referred by counselors. The criteria for evaluating and identifying candidates for inclusion in the program include:

1) available space in the program (average 28),

2) consensus that the individual has potential for growth through the program,

3) within one year of parole eligibility or discharge date,

4) no evidence of psychotic problem solving process,

5) not acting out homosexually, and

6) no person whose crime has labeled him a major security risk.

In addition to the aforementioned criteria excerpted from the program handbook, one program counselor and the project consultant were asked whether admission could be negatively affected by: (1) age, (2) duration of drug usage, (3) type of drug used, (4) history of emotional illness, (5) length of sentence and (6) size of group. Age and type of drug used were not considered to be factors impacting upon an individual's admission. Emotional illness, on the other hand, was indicated by both to be a factor for rejection or removal; particularly if such a problem hindered communication or was potentially negative for the group as a whole. However, a history of emotional illness would not in itself affect admission.

The length of an individual's sentence was affirmed as a factor affecting admission, thus supporting the prescribed documented screening criteria. Program staff also reported that the size of the group would affect admission, because without an available bed a new member would not be accepted into the project. No outclients are accepted.

Program participants who were interviewed were each asked, "What type of selection process was involved in becoming a member?" Each responded that the screening of potential members was done by the counselors through interviews with the inmates. Program members reported that questions they

were asked covered topics from family problems and drug habits, to their expectations of the group process. When asked if they would change the selection process, only one respondent replied "yes". He elaborated by suggesting that the entire group be allowed to talk with and interview the program candidates prior to admission into the group project.

5.4.3 Treatment Program. The most serious issues for the client to overcome or to deal with, according to interviews with the Georgia Industrial Institute counselor and consultant, are for him to admit he has a problem, that drugs are a problem and then to develop a trust for the in-house community as a group that will support him while he deals with his problem. Trust is the most critical issue in the treatment program.

A client's progress is measured subjectively, though there are strict rules for which disobedience can have the member removed with no possibility for returning. Program members at Georgia Industrial Institute were unsure how successful program completion was determined; however, one participant said for him it would be when he was "satisfied". The Georgia Industrial Institute handbook indicates that successful completion of the program will be based on individual in-depth evaluations of each inmate. To be considered a "successful completion," consensus must be reached between the group leaders concerning an inmate's personal growth, responsibility and rehabilitation.

5.4.3.1 Group Counseling. A scheduled routine pattern for group counseling operates at Georgia Industrial Institute. There are two groups, each meets once a week on alternating Wednesdays and Thursdays. The groups are approximately the same size and are confrontation, discussion, problem-solving eclectic modalities. They are not theme or topical by design. The groups meet with the psychologist/consultant every other week; thus the variation in meeting times. The psychologist's role also varies. Sometimes he is an observer and at other times an active group member, but always he provides some constructive feedback to the counselors on handling group situations. This is in fact his primary function.

The group sessions are held in the afternoon which means that those individuals assigned to work detail or class at the appointed group meeting time are excused to attend the counseling session. The drug and alcohol counseling session takes precedence over other activities.

5.4.3.2 Individual Counseling. A once a month meeting between the drug and alcohol program members and their individual counselor is standard. One of the two program counselors is assigned as the individual counselor to each program member. However, each counselor has an additional caseload of approximately 35 non-program members. These individuals also require one-to-one assistance from the project counselor.

The counselor schedules monthly meetings with clients. In addition both program and non-program members can drop in, request additional time or the counselor can ask to see an inmate. There were no complaints or problems conveyed regarding individual counseling schedules or time.

5.4.4 Support Services. Support services include educational activities, recreational, medical services and security. These are support services that are directed toward bettering the drug and alcohol program and assisting individual

members. However, at GII, the drug group members themselves provide a service. This is unique among the four pilot projects. The members support the "Get Smart" operation of a local girls club. Girls club members are told of the "path" to prison and of inmates' personal experiences. The drug program members try to demonstrate the "no-win" route and show the girls there is an alternative. Support services at Georgia Industrial Institute are a two-way street. While providing a community service, the inmates too find a little "self-esteem" and self-help, through this process.

5.4.4.1 Education. Academic and vocational courses are provided at Georgia Industrial Institute, and program members are encouraged to participate. There were complaints that there are no vocational training programs from which to choose, and in fact only one of the five inmates interviewed was involved in vocational training. However, referring to Section 3.5.1, Georgia Industrial Institute has more vocational opportunities/choices than any other facility. Academic participation was divided, with two individuals in GED and two in college courses. One person was not involved in academic instruction. He was involved in no education activity of any type.

5.4.4.2 Recreational. Participation in recreation was minimal; only two of the five persons interviewed indicated an involvement in recreational activities: one was engaged in weight lifting, the other in softball. There was no particular pattern discernable as to the cause of non-participation by the other three, one was in college and said "time didn't permit"; one of the other two was involved only in GED and the last person was involved neither in academic nor vocational training. He was assigned solely to details each day driving a tractor and was too tired in the evening for recreation.

The counselor commented that movies, intramural sports and gym twice a week were available to the program members, but recreation was voluntary. There was no group recreational activity in process.

5.4.4.3 Medical Services. Comments on the status of health care at Georgia Industrial Institute ranged from a positive commentary by counseling staff and some inmates to negative remarks by other program members. Correctional officers made no statements regarding medical services.

There is a hospital floor at Georgia Industrial Institute with an in-house staff doctor and physician's assistant as well as other support medical personnel. Medication is dispensed by the medical staff and sent to dorms in locked containers. Prepared medications are distributed by correctional officers to the proper inmates as indicated. This holds true for inmates living in the general population, with no difference in the treatment of program and non-program members.

Inmate responses to the question, "what type of medical services are available to program participants" evidenced a broad range of opinion:

- "medical floor, they'll treat you right"
- "went to get glasses, took 6 months"
- "don't want to deal with people"
- "conflict between Talmadge and staff here"
- "not too good".

5.4.4.4 Security Staff. An effort was made at Georgia Industrial Institute during orientation to the new building to formally orient security staff to the drug/alcohol program. As one officer stated, "I was trying to learn the control panel and rehabilitation" at one time. A refresher session regarding the program's purpose and operations was requested by security staff interviewed.

Security staff are assigned on a more permanent basis to B-Building than other security posts which rotate frequently. This comports with the ideal arrangement for therapeutic communities. Officers are screened, and if they don't work out, are transferred. "The method of security should be firm but fair and if it isn't ,the correctional officer is removed". Security staff have been requested to call counselors if an inmate on C or D range of B-Building acts out. This would not be the case for someone from general population, but this procedure is followed for program members. There is a better relationship between correctional officers and program counselors then generally exists between security and treatment personnel. Security staff tries to support the therapeutic community, but it takes a special type of officer to accommodate this support arrangement between security and treatment staffs.

During interviews with the correctional officers, they recommended that to further integrate security and treatment, correctional officers be allowed to participate in community "house" meetings--sessions held to discuss housekeeping issues. The correctional staff felt they could help prevent potential problems if they were involved in these meetings.

5.4.5 Continuity of Services. A client in good standing is never removed from the drug and alcohol program and returned to general population. The only exit available is parole, transitional center or expiration of sentence; therefore, no institutional follow-up activities such as out-client counseling have been needed. No out-client or graduate caseload exists. The same follow-through services are available to Georgia Industrial Institute inmates as are available throughout the system; 18% of those exiting the GII between January 1980 and March 1981, were sent through a transitional center, 64% were paroled. Post-release plans are required for paroled inmates not identified as Youthful Offenders; however, such plans are the responsibility of and are to be executed by parole officers not by DOR's institutional staff. Georgia Industrial Institute counselors do not prepare post-release plans for non-Youthful Offenders departing the institution via parole.

The remaining exit population--those with sentences expiring or commuted sentences--are to have pre-release interviews and post-release plans. The lack of available resources and reference information affected the thoroughness with which Georgia Industrial Institute counselors were able to provide pre-release services. In addition, time caused the absence of some pre-release services. For example, in "mass-release" cases counselors are not informed soon enough to provide exit interviews. Even when exit or pre-release interviews are conducted, the counselor has little information, such as community services and contacts which he can pass along to the inmate being released. There are no handbooks with information to assist in this process. Again the only certain resource is the Department of Labor contact.

There is an additional program problem regarding continuity of services. No exit interview or formal exchange of "good-byes" is scheduled with group members. This issue particularly disturbs the psychologist/consultant, who feels that abrupt departures such as mass releases and unanticipated departures are

damaging to the group process because of the lack of closure. A family member is leaving and the de-population and future absence are major emotional interruptions in the lives of the remaining members. Those left behind are troubled and so is the inmate leaving for he leaves the support derived from the group. This need for an exit process has been recognized but has not been addressed.

5.4.6 Recommendations.

* Provide a refresher training course for correctional officers assigned to B-Building to inform them of the purpose and procedures of the drug and alcohol program.

* On a trial basis have a representative correctional officer attend and participate in community "house" meetings.

* Develop and implement an exit process, one that is quick to conduct and adaptable to the circumstances of the departure.

* Initiate post-release group sessions for group members remaining in order for them to deal with their personal emotions concerning the departure of one of the group.

* Promote participation in vocational education.

* Develop group-focused recreational activities in an effort to educate and instruct inmates on constructive ways to use leisure time.

6.0 DATA ANALYSIS

Two types of data were considered indicative of the impact/effect of the drug and alcohol programs upon their members: (1) disciplinary report rates including the resulting amount of timeout and (2) return-to-prison rates. Disciplinary reports were used to gauge impact on inmate behavior while institutionalized. Return-to-prison data were used to determine longer range effect. Caution on return-to-prison data has already been expressed. The initial results, however, are presented in order to show what is occurring in the early stages of the analysis effort.

Before presenting the results of these two data categories, a description of the two comparison groups is important. Comparison Group One is made up of drug and alcohol program members and Group Two includes potential program members who were screened and who met criteria for inclusion in the program but either (1) their sentence length did not comply with the required timeframes or (2) they were not interested in participating--they were not willing to volunteer. Seventy-nine percent (79%) of Group Two were excluded from program participation because of insufficient time remaining on their sentences; so shorter sentence length is actually an artifact of the selection process in the non-program member comparison group. Twenty-one percent (21%) of Group Two declined the opportunity to participate.

The inmate data for both Groups One and Two was compiled from monthly reports submitted by each project. These records were used to identify inmates who had been screened, those who were accepted or rejected, why they were rejected and those who wished not to participate. In addition, program counselors were asked to review a composite list of program members and identify entry and exit dates and note the type of exit such as paroled, removed for rule infractions, and/or sent to a transitional center. Following this step, a computerized program database was created.

The information in the computer system is only as good as the data provided by the programs. For example, the drug and alcohol project at the Women's Unit either failed to submit monthly reports or submitted partially completed records. Consequently, there is no female comparison group. Female offenders screened and rejected because of sentence length problems and those unwilling to participate were so seldom noted that Group Two does not include any female offenders. Female offender data, however, are presented for program participants but are not used for direct comparisons.

Limited data are available for program participants at Metro CI simply because of the short time the program has been operational. Even though the program was transferred from Stone Mountain CI and data for that program were available, combining the information was avoided since the settings, staff and support services differed.

The majority of data used for analysis is from Georgia Industrial Institute and the Youthful Offender Unit at the Middle Georgia Correctional Institution. Groups One and Two are comprised largely from the data supplied by these two projects. Coincidentally and fortunately, these programs have similar inmate populations--young male offenders. However, GII program inmates are not sentenced under the Youthful Offender Act. Nonetheless, the populations used

for the analysis are dominated by these two facilities and consequently by young male offenders.

6.1 Description of the Populations

6.1.1 Group One--Program Members. The data available on program members at the time of analysis included: 245 males and a subset of 44 females for a combined total of 289 inmates participating in the drug and alcohol program. More inmates have been served at this writing; but at the cut-off period used for data analysis 289 records were accessible.

The average age of the 289 program members was 21.8 years. The average age for the male offenders participating in the program was 21.1 years and for female program members the average age was 25.6 years.

The racial composition was dominated by whites. White males represented 79% of all men in Group One and white females accounted for 64% of the female subset. The population was comprised of 194 white males, 51 non-white males and 28 white females and 16 non-white females.

For male offenders in Group One the most serious offense types were property crimes, constituting 63%. Twenty-four percent (24%) were violent personal crime types and 11% were drug related. Group One female offenders' most serious crime type differed from that of their male counterparts. Twenty-five percent (25%) of their most serious offenses were property and fifty-five percent (55%) were of a violent personal type. A higher percentage of women likewise had life sentences.

Of the diagnostic behavior descriptions assigned program members, 51% of the behaviors identified included alcohol or drug related involvement, i.e., alcoholic, drug abuser. Refer to Appendix 13 for a breakdown of inmates' diagnostic behaviors.

6.1.2 Group Two--Non-ProgramMembers. The comparison group of non-program members was comprised of 68% white males and 32% non-white males or a total of 45 white and 21 non-white male offenders. A total of sixty-six male offenders was used for comparison. These offenders were screened and met admission criteria except for sentence length and/or willingness to participate. The greatest number of males in the comparison group are from GII.

The average age of the male offenders in Group Two is 21.0 years. This is also the average age of Group One male offenders. Group Two ages ranged from 18.8 years to 28.2 years.

Property crimes accounted for forty-five percent (45%) of the most serious crime types for members in Group Two. Violent personal crime types represented 35% and 2% were non-violent personal offense types. Group Two was eleven percentage points higher in the violent personal crime type category than their male Group One counterparts. This may be a reflection of the screening criteria which uses sentence lengths as an admission factor. Violent crimes tend to be coupled with longer sentences and, if sentences were too long to meet program admission criteria, an individual was not accepted. He would by virtue of the screening procedure and rejection be admitted to the Group Two database.

Forty-four percent (44%) of all inmate diagnostic behavior codes for Group Two inmates identified some type of substance abuse/use tendency. Thirty-one percent (31%) of the behavior descriptors noted "drug abuse" behaviors. This is approximately ten percentage points below the Group One figures indicating that perhaps Group One program members had a slightly higher need for treatment than did the Group Two non-program participants.

6.2 Disciplinary Reports and Timeout Rates

Disciplinary reports and timeouts are used to weigh the effect of program participation on an inmate while institutionalized. To compare "pre-" and "post-" data, program screening is considered as the departure point for Group Two data analysis. This is based upon the fact that if sentence lengths were appropriate and/or an individual consented to participate, screening would have marked the transition from general population to program membership. Group One pre- and post-program data were based upon program entry.

Using program entry to distinguish "pre-" and "post-" data, disciplinary reports were calculated for the 289 Group One members. Prior to program entry Group One had accumulated 213 disciplinary reports; after program entry and throughout the life of the grant there were 121 DRs, representing a decline of -43%. If female offender data is excluded a pre-program entry total of 171 disciplinaries remain attributable to the male program population. Post-program totals are 100 disciplinaries resulting in a forty-two percent decline (-42%) for male program members.

Comparing Group One data with Group Two pre- and post-screening, program members have a slightly greater decline. Using the same time constraints and method of calculation, a pre-screening total of 87 disciplinaries was determined for Group Two and a post-screening drop to 51 DRs for a forty-one percent (-41%) decline. Refer to Tables 3 and 4 for the data display.

TABLE 3

COMPARISON OF DISCIPLINARY REPORT RATES:
PROGRAM MEMBERS AND NON-PROGRAM MEMBERS

Program Members (Group One)			Non-Program Members (Group Two)		
#DRs Pre-Entry	#DRs Post-Entry	Percent Change	#DRs Pre-Screening	#DRs Post-Screening	Percent Change
213	121	-43%	87	51	-41%

TABLE 4

COMPARISON OF DISCIPLINARY REPORT RATES:
MALE PROGRAM MEMBERS AND MALE NON-PROGRAM MEMBERS

Male Program Members			Non-Program Members		
#DRs Pre-Entry	#DRs Post-Entry	Percent Change	#DRs Pre-Screening	#DRs Post-Screening	Percent Change
171	121	-42%	87	51	-41%

The data displayed in the preceding table is an aggregate of the data available for both Groups One and Two; but as already stated the aggregate data is spotty for many institutions--that is, not every month is accounted for and data per institution program is incomplete. However, one institution did submit complete records on a per month basis during grant operation. Georgia Industrial Institute routinely provided records, therefore Groups One and Two are dominated by this data. In an analysis of aggregate data, however, inconsistent and sporadic reports from programs may off-set real outcomes/effects. Consequently, the more appropriate and statistically valid comparison is to use Georgia Industrial Institute data and compare Group One and Group Two using only this institution's information. This single focus and data analysis follow on Table 5.

TABLE 5

GEORGIA INDUSTRIAL INSTITUTE
DISCIPLINARY REPORT RATES
PROGRAM MEMBERS VS. NON-PROGRAM MEMBERS
JULY 1979 - MARCH 1981

Program Members			Non-Program Members		
#DRs Pre-Entry	#DRs Post-Entry	Percent Change	#DRs Pre-Screening	#DRs Post-Screening	Percent Change
79	23	-71%	87	47	-45%

The number of disciplinary reports pre- to post-program entry dropped by fifty-six reports or -71% for drug and alcohol community members. This decrease is twenty-six percentage points greater for program members. In great part the decline can be attributed to the program structure and program rules. The GII drug and alcohol program is particularly rigid about remaining free of major disciplinary reports. A participant can be removed from the program for a major disciplinary such as possessing contraband such as drugs and is automatically removed upon receipt of his second disciplinary report. Once a member is removed from the program as a result of a punitive step he may not re-enter. Members are aware of this procedure. Thirteen of the fourteen

negative terminations or unsuccessful exits from the program were for program and/or institutional rule violations. This suggests that strict rule enforcement of the program may lead to fewer disciplinary reports. Other reasons for the decline may be as noted in Section 5.4.4.4, the correctional officers are more willing to work with the program and are less quick to write up members. The correctional officer has agreed to call a counselor if there is trouble. Because inmates in the program have a feeling of family and foster respect for one another, theft and violence are minimized. A caring attitude and the knowledge that each is held accountable for the actions of other program members may contribute to the significant decline in DRs too.

Time out is considered to suggest the severity of offenses which result in disciplinary reports. Assessing timeout data (Table 6) is used as an indicator of degrees of behavior change.

TABLE 6

CHANGE IN TIMEOUTS FOR PROGRAM MEMBERS
AND NON-PROGRAM MEMBERS AT GEORGIA INDUSTRIAL INSTITUTE

Program Members			Non-Program Members		
# Days Timeout Pre-Entry	# Days Timeout Post-Entry	Percent Change	# Days Timeout Pre-Screening	# Days Timeout Post-Screening	Percent Change
1,860	1,087	-42%	2,172	1,359	-37%

The change from pre-program entry to post-program appears more favorable for program participants than for non-members at Georgia Industrial Institute. The percent decrease for program members is five percentage points better. This data display again demonstrates a more favorable change in inmates exposed to the drug and alcohol program; however, what may be even more significant is the overall average number of days lost per inmate as a result of timeouts.

When comparing timeout data about Group One and Group Two members with data covering the entire institution population (Table 7), program members lose less time. An FY80 timeframe was used to calculate the average number of days lost per inmate, because data for the general population was calculated on a fiscal year and the entire year fell within the grant period.

TABLE 7

AVERAGE NUMBER OF DAYS LOST PER INMATE
AS A RESULT OF TIMEOUT IN FY80 AT GII

General Population Avg. Days Lost	Program Members Avg. Days Lost	Non-Program Members Avg. Days Lost
13	8 days	14 days

Comparing the two sub-populations with the entire institutional population, program members fared extremely well, losing an average of five days less per person for the year. Equally as significant is that the general population lost an average of 13 days per inmate during FY80 and that the special need sub-population of drug and alcohol abusers left unattended averaged a loss of one day more than the overall institution. Again, if treatment intervened then the special need population of drug and alcohol offenders who participated in the program lost an average of five days less than the general institution population and six days less than their substance abuse non-participant counterparts. This difference may suggest that programs such as the community treatment model at GII can help minimize the amount of time an individual is institutionalized by reducing the amount of time forfeited due to disciplinary behavior problems.

The final analysis approach using disciplinary reports focused on two specific types of infraction categories: (1) Violation Against Person (Code B) and (2) Contraband (Code D). Code B comparisons are presented to demonstrate the effect of the programs upon person-to-person aggressive behaviors. Code D infractions are associated with contraband violations, including drugs. When comparing pre- and post-program entry Code B and D infractions, a significant change is noted for program members with contraband violations. There is also a decline in Code B infractions but it is closely matched by the comparison group who as a whole decreased to a greater extent from pre- to post-screening. (Tables 8 and 9 present the Code B and Code D comparisons, respectively.)

TABLE 8

COMPARISON OF VIOLATIONS AGAINST PERSON (CODE B)
INFRACTIONS FOR GII PROGRAM AND NON-PROGRAM MEMBERS

Program Members			Non-Program Members		
Number Violations Pre-Entry	Number Violations Post-Entry	Percent Change	Number Violations Pre-Screening	Number Violations Post-Screening	Percent Change
16	8	-50%	27	13	-52%

TABLE 9

COMPARISON OF CONTRABAND (CODE D) INFRACTIONS
FOR GII PROGRAM AND NON-PROGRAM MEMBERS

Program Members			Non-Program Members		
Number Violations Pre-Entry	Number Violations Post-Entry	Percent Change	Number Violations Pre-Screening	Number Violations Post-Screening	Percent Change
10	2	-80%	15	10	-33%

The significant reduction in Code D infractions, again is considered as a positive outcome of the program and its effect on behavior.

Disciplinary report data accompanied with timeout and code infraction information were analyzed from a number of perspectives using like population groups for comparison. In each case excluding the comparative results of Code B infractions, program member group outcomes were more favorable. These consistently more favorable outcomes for program members suggest that program participation does have some positive impact on an inmate's behavior while he is institutionalized. Behavior of Group One and Two members alike improved, but there were greater increases in positive behaviors or declines in problem behaviors for program members than for their comparison group--counterparts who did not receive the benefits of the community treatment program.

Time and additional data will resolve the questions and curiosities regarding the effects of the other three pilot programs, but given the common components of the programs as described in Section 3.0, similar outcomes are expected. A preliminary review of the change in disciplinary report rates per institution from pre- to post-entry are favorable (Table 10).

TABLE 10

CHANGE IN NUMBER OF DISCIPLINARY REPORTS FOR
DRUG AND ALCOHOL PROGRAM PARTICIPANTS BY PROGRAM

Program Institution	#DRs - Pre- Program Entry	#DRs Post- Program Entry	Percent Change
Women's Unit	42	21	-50%
Youthful Offender Unit	74	68	-08%
GII	79	23	-71%
Metro CI	18	9	-50%
Total	213	121	-43%

6.3 Return-to-Prison Rates

Tables 11 and 12 reflect the rate of return-to-prison for program members and Group Two comparison members. A total of 65 releasees from the program was used for analyzing return-to-prison rates.

TABLE 11

ONE-YEAR RETURN-TO-PRISON RATES FOR DRUG AND ALCOHOL PROGRAM PARTICIPANTS: JANUARY-DECEMBER 1980

Quarter of Release	Number Released	Percentage Returned Within-One-Year**
*January-March '80	8	
*April-June '80	12	20.0%
July-September '80	13	
October-December '80	32	

*Those released from January-June 1980 were within the parameters of the twelve-month time required to calculate return-to-prison rates. Of the total (20), four inmates returned within the first year.

**As of June 30, 1981.

TABLE 12

ONE-YEAR RETURN-TO-PRISON RATES FOR NON-PROGRAM PARTICIPANTS: OCTOBER 1979-DECEMBER 1980

Quarter of Release	Number Released	Percentage Returned Within-One-Year**
*October-December '79	7	
*January-March '80	8	
*April-June '80	4	32%
July-September '80	7	
October-December '80	2	

*Three quarters of data on Group Two were available from which to assess the rate of return to prison for non-program participants. Of the nineteen that could have remained free during the twelve-month period, six committed some offense which returned them to prison.

**As of June 30, 1981.

The non-participant comparison group had 21 releasees for the same period of time from January through December of 1980. However, an additional quarter of data was available for Group Two members, increasing the total releasees to 28. Using a one-year period to determine return-to-prison rates, 20 inmates who were program members had been released for at least a twelve-month period. Of this 20, four offenders returned to prison within the first year of their release. This is a return rate of 20%.

Nineteen non-program comparison group members were released from prison and had the opportunity to be free for at least a year. Of these nineteen, six returned within the first year. This results in a 32% return rate which is twelve percentage points higher than the rate of return for inmates with substance abuse problems who received treatment in one of the Drug/Alcohol pilot projects. Intervention through the methods used by the community treatment programs seems to have had some impact on those inmates served. If indeed it is the purpose of rehabilitation to effect a person in such a way that he or she will not return to prison, then the early results presented here are encouraging: these drug and alcohol treatment programs in an in-house community setting appears to have successful rehabilitative promise.

7.0 CONCLUSION

The uniqueness and strength of the Standards Implementation Program for Drug and Alcohol Abuse Offenders in Georgia Correctional Institutions rest with the structured therapeutic living communities--the 24-hour peer supported residential units where there was consistently reported a sense of belonging and caring. This sense of community was evidenced through inmates' responses to the interview questions such as "what rewards or privileges do you receive as a program member?" Responses included: "privacy", "respect" and the absence of stealing within the group. Correctional officers--those informed about the program and those with less of an understanding--repeatedly noted that inmate group members watched out for one another, acted like a family, and that there was less stealing among the group participants. Disciplinary reports, especially at GII support inmates' and correctional officers' perceptions of fewer problems and better behavior.

The issue of autonomy cannot be stressed often enough as a crucial component of community living. Program participants commented frequently on the importance of being able to settle their own differences. Counselors and the psychologist/consultants lauded the program's design and operation within the institution setting. Consultants and counselors agree that the community design is an effective mode for change and rehabilitation--i.e., relying on self-motivation and peer support.

Compliance with LEAA "Part E" requirements and grant goals was facilitated through the use and merging of the pre-existing institutional programs or services including intake, education, medical and counseling. These services/programs were available at each facility prior to grant implementation. The major effort, therefore, for the four programs was repackaging available resources and upgrading the quality of services.

The conclusion of this evaluation effort is that the overall program's success or promise lies in the "packaging". Specifically, the therapeutic community appears to be practical and workable not only for substance abusers but for other defined sub-populations within the prison system as well. The issue of drug/alcohol abuse as the focus for the communities may well be of less importance to the group process than the simple commonality of an issue, any issue with which to identify. The sameness of purpose for group members appears to be more the cohesive factor than the specific problem focused upon. In other words, as a group, substance abusers are not believed to be more responsive to community/familial environments than other subsets of the prison population. A group living arrangement that is both purposeful and supportive is seen to be the effective rehabilitative approach and a model worth replicating.

8.0 RECOMMENDATIONS

The Office of Research and Evaluation makes the following recommendations concerning the Drug and Alcohol Program:

1) As with any program the Drug/Alcohol Program must be supported by administrators and managers at the institutional and central office administrative levels. This support is particularly crucial in the early planning and implementation phases. Implementation must be supported and monitored by top administrators and middle managers to insure that the purpose and intent of the project are pursued.

2) Expand therapeutic communities for inmates with substance abuse problems to additional correctional institutions. When planning for the future implementation of these programs, develop a well defined treatment design accompanied by written implementation and operating procedures. The experiences of the four programs that operated during the twenty-one month grant period are vital resources for the basis of this plan.

3) Re-establish the Women's Unit Drug and Alcohol treatment community. Prior to the re-opening, develop a plan for phased implementation. Support must come from institutional administrators and must accompany a corresponding commitment from service delivery staff. A comprehensive plan for the therapeutic drug and alcohol treatment community at the Women's Unit would include a clearly described/defined path linking program entrance to successful program completion/termination criteria. Replicating either the phase program used by Metro Correctional Institution or the cumulative attendance count used by the Youthful Offender Unit might be considered.

4) Communicate clearly to staff in direct service delivery positions the expectations of implementation strategies, purposes and goals, and provide them in writing during the earliest stages of program development--preferably during the planning stages.

5) Prescribe and adhere to prescribed program schedules. Plan group counseling sessions well enough in advance to allow participants the opportunity to prepare for and anticipate the meetings. Schedules used by the programs at Georgia Industrial Institute and Metro Correctional Institution provide good examples to be followed, since their schedules are routinized. Program staff must work with the administration to avoid pre-empting program activities, except in unusual or extreme circumstances. Any re-scheduling should be done by consensus of administrators and program staff.

6) Develop a guideline manual based upon the experiences, positive and negative, of the four drug programs that operated during the grant period. The manual should describe and define in general terms how to plan, develop, implement, routinize and operate a therapeutic treatment community within the confines of a correctional setting. A cooperative effort among Counseling Services, Planning, and Evaluation staff might be considered to produce the manual. There should be enough detail and direction so that administrators, managers, and line staff who follow the guidelines can be assured of a coherent

program. However, the manual should also allow for individual institutional differences, different sub-populations, and creativity on the part of staff and participants.

7) Provide to all institutional counselors a resource handbook identifying community treatment and assistance services statewide in an effort to improve the pre-release activity and preparation of post-release plans. The handbook should be similar to the Department of Human Resources Directory of Alcohol and Drug Abuse Services. Using this publication as a data base other community resource information should be researched and combined to result in a comprehensive document. Other types of information that may be useful include crisis telephone numbers operating in various communities throughout the state, relocation assistance groups, and educational and vocational programs/opportunities. Once compiled, the information should be computerized to facilitate easy update and rapid generation of copies. A combined effort of the Evaluation, Systems Development, Counseling Services, and Planning staffs to accomplish this publication is encouraged.

8) Continue the part-time support and assistance of psychologist/consultants to each of the treatment communities currently operating and provide such support to any new programs implemented or reinstated.

9) Integrate recreational activities as a defined component of each treatment community and move closer toward completing a wholistic rehabilitative treatment concept. Provide program members instruction on the constructive use of leisure time. Afford program members avenues through the program in which to practice tips received from the instruction on recreational activities and use of leisure time.

10) Assign a core of selected security staff on a permanent basis to each of the in-house communities and to any new therapeutic program initiated. Correctional officers should be interested in the program and in rehabilitative processes. Accompany assignment to the in-house unit with a formal orientation to the purpose, structure and operations of the program.

11) Foster cooperation and integration of medical and counseling services toward common goals. Good communications are necessary. Medical staff should inform counselors of inmates with problems such as epilepsy or those being treated with mood-altering medications and likewise should expect counselors to inform them of inmates who have problems with medication or who evidence radical changes in behavior.

12) Ensure linkages and cooperation for services inside the correctional system as well as developing a planned exit procedure allowing for some continuity of care. Develop exit sessions or procedures for use at each of the programs. Provide members leaving the group with an opportunity to say goodbye and afford those remaining the opportunity to do likewise. In addition, group members remaining in the program at the institution should be allowed to express their feelings about the loss of a group member whether the feelings are of envy, joy, sadness, etc.

13) Develop data collection forms and client record requirements along with any program plan. Initiation of data forms should coincide with program start-up.

14) Initiate a revised monthly report form. A sample of the necessary revisions is provided in Appendix 12. At a minimum monthly forms should identify the institution originating the numbers; the current form does not.

15) A semi-annual progress report using the monthly report data should be generated by the Office of Research and Evaluation and disseminated to the Director of Counseling Services, to the institution's administration of each program, and to the line service delivery personnel. This will insure continued data reporting and provide some analysis of the information compiled and maintained to review impact and program success.

BIBLIOGRAPHY

Adams, Stewart, Ph.D., "Evaluative Research in Corrections, A Practical Guide" Prescriptive Package, U. S. Department of Justice, Law Enforcement Assistance Administration, National Institute of Law Enforcement and Criminal Justice: March 1975.

Auerbach, Stephanie, Research Proposal for the Evaluation of the Drug Abuse Treatment Program, Research Review Board, Department of Offender Rehabilitation: July 1973.

"Case Management, Section 4000", Statewide Services Contract Program Review Manual, Treatment Program Monograph Series Number 4, U. S. Department of Health, Education and Welfare, Public Health Services: Alcohol, Drug Abuse and Mental Health Administration, Division of Community Assistance, National Institute on Drug Abuse.

"Clinical Record Support for Drug Abuse Treatment Programs", Treatment Program Monograph Series Number 5, U. S. Department of Health Education and Welfare, Public Health Services, Alcohol, Drug Abuse and Mental Health Administration, Division of Community Assistance, National Institute on Drug Abuse.

"Conditions for Participation in Funding Under the Special Corrections Program (Part E) of the Crime Control Act", Guideline Manual, State Planning Agency Grants M4100. IF, U. S. Department of Justice, Law Enforcement Assistance Administrtation.

Drug Abuse Program Handbook. Metro Correctional Institution: November, 1980.

Drug Abuse Program Middle Georgia Correctional Institution - Women's Unit: Revised November 22, 1980.

Guess, L. Lynn and Tuchfield, Barry, "Manual for Drug Abuse Treatment Programs Self-Evaluation", Treatment Program Monograph Series, Research Triangle Institute.

Guess, L. Lynn and Tuchfield Barry, "Manual for Drug Abuse Treatment Programs Self-Evaluation Supplement I: DARP Tables", Treatment Program Monograph Series, Research Triangle Institute.

Guess L. Lynn and Tuchfield, Barry, "Manual for Drug Abuse Treatment Programs Self-Evaluation Supplement II CODAP Tables", Treatment Program Monograph Series, Research Triangle Institute.

McFerrin, Liz and Langston, Robert, "Community Treatment Drug Program, Handbook, Georgia Industrial Institute: August 1979.

"Quick Evaluation Methodology", Special Action Office Monograph Series A, Number 2, Executive Office of the President, Action Office for Drug Abuse Prevention: October 1973.

Smith, Roger, "Drug Programs in Correctional Institutions", Prescriptive Package, National Institute of Law Enforcement and Criminal Justice, Law Enforcement Assistance Administration, U. S. Department of Justice: July 1977.

"The Design and Planning of TASC Evaluations," Office of Criminal Justice Programs, Law Enforcement Assistance Administration. Washington, D.C., November 1979.

NOTES

[1]Drug Abuse Program. Middle Georgia Correctional Institution-Women's Unit: revised November 22, 1980.

[2]Drug Abuse Program Handbook, Metro Correctional Institution, November 1980.

[3]Community Treatment Drug Program, Georgia Industrial Institute, August 1979 by Liz McFerrin and Robert Langston.

[4]Middle Georgia Correctional Institution, Women's Unit Drug Abuse Program Handbook, revised November 22, 1980.

APPENDIX I

DRUG AND ALCOHOL PROGRAM EVALUATION

Interview for Counselors/Consultants

Title of Person Interviewed: _____

Institution: _____

Period of Time Involved with Program: _____

Percent of Time Devoted to Program: _____

Caseload of Program Participants: _____

1(a) What are the specific objectives of your treatment program? _____

_____

_____

1(b) How do you assess your progress toward meeting those objectives? _____

_____

_____

_____

_____

_____

1(c) What do you consider to be the most serious problems you have to deal with in meeting the objectives of your overall treatment program?

_____

_____

_____

2(a) Do you measure client progress? ____Yes ____No If yes, how is the progress measured?

_____

_____

_____

_____

NOTE: If documentation on program such as orientation packages, rules and regulations, selection criteria has not been obtained, request and receive copies.

2(b) What determines a participants successful completion of the program? Is there a a time requirement?

3(a) Do you conduct urinalysis tests? ___Yes ___No If so, how often are tests administered? (Remind person this is not a grant requirement.)

3(b) What happens to a client with a positive test result?

4. How many clients are currently (date) involved in the program?

5. In the current group are the following service areas provided, briefly describe each service that is provided.

5(a) Individual Counseling: ___Yes ___No If yes are these sessions scheduled? How

5(b) Group Therapy: ___Yes ___No If yes are these regularly held sessions? What is the schedule?

5(c) Job/Vocational Counseling: ___Yes ___No

5(d) Health Care: ___Yes ___No

5(e) How is medication dispensed? Is this different from the method used for the general population?

5(f) Academic Education e.g., GED, Basic Ed: ___Yes ___No

5(g) Vocational Education: ___Yes ___No

5(h) Cultural/Recreational: ___Yes ___No

6(a) Are there services you would like to provide that you are currently unable to provide?

___Yes ___No If yes, describe: _____

6(b) Why are you or the program unable to provide such services? _____

7. Do any of the following affect admission to your program? If so, how do they affect admission?

7(a) age: _____

7(b) duration of drug use: _____

7(c) type of drug use: _____

7(d) history/duration of alcoholism: _____

7(e) history of emotional illness: _____

7(f) length of sentence: _____

7(g) size of group: _____

7(h) other: _____

8. If a client is removed are there alternatives to continue dealing with his/her drug and/or alcohol problems?

9(a) What sort of follow-up activities, if any, do you conduct for clients who have graduated but have not been released?

CONTINUED

1 OF 2

9(b) dropped out or otherwise left treatment: _____

10. Are there any features of your program you consider particularly innovative or unusual?

11. Would you continue the program? ____Yes ____No If yes, would you make any changes, if so please describe.

12. Has the arrangement with the consultant been beneficial? Are you in favor of continuing the consultant's role?

APPENDIX 2

Facility

DRUG AND ALCOHOL PROGRAM EVALUATION
CORRECTIONAL OFFICER INTERVIEW

1. How long have you been assigned to dormitory? _____

(Use building number or name of hall, etc.)

2. Are you aware that dormitory _____ houses inmates in a special drug and alcohol treatment program?

Yes____ No____ If yes, continue, if no stop inquiry.

3. What is the purpose of the drug and alcohol program? _____

4. Do you think the purpose is being accomplished? Yes____ No____ If yes, why?

5. Have you noticed any differences between dormitory _____ and the other dormitories?

Yes____ No____ If yes, probe to discover if the differences are in program participants behavior i.e., more or less problems, DRs or in a cleaner/dirtier environment, etc.

6. Have you received any special instructions regarding your duties as a correctional officer in relationship to dormitory _____?

Yes____ No____ If yes, what? _____

7. Are correctional officers involved in any group counseling sessions? Yes___ No___

If yes, is this unique to the drug and alcohol program? Yes____ No____.

7. (continued.) Are correctional officers involved with the program in any way outside the general/normal secutiy responsibilities of their position?

Yes____ No____ If yes, HOW? _____

8. Do you think the program should continue? Yes___ No___ No Opinion ___

9. Are there changes you would make? Yes____ No____ If yes, WHAT? _____

10. Do you have any general observations or comments you would like to make about the program and or the program's participants?

Yes____ No____ If yes, explain. _____

_____ Institution_____

Name or Identification

DRUG AND ALCOHOL PROGRAM PARTICIPANT INTERVIEW

1. When did you become a member of the drug/alcohol program? _____

2. What type of selection process was involved in becoming a member?

3. Was the decision to participate in the program your decision? Did you volunteer?

4. Would you change the selection process, if you could? _____How?

5. How long does it take for a person to complete the program successfully?

6. How is it determined that a participant has successfully completed the program? What is defined as success and who determines the successful completion?

7. After a program member successfully completes the program what happens?

8. What is the purpose of the drug and alcohol program?

9. Do you participate in any of the following, if yes please describe?

academic classes YES ____ NO _____

vocational classes YES ____ NO _____

Recreational YES ___ NO ____

Group Sessions YES ___NO ____

Individual Couns.' YES ___NO ____

10. What type of medical services are available to program participants?

Is this any different from services provided non-members? _____How?

11. Tell me what a typical day includes for you, would this be different if you weren't a program member?

12. Are there any extra responsibilities placed on program participants that are not necessarily placed on non-program members? _____What?

13. Are there any special privileges or rewards available to program members that are not available to others? _____ What?

14. If you could make changes to imporve the program what would you change or add?

15. Do you have any general comments about the program that you would like to pass along?

ALCOHOL AND DRUG PROGRAM
CLINICAL RECORDS

The following procedures are required in compliance with Federal Regulations and authorized under the Department of Offender Rehabilitation Practices and Procedures (Chapter 7020, Counseling Services; section 7025.05, Clinical Records; subsections 7025.01, Records Utilization and 7025.02 Confidentiality):

Clinical files for the Drug and Alcohol Programs located at Georgia Industrial Institute, Stone Mountain Correctional Institution, Youthful Offender and Women's Units will be kept in locked filing cabinets in each program staff counselor's office.

Each inmate in the program will have a clinical file set up by his/her counselor. This file will be in a separate folder from the inmate's institutional file. Information contained in the institutional file will be available to all institutional staff, whereas information contained in the clinical files will be confidential and consequently only the program personnel will have access to these files. If the inmate is transferred to another institution or a community center, the program staff counselor may share pertinent information from the clinical files if the information is useful for personal growth and future treatment of the inmate.

The counselor will use the clinical files for documentation of individual and group counseling sessions. During and after each individual counseling session the counselor will write facts and impressions which he believes will help in future treatment of each inmate.

The counselor will also use the clinical files for results of assessment tests given specifically to inmates in the Drug and Alcohol Program. The program screening results will become a part of the inmate's clinical file.

A program log book will be kept in the correctional officer's duty station. Pertinent information concerning events in the housing unit will be written in the log. Only the program personnel will have access to the log book.

If an inmate leaves the program due to discharge, parole, transfer or any other reason, the inmate's clinical file will be kept in a locked filing cabinet in a locked office. Regular institutional files are stored for a minimum of three years and then destroyed: The same time period will be in effect for clinical files, and then these files will also be destroyed.

Institution

UNIFORMITY OF FILE CONTENT

INSTRUCTIONS: Request a description of the contents of typical client files and obtain samples of all forms used.

Review files to determine in which type of file the following information is to be included.

Once it has been established what information is to be maintained and in what record the information is to be stored, begin to review files. Use the supplemental file review form to record results from file reviews.

CLIENT INFORMATION	FILE TYPE (check the column) Clinical Record	Permanent Record	Not Required
1. Personal History	_____	_____	_____
2. Drug History	_____	_____	_____
3. Medical History	_____	_____	_____
4. Physical Examinations	_____	_____	_____
5. Medical/Dispensing Records	_____	_____	_____
6. Laboratory Tests	_____	_____	_____
7. Urinalysis Tests	_____	_____	_____
8. Client Treatment Plans	_____	_____	_____
9. Treatment Plan Updates	_____	_____	_____
10. Counseling Notes	_____	_____	_____
11. Support Services	_____	_____	_____

Is each of the sample folders/files organized in a consistent/prescribed manner? YES____ NO____

Are counseling notes to be arranged in reverse chronological order? YES____ NO____

Are counseling notes, treatment plans, periodic assessments and other documents to be signed and dated by appropriate staff members? YES____ NO____

RECORDKEEPING SYSTEM OVERVIEW

COMMENTS

a. Do written procedures exist that describe the program's recordkeeping system? Yes____ No____

If YES, obtain and review a copy of these procedures.

b. Do new staff members receive an orientation concerning the recordkeeping system and the confidentiality of client information? Yes____ No____

c. Does the program have a form for documenting disclosures of client information? Yes____ No____

d. Are client records stored in close proximity to treatment staff work areas?

e. Is access to client records limited to only authorized individuals? Yes____ No____

f. Are the file cabinets and the room where the records are stored locked when not in use? Yes____ No____

g. Are client case folders filed in a neat and convenient manner? Yes____ No____

h. Are active client files separated from inactive files? Yes____ No____

i. Are sign-out procedures or other means of monitoring the location of files used in the file room? Yes____ No____

j. If a client is transferred to another facility or community center, is clinical file information stored? Yes____ No____

k. Is there a program log book in C. O. duty station? Yes____ No____
Who has access to log? _____
Are events of DA unit recorded? Yes____ No____
How often? _____

l. How long are clinical files retained for persons leaving program? _____
Where are they kept? _____

Institution ____________

FILE REVIEW SUPPLEMENT

Active or Departure Code	CLINICAL RECORDS		PERMANENT RECORDS	
	File Identifier (e.g. #/name)	Contents (e.g. counseling notes, drug history)	File Identifier (e.g. #/name)	Contents (treatment plans personal history)

APPENDIX 7

APPENDIX 8

ALCOHOL AND DRUG PROGRAM: MONTHLY REPORT

1. Month:_____ Year:_____

2. Number of residents the first of the month:_____

3. Number of residents at the end of the month:_____

4. Number of inmates who applied and referred to the A/D Program:_____

5. Number of inmates screened for the A/D Program:_____

6. Number of inmates accepted into the A/D Program:_____

7. Number of inmates who were rejected from the A/D Program:_____

8. Number of inmates who were removed from the A/D Program:_____

9. Inmates accepted and number	10. Alcoholic	11. Drug Addict	12. Both	13. Inmates Rejected	14. Reason rejected (use back if needed

15. Removed resident/number	16. Reason removed

17. Number of disciplinary reports per code: (i.e., (6) C-16)_____

18. Number of use of force reports:_____ 19. Number of escapes:_____

20. Number of group therapy sessions:_____

21. Number of individual therapy sessions:_____

22. Number of house meetings and other meetings:_____

23. Number of successful completions:_____

24. Number of referrals to a pre-release center:_____ 25. Number released to pre-release center_____

26. Number of comments (include problem areas, needs, suggestions and recommendations, etc.

APPENDIX 9

THE STEPS OF THE DIAGNOSTIC PROCESS

Step 1 — Receive pick up orders from Central Office

Step 2 — Pick up from county jail.

Step 3 — I.D.
- a. Fingerprinted
- b. Photographed
- c. Establish File

Step 4 — Medical Examination
- a. Tests
- b. X-Rays
- c. History
- d. Profile

Step 5 — Orientation and Initial Interview
- a. ETS Information
- b. Rules and Regulations
- c. Demographic Information
- d. Behavioral Observation

Step 6 — Testing
- a. Sixteen Personality Factors (16 PF)
- b. Clinical Analysis Questionnaire (CAQ)
- c. Culture Fair IQ
- d. Wide Range Achievement Test (WRAT)
- e. General Aptitude Test Battery (GATB)

Step 7 — Labor Interview
- a. Vocational History
- b. Educational Status
- c. GATB Interpretation
- d. Inmate Interest

Step 8 — Sociological Interview
- a. Background Information
- b. Impressions
- c. History

Step 9 — Classification
- a. Intake Assessment
- b. Check of Information
- c. Assignment Recommendations

Step 10 — Assignment
- a. Done by Classification Analyst in Central Office

Step 11 — Transfer

Step 12 — Extended Assessment
- a. Additional Diagnostic Information

METRO CORRECTIONAL INSTITUTION
UNIT RULES

1. Obey Local, State and Federal Laws.
2. Obey Institutional and D.O.R. rules and regulations.
3. Not take any drugs without a doctor's supervision.
4. Not participate in any form of violence.
5. Maintain confidentiality outside the program.
6. Not to participate in behavior which is contrary to program goals.
7. Maintain cleanliness at all times.
8. Remain in the unit until the program is completed or for a definite reason I need to end program participation.

GEORGIA INDUSTRIAL INSTITUTE
PROGRAM RULES

All program participants are expected to abide by the institutional rules, however, certain behavior will not be tolerated and can result in removal from the program.

No stealing

No violence or threats of violence

No drugs or alcohol

No homosexual activity

Each inmate will be expected to actively participate in group therapy. Each inmate is responsible as an individual and responsible to the group.

Middle Georgia Correctional Institution

Women's Unit

Residents are expected to abide by all institutional rules and regulations. Certain institutional rules have been combined with therapeutic rules to create the program's Cardinal and House rules.

CARDINAL RULES

No stealing

No violence or threats of violence

No drugs or alcohol or other intoxicating substance

Everyone is subject to therapy

HOUSE RULES

No horseplaying

No lying

No littering

The breaking of Cardinal rules will not be tolerated in any manner and will result in possible removal from the program. This is necessary to protect the mission of the program as well as the residents, and one is expected to be made fully aware of these rules.

The breaking of a house rule will result in therapy and possible removal from the program for the first offense, and it is to the residents advantage to abide by them.

Residents are expected to maintain a clear disciplinary record while in the Drug Abuse Program.

Youthful Offenders

House Rules

1. Beds are to be made in a tight manner from 6:30 a.m. until 4:30 p.m. Monday - Friday.
2. Your feet have to be on the floor by 5:35 a.m. and you can't lay back or sit on your bed until 4:30 p.m.
3. You can't have your eyes closed, or your face covered where your eyes can't be seen from 5:35 a.m. until 4:30 p.m.
4. You can't have clothes under your mattress on Friday from 5:35 a.m. till 4:30 p.m.
5. If your bed is next to a window or a heater or you are the closest one to them, it is your responsibility to keep them clean and dust free for inspection.

6. You can't sit things in the window sills or sit in them.
7. No loud talking on the hall and it is to be quiet time after 10:00 p.m.
8. No talking or yelling, or throwing things out of the windows or off the porch.
9. No more than two people in a room after kitchen help has been called, and no more than four people in a room anytime.
10. No fast walking or running anywhere on the hall.
11. No talking in any lines and no talking in the chow hall except to the officer.
12. No betting, gambling, selling or buying on F-Hall is permitted.
13. No loud talking at the movies.
14. No Loitering on F-1 or in the hallways.
15. No disrespecting other residents.
16. No lying.
17. No unnecessary noise in the T.V. room.
18. No sitting on any tables.
19. No horseplaying.
20. No cheating at cards.
21. No going in anyone's cot or locker when they are not present.
22. Be in your assigned area for lunch and supper.
23. Know the word for the day by 12:00.
24. NO STEALING!
25. Do not lay things around or you will be cited for irresponsibility.
26. Do not look in any of the structures or section heads log book.
27. Flush toilets when you use them.
28. You must wipe out a sink after you use it.
29. Don't leave chairs out.
30. Put books, magazines, papers etc. in their proper place when you are through with them.
31. All pull-ups must verbally be accepted by saying, "I accept."
32. Don't play with therapy, laugh at people with prescription or conditions and don't talk to people on condition.
33. Do not play getback at all.
34. Do not buck on prescriptions or conditions.
35. No more than three items on a locker at any time and not before 4:30 p.m. on weekdays.
36. F-2 residents are not allowed on F-1 after kitchen has been called.
37. F-1 residents are not allowed on F-2 after kitchen help has been called except to get water.

38. No more than two residents in a room after 10:00.
39. No shoes are to be left on the floor Monday thru Friday.
40. House Rules consist of any sign anywhere on F-Hall including the bulletin board, bathroom, card room etc.
41. No Feedback.
42. F-1 must use F-1 restroom/shower and not F-2. Vica versa.

HOUSE COORDINATOR - ONE POSITION

APPENDIX II

I. QUALIFICATIONS -

1) Must have held at least two lower positions in the structure satisfactorily.

2) Essential that person show maturity and excellent relationship with staff personnel.

3) Preferred that person show signs of leadership, i.e.; sets good example for peers, cooperative with staff and peers.

4) Essential that person be good listener and communicate well.

5) Needs ability to organize, and to pass down instructions to other structure members.

II. RESPONSIBILITIES -

1) Supervise activities of and assist other structure members.

2) Ensure that other structure members are doing their jobs as outlined in this booklet.

3) Provide counselors with information regarding atmosphere of dorm; problems with any phase of dorm operations, etc.

5) Take action to resolve problems and meet needs with assistance of staff.

6) Deal with structure members who are setting poor example as failing to do job properly.

7) Conduct community m-etings weekly.

8) Be responsible for order being kept on dorm and ensure that dormitory is kept clean.

9) Maintain list of people qualified for rooms and structure promotions. Make this available to counselors.

ORIE...ATION COORDINATOR - ONE POSITION

I. QUALIFICATIONS -

1) Must have satisfactory expeditor for 30 days.

2) Must have ten groups completed.

3) Essential that person have good listening skills, communicate well, and have some skill at problem recognition.

4) Preferred that person have good knowledge of drug/alcohol effects on behavior and physical self.

5) Preference given to person who expresses interest in assisting new residents in making adjustment to drug dorm.

6) Person sets good example for peers.

II. RESPONSIBILITIES -

1) To assist new residents during orientation in learning hall policies, rules, procedures, etc.

2) To meet with new residents twice weekly to review rules, regulations, etc., and to assist those having difficulty in learning and to aid them in adjusting to dorm.

3) Assemble clinical folder with all proper forms in place.

4) Assure that each new resident has "post relase plan" form.

5) Familiarize each new resident with "inmate request form", telephone call passes, hair-cut passes, post release plan forms.

6) Be responsible for gathering the forms mentioned above and turn them over to counselor's aide.

7) Seek assistance from expeditors, when needed, to deal with new residents that are causing problems. To report to counselors new residents that are having problems with adjusting to drug dorm setting.

8) To keep new residents on their toes during orientation. Assist them in developing respect for themselves and their

fellow residents.

9) Report names of those who are causing problems to the Chief Expeditor.

CH. OF EXPEDITOR - ONE POSITION
SENIOR EXPEDITOR - ONE POSITION

I. QUALIFICATIONS - 1) Must have been satisfactory as an expeditor for 30 days.

2) Must have ten groups completed.

3) Must have willingness to explore problems with residents and assist them with self-help.

4) Must possess good listening skills, should communicate well with peers.

5) Preferred that person have good factual knowledge of drugs/alcohol; also preferred that person be able to discuss role of drug use and criminal activities.

6) Familiarity with alternatives to drug use; leisure time activities, etc.

7) Chief will be considered on basis of overall participation and record as wel as one thru six above.

8) Senior will be subordinate position.

9) Person sets good example for peers.

II. RESPONSIBILITIES - 1) Supervise and coordinate activities of Expeditors.

2) Make written schedule of two hour shifts for Expeditors.

3) Pull shifts for Expeditors who are ill or who have conflicting duties - group, medical lay-ins, or other necessary absences.

4) Report problems with Expeditors to House Coordinator.

5) Meet bi-monthly with Expeditors to discuss problems, suggestions, etc., and to resolve these. Also give feedback on performance.

6) Meet with counseling staff monthly at structure meeting.

7) Deal with Expeditors who are causing problems; assist Expeditors who are having problems.

8) Issue prescription, conditions, pull ups etc. as needed for Expeditors who are setting poor examples for peers. Report same to House Coordinator.

XPEDITOR - SIX POSITIONS

I. QUALIFICATIONS - 1) On dorm 60 days or more.

2) Resident of the month at least once during first 60 days.

3) Must have held position as satisfactory section head or section head coordinator.

4) Six months clear conduct record.

5) Must have 5 group completions.

6) Preference given to those who have longest clear conduct and most PER(E)'s and qualify under one thru five above.

7) Must be thoroughly familiar with dorm rules, policies, and procedures.

8) Person sets good example for peers.

II. RESPONSIBILITIES - 1) Keep order on dormitory.

2) Enforce rules and regulations pertaining to dorm conduct, use of facilities, etc.

3) To assist section head coordinators with problems arising with section heads.

4) Issue prescriptions and/or conditions, if needed, to residents who violate rules. Note: An effort to resolve problems by using pull-ups or small group confrontations should be exercised prior to the condition or prescription being issued.

5) Pull two hour shift as scheduled by Chief Expeditor.

6) Meet with counseling staff on monthly basis to discuss problems, suggestions, etc.

7) Meet as a group to confront residents who are causing problems; or meet as a group to help with a resident who is having problems. Report problem and suggested solution to Senior Expeditor who will report this to counseling staff.

8) Offer support to other structure members as needed.

SECTION HEAD COORDINATOR - TWO POSITIONS

I. QUALIFICATIONS - 1) On dorm for 30 days or more.

2) Resident of the week for his section at least twice during first 30 days.

3) Must have been probed from orientation by counseling staff.

4) No disciplinary reports for past six months, or...

5) May qualify after 60 days on dorm with no D.R.'s and one PER(E), provided he qualifies alos under one, two and three above.

6) Person sets good example for peers.

II. RESPONSIBILITIES - 1) Supervise activities of one section head on F-1 and three section heads on F-2.

2) To meet with four people supervised on a bi-monthly ba to discuss problems and to give feedback to each on their job performance.

3) To assist section heads in personal development and preparation for promotion in the structure.

4) To deal with problem residents in sections by assigning prescriptions or conditions with counselor or officer approval.

5) To be responsible for writing in on inspection sheet under "TOTAL" the total of rating for those residents reported by the section head.

6) To meet with counseling staff on monthly basis for problem discussion, etc., also for feedback on how they are pe forming.

7) To report section heads who are doing poor work to the House Coordinator.

8) To maintain waiting list of potential residents for promotion to section head; these names will be given counselor's aide.

TION HEAD - SIX POSITIONS

I. QUALIFICATIONS -

1) On dorm for 30 days or more.

2) Resident of week for his section at least once during first 30 days.

3) Must have been probed from orientation by peer group.

4) No disciplinary reports for past 90 days.

5) May qualify after 60 days on dorm with no disciplinary reports providing he qualifies under two and three above.

6) Qualified residents will be placed on waiting list if positions are filled.

7) Person sets good example for peers.

II. RESPONSIBILITIES -

1) Responsible for cleanliness of assigned section.

2) Make written schedule for residents in the section to clean up on daily basis.

3) Meet with residents in section once a week to inform each of assigned clean up day and to discuss problems, etc. in his section.

4) Report names of those who are constantly violating rules or failing to clean their area to the Section Head Coordinator.

5) Inspect his section daily for each resident and rate them on inspection sheet.

6) Report problems to Section Head Coordinator,

MERIT/DEMERIT SYSTEM - DRUG PROGRAM

Merits will be awarded for doing something productive as per the attached list. Demerits will be awarded for counter-productive behavior. You may use merits as follows:

1. Five merits entitles you to see a movie.

2. One merit entitles you to use tapes for one hour.

3. Twenty merits saved, places your name on the list for a semi-private room. Once you have saved the merits and have your name on the waiting list for rooms, then you may use them as in number 1 or 2 above.

4. PER(E)'s = merits - for this you may see a movie , or Listen to five hours of taped music. You can still use the PER(E) for "special visits" or extra phone calls if you request them from your counselor.

5. Demerits may be worked off at a rate of one hour per demerit or a suitable condition/prescription of one hour per demerit. This must be approved by a staff member.

6. Merits may not be earned by voluntarily doing work or condition/prescription as mentioned in number 5.

7. For Room Rent- 1-merit per week- collected at the end of the month- failure to pay for room - means Room removal at the end of that month.

8. A total of 25- demerits will bring about- placing the subject on probation - with the possibility of program removal.

9. One merit entitles the subject to three games of his choice on any of the recreation equipment available in the new game room.

10.

MERIT/DEMERIT SYSTEM - DRUG DORM

ACTION	MERITS	DEMERITS
1) PN(E)	1	--
2) PER(E) Monthly	5	--
3) D.R.	--	10
4) PER(U)	--	3
5) PN(U)	--	1
6) Program Completion	5	--
7) SE (rated 5)	5	--
8) Daily Inspection RAting	--	--
Of 20 or more	2	--
9) Daily Inspection Failure	--	1
10) Contributions to Dorm	--	--
1) Suggestion Used	2	--
2) Leading Voluntary Group	--	--
successfully for month	5	--
11) Contribution to Peer	--	--
1) Obvious assistance to fellow resident in working out personal growth problem over a months period	5	--
12) Resident of Week (each section)	1	--
13) Resident of Month (each section)	5	--
14) Promotion in Structure	5	--
15) "Hall Helper" Award	5	--
16) COMPLETION OF DRUG PROGRAM	10	--

APPENDIX 12

ALCOHOL AND DRUG PROGRAM MONTHLY REPORT

Institution: _____ Date: _____
(month) (year)

1. Average monthly population: _____
2. Number applying or referred to A/D program: _____
3. Number screened for A/D program: _____
4. Number accepted into A/D program: _____
5. Number rejected or refusing entry: _____
6. Number successfully completing program: _____
7. Number leaving program while in good standing but prior to project completion _____.
8. Number removed as a negative action: _____
9. Number of referrals to a transitional center: _____
10. Number released to a transitional center: _____
11. Number pre-release conferences/interviews: _____
12. Number post-release plans: _____
13. List of inmates accepted into program (use numbers):

_____ _____

_____

_____

_____

14. List of inmates declining participation or rejected (use numbers and state reason for rejection)

_____

_____

15. Number disciplinary reports: _____
16. Number excapes: _____

INMATE DIAGNOSTIC BEHAVIOR
PROGRAM MEMBERS AND NON-MEMBERS COMPARISON

Diagnostics	Program Members Male N=245 Number Behavior Codes	% Total	Program Members Female N=44 Number Behavior Codes	% Total	Non-Program Members Male N=66 Number Behavior Codes	% Total
Escape Tendencies	26	11%	17	39%	15	23%
Assaultive	30	12%	10	23%	20	31%
Suicidal	12	5%	9	20%	4	6%
Narcotic	2	1%	5	11%	0	0
Homosexual	1	0	0	0	0	0
Epileptic	1	0	0	0	1	2%
Withdrawn	0	0	1	2%	0	0
Poor Reality Contact	5	2%	3	7%	3	5%
Alcoholic	5	2%	0	0	1	2%
Manipulative	9	4%	0	0	5	8%
Drug Abuser	99	41%	6	36%	31	48%
Drug Experimenter	21	9%	7	16%	3	5%
Alcohol Abuser	52	21%	1	2%	9	14%
None	62	26%	0	0	8	12%
Total Reported	325	100%	69	100%	100	100%

NOTE: Since there can be up to two behavior codes per inmate, the number of cases reported may exceed the number of cases. This table counts behavior problems, not inmates.

SOURCE: Georgia Department of Offender Rehabilitation
Office of Research and Evaluation
Systems & Statistics Unit
August 1981

APPENDIX 13

APPENDIX 14

MOST SERIOUS CRIME TYPE FOR PROGRAM & NON-PROGRAM MEMBERS

Crime Type	Male		Female
	Program Members	Non-Members	Program Members
Violent Personal	24%	35%	55%
Non-Violent Personal	0	2%	0
Property	63%	45%	25%
Drug Sales	6%	9%	14%
Drug Possession	5%	9%	5%
Victimless	0	0	0
Other	2	0	2%

SENTENCE IN YEARS

Years	Male		Female
	Program Members	Non-Members	Program Members
00.0-01	0	0	0
01.1-02	2%	15%	0
02.1-03	4%	17%	0
03.1-04	4%	0	0
04.1-05	9%	12%	16%
05.1-06	4%	9%	5%
06.1-07	3%	3%	11%
07.1-08	0	3%	7%
08.1-09	0	0	2%
09.1-10	3%	6%	16%
10.1-12	0	5%	2%
12.1-15	1%	5%	14%
15.1-20	0	17%	7%
20.1-over	0	3%	0%
Life	0	3%	11%
Death	0	0%	0%
Youthful Offenders	68%	3%	7%

APPENDIX 15

CULTURE FAIR IQ SCORES

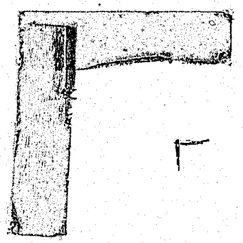
IQ Scores	Male		Female
	Program Members N=245	Non-Members N=66	Program Members N=44
Less than 70	1%	3%	0%
70 and up	99%	97%	100%

SELF REPORTED EDUCATION

Education	Male		Female
	Program Members N=245	Non-Members N=66	Program Members N=44
Less than grade 7	2%	3%	7%
Grade 7	8%	9%	2%
Grade 8	11%	22%	5%
Grade 9	16%	15%	12%
Grade 10	15%	12%	10%
Grade 11	8%	9%	2%
Grade 12	40%	28%	56%
More than grade 12	1%	2%	5%

FUNCTIONAL EDUCATION LEVEL

WRAT Scores	Male		Female
	Program Members N=245	Non-Members N=66	Program Members N=44
Less than grade 6	50%	61%	23%
Grades 6-8	41%	33%	49%
Grade 9	6%	5%	14%
Grade 10	1%	2%	9%
Grade 11	1%	0%	3%
Grade 12	0%	0%	0%
more than grade 12	0%	0%	3%



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