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Process Evaluation of the Residential Substance Abuse Treatment (RSAT) Programs at New Jersey Correctional Facilities

Final Report

Donald T. DiFrancesco, Acting Governor

State of New Jersey Department of Corrections

Susan Maurer,
Acting Commissioner

Prepared by
The Criminal Justice Center of
The College of New Jersey
March 2001

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DONALD T. DIFRANCESCO
Acting Governor

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July 3, 2001

Ms. Laurie Bright, Grant Manager
National Institute of Justice
Office of Research and Evaluation
810 7th St., NW
Washington, D.C. 20531

Dear Ms. Bright:

I have enclosed an original and two copies of the Final Project Report - "Process Evaluation of the RSAT Programs at the New Jersey Correctional Facilities" - NIJ Grant #1999-RT-VX-K023. Robert J. McCormack, Ph.D., The Criminal Justice Center of The College of New Jersey, served as one of the Co-Principal Investigators and is the author of this report.

I regret to inform you that the report contains information that the New Jersey Department of Corrections (NJDOC) can not support. Throughout its entirety, the report reflects little understanding and insight into a correction-based treatment environment. Although the NJDOC sought a meeting with the Co-Principal Investigator/author to discuss our concerns, Dr. McCormack was unwilling to meet with us and insisted that his report stand as initially written. A copy of our Department's correspondence on this issue is attached; Dr. McCormack responded to us in our follow-up e-mail and phone call to him.

Consequently, in a separate document, the New Jersey Department of Corrections is conveying information to clarify and to correct the project's final report. A copy is enclosed for your review.

As you may recall, the NJDOC pursued grant funds from NIJ for this process evaluation and a companion outcome evaluation of our RSAT programs. Dr. McCormack and Dr. Mario Papparozzi were to serve as the Co-Principal Investigators. The NJDOC expected to rely heavily on the expertise and experience of Dr. Papparozzi in the conduct of this research. In the midst of the process evaluation, however, Dr. Papparozzi left his position with The Criminal Justice Center, The College of New Jersey, to assume a new position as Chairman of the New Jersey State Parole Board. He informed us that the demands of this new job would preclude his continued involvement in the process evaluation and prompted him to withdraw entirely from the outcome evaluation.

Dr. Papparozzi's departure from these projects left a significant void in the critical experience and expertise necessary to conduct this research adequately. As a result, the NJDOC proposed to NIJ that Dr. McCormack conclude the process evaluation and that the outcome evaluation be terminated prematurely.

NIJ endorsed this proposal. Unfortunately, the process evaluation report reflects the aforementioned void. It is our hope that our accompanying document will serve to mitigate this shortfall. Please contact Ms.Therese Matthews, Grants Manager, at (609) 984-0203 or me directly at (609) 292-9974 if you have any questions or require additional information.

The New Jersey Department of Corrections appreciates the support of the National Institute of Justice in our efforts to evaluate the quality and effectiveness of our RSAT programs. In addition, we appreciate your understanding in these unusual and difficult circumstances.

Very truly yours,

Diane M. Zompa, Ph.D., Director
Office of Community and Drug Programs

Enclosures
c: Susan Maurer, Acting Commissioner
Jeffrey Burns, Assistant Commissioner
Therese Matthews, Grants Manager

APOLOGIA

An Argument in support of the New Jersey Department of Corrections
1998 Residential Substance Abuse Treatment model
and its Research Methodology

J. Ted Levay, Supervisor and T. M. Morawski, Administrative Analyst
Offices of Community and Drug Programs

June 29, 2001

PAGE ONE
ARGUMENT

Process Evaluation of the RSAT Programs at the New Jersey Correctional Facilities is prepared by The Criminal Justice Center of The College of New Jersey with Robert J. McCormack as its principal author. The Process Evaluation fails to remain focused on the historical period of 1998, retrieve information concerning the daily operational activity and compare it to the policy governing the process. The misinterpretation of the "estimates of completion" critically reduced the database's potential. The author does not recognize continuum care program components and the interaction of their activities. These confusions mislead the reader by drawing unfounded conclusions or creating errors logic. The New Jersey Department of Corrections cites the following examples:

Part I Correctional Background and Literature Review
Author's Statements: "In order to deal with the burgeoning drug dependent inmate population in the state, the New Jersey Department of Corrections (DOC), in **the late 1980s**, began to develop experimental "therapeutic community" (TC) programs in their **juvenile** correctional facilities. The New Jersey Therapeutic Community treatment programs for adult residential substance abusers commenced **in March of 1990** with the creation of the Southern State PIER Program, and the culminated with the creation of the largest of the TC Programs at South Woods in May of 1997." (Page 2)

DOC's Response: The statements are historically inaccurate, but more importantly the author misidentifies an adult facility as a juvenile facility, which is under a separate authorities.

Part I Correctional Background and Literature Review
Author's Statement: "While making great strides in terms of program implementation, the Department apparently did not anticipate the eventual need for program evaluation". (Page 2)

DOC's Response: This significant statement is misleading. Its placement in the first section of the report sets the tone for the remainder of the report. In fact, the Office of Drug Program Operations established a database in 1989 for tracking inmate and parolee movements throughout the continuum of care. From this database routine program evaluations were generated as required grant products for continued funding. The Semi-Annual and Annual program evaluations were forwarded to the New Jersey Attorney Generals Office, our state monitoring and channel for federal funding. Continuation of funding to this date is evidence that the program evaluations with associated data were acceptable.
Additionally, the Department's database yielded extensive yearly Inmate Profiles, which were forwarded for inclusion in federal databases.

Author's Statement continues "As a result, a tracking system to monitor inmate progress [or lack of it] through the TCs and the newly added continuum of care components was never developed. This tracking void makes it virtually impossible to determine the reasons for individual inmate success or failure in a particular program, the relative effectiveness of the TC programs, or the impact of the various treatment components on TC participants." (Page 2)

DOC's Response: If this statement refers to inmate clinical progress tracking, program impact on the inmates success or failure, and measurement of program effectiveness, then the data is available for review by the author.

- Regarding clinical progress, records are maintained in TC manual record files and correctional facility Classification departments on site or at NJDOC Central Office. Although an integrated record tracking system containing all information on a given inmate is not currently in place, access to electronic classification records were made available to the researchers from a DOC office in close proximity to The College's office.
- Regarding the measuring of program components and their effectiveness, it was understood that TCNJ researchers were to evaluate as noted. " A key method of assessing correctional treatment programs is through the use of the Correctional Program Assessment Inventory (CPAI), an evaluation tool developed by Drs. Paul Gendreau and Don Adams." (McCormack, Final Report, pg. 45). Arrangements were made for the Co-Principal Investigators to conduct the CPAI at the correctional-based TCs and Residential Community Release Agreement Programs, but the evaluations were not conducted.

PART II HISTORY AND SYSTEMS ANALYSIS OF RSAT PROGRAMS

RSAT Program Structure and Operations

Classification and Assignment

CRAF Intake Unit

Author's Statement: "CRAF holds four classification hearings each week, and assigns inmates to programs and institutions throughout the state based on inmate need and available bed space." (Page 16)

DOS's' Response: This statement introduces the author's misunderstanding of DOC's mission, the classification process, and the fundamental understanding of the assessment process. It is necessary to understand the agency-culture, recognize competition between programs for inmates who are Full Minimum or FM eligible, and understand the processing of these inmates throughout the system.

There is a distinction in the authority and the mission between the Inter-Institutional Classification Committee, Institutional Classification Committee, and the Residential Community Release Agreement Programs, Assessment and Treatment Centers.

- The primary mission of Department of Corrections in practice is "public safety, security of the facility, staff, and inmates, and maintaining order (discipline). Only after security concerns are addressed are "Inmate needs" considered.
- The Inter-institutional Classification Committee is an assembly of representatives from different correctional facilities that are responsible for determining the correctional facility to which an inmate is assigned and approve requests for transfer from one correctional facility to another. (New Jersey Administrative Code, Title 10A) They meet at Central Reception and Assignment Facility four times weekly.
- When the inmate resides at the assigned parent correctional facility, that Institutional Classification Committee or Residential Community Release Agreement Program -- Assessment and Treatment Center assigns the inmate to a treatment programs. They use the results of the full A.S.I. and extensive interviews and a battery of assessment instruments to assess client for program matching, such as therapeutic communities or community release programs.

Accurately stated, CRAF, the intake unit holds four classification committee meetings each week, and assigns inmates to correctional facilities throughout the state based upon the inmate's age, size, offense, sentence, previous incarcerations, mental status, security needs and available bed space, followed by treatment needs (NJDOC Administrative Code, Classification).

PART II HISTORY AND SYSTEM ANALYSIS OF RSAT PROGRAM

RSAT Program Structure and Operations

Classification and Assignment

County Jail Confinement

Author's Statement: "Clearly, the program is not reaching a significant number of the approximately 3,000 state inmates confined in county jail facilities. Since this population includes many young, non-violent, substance-addicted offenders, who without treatment will predictably re-offend upon release, the program should be expanded to evaluate and provide treatment programs for these inmates." (Page 17)

DOC's Response: In New Jersey, a jail is a county institution that primarily confines individuals awaiting trial or adults serving short sentences, generally one year or less. A jail may be under the control of the sheriff or the board of chosen freeholders. In optional charter counties, the jail may be under the control of the county executive or county manager. County government is responsible for the cost of operating the jails.

The Commissioner of the Department of Corrections is authorized to promulgate rules and regulations to establish minimum standards for the care, treatment, government and discipline of inmates in county jails (N.J.S.A. 30: 1B-10). The only remedial action that may be taken by the Commissioner is he may order a phased restriction of admission of new state-sentenced inmates into that facility. (N.J.S.A. 30:8-57). The county jails are inspected on a regular basis to monitor compliance with the Department's minimum standards. In the county jail, services vary considerably from county to county.

As noted, the Department has the authority to inspect and observe if minimum standards are maintained. In 1982, the County Correctional Policy Act was passed by the New Jersey Legislature for the purpose of providing State grants to participating counties under the county assistance program in exchange for the placement of certain State prisoners in medium and minimum-security jails. The program is funded through bond monies. NJDOC allocates these funds to counties to house state-sentenced inmates in their jails, but it is at the discretion of the counties to hold state-sentenced inmates. Several counties do not want to house state-sentenced inmates and in practice do not house them.

In conclusion, Department of Corrections can write minimum standards and inspect for compliance, but has little enforcement authority. County government operates the county jails. Also, to provide services to county jails and then to evaluate those programs was outside of the scope and goals of the process or outcome evaluation. The evaluation was concerned with prison-based RSAT funded slots. In state terminology, youth and adult complex correctional facilities with established TCs.

Unrecognized by the author, NJDOC pro-actively funds, participates in the Drug Court Initiative Steering Committee, and negotiates the quality and quantity of services for the five specialized Drug Courts, in the most crime-burdened vicinages. The Drug Courts offer intensive six-month residential substance use disorder treatment with aftercare as an alternative to incarceration. Plans to expand to the remaining ten vicinages are currently under review by the State Legislature.

For many years, NJ has offered the Intensive Supervision Program, a nationally recognized probation program supported by the Administrative Office of the Courts. A panel of three judges review individuals, similarly described by Dr. McCormack, for release to intensive probation supervision after serving some time incarcerated.

Part II HISTORY AND SYSTEM ANALYSIS OF RSAT PROGRAMS

RSAT Program Structure and Operations

Classification and Assignment

Administration of the Addiction Severity Index (A.S.I.)

Author's Statement: "The Policy directive (DOC Policy Paper 4A 1.2) clearly intends that *all* inmates will be subject to an ASI evaluation". (Page 18)

DOC's Response: Again, this is from an Administrative Policy Manual, an internal document, which is used to guide the facility in daily operations, but is not a rule-made Department Policy. Hence does not carry the weight of Commissioner review or approval.

Background of ASI Form

Author's Statement's: "The Addiction Severity Index currently utilized by the DOC is an abbreviated version of one developed by the University of Pennsylvania's Veterans Administration Center for Studies of Addiction in 1980 (see appendix B). (Page 18)

... While indicating that the longer ASI has been used for the assessment of other groups of subjects, the Guide cautions about the reliability and validity of the administration of the instrument under different circumstances. (Page 19)

... The ASI form currently being used by NJDOC is not the same as the one developed by the University of Pennsylvania. It is an amended and abbreviated version of the original, referred to as the "short" form and deals almost exclusively with inmates' substance abuse problems. The short form records information with regard to inmate personal data, arrest and conviction history, and substance abuse and treatment history. Additionally, it requires the interviewer to intuitively rate the severity of the addiction. See Illustration #1, following pages) By comparison, it should be noted that the short form, which is not scorable, is less objective than the long one, and thus scientifically less effective in quantifying the severity of addiction, or for making assignments to the various drug treatment programs available." (Page 20)

DOC's Response: The Journal of Substance Abuse Treatment 18 (2000) 349 – 358 article on *Effectiveness of Screening Instruments in Detecting Substance Use Disorders among Prisoners* states that this study examines the effectiveness of several screening instruments in detecting substance use disorders among prison inmates. A sample of 400 male inmates were administered eight different substance abuse screening instruments and the Structural Clinical Interview for DSM – IV (SCID – IV), Version 2.0 Substance Abuse Disorders module. The latter was used as a diagnostic criterion measure to determine the presence of substance use disorders. Based on the positive predictive value, sensitivity, and overall accuracy, ... the Alcohol Dependence Scale/Addiction Severity Index – Drug Use section was found to be one of the most effective in identifying substance abuse and dependence disorders. In layman's terms, the short form can be used for the prison populating and is considered an effective instrument.

Furthermore, the ASI author reviewed and modified the short form (the Alcohol Dependency Scale/Addiction Severity Index – Drug Use section) as a screening tool for NJDOC inmate population by adding two questions. The author notes in his 5th Edition, while individual items should not be removed from the ASI, items can easily be added to each section, to better reflect the client population and the needs of the facility. (McLellan, 1992)

If the author in his *Final Report* searched the Literature more diligently, a great deal of misunderstanding could have been avoided. The Department intended the short form to be used as a screening instrument to identify inmates who would later receive more extensive assessment at a TC. It was not used for "quantifying the severity of the addiction, or for making assignments to the various drug treatment programs". The ASI was not designed for broad-based use... it can and should be used in conjunction with other instruments that, collectively, provide a complete and accurate picture of the client. (McLellan, 1992)

Department of Corrections would follow with subsequent assessments to support the veracity of the process to identify addicted inmates, their addiction severity, and their assignment to a suitable treatment program. Upon arrival to a correctional facility from C.R.A.F., the inmate is called to the TC for an extensive personal interview. The classification file would be reviewed prior to the interview and while at the TC the seven-section ASI (Long Form) would be administered. Acceptance into or rejection from the TC program would be made during a 30-day Orientation at the TC, not at Reception and the recommendation reviewed and confirmed by the Institutional Classification Committee. The author neglected to mention in his Final Report the Department's use of the long ASI form to determine appropriate level of treatment and the TC's participation in evaluating the candidate's suitability for treatment.

We further support the use of ASI on prison population, by referring you to PAGE SIX, The original rationale for the use of the ASI, coupled with the majority of states use of the ASI for their Drug Courts, 43% (Peyton, 2001) and state correctional facilities.

NJDOC and its contacted TC agency used the A.S.I. Severity Ratings to assist clinicians in referral/treatment planning. Traditionally, the Composite Scores are used for research purposes and are the mathematically-weighted numbers used to measure change over time. Although we did not use the Composite Scores at screening or assessment, that did not exclude the author or his assistants from calculating the Composite Scores from existing screens.

Organization of the NJ DOC ASI Team

Author's Statement: "During an interview with the Department's, training officer it was indicated that perhaps there was one other full time evaluator during that period" (1998). (Page 20)

DOC's Response: This statement is inaccurate because it applies to 1990 (DOC's ASI Trainer). In 1998, DOC had two full-time evaluators from the Office of Drug Program Operations and trained rotating teams of evaluators from the correctional facilities, which afforded a total of five screeners per week.

ASI Reliability

Author's Statement: "After observing the ASI administration, probably the most serious concern on the part of the researchers was the reliability of the instrument to objectively assess the levels of substance abuse

among inmates. Given the lack of background information on the inmate being evaluated as indicated above, the evaluators rely exclusively on their ability to assess the veracity of the answers of the interviewee during a ten-minute interview." ... "More appropriate and objective instruments specifically created for screening correctional inmates for drug abuse have been developed over the past several years. The Texas Christian University Drug Screen" is suggested. (Page 23)

DOC's Response: Space considerations rendered it impractical for all screeners to review folders during the short stay at Reception.
The A.S.I.'s rates high on reliability when used as a clinical instrument for referral and treatment planning. (A.S.I. 5th Edition) The Department used the instrument in this manner. A Ph.D. in Psychology, the ASI Supervisor, reviewed the inmate folders prior to and then reconciled the ASI ratings after its administration. As previously stated, a thorough review of background information was conducted when the inmate was administered the long form ASI at the TC interview,
The Texas Christian University Drug Screen is not validated at this point. This is borne out by the author's own statement (McCormack, p.50).

The original rationale for the Department's use of the Addiction Severity Index:

- The encouragement from U.S. Department of Justice technical advisors
- The most widely used of the addiction assessment tools in the field, with high acceptance throughout the U.S. and fifteen other countries
- It has strong scientific reliability and validity, confirmed in studies published in leading journals
- Designed to document lifetime drug/alcohol use
- Designed to identify cause and effect in the lifestyle
- The encouragement of the NJ Attorney's Generals Office, Division of Criminal Justice
- New Jersey's Single State Agency, Department of Health and Senior Services used the instrument

Estimates of Program Completions

Author's Statement: "Discussions with the Department's training officer and RSAT historian revealed that only about 1,200 of the 6,000 inmates who have been assigned to TCs since 1990 have completed the program. Roughly 40% are given "unfavorable terminations," 40% leave for treatment, parole or other administrative reasons, and approximately 20% complete the program." (Page 24)

DOC's Response: Again the author misinterprets, lacking a full understanding of the continuum of care components and the linkage between program components. We would say:

- 40% are identified as "unfavorable terminations" (which is the national average)
- 40% leave for treatment, parole, or other administrative reasons; this category represents those who moved through the continuum of care, and received further treatment or specialized supervision. This is an important objective for successfully transitioning offenders into the community.
- 20% are identified as "program completions".

Hence, we believe that 40% were "unfavorably terminated" and 20% complete the program and 40% would need further analysis to determine what occurred. The analysis was not done.

The Role of the Case Manager

Author's Statements: " ... the case Manager's role was to provide DOC oversight and supervision of the TCs being operated by CMS (and other service providers), to assure that it was fulfilling its contractual treatment obligations."

"Despite significant efforts, the researchers could find no DOC person with the designation "case manager," or anyone filling that role as defined in the DOC's Treatment Policy memorandum. Some of the duties seem to be carried out by a variety of individuals: at the beginning of the continuum of care process by ASI technicians; in mid-process by counselors at the TCs; and at the end by parole officers. There appears to be no one group that has responsibility for developing, implementing and monitoring an inmate's treatment plan from classification through release from parole, or for bridging the "oversight" gap that exists between the DOC and CMS once the inmate is placed in CMS custody. Given the critical nature of the case manager's role in the continuum of care process, and the breadth of services they are required to provide to TC clients, it would seem that a large number of Case Managers should be in place to shoulder the case load of some 1200 or so inmates currently in therapeutic communities." (Page 26)

DOC's Response: The focus of the evaluation is 1998. In that year, NJDOC provided significant oversight, supervision, communication and technical assistance with CMS through:

- Quarterly meetings with correctional facility administrators and staff , who housed TC programs
- Weekly contact with Correctional Management Services, drug program administrator
- Monthly meetings with CMS TC program supervisors
- Visits to TC programs by NJDOC case managers and the Supervisor of the Office
- Quarterly meetings with IPDP officers, the specialized parole officers
- The Office provided, coordinated, and financed training for CMS staff
- Provided technical assistance for the development of TC program manuals

During 1998, Project Reform (Stop the Revolving Door) funded by the Governor's Office facilitated a staff of Case manager Supervisor, two regional caseworkers assigned to monitor and develop treatment plans, a State Parole Board Counselor and two Data Machine Operators.

The current staffing pattern and system is different from the 1998. The system is connected by program and agency interfaces. Our oversight is accomplished by program monitoring to assure integrity of the continuum of care. Traditional casework is replaced with system oversight.

PART II HISTORY AND SYSTEM ANALYSIS OF RSAT PROGRAMS

RSAT Program Structure and Operations

Treatment

Qualitative Analysis of Treatment Facilities, The Therapeutic Communities

Author's Statement: " ... However, a number of issues related to access to data (which CMS believed to be confidential) were never satisfactorily resolved between the researchers, the DOC, and CMS before the

grants were terminated. Therefore, information vital for an effective evaluation, e.g., the CMS contract with DOC, the inmate's records during TC participation, inmate and staff turnover rates, etc., never became available." (Page 32)

DOC's Response: We disagree with the above statement. Some of the information was provided, while other requested information was questioned as to how it related to the research questions. DOC requested further clarification as to the scope of the project and the relevancy of the information requested to the project scope. The author was not responsive.

PART III DATA ANALYSIS AND CPAI ADMINISTRATION

Administration of the CPAI

Author's Statement: The last paragraph beginning "Research Team #2 ...it was learned that the project director had hired the Center for Therapeutic Research (the owners of the SEEQ materials) to train DOC personnel to conduct an independent study of the therapeutic communities at the same time the researchers were engaged in the NIJ evaluation." (Page 46)

DOC's Response: The author misunderstood the Department's "independent study". The research evaluation conducted by the author examined the inmates participating in the Department's TC programs during the calendar year of 1998.
Since 1998 the TC programs have undergone significant change under the leadership of Diane M. Zompa, Ph.D., Director of our Department's Offices of Community and Drug Programs. As part of that change the Department undertook a Quality Assurance Initiative to identify Therapeutic Community weaknesses and to develop strategies to address those weaknesses.

Development of an Alternative Methodology

Dr. McCormack's proposed a sample change to include offenders who were assessed for treatment after September 1, 2000. He informed this Department that additional time would be necessary to build a sufficient sample size of 500 and suggested that we request an extension of the outcome evaluation. The Department does not support this request for a grant extension and questions whether NIJ would support a significant change in the original research design. (Page 47)

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TABLE OF CONTENTS

ILLUSTRATIONS

PROCESS EVALUATION OF THE NEW JERSEY DEPARTMENT OF CORRECTIONS RSAT PROGRAM

PART I CORRECTIONS BACKGROUND AND LITERATURE REVIEW

Statistics indicate that since the early 1970s the prison population in the United States has grown incrementally. The incarceration rate, which in 1972 was approximately 100 per 100,000 of the population, accelerated by 1999 to 682 per 100,000 (Beck, April 2000). Much of the increase, particularly since the early 1980s, is attributed to an increasingly conservative perspective in the country vis-a-vis crime and punishment, and the federal government's war on drugs. During the 1980s congress enacted laws that prescribed severe mandatory sentences for violent criminals and drug offenders. These laws were subsequently adopted by many states. During that decade and into the mid 1990s the federal government allocated billions of dollars to provide funding for new prison construction and increased resources to the courts and law enforcement. These funds were designed mainly to improve the criminal justice system's capability for arresting, processing and incarcerating serious, recidivating, drug-addicted offenders.

These moves by the federal government - which by nearly all accounts have not stemmed the flow of drugs into the United States or impacted significantly on their availability on the street - have created an ancillary problem for both the country and correctional authorities: namely, how to manage a largely addicted national prison population of over 1.8 million (Beck, April 2000).

The State of New Jersey is ahead of the national curve in terms of increases in the prison population and recognizes the need for more effective drug treatment programs to curb this increase. The number of inmates is over 31,000 for the first time, a fivefold increase over the 1980 figure of just less than 6000. A recent New York Times article attributed the increases to two dominant factors: a) the large numbers of drug offenders being sentenced under New Jersey's mandatory minimum sentence legislation

passed in the 1980s, and b) an increasingly conservative state legislature, which recently enacted both a "three strikes law" (life sentences to violent, three time convicted offenders), and an 85% rule (no parole for certain violent offenders until they serve 85% of their sentence), without a single dissenting vote. Former Corrections Commissioner John S. Terhune is quoted as predicting that the current inmate population will increase by another 20% to 37,000 by the year 2005 (Mansnerus, 1999).

In order to deal with the burgeoning drug dependent inmate population in the state, the New Jersey Department of Corrections (DOC), in the late 1980s, began to develop experimental "therapeutic community" (TC) programs in their juvenile correctional facilities. The New Jersey Therapeutic Community treatment programs for adult residential substance abusers commenced in March of 1990 with the creation of the Southern State PIER Program, and culminated with the creation of the largest of the TC Programs at South Woods in May of 1997. The intent of the TC programs was to provide effective treatment to the large number of inmates who are chronic substance abusers, and to attempt to break the cycle of recidivism inherent to that group. The Department expanded the existing programs in September of 1998 to include a 'Continuum of Care' component. The underlying assumption of the Continuum of Care concept was that drug addiction is an ongoing, life long disease with a high probability of relapse. If chronic substance abuse offenders can be identified during the classification process and assigned to TC programs utilizing the continuum of care protocol, then the cycle of substance abuse, crime, incarceration and re-incarceration can be broken. The ideal scenario, according to a 1999 DOC memorandum, occurs when an offender is identified at reception as in need of treatment, assigned to an appropriate treatment program, and, when eligible, processed through a community treatment program prior to release (DOC Memo, 9/21/99). While making great strides in terms of program implementation, the Department apparently did not anticipate the eventual need for program evaluation. As a result, a tracking system to monitor inmate progress [or lack of it] through the TCs and the newly added continuum of care components was never developed. This tracking void makes it virtually impossible to determine the reasons for individual inmate success or failure in a particular program, the relative effectiveness of the TC programs, or the impact of the various treatment components on TC participants.

It seems clear that if we as a nation are serious about addressing the drug abuse-crime relationship, then the treatment of substance abusers currently under some form of correctional supervision should be a major policy objective. It is also clear that treatment without evaluation leaves correctional officials without the information needed either to enhance effective programs and procedures, or to abandon failing ones. The following brief review of the literature summarizes drug treatment programs in corrections, and the encouraging findings from evaluations of therapeutic community programs throughout the nation.

RELATIONSHIP BETWEEN DRUGS AND CRIME

Drug abuse has consistently been linked to a high rate of criminal activity (Wish et al., 1984). In a national study conducted in 13 major cities, 44-87% of arrestees used illegal drugs. Results from the 1991 National Household Survey on Drug Abuse showed that drug use is a strong correlate of criminal behavior. Even after controlling for other variables such as age and race, the survey results found drug use indicators to be significantly related to criminal behavior, in terms of both property and violent crimes (Harrison & Gfroerer, 1997). The only greater predictor was age.

Currently, half of state inmates and a third of federal prisoners report committing their offense under the influence of alcohol or drugs (Mumola, 1999). Drug-using felons are also more likely to recidivate. Sixty to seventy-five percent of untreated parolees who have histories of heroin and/or cocaine use are reported to return to using these drugs within 3 months after release and to become re-involved in criminal activity (Wexler et al., 1988). The effects of this relationship have been seen in all parts of the criminal justice system, particularly corrections. According to an NIJ report (Lipton, 1992), since the second half the 1980s there has been a marked growth in prison and jail populations, continuing a trend that began in the 1970s. A significant source of these increases is the number of offenders sentenced to jail and prison for drug offenses. Prisons and US jails house one of the highest concentrations of substance abusers in the world (Tesoriero et al., 1999). The prison population increased two-and-a-half times between 1990 and 1993 alone. More than 80% of these inmates recidivate and

about three in four have used drugs. The US prison population has increased over 50% since 1981, due in large part to a national crackdown on drug related crimes (Lipton et al., 1992).

According to the National Institute of Justice's (NIJ) Drug Use Forecasting data (DUF), obtained from a program that monitors the results of drug testing of arrestees in 22 of the country's largest cities, 60 % of detained arrestees tested positive for the consumption of at least one drug (excluding alcohol) prior to arrest (Leukefeld and Tims, 1993). Numerous studies have highlighted the fact that the majority of offenders under correctional supervision have abused drugs (Mumola, 1999) and that their drug abusing lifestyle has caused numerous problems for the criminal justice system as well as their families and other community-based social service delivery systems (McShane & Krause, 1993). Results from a study in New York City reported that 80% of those arrested and charged with serious non-drug crimes tested positive for drugs, primarily cocaine and heroin (Wish et al., 1984). McNeece et al. contend that, "From what we have learned about fighting the war on drugs, at least three points have become increasingly clear: (1) incarceration does little to break the cycle of illegal drug use and crime, (2) offenders sentenced to incarceration for substance-related offenses exhibit a high rate of recidivism once they are released, and (3) drug abuse treatment has shown to be demonstrably effective in reducing both drug abuse and drug related crime" (McNeece et al., 1999). Unfortunately, most offenders do not take advantage of prison drug treatment programs. "Most drug-using offenders have avoided treatment while active in the community, although some have experienced detoxification several times." According to one report (Lipton, 1992), more than 70 percent of active street addicts NYC have never been in treatment nor intend to enter treatment for their addiction. In both state and federal prisons, the percentage of addicted inmates who reported being treated for drug abuse since their admission dropped since 1991 (Mumola, 1999).

HISTORY AND PHILOSOPHY OF CORRECTIONAL DRUG ABUSE TREATMENT

Tesoriero et al. present a history of drug abuse treatment in the prison setting beginning with the opening of U.S. Public Services hospitals in Lexington, Kentucky and Fort Worth, Texas in 1935 and 1938 respectively. These facilities were designed to provide institutional-based drug treatment programs for offenders and, since those efforts were seen as seminal, to eventually evaluate such programs via clinical research centers to determine if such rehabilitation was possible. However, the shift in correctional paradigms from rehabilitation to "just desserts" as a result of the 1974 Martinson Report resulted in the termination of these programs and existing plans to expand them. Eventually though, as a result of prison overcrowding beginning in the 1980s, the concomitant increase in the number of addicted inmates, and encouraging new findings from experimental institutional-base drug treatment programs, residential substance abuse treatment programs have been revitalized. Substantial funding for such programs was provided by Congress in the 1986 Anti-Drug Abuse Act.

A 1989 NIJ report showed that the percentage of prison inmates in drug treatment programs had risen from 4% in 1979 to 11% in 1987 (Tesoriero et al., 1999). In both state and federal prisons, about a quarter of all prisoners from 1991-1997 participated in either drug treatment or other drug abuse programs since admission (Mumola, 1999). These numbers, however, are low when considering how many substance-abusing inmates are not in drug treatment. Among specific types of programs, more state prisoners participated in self-help or peer groups and drug abuse education classes than in residential treatment and professional drug abuse counseling however. Brown (1992, in Tesoriero et al., 1999) reports that at least 65% of those inmates in need of substance abuse treatment do not receive it. Lipton et al. (1992) reported that

> "recent incomplete surveys of treatment for incarcerated drug abusers show that thirty-nine states use preliminary assessment procedures with newly sentences inmates; forty-four states allow Narcotics Anonymous (NA), Cocaine Anonymous (CA), or Alcoholics Anonymous (AA) self-help group meetings once or twice a week; 44 states have some form of individual counseling available for drug users; thirty six states have group counseling in which small groups of inmates meet once or twice weekly with a therapist; and thirty states have some types of intensive residential program, often based on the TC model..." [The TC model is a more intensive level of treatment where inmates are isolated from the general prison population].

Thus, the majority of states have some type of drug treatment services available. The issues are how available are these services, and are they available to all drug-addicted inmates? Several studies cited by Tesoriero et al. indicate that while drug treatment in prisons is becoming more widely available, the overwhelming majority of inmates with drug problems receive no treatment. Evidence seems to support the claims that the war on drugs has not provided any relief of our nation's drug problem (Nadelmann, 1988; Duke and Gross, 1993; Bugliosi, 1996) with the US continuing to have the highest drug use rates of any industrialized nation (Currie, 1993).

As a response to this fact, Congress enacted the Crime Act of 1994, which provided substantial resources for Federal and State jurisdictions for the first time to expand drug abuse treatment for drug abused offenders entering the criminal justice system. As a result, two federal government initiatives to aid states in their efforts to begin or expand comprehensive programs were created. Project REFORM (funded by the Bureau of Justice Assistance) and Project RECOVERY (funded by the Center for Substance Abuse Treatment) assist states in the development of effective prison-based treatment for incarcerated drug abusers. Project REFORM, for example, laid the groundwork for the development of prison-based treatment for incarcerated drug abusers. "Perhaps, most important, it had a catalytic effect on the correctional community in general, promoting corrections officials to shift their thinking toward rehabilitation, a concept that had been in abeyance for some time" (Lipton, 1995). Eleven states participated in Project REFORM and implemented comprehensive treatment plans resulting in a significant expansion in the availability of drug treatment service for inmates (Lipton 1998). It also had indirect beneficial effects on the correctional systems of the participating states. Some 22 states were given support to expand or expand drug treatment in the state. The Center for Substance Abuse Treatment's funding of Project RECOVERY in 1991 provided funding for technical assistance and training for states planing to implement new prison drug treatment programs. [1]

[1] For a detailed description of treatment system components implemented from Project REFORM see Lipton 1992; and 1998).

EFFECTIVENESS OF TREATMENT

According to the National Institute on Drug Abuse (NIDA), the myths surrounding the issue of drug dependency, which characterize addicts as morally weak or criminogenic, make it difficult for average non-abusing citizens to understand the true nature of drug dependency. Myers et al. found that, "these myths have not only stereotyped those with drug-related problems, but also their families, and communities, and the health care professionals who work with them. Drug abuse and addiction comprise a public health problem that affects many people and has wide-ranging social consequences. It is NIDA's goal to help replace these myths and long-held mistaken beliefs about drug abuse and addiction with scientific evidence that addiction is a chronic, relapsing, and treatable disease" (Myers et al., 1998). According to NIDA, addiction originally starts with a conscious choice to use drugs. Continued use can result in long-term compulsive drug craving and usage for which treatment is necessary.

A variety of approaches are used in treatment programs to help patients deal with these cravings and possibly avoid drug relapse. NIDA research shows that addiction is clearly treatable. Through treatment that is tailored to individual needs, patients can learn to control their condition and live relatively normal lives. Treatment can have a profound effect not only on drug abusers, but on society as a whole by significantly improving social and psychological functioning, decreasing related criminality and violence, and reducing the spread of AIDS. It can also dramatically reduce the costs to society of drug abuse (Myers et al., 1998).

In Principles of Effective Intervention with Offenders, Paul Gendreau concurs with Myers et al. that drug treatment can be effective. He references a survey by Lipsey (1992) of 443 correctional programs that included control group comparisons to support the notion that treatment works. The survey found that "...64% of the studies reported reductions in favor of the treatment group. The average reduction in recidivism was 10%. In some of these programs (therapeutic communities), reductions in recidivism was as high as 18%" (Gendreau, 1996, p. 118).

Palmer's 1996 examination of 32 meta-analyses and literature reviews also yielded results favoring treatment, the most effective being behavioral approaches and life skills programs. Behavioral approaches include contracting and token economies. Life skills programs include academic training, vocational training, outdoor experience, and drug treatment. This diverse yet conceptually coherent approach was among the more successful approaches observed by Lipsey (1992). Gendreau found that behavioral intervention strategies work best by providing intense services which occupy 40% to 70% of an offenders time over a 3 to 9 month period. He defines behavioral strategies as programs based on the principles of operant conditioning. "At the core of operant conditioning is the concept of *reinforcement*, which refers to the strengthening or increasing of a behavior so that it will continue to be performed in the future" (Gendreau, p. 120). Positive reinforcements (those that are pleasant and desirable) are more effective and ethically supportable to strengthen desired behavior as opposed to negative (punishment) reinforcements, according to the author. He recommends utilizing at least two of the following positive reinforcement strategies in offender behavioral treatment programs:

a) **Token economies** which motivate offenders (in groups) to behave in pro-social ways by awarding tangible or symbolic "tokens" such as points.
b) **Modeling** or using role models who demonstrate desired behavior that the offender can benefit from imitating.
c) **Cognitive behavioral** treatment models that "...are intended to change the offender's cognition, attitudes, values, and expectations that maintain antisocial behavior." [2]

Gendreau maintains that his research on "punishing smarter" programs which utilize intensive supervision (ISP) have shown them to be failures. This type of strategy includes a subgroup of programs that greatly increase the contact between supervisors and offenders such as home confinement, electronic monitoring, shock incarceration and boot camp. According to Gendreau, "The analysis (of punishing smarter programs) consisted of 174 comparisons between a punishment group and a control group. ... (and) produced, on average, a slight increase of recidivism of 2%" (Gendreau, pp. 126-127). The offender

[2] Recommended reading, *The Psychology of Criminal Conduct*, by Andrews, D and Bonta, J. (1994), published by Anderson for more information on Modeling therapy and, Contemporary Behavioral Therapy, 2nd Edition (1993), by Spiegler, M and Guevremont, D., published by Brooks/Cole for additional information relative to cognitive behavioral treatments.

behavior modification literature clearly indicates that "disastrous consequences occur in programs in which punishment and control are emphasized over all else" (Gendreau, p. 129). He concludes the article by indicating the evidence is persuasive that specific styles of service delivery (utilizing behavioral strategies) can reduce offenders' criminal behavior to a degree that has profound policy implications (Gendreau, p.130).[3]

It has been estimated that 62% of all U.S. prisoners used drugs on a regular basis prior to imprisonment (Innes, 1988). Since American correctional institutions manage such a high percentage of drug addicted clients, a number of treatment programs have been developed over the years that take into account institutional factors such as custody requirements, projected time in confinement, cost of treatment, levels of addiction, etc. Unfortunately, this institutional triage screens out many individuals who otherwise should receive intensive drug abuse treatment. Gerstein and Harwood (1990) estimate that more than 1 million persons in custody or under community supervision need drug treatment, yet only one in 10 receive the needed services. Heroin and crack addicts, the most serious of these offenders, are responsible for a disproportionate amount of crime according to Tesoriero et al. (1999), and should receive treatment priority, particularly pending release back into the community. "From a criminal justice perspective, any measurable reduction in an inmate's dependency on drugs can be expected to result in a decrease in disruptive behavior while in prison and a reduction in criminal behavior upon release" (Tesoriero et al).

Brown (1992) points out that prison-based drug treatment programs fall into four general categories:

1) **Incarceration without specialized drug treatment services** (experienced by 65% of inmates in need of such treatment).
2) **Drug education and counseling programs** (individual or group) are the most common in facilities with specialized treatment components.
3) **Self-help groups** initiated by inmates such as Alcoholics Anonymous (AA) and Narcotics Anonymous (NA).
4) **Therapeutic Communities** (TCs)

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[3] For comprehensive discussion of prison based TC evaluations see Rouse, 1991, Leukefeld and Tims, 1992, and Lipton, 1994 in reference section.

THERAPEUTIC COMMUNITY PROGRAMS (TCs).

Research indicates that with the exception of TC programs, there is little support for the effectiveness of residential substance abuse treatment programs (Lipton et al. 1992). Expecting drug education programs to reduce future use for inmates who are described as "fairly sophisticated street pharmacologists" is naive, and individual counseling programs have been shown to have little impact on reducing recidivism. Likewise, AA and AN programs, despite anecdotal evidence, lack scientific research supporting their effectiveness (Lipton et al., 1992). As indicated above, 75% percent of "untreated cocaine or heroin users - essentially drug free during confinement - recidivate within three months of release on parole" (Wexler et al., 1988).

"A TC is a residential treatment environment that provides an around-the-clock learning experience in which the drug user's changes in conduct, attitude, values, and emotions are implemented, monitored, and reinforced on a daily basis" (DeLeon 1986 in McNeece et al.). Typically, a TC is highly structured, and treatment lasts anywhere from 3-15 months. The treatment philosophy of therapeutic communities is that substance abuse is a disorder of the entire person, that the problem lies in the person, not the drug, and that addiction is only a symptom and not the essence of the disorder (Pan et al., 1993 in McNeece et al.). A therapeutic treatment program may include individual, group, and family counseling. The TC staff generally are recovering addicts who have successfully completed treatment in a TC. The key component, however, is the peer encounter that takes place in the group process.

Tesoriero et al. found, in reference to the TC approach, that there is a vast amount of research to indicate that residential drug treatment in a prison setting does produce favorable outcomes. He points to Rouse's research that indicates that, "In every case where statistics are available, the recidivism rates of program participants [in TC programs] are at least 10% lower than a control group" (Rouse, 1991).

Wexler (1994) describes the general features of therapeutic community drug treatment models as follows:

- Treatment services based on a clear and consistent treatment philosophy
- An atmosphere of empathy and safety
- Recruitment and maintenance of a committed, qualified staff
- Clear and unambiguous rules of conduct
- Use of ex-offenders and ex addicts as role models, staff, and volunteers
- Use of poor role models and peer pressure
- Provision of relapse prevention programs
- Establishment of continuity of care throughout custody and community aftercare
- Integration of treatment evaluations into the design of the program

Other research indicates that isolating inmates in a TC away from the general population is important (Wexler and Williams, 1986). It is important to gauge the intensity of the program to the needs of the participants (McLellan et al., 1986). Inmates who are remanded to community-based drug treatment programs do as well as those who participate voluntarily (Hubbard et al., 1989).

Before 1980, relatively few evaluations of drug treatment programs (including therapeutic communities) were conducted. The TC approach is one of the few programs that has undergone rigorous evaluations in several sites across the country. Presently, evaluations of therapeutic communities, sponsored by the NIJ, are currently under way or completed. Some of the states involved, such as New York, Oregon, Delaware, and California, have presented encouraging evidence that therapeutic communities work to prevent future drug use and crime. This research indicates that the TC approach produces favorable outcomes for drug addicted inmates who go through the program.

In the next section of this report, the researchers present the results of a year-and-a-half process evaluation of the therapeutic community/continuum of care treatment programs provided to substance abusers residing in correctional facilities in New Jersey.

PART II: HISTORY AND SYSTEMS ANALYSIS OF RSAT PROGRAM

The Process Evaluation of the New Jersey Department of Corrections' residential substance abuse treatment (RSAT) program was implemented as part of the nation-wide effort by the National Institute of Justice to determine the effectiveness of this type of treatment. These programs were established over the years by state legislation and supported by federal funds. The National Institute of Justice provided additional funding for their evaluation, and by 1998, seventeen states had already been awarded funds for conducting local (statewide) evaluations. The New Jersey Department of Corrections, in collaboration with The Criminal Justice Center at The College of New Jersey, responded to the solicitation from the NIJ to assess the RSAT Program in New Jersey, and in 1999 was awarded grants to provide Process and Outcome evaluations. This report deals only with the Process Evaluation of the RSAT Program.

A process evaluation is one in which the focus is on the local program's adherence to the original design model. In it, researchers collect data by observing program functions, examining program documents, and interviewing staff to determine whether the program is reaching the target population, and whether the program is being implemented as designed. The information obtained from the process evaluation can then be utilized in making management decisions by the agency responsible for the program.

Generally, this Process Evaluation sought to:

1. Examine the implementation of the NJDOC assessment and screening protocol, and provide a qualitative systems analysis of the program's "Continuum of Care" component.
2. Identify the type of treatment interventions and program components used by all RSAT delivery systems, and
3. Conduct an objective assessment of the appropriateness of treatment, and the extent to which the programs adhere to principles associated with successfully reducing recidivism.

The two Co-Principle Investigators (Co-PIs) at The Criminal Justice Center were Drs. Robert J. McCormack, the Center's Director, and Mario Paparozzi, its Associate Director. The research tasks were divided among two teams, each led by one of the two Co-PIs.

Dr. McCormack's research team (Team 1) was responsible for developing the literature review, reviewing DOC materials relative to the RSAT Program, and conducting a systems analysis of the entire RSAT process, as well as conducting the day to day administration of the grant. Dr. Paparozzi's research team (Team 2) was to select random samples of inmates who participated in the RSAT program (the experimental group), and of inmates with similar backgrounds, who for administrative reasons did not participate in the RSAT program (the comparison group). Additionally, Team 2 was to administer the Correctional Program Assessment Inventory (CPAI), an instrument that examines the effectiveness of corrections drug treatment programs. Finally, the team was to interview RSAT-involved inmates regarding the impact of the program on the quality of their lives, particularly as this related to increased involvement in families and communities. Both teams were to contribute to report writing. The results of the system analysis of the RSAT program are reported in the following portions of this section. The results of the research conducted by Research Team #2 can be found in Section III of this report.

The Process Evaluation of the New Jersey Department of Correction's (DOC) Residential Substance Abuse Treatment Program (RSAT) began on October 1, 1999 (its original January 1, 1999 starting date was postponed because of funding delays). The DOC and the Criminal Justice Center at The College of New Jersey (TCNJ) were informed, at about the same time (October 1999), that the National Institute of Justice had awarded them the Outcome Evaluation for RSAT as well. Both grants involve a collaborative effort between the DOC and TCNJ.

After initial meetings with Department of Corrections officials in early October 1999, the first stage of the Process Evaluation commenced with a literature review of drug abuse treatment generally, of correctional residential substance abuse treatment programs, of the structure and modalities of the programs, and of program evaluation protocols. Simultaneously, an Institutional Review Board (IRB) was established at TCNJ to review the methodology, relative to issues pertaining to studies involving human

subjects. It met in October 1999 and approved the methodologies of both the Process and Outcome Evaluations. During November and December of 1999, researchers conducted site visits at the DOC's Central Reception Assignment Facility (CRAF). Work commenced on the selection of the experimental and comparison groups, and the data collection associated with those groups. (This latter process will be discussed later in some depth).

RSAT PROGRAM INCEPTION

As indicated in Part I, the New Jersey Therapeutic Community (TC) treatment programs for adult residential substance abusers commenced in 1990. The intent of the programs was to provide effective treatment to the large number of inmates who are chronic substance abusers, and to attempt to break the cycle of relapse and recidivism inherent in that group. In March of 1990, the Southern State Correctional Facility's "PIER" Program (Persons Incarcerated Entering Recovery), and the "Ackerman Program" for female inmates at Edna Mahan Correctional Facility, began operations. The "BRIDGE" Program (Beginning Recovery Involving Dedication, Gratitude and Effort) at Riverfront began in 1992, followed by "No Return" at Northern State in November 1996 (which moved to Garden State in 1998), and "First Step," also at Garden State, in February 1997. The largest of the TC Programs, at South Woods, created in May of 1997 to hold 500 inmates in four separate units, was not fully operational until January of 1999. A Community Readjustment Unit was begun in 1997 to deal with the special problems of program failures, and most recently a "STIPP" Program (Special Treatment, Intervention and Prevention Program) has been initiated for inmates who have violated the "zero tolerance" policy of the Department, i.e., tested positive for drugs. The Department expanded the existing programs in September of 1998 to include a "Continuum of Care" component, which provides continued supervision and treatment to addicted inmates after completion of the TC segment of the RSAT program. These programs were supported by various federal grants over the years.

From the beginning, the therapeutic community program, which became known as the Residential Substance Abuse Treatment Program (RSAT), has been dynamic, recreating itself several times by

eliminating structural elements that have not proved successful, and adding new treatment modalities, eligibility requirements, and policies and procedures. This has been particularly true in 1999 and 2000, during which time the program was expanded by adding additional screening personnel, reaching out to a more inclusive inmate clientele (all inmates passing through the Central Reception Assignment Facility are now evaluated for substance abuse), and strengthening its community treatment component. During all of this time, however, no formal evaluation of the TCs by independent researchers has been undertaken.

RSAT PROGRAM STRUCTURE AND OPERATIONS

CLASSIFICATION AND ASSIGNMENT

Within the New Jersey Department of Corrections, the intake process for inmates is monitored by Central Reception Assignment Facility (CRAF) operations. The CRAF Intake Unit is responsible for determining the optimal placement for the inmate based on inmate need and institutional space, while the Reception Unit is responsible for the inmate evaluation and classification process. Assignments to facilities are then implemented. Each aspect of the intake process was visited and observed by the researchers.

Central Reception Assignment Facility (CRAF)

The researchers observed the operations of the Central Reception Assignment Facility (CRAF) during visits to that facility in Trenton during November and December 1999. All of the top-level officials of CRAF were interviewed during this period, as well as observations of the three-day intake orientation, the so-called "batching" process, the administration of the Addiction Severity Index (ASI) questionnaire, and a Classification Committee meeting. Male offenders are classified and assigned to various institutional facilities and programs at CRAF. The classification for female offenders is conducted at the Edna Mahan Correctional Facility for Women (EMCF).

CRAF Intake Unit

The institutional gatekeeper for CRAF is its Intake Unit, which maintains the "Daily Housing Population Report." This report contains the operational capacity of every facility and program operated by the Department, their daily inmate count, and the operational capacity variance (the bed space or lack thereof) for each institution. The Intake Unit maintains an ongoing (daily) liaison with these facilities and with the parole board in order to maximize the placement of state inmates being held at county jails into state operated programs and institutions. It utilizes a computerized program for its inmate tracking, which allows for real-time accuracy of the count. The CRAF facility has an operational capacity of 1174 inmates, and the number of admissions to the reception facility on any given day is a function of the available space at that facility. CRAF holds four classification committee hearings each week, and assigns inmates to programs and institutions throughout the state based on inmate need and available bed space. In many instances, individuals assigned to drug treatment programs are temporarily assigned to the general population in the institution in which the TC program is housed until space in the program opens up. The wait can be anything from several days to several months. The waiting list for each program is also computerized and monitored by the Intake Unit, and is maintained in chronological order to assure timely placement.

County Jail Confinement

Many state inmates are confined in county jail facilities for long periods of time because of overcrowding at state institutions. They stabilize their drug addiction through forced abstinence ("cold turkey"). through the services of contract drug-treatment providers, or, in some cases, as a result of hospitalization. Depending on the level of internal security at these facilities, inmates have been drug free for considerable periods of time before admission to CRAF for classification. Many of them are given custody status by CRAF's classification unit while at the county jail based upon their inmate file, but are not screened by ASI evaluators. Some of them never make it to a state institution. They either "max out" or become eligible for parole while in county facilities. A significant percentage of them are chronic drug

users in serious need of treatment, which is not being provided. (Internal studies by the DOC indicate that between 65% to 75% of state inmates have chronic drug/alcohol dependency. The national average is 80%. See Profile of Male Offender Statistical Analysis, NJDOC, 1999).

Clearly, the program is not reaching a significant number of the approximately 3000 state inmates confined in county jail facilities. Since this population includes many young, non-violent, substance-addicted offenders, who without treatment will predictably re-offend upon release, the program should be expanded to evaluate and provide treatment programs for these inmates.

CRAF Reception Unit

All state inmates being transferred from county jail facilities to state institutions must be evaluated and classified. The process begins at the CRAF Reception Unit. The Reception Unit regime is generally a three-day process. The first day involves an orientation and medical and dental screening. The second day involves a "batching" process, which includes a battery of inmate interviews by psychologists, social workers, classification specialists and addiction severity index evaluators. On the third day, after a review of the inmate's medical history and batching reports, the Institutional Classification Committee meets individually with each inmate and assigns him to an appropriate correctional facility. Inmates may be assigned or referred to one of the following programs or institutions:

(1) a Therapeutic Community Program (TC) for inmates with an ASI score of 5 or higher, who have 6 to 30 months before parole eligibility;[4] who are eligible for full minimum security and who are also eligible for participation in the Intensive Parole Drug Program upon release to parole;
(2) a Community Readjustment Unit for community offender failures of one kind or another;
(3) a Residential Community Release Program for specified inmates with less serious substance abuse problems (scores of from 1-4 on the ASI);

[4] The September 1, 1998 Memo indicated 12 to 30 months before parole eligibility. This was superceded by a September 21,1999 Memo, "New Jersey Department of Corrections Substance Abuse Treatment Policy and Procedures - Revision" which reduced the minimum time before parole eligibility to 6 months and contained other programmatic changes.

(4) the Supervisor, Office of Drug Program Operations, for inclusion in an expedited substance abuse program to insure appropriate treatment for inmates with chronic addiction problems and minimal length of sentence;

(5) a correctional facility with a deferred treatment intervention for inmates who have been identified as having severe ASI of 5 or higher) or moderate (ASI score of between 1 and 4) substance abuse problems but with over 30 months before their parole eligibility date; or

(6) another correctional facility for inmates with an ASI score of zero or for those not eligible for full minimum custody.

Due to severe internal pressures related to prisoner logistics, the CRAF classification process from reception to institutional assignment is concerned primarily with maximizing the utilization of available bed space.

Administration of the Addiction Severity Index (ASI)

The current DOC policies and procedures for the administration of the Addiction Severity Index (ASI) questionnaire are presented in a CRAF policy directive. This document specifies that:

a) an ASI representative, following the scheduled batch processing (i.e., the medical, psychological, classification evaluations referenced previously), shall interview *all* inmates received at the Central Reception and Assignment Facility.

b) all ASI interviews shall be conducted at the housing unit (Section 3.2);

c) ASI staff interviewers shall inform the housing unit officer of any inmate(s) who has not been interviewed;

d) arrangements should be made between the ASI interviewer and the housing unit officer to have the inmate(s) (who have not been interviewed) available the following day to have the ASI completed.

-DOC Policy Paper, 4A:1.2

The policy directive clearly intends that *all* inmates will be subject to an ASI evaluation.

Background of ASI Form

The Addiction Severity Index currently utilized by the DOC is an abbreviated version of one developed by the University of Pennsylvania's Veterans Administration Center for Studies of Addiction

in 1980 (see appendix B). According to the guide for its administration, it was "designed to provide important information about those aspects of a patient's life that may contribute to his or her substance abuse syndrome" (Univ. of Penn. *Guide*). The original, longer ASI form is comprised of four parts, and gathers data as to general information about the patient, their legal status, family history, and family/social relationships. Each of the areas is scored and given a Severity Profile rating. The guidebook indicates that there are "...complicated (statistical) formulas used in the calculation of these composites (scores on the instrument)... (which) have been very useful to researchers as mathematically sound measures of change in a problem status....These (severity) ratings...are perhaps the most vulnerable of all ASI items to the influences of poor interviewing skills, patient misrepresentation or lack of comprehension, and even the surroundings under which the interview is conducted" (Guide, p.3).

While indicating that the longer ASI has been used for the assessment of other groups of subjects, the Guide cautions about the reliability and validity of the administration of the instrument under different circumstances:

> ***Appropriate Populations - Can I use the ASI with samples of Substance Abusing Prisoners or Psychiatrically Ill Substance Abusers?***
>
> > *Because the ASI has been shown to be reliable and valid among substance abusers applying for treatment, many workers in related fields have used the ASI with substance abusing samples from their populations. For example, the ASI has been used at the time of incarceration and/or parole/probation to evaluate substance abuse and other problems in criminal populations. In addition, because of the widespread substance abuse among mentally ill and homeless populations, the ASI also has been used among these groups. While we have collaborated with many workers on the use of the instrument with these populations, it should be clear that there are no reliability or validity studies of the instrument in these populations.*
>
> *(Guide, pp. 3/4)*

The ASI form currently being used by the NJ DOC is not the same as the one developed by the University of Pennsylvania. It is an amended and abbreviated version of the original, referred to as the "short" form, and deals almost exclusively with inmates' substance abuse problems. The short form records information with regard to inmate personal data, arrest and conviction history, and substance abuse and treatment history. Additionally, it requires the interviewer to intuitively rate the severity of the addiction. (See Illustration # 1, following pages) By comparison, it should be noted that the short form, which is not scorable, is less objective than the long one, and thus scientifically less effective in quantifying the severity of addiction, or for making assignments to the various drug treatment programs available.

Organization of the NJ DOC ASI Team

The Addiction Severity Index (ASI) Team is supervised by the director of community programs. It is coordinated on a day-to-day basis by a supervising program specialist, assisted by a technical assistant. The team is comprised of six ASI evaluators, four of whom have been hired over the last year or so. During the year 1998, the target year of the Process and Outcome Evaluations, the assessment team consisted of at least two full time evaluators. During an interview with the Department's training officer, it was indicated that perhaps there was one other evaluator during that period. He indicated that he believed all of the evaluators had college degrees.

The ASI Training Program

ASI evaluators are given a one-week training program to orient them to the Department of Corrections and to the ASI Team operations. Two days of the training program are devoted to the policies and procedures related to administering the ASI. The trainees view a series of video tapes created by the developers of the ASI instrument, the University of Pennsylvania's Veterans Administration Center for Studies of Addiction. The trainees are given the opportunity to conduct

NEW JERSEY DEPARTMENT OF CORRECTIONS
RECEPTION CENTER/SUBSTANCE ABUSE DATA

Interviewer's Initials

Interview Date ____/____/____ Time Begun ____ : ____ AM/PM

Institution ____ Time Ended ____ : ____ AM/PM

Satellite ____ Birthdate ____/____/____

Inmate # ____ Male/Female First Name ____

Last Name ____ City ____

Home Address ____ County ____

State ____ Zip Code ____ Last Grade School (Completed) ____ ____

Telephone (____)____ SS# ____-____-____

Race ____ Marital Status ____

ARREST / CONVICTION / SENTENCING INFORMATION

arrests prior 24 months

Total prior arrests

Total prior convictions

Total prior incarcerations

Total Term ____ yrs. ____ mnths.

Man Min ____ yrs. ____ mnths.

PED or Time Goal

Actual Max

Date admitted County Jail

Date admitted Reception

Current offense ____

SUBSTANCE ABUSE INFORMATION

Was crime drug influenced? YES NO

If drug influenced, why?

1) money to support habit
2) high at time of offense
3) both

If drug offense, was it purely for profit? YES NO NA

Primary drug use ____

Year of 1st use ____ Primary drug route use ____

Frequency use (primary drug) ____

Weekly cost of total habit $____

ADDICTION SEVERITY INDEX RATING

Severity Profile

DRUG	ALCOHOL

0-1 No real problem, treatment not indicated
2-3 Slight problem, treatment probably not necessary
4-5 Moderate problem, some treatmen indicated
6-7 Considerable problem, treatment necessary
8-9 Extreme problem, treatment absolutely necessary

RACE

White - WH Black - BL American Indian - AI Alaskan Native - AN Asian Pacific Islander - API

HISPANIC: Puerto Rican - HPR Mexican - HM Cuban - HC Columbian - HCO Dominican - HDO Other - HS

DRUG/ALCOHOL USE

	Past 30 Days	30 Days Before Incarceration	LIFETIME USE Years	LIFETIME USE Months
01 Alcohol - Any use at all				
02. Alcohol - To intoxication				
03. Heroin				
04. Methadone				
05. Other opiates / analgesics				
06. Barbituates				
07. Other sed. / hyp. / tranq.				
08. Cocaine				
09. Amphetamines				
10. Cannabis				
11. Hallucinogens				
12. Inhalants				

13. More than one substance per day (include alcohol) ____ DAYS ____ YEARS ____ MONTHS

14. Which substance is the major problem? (Please code as above; or
00 - No problem;
15 - Alcohol & Drug: Dual Addiction;
16 - Polydrug: when not clear, ask) ____

15. How long was your last period of voluntary abstinence from this major substance? (00 - never abstinent) ____ MONTHS

16. How many months ago did this abstinence end? (00 - still abstinent) ____ MONTHS

Illustration #1: "Short Form" of Addiction Severity Index (ASI) used by NJ Department of Corrections; pages 1 and 2

17. How many times have you:

Had alcohol d. t. 's
Overdosed on drugs

18. How many times in your life have you been treated for:

Alcohol Abuse
Drug Abuse

19. How many of these were detox only?

Alcohol
Drug

19a. How many of these programs did you complete?

20. How much would you say you spent during the last 30 days, before incarceration, on:

Alcohol
Drug

21. How many days have you been treated for alcohol or drugs in the past 30 days? (Include N.A., A.A., psychiatrist)

22. How many days in the last 30 days (prior to incarceration) had you experienced:

Alcohol Problems
Drug Problems

DRUG/ALCOHOL USE

FOR QUESTIONS 23 & 24, PLEASE ASK PATIENT TO USE PATIENT'S RATING SCALE

23. During the past 30 days, how troubled or bothered have you been by:

Alcohol Problems
Drug Problems

24. At this point in time, how important is it to you to get treatment for :

Alcohol Problems
Drug Problems

INTERVIEWER SEVERITY RATING

25. How do you rate the inmate's need for treatment for:

Drug Problems
Alcohol Problems

CONFIDENCE RATINGS

Is the above information significantly distorted by:

26. Inmate's misrepresentation? 0 - No 1 - Yes

27. Inmate's inability to understand? 0 - No 1 - Yes

COMMENTS

Illustration #1 (continued): "Short Form" of Addiction Severity Index (ASI) used by NJ Department of Corrections; pages 3 and 4

mock administrations of the ASI. Their initial evaluations are critiqued by peers and veteran members of the team. [Gonzalez, 1999, personal interview]

Suggested Changes in ASI Administration

The locale used for administering the ASI evaluation, specified as "the housing unit" in the CRAF Policy Directive previously cited, appears to diminish the effective administration of the instrument. The ASI interviews generally occur after the batching process has been completed. During that process, the social worker, psychologist and classification specialist have access to each inmate's personal files. Background information contained therein is utilized to aid their determinations. In contrast, ASI evaluations take place in other parts of the institution, remote from the inmate files and lacking in privacy. Evaluators rely on the veracity of the inmates' answers to determine the number of prior arrests, the nature and seriousness of the current and prior offenses, the extent of prior drug and alcohol use, and any prior substance-abuse treatment they have received. There are, most likely, legitimate institutional concerns, such as prisoner control, that have influenced the development of the process as it now exists. However, the researchers feel that administration of the ASI would be improved significantly by making its administration an integral part of the "batching" process, or by requiring ASI evaluators to review an inmate's personal file at some time during the assessment.

ASI Reliability

After observing the ASI administration, probably the most serious concern on the part of the researchers was the reliability of the instrument to objectively assess the levels of substance abuse among inmates. Given the lack of background information on the inmate being evaluated as indicated above, the evaluators rely exclusively on their ability to assess the veracity of the answers of the interviewee during a ten-minute interview. Certainly, the ASI training program (however brief), the evaluator's prior educational and employment experiences, and their current

experience as an ASI evaluator contribute to this ability. However, the determination of the critical level of substance abuse for each administration of the ASI appears to be largely a subjective one. There is no quantifiable (objective) part of the instrument which the evaluator can utilize to make a reliable distinction between a score of four or five, for example, which is crucial to the decision to admit or reject an inmate for participation in a Therapeutic Community Program.[5]

For these reasons, the researchers recommend that the use of this form be reviewed. More appropriate and objective instruments specifically created for screening correctional inmates for drug abuse have been developed over the past several years. The Texas Christian University Drug Screen ("TCUDS"; see Appendix C), developed by Drs. Dwayne Simpson, Kevin Knight and Kirk Broome, is being used as the primary screening tool for assessing drug abuse problems and treatment needs by the Texas Department of Criminal Justice. Twelve other states have recently adopted or are considering adopting the instrument. It includes a nine point scoreable questionnaire that discriminates between relatively severe drug related problems and those that are less severe. The instrument also indicates the drug(s) the respondent feels is responsible for his or her drug-related problems.

Estimates of Program Completion

Discussions with the Department's training officer and RSAT historian revealed that only about 1200 of the 6000 inmates who have been assigned to TCs since 1990 have completed the program. Roughly 40% are given "unfavorable terminations," 40% leave for treatment, parole or other administrative reasons, and approximately 20% complete the program. The following chart,

[5] These statements may appear to dispute the researcher's comments in the Interim Report dated 7/30/00, which indicated that despite the lack of quantifiable results, " ...the ASI form [being used by the DOC], when administered by trained, experienced social workers, can discriminate between inmates who have moderate to severe levels of addiction...and those with low levels or no addiction problems." The comment was included in the report as a result of a suggestion by the DOC Project Director, in place of the original language used by the researchers.

derived from DOC figures, indicates the number of inmates "graduating" from the various treatment programs in 1998 and 1999.

Illustration #2

Graduates of NJ DOC Therapeutic Communities

Program	1998, Males	1998, Females	1999, Males	1999, Females
Edna Mahon Ackerman Program		43		47
Garden State First Step Program	78		111	
Garden State No Return, Units 1&2	86		74	
Riverfront BRIDGE Program	20		40	
Southern State PIER program	30		53	
South Woods Community Returns	1		54	
South Woods NuWay Program	58		201	
Totals, all TCs	**1998:**	**316**	**1999:**	**581**

The Role of the Case Manager

According to the New Jersey Department of Corrections Substance Abuse Treatment Policy and Procedures, a Case Manager is

> "an individual who possesses addiction treatment expertise, and is responsible to oversee an offenders' treatment plan, inclusive of the coordination of services with all providers throughout the continuum of care....Case managers have the unique role to serve as the linchpin between an offender and the continuum of care treatment providers. They are on the staff of the Office of Drug Program Operations, Division of Parole and Community Programs. As specialists in addiction treatment, Case Managers are responsible for establishing, upon admission, an inmate's treatment plan and overseeing its implementation. Case Managers make site visits to the treatment providers to monitor client treatment progress and resolve issues of mutual concern." - (Treatment Policy, 9/1/98).

The role of the Case Manager was created at about the time that Correctional Medical Services (CMS), the Department's contract provider for medical and substance abuse treatment services, was delegated the responsibility for the operations of the therapeutic communities (TCs) in 1996.

According to the DOC Memorandum referenced above, a TC refers to "a self-contained unit within a correctional facility which houses inmates assigned to a treatment program in which trained staff provide intensive therapeutic intervention and programming" (Treatment Policy, 9/1/98). From reviewing the DOC literature at the time, it is clear that the Case Manager's role was to provide DOC oversight and supervision of the TCs being operated by CMS (and other service providers), to assure that it was fulfilling its contractual treatment obligations.

Despite significant efforts, the researchers could find no DOC person with the designation "case manager," or anyone filling that role as defined in the DOC's Treatment Policy memorandum. Some of the duties seem to be carried out by a variety of individuals: at the beginning of the continuum of care process by ASI technicians; in mid-process by counselors at the TCs; and at the end by parole officers. There appears to be no one group that has responsibility for developing, implementing and monitoring an inmate's treatment plan from classification through release from parole, or for bridging the "oversight" gap that exists between the DOC and CMS once the inmate is placed in CMS custody. Given the critical nature of the case manager's role in the continuum of care process, and the breadth of services they are required to provide to TC clients, it would seem that a large number of Case Managers should be in place to shoulder the case load of some 1200 or so inmates currently in therapeutic communities.

TREATMENT

Correctional Medical Services' Therapeutic Communities

Until 1996, specially selected and trained DOC staff and professionals operated the therapeutic communities throughout the state. In April of 1996, the NJDOC contracted with Correctional Medical Services (CMS) to run the day-to-day activities of the TCs in order to improve the quality of services delivered to addicted inmates. A component of Spectrum Healthcare Services, Inc., CMS is the nation's leading provider of contract healthcare services to prisons and jails. CMS contracts with physicians and employs healthcare professionals who provide care to inmates at correctional facilities in 27 states. Correctional institutions across the country, including facilities in Ohio, Wyoming, St. Louis, and Michigan, have partnered with CMS to provide better health care for inmates in a secure environment. Through effective cost-control systems, CMS claims to significantly increase the quality of inmate health care, while controlling costs. By enhancing on-site resources, focusing on both prevention and early detection, and utilizing its national buying power, CMS promises to reduce the cost of providing medical, dental, and mental health care for inmates (CMS 2000).

It was the intention of both the process and outcome evaluations to assess CMS' impact on inmate treatment in the TCs. Researchers visited each of the DOC's ten TCs being operated by CMS. All of the TCs utilize a structure that is best described by the generic description contained in the CMS/SBS (Spectrum Behavioral Services) Resident Handbook (CMS/SBS TC Residential Handbook). The following is a synopsis of a 30-page outline of CMS/SBS program goals; structure; day to day operations; treatment activities; and staff organization. While there is some variation in TC programming, almost all NJ DOC TCs follow this protocol.

> The Resident Handbook provides audiences from the substance abuse treatment and human service communities, both prison and community-based, with a generic description of the organization and management of the prison-based therapeutic

communities (TC) operated by CMS (a division of Spectrum Behavioral Services) under contract with the New Jersey Department of Corrections (NJDOC). According to CMS, a TC is "a communal, drug-free residential rehabilitation center in which chemical dependency is treated as a topic in the individual's life which contributes to other areas of life being out of control. Within the structure of each TC, techniques are used to re-direct the recovering addict's lifestyle so he/she has the opportunity to become responsible individuals" (CMS:5). The underlying philosophy of the TC is that "recovery is possible for anyone at any time with no greater prerequisite than a sincere desire for, and commitment to change" (p. 5). Recovery involves learning to live life comfortably and enjoyably as a substance-free, crime-free member of the community. It also involves learning how to work, to develop effective and satisfying interpersonal relationships, to strengthen interpersonal relationships, to strengthen family ties, and to practice leisure activities, all without the need for or use of drugs (CMS:5).

Generally speaking, a TC represents a highly structured environment with defined boundaries. It employs community-imposed sanctions and penalties as well as earned advancement of status and privileges as part of the recovery and growth process. Inmates in a therapeutic community are known as family members or residents as in any family setting. They are not patients, as in an institution. These residents play a significant role in managing the TC and acting as positive role models for others to emulate. Members and staff act as facilitators, emphasizing personal responsibility for one's own life and for self-improvement. Peer pressure is most often the catalyst that converts criticism and personal insight into positive change. High expectations and high commitment from both members and staff support this positive change. Insight into one's problem is gained through group and individual interaction, a key component of any TC program.

The Therapeutic Community structure is based on both a social and business hierarchy model. By dividing the community into separate departments and job functions, harmony between social, interpersonal relationships and everyday work responsibilities can be achieved. The Resident Structure is a hierarchy, which can be broken down into four tier systems of operations. On the highest management level is the T.O.P. (top of the population) made up of the more experienced residents who, in linear chain of command,

oversee mid-level managers (department heads), line managers (department head aides) and lower level of line operations (See Illustration #3).

The Resident Handbook was prepared to help members understand why they are in the program, what they will be experiencing and learning, and how to familiarize themselves with the concepts of the therapeutic community environment. Program residents are expected to be available to participate in programs on a full-time basis. Individuals who do not have a GED should have ½ day school, ½ day treatment cycle; individuals with a GED or higher should participate in a full day program. Once individuals move out of the orientation phase, the treatment team may allow other activities for the participants such as work off unit, etc. All participants have a job within the program and all job functions within the program can have a dollar value attached to them. Residents in orientation are allowed to participate on a full-time basis until they have at least completed orientation.

Residents are expected to follow a list of program rules and regulations outlined in the Handbook.[6] Those who commit infractions of program rules receive various types of disciplinary actions, the severity of which are contingent upon the nature and frequency of the infraction(s). Residents and staff confront those who do not comply with program rules. Infractions are reported to the Coordinators, and they in turn report the infractions to staff. The choice of sanctions and work assignments depends upon the nature and seriousness of the infraction(s).

The TCs in New Jersey incorporate three phases. The first phase of the program is orientation, which lasts a minimum of 30 days. The primary objective of this phase is to help residents understand all the rules and regulations of the program and the basic concepts of the TC. The top of the populations (T.O.P.), and program staff are responsible for the indoctrination of new residents. At the orientation phase, emphasis is not placed on the technical aspects of the program as much as with just getting the new residents to accept the new way of life and beginning the process of changing behaviors

[6] See Appendix

RESIDENT'S ORGANIZATIONAL CHART

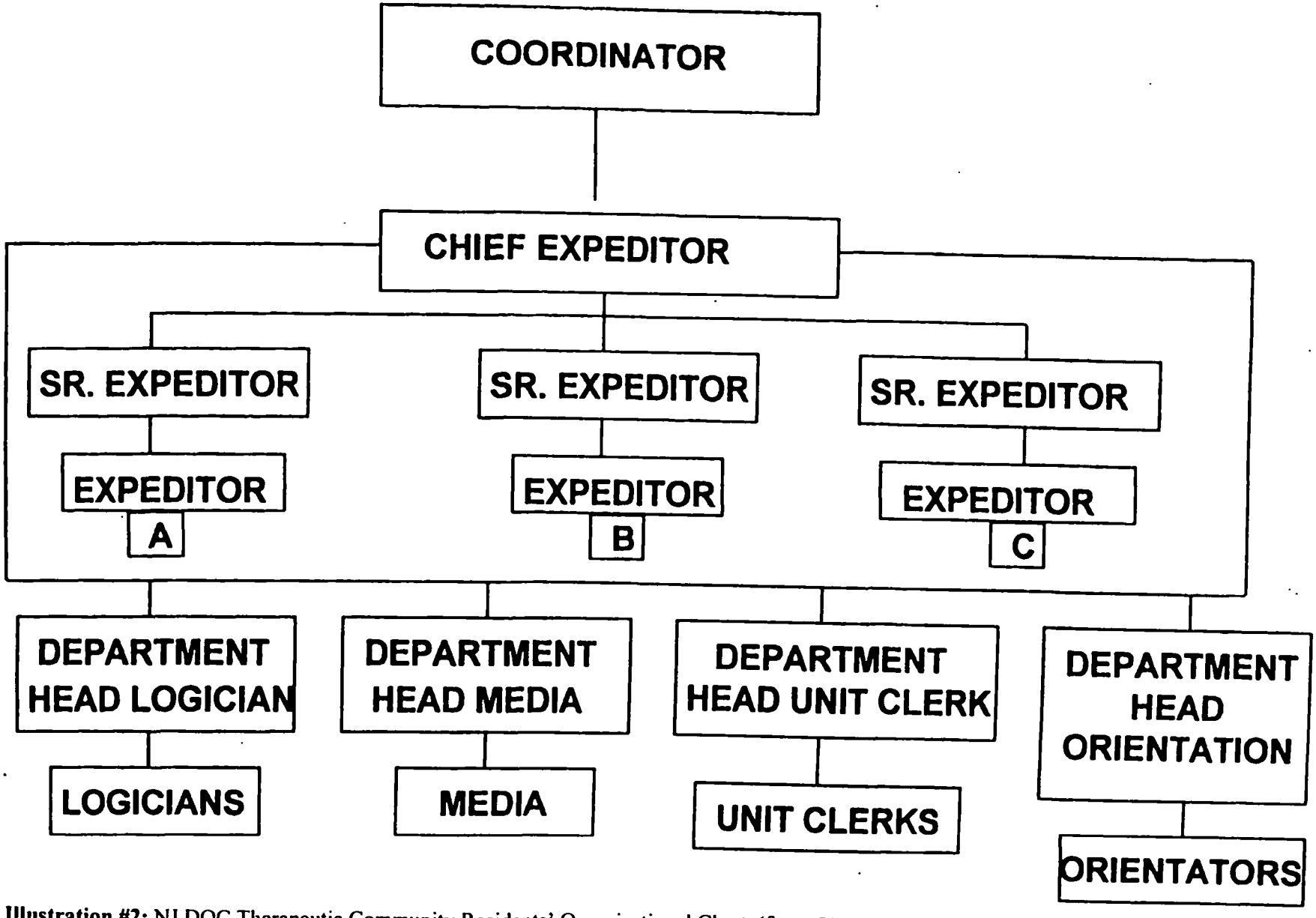

Illustration #2: NJ DOC Therapeutic Community Residents' Organizational Chart (from CMS Handbook)

and attitudes. New residents will also learn self-discipline and awareness to withdraw from old negative behavior patterns. The main treatment phase of the program is where the tools of a TC are tested to their fullest. The primary objectives of treatment are self-discipline and acceptance of authority by adhering to all general program rules and regulations, along with other rules that govern this phase. Through the use of program clinical tools, residents will continually identify negative behaviors and attitudes and begin the process of ridding themselves of such behaviors. Residents are encouraged to adopt a structured lifestyle, with emphasis on time management and resource allocation. Ultimately, when residents move on to another phase, or are paroled, they will continue using their "tools" at home and in the recovery.

When the aforementioned objectives are met, residents will move on to a re-entry phase where they will begin to plan and prepare for reintegration into their respective communities. In the re-entry phase residents focus on skills such as resume writing and job search skills. They will also focus on follow-up therapy that includes such areas as family and individual counseling and various other outpatient programs. Residents will also encounter the reality of dealing with impending relapse.

Activities for the residents of the TC include several meetings held at various times throughout the day, each with their own specific purpose. Morning meetings are held to lift residents' spirits and to begin their day on a positive note. Meetings can include song and dance, jokes, charades, poetry, current events, etc. Evening meetings are held to filter down information from staff to community, answer questions about program rules, and introduce new residents to the community. House meetings are held to go over any family issues concerning school problems, security procedures, program and over-all family behaviors. General meetings are held when residents have regressed to the point in treatment where they are close to being discharged from the program. Under supervision of the Counseling Staff, the resident population of the section to make a last concerted effort to encourage the residents considered for discharge to change their behaviors and/or attitudes.

Other activities during treatment include seminars, workshops and groups. Seminars are held to broaden one's scope and horizons and can be on current events or any subject. Workshops are offered to give residents instructions on life skills and

techniques that can be utilized in daily living. Topics may include budgeting; investments; resume writing; education; parenting; among others. Finally, various groups are used to recognize and ventilate feelings and emotions in a positive atmosphere. They provide reinforcement and support from staff and residents. These groups can be encounter groups where residents can verbally confront behaviors; psychotherapy groups where staff leads residents in a safe and caring atmosphere to discuss problems and issues; and participation in group activities.

- Spectrum Behavioral Services, Resident Handbook

Qualitative Analysis of Treatment Facilities

The Therapeutic Communities

During the qualitative analysis of the therapeutic communities, researchers made one or two-day structured visits to each of the Department of Correction's ten TCs. They interviewed staff, observed programs-in-progress, and monitored the day-to-day operations of each. This was to be followed by a similar analysis of other parts of the "Continuum of Care" service components during the remainder of the calendar year 2000. Once the qualitative analysis was completed, Research Team #2 was to revisit each TC, or a sample of the TCs, and administer the Correctional Program Assessment Inventory (CPAI), for a more in-depth and quantitative analysis of that program.

Research Team #1 met several times with the regional director of Correctional Medical Services (CMS) and DOC staff to set the ground rules for the evaluation visits to the TCs. Generally, the conditions for the visits were acceptable to the researchers. However, a number of issues related to access to data (which CMS believed to be confidential) were never satisfactorily resolved between the researchers, the DOC, and CMS before the grants were terminated. Therefore, information vital for an effective evaluation, ex., the CMS contract with DOC, the inmate records during TC participation, inmate and staff turnover rates, etc., never became available.

Despite these unresolved issues, researchers made their first evaluation visit to the Garden State Correctional Facility early in February of 2000. By mid March the three therapeutic communities at Garden State had been visited a total of six times. All of the senior CMS staff and DOC officers available during those visits were interviewed. Researchers also observed peer group counseling sessions, encounter group sessions, and didactic training sessions. From mid-March through mid-June, the seven other therapeutic communities in the state were visited by the research staff. Essentially the same qualitative evaluation activities were involved in each visit. The brief descriptive narrative of each of the TCs was developed from research field notes.

1. Garden State Prison TCs

There were three therapeutic communities operating in the Garden State Correctional Facility (Garden State) at the time this researcher made his visits. One of the TCs had bed space for 188 inmates, and the other two each had space for 160. Generally, Garden State is intended for inmates 26 years of age or under.

On the first visit, the researcher met with the acting director of Garden State, the regional director of CMS and two of the TC directors, who provided an overview of the prison's residential substance abuse treatment program. During the course of this visit and five subsequent ones, the researcher was able to inspect all three of the TCs, interview staff members, sit in on peer counseling sessions, didactic sessions, encounter groups, and interact with the inmates. At the time of the first visit, early in February of 2000, two of the TCs were operated in conformity to the traditional CMS format described previously. The third was in the process of being reorganized from a Special Treatment, Intervention and Prevention Program (STIPP) for inmates who had violated the "zero tolerance" program of the Department (i.e., tested positive for drugs), into a traditional therapeutic community. This new TC would eventually be called "No Return Unit 2" (NRU2), and mirror "No Return Unit 1" (NRU1), which was well organized and housed

in an immediately adjacent area of the facility. Both of these TCs were fully segregated from the general prison population. Inmates in the third TC, called "First Step," or "West House," shared some of the prison facilities with the general prison population, making security issues here a higher priority. As in all of the TCs, specially selected and trained DOC guards were assigned around the clock. Their job was to interact with the civilian TC directors, counselors and staff, to monitor traffic in and out of the TCs, and to assist in maintaining order when and where necessary.

The staffing of the TCs is generally comprised of a director, 2 senior or supervisory counselors, and 4 or 6 counselors, depending on the size of the TC. Each counselor had a case load of between 20 and 25 inmates; supervising counselors had a reduced case load due to their additional duties. Each of the counselors is required to have a one-on-one counseling session with each of their charges at least twice a month. At the time of the researchers' visits, one of the directors was supervising both NRU1 and NRU2, until a new director could be found for the new TC.

Staff turnover seemed to be a major problem in the TCs. CMS appears to have a reasonable track record for promoting from within, which is evidenced by the employment longevity of directors and supervising counselors. Many of them had been with CMS for a number of years and had reached their current positions by climbing the organizational ladder. CMS' record with entry level counselors was not as impressive. Among the five counselors at one Garden State TC, employment longevity was 2½ years, 2 years, 3 months, 9 months and 3 months. Figures for the second TC were 2½ years, 2½ years, 2 years, 2 months, and one position was vacant as a result of a turnover. The final TC's counselor employment figures were 4 months, 2 weeks, 1 year, 4 months, and 10 months.

2. Riverfront State Prison TC

The BRIDGE ("Beginning Recovery Involving Dedication, Gratitude and Effort") therapeutic community program is housed at Riverfront State Correctional Facility in the City of Camden. This TC houses 117 inmates, most of whom are 27 years of age or older. It shares facilities such as the mess hall, classroom space and recreation areas with inmates from the general population of the institution. As with the one facility at Garden State, this makes the problem of maintaining security and monitoring of inmates a more immediate and ongoing problem. Additionally, it has visiting hours twice a week, which further complicates security issues. The Bridge has a dynamic director and an enthusiastic staff, who seem to interact well with the inmates under their supervision. According to the director, the orientation phase of the TC program is the most important. It involves convincing inmates that the program is unique, that they have been in other rehab situations before, and that this may be their last chance to secure a decent life. Since most clients are in their late twenties or thirties, they understand the situation. As they become members of the community and accountable for other inmates' conduct, they gain status and prestige and become role models for other prisoners. The director reports that as they work their way through treatment and into the reentry phase, they tend to have a more disciplined approach to their addiction and realize, perhaps for the first time, that they will be in control of their future.

The researcher sat in on a didactic session conducted by an addiction counselor with many years experience. A recovering alcoholic himself, he ran the session with great enthusiasm. It was easy to tell that the counselor had full comprehension of the process of recovery and relapse. Each of the inmates was attentive, and contributed to the session by presenting personal experiences as cases in point.

Discussion with the staff revealed that counselor turnover was a serious factor affecting inmate success or failure. The researcher found employee retention problems similar to those

reported at Garden State TC. Training for replacement personnel was inadequate and in many cases "on the job." There was one counselor at this TC whose only credential was a high school diploma, and who was working to acquire a certificate as a Certified Alcohol and Drug Counselor (CADC).

3. Southern State Prison TC

The director of the "PIER Program" therapeutic community at Southern State Prison was a well-qualified individual who seemed to have been able to develop his staff into a well-coordinated team. His staff looked to him for leadership and he felt comfortable about delegating authority to his subordinates. His main concern was that because salaries are so low ($25,000 to $30,000), he is unable to get qualified counselors. When a counselor leaves, his or her case load is distributed among the other staff. There was a 5-month delay in filling two recent staff positions and he finally had to take someone he did not want because no one else was available. According to the director, since CMS began operations in New Jersey in April 1996, the turnover rate among counselors has been "huge." This, he said, is true not only at Southern State, but at all of the other TCs as well.

The inmates agreed to let the researcher sit in on a group counseling session lead by one of the new counselors. He was a minister with no degrees and had been at the TC for only two months. The counselor introduced the session's theme of family responsibility, and the inmates participated enthusiastically, relating how drugs and alcohol had affected their previous behavior and seriously impacted their personal relationships. Almost all of the twenty or so inmates spoke during the hour and twenty-minute session. The session ended abruptly as time ran out without the usual "wrap up" or "pulling together" of the most important parts of the discussion. A number of inmates asked whether the researcher would report that the program be maintained. Most of them felt that they were getting help from the program and hoped that it would be continued.

4. Edna Mahan Correctional Facility for Women TC

The "Ackerman Program" at Edna Mahan Correctional Facility is the only New Jersey DOC therapeutic community for women. The researcher met with the administrator of the facility and the director of the TC on the first visit. During the course of this visit the researcher toured the TC and met with the staff. The program's facility has 56 beds for severely addicted inmates. The administration of the TC is comprised of an all-female staff of a director, a senior or supervising counselor, and two counselors. Each of the counselors has a caseload of approximately 24, and the senior counselor approximately 10 to 12.

The atmosphere is relaxed and almost campus-like, despite the DOC security presence at the entrance to the TC. Most inmates participate in the program for approximately a year. There is a two-month orientation phase, a six to seven month treatment component, and a one to 3 month transition phase, during which the inmates are prepared for release directly into a halfway house. The treatment program is basically the same as the other TCs.

During a second visit the researcher was invited to sit in on a staff meeting to realign the "structure board" (see previous illustration). The structure board is an inmate hierarchy that signifies status within the TC. Positions are awarded as promotions (or in some cases demotions) for demonstrating personal growth and for assuming leadership within the TC family. During the course of the meeting, the entire Ackerman TC staff discussed the progress (or lack thereof) of each inmate, and made decisions relative to their positions on the structure board. It was clear that the staff was well informed of the strengths and weakness of their clients. Any disputed moves on the board were negotiated with the director.

The director of Ackerman is exceptionally well qualified for the position. She has a graduate degree and is a certified drug counselor who has worked with addicts and the mentally ill for many years. The senior counselor and one of the counselors are college graduates and the other counselor is working on an associates degree. Before the current director was hired, the TC

was without one for over six months; the senior counselor was acting director. The senior counselor has been with CMS for 21/2 years. One counselor has been employed for 11/2 years and the other for 9 months.

5. South Woods State Prison TCs

South Woods State Prison's "NuWay Program" is comprised of four therapeutic communities, with combined space to accommodate approximately 448 inmates. South Woods' first TC became operational in 1997 and the last was fully operational by January of 1999. The researcher met with the two directors and four of the senior counselors, all of whom had over 2 years work experience at South Woods. The turnover rate among counselors once again was indicated to be a serious problem. At the time of the visit there was only one counselor vacancy among the four TCs. However, in two of them, 8 out of 13 counselors had less than one year at the facility, and in another, 5 out of 12 had less than a year. The researcher was informed that the turnover rate among the inmates, which had for some time been high (25%), had recently been reduced to about 10%.

The researcher's general impressions included the fact that the physical space allocated to the TCs was more prison-like than any of the other therapeutic communities visited. There seemed to be more of a DOC presence, and a greater emphasis on security and less on the development of a community or family support environment. The office and counseling areas for the TC staff were less than adequate for the rehabilitative task that was expected. Quite frankly, the TC area, with room for over 425 beds, seemed too large, and some of the beds in the TCs were utilized to house non-TC inmates. The inmates were provided with a full schedule of activities, as in the other TCs. This schedule included: didactic morning meetings (8am to 11am); lunch and a lock down (11am to 1pm); peer counseling, encounter group sessions and AA and

NA sessions (1 to 3:45pm); dinner and lockdown (4 to 5:30pm), followed by an evening meeting, recreation, and a meeting of department heads before final lock down at 7:30pm.

Pre-Release Inmate Assessment Centers

The "Continuum of Care" process of the New Jersey Department of Corrections provides that inmate assessments be made 60 to 90 days prior to release to a community corrections program. Community corrections programs include halfway houses, community treatment facilities and a variety of parole supervision programs. Currently, there are two assessment centers in the New Jersey correctional system, both run by Community Education Centers (CEC), a private vendor: Talbot Hall in Kearny, and the Albert M. "Bo" Robinson Education and Training Center in Trenton.

The Assessment Centers are designed to serve all pre-release inmates, which means that at any given time a portion of the residents are individuals who have completed a therapeutic community program at one of the ten TCs located throughout the state. The objective of these assessment centers is to provide a comprehensive inmate profile prior to release in order to:

1) determine the participant's risk of recidivism,
2) assess the criminogenic needs that will be addressed in the program,
3) define responsivity characteristics, i.e. determine the types of treatment to which the participant is likely to respond, and
4) evaluate the magnitude and duration of any alcohol or substance abuse problem.

According to CEC, "All participants complete a battery of assessments that provide insight into specific rehabilitation needs. Areas assessed include academic, vocational and employability factors, as well as substance abuse relapse probability and risk of recidivism" (CEC, 2000). The assessment process is ongoing while the participant works his way through the 60 to 90 day program and develops a personal plan for rehabilitative success upon release to community corrections.

1. Talbot Hall

Talbot Hall opened in 1997 to provide assessment, rehabilitation services, and life-skills training services to DOC inmates 60 to 90 days prior to release to community correctional facilities. The researcher visited the facility in late September of 2000 and met with the director and two deputy directors to discuss the operations of the assessment process.

During a tour it was clear that the extensively renovated facility incorporated all of the features necessary to carry out its goals. One of the major differences between Talbot Hall and the therapeutic communities is that it is an independently operated entity, separate and apart from any DOC detention facility. DOC presence is minimal; several internal affairs officers were present, but no uniformed members of the DOC were evident.

Inmates are housed in one of three units. Each unit has a manager, 2 unit supervisors, 6 to 9 senior counselors, and 5 counselors. The living quarters resemble college dorms with neatly made up bunk beds, writing spaces, and places to store personal items. There seems to be adequate classroom space, as well as areas for plenary sessions for the units, computer labs, and large recreation and dining areas. Every aspect of the facility seemed to be well-organized and well run. The directors indicated that Talbot Hall accommodates over 2000 inmates a year. The facility takes high-risk inmates, some of whom have the potential for violent recidivism or serious criminal acts.

Assessors at both Talbot Hall and Bo Robinson use a process called "convergent validity," which incorporates assessments from a number of vector points, measured by multiple questionnaire administrations and one-on-one counseling sessions. The Department of Corrections makes the release decision at a reclassification hearing based on the inmate's assessment. Inmates who are judged to be "Very High Risk" are returned to prison to serve additional time. For some, "Halfway House/Substance Abuse Treatment" is recommended, which requires that the inmate receive additional substance abuse treatment at a halfway house before work/school release. Inmates recommended for "Traditional Halfway House" are placed in a live-

in environment with release during the day for work or school, some treatment sessions, and weekend furloughs.

2. Albert M. "Bo" Robinson Education and Training Center

This center, completely renovated for its current use as an assessment center, opened in 1997. It can hold up to 320 residents with full-minimum status; however, at the time of the researcher's visit in October of 2000, it had only 309. At that time the administrators of the facility were considering moving to a modified therapeutic community model, which would incorporate didactic sessions, small group counseling, and relapse prevention strategy sessions in addition to their own current testing and diagnostic programs.

As with Talbot Hall, the facility seemed to be well-organized and well run. On the inside, facilities for the inmates replicated those of Talbot Hall; however, the exterior of "Bo" Robinson resembles a DOC facility. The center provides counseling and life-skills training, and work-release programs for residents who have achieved their treatment goals.

PART III: DATA ANALYSIS AND CORRECTIONAL PROGRAM ASSESSMENT INVENTORY (CPAI) ADMINISTRATION

As was indicated earlier, the Process Evaluation tasks were divided between the two Co-Principal Investigators and their research assistants. Research Team #1, directed by Dr. Robert Mc Cormack, conducted the qualitative systems analysis, which has been discussed up to this point. Simultaneously, Dr Mario Paparozzi and Research Team #2 were working with DOC staff to establish the experimental and control groups of inmates who had participated in the RSAT program during calendar year 1998. This data, a snapshot profile of inmate demographics, would become the foundation of an inmate tracking system, following inmates' progress through the continuum of care process, and eventually, in the Outcome Evaluation, determining the effectiveness of the various components of the continuum and their impact on inmate recidivism. Research Team #2 was also preparing to conduct the Correctional Program Assessment Inventory (CPAI) and, during the latter part of the Process Evaluation, to interview participants in the program relative to the RSAT program's ability to strengthen family and community bonds.

INMATE COHORT DATA: 1998

A number of DOC staff assigned as liaison and resource personnel to the researchers had been involved in the residential substance abuse treatment programs for some time. The original DOC Project Director had been directing RSAT programs for over ten years and, in fact, had been the originator of many of them. Other DOC staff members were assigned to the RSAT evaluation upon project funding, and were not as familiar with many of the program's intricacies as the project director. The initial cohort data was generated shortly after the project began in October of 1999 by a combined group of DOC staff and Team #2 researchers. The group was to draw data related to all of the 1998 inmates who had been administered an Addiction Severity Index (ASI) questionnaire and had been determined to be in need of intensive drug treatment. Within this cohort there were two inmate subgroups in which the researchers had an interest. The

first subgroup of inmates were those assigned to one of the existing therapeutic communities (TCs); the second group was comprised of inmates with comparable ASI scores who had not been assigned to TCs. Inmates in this second subgroup were assigned instead to the general population for administrative reasons, such as not being eligible for minimum custody; having detainers on file; having received poor psychological evaluations; having been committed for a sex offense, etc. Researchers were to select an appropriate random sample from the first subgroup to serve as the experimental cadre, and a similar sample from the second subgroup to use as the comparison group. For some unexplained reason inmates who scored 6 or above on the ASI instrument were erroneously used to form the large research cohort from which the two subgroups were to be identified. This despite the fact that according to standard DOC practice for many years, inmates with scores of 5 or above on the ASI instrument were determined to be in need of intensive drug treatment and therefore eligible for placement in TCs. An early report from Research Team #2 attests to the confusion.

> The sampling frame is all inmates assessed on the Addiction Severity Index (ASI) at six or above during calendar year 1998 (N=3,300). We initially indicated that a score of five or above would serve as the cut off point for sample selection. However, as a result of work conducted during the process evaluation, we learned that the department of corrections uses a score of six or above as a mandatory referral for an RSAT (TC) program. Lower ASI scores may or may not result in a referral.
>
> - Paparozzi, October 1999

It is not clear who dissuaded the researchers from using the score of 5 or above as the TC referral criterion, or how the sampling error was made. We believe however, that since the sample was drawn by DOC staff who should have known the protocol for the DOC's therapeutic community selection, the mistake should have been noted immediately and corrected before the sample was drawn. As it was the researchers spent weeks analyzing the flawed database before discovering the sampling error.

Additional problems with the data analysis occurred as a result of the discovery that the DOC's information management system did not contain much of the data need to effectively

accomplish project goals as indicated above. The following data collection overview report was submitted by Research Team #2 early in 2000.

> The information provided to the researchers by the NJDOC liaison was initially incomplete (several fields contained no information). This missing data presented a problem for the implementation of the proposed research design.
>
> A second attempt to obtain the missing data was confounded because the first round of information provided in response to the request for more complete data included inmates from calendar years 1998 and 1999 (we needed to limit our research to 1998 only).
>
> A more significant problem was detected relative to the fact that so many of the inmates assessed in calendar year 1998, who were made part of the sample based on their ASI scores, were reassessed in 1999. Some of the reassessments produced different ASI scores that made those inmates ineligible for inclusion in the sample.
>
> We feel that much more work will need to be done before an appropriate study population can be finalized. Our concerns are based upon our initial findings that revealed the following:
>
> a. Manual file review is needed in order to clarify assessment scores, assessor names, actual assignment to an RSAT program, and other missing and/or ambiguous data.
> b. The rate of attrition in the RSAT programs may be higher than expected. If this proves to be the case, in fact, there will be a need to again increase the sample size quite considerably.
>
> At this point, we are accepting the study population as more of an exploratory rather than a final sample selection. In the months ahead, efforts will be made to sort and clean the data in order to assure stable experimental and comparison groups as well as a sufficiently large sample size.
>
> - Paparozzi, March 2000

With respect to the attrition rate in TCs (noted in b. above), the DOC's own estimate of program attrition, previously cited, placed that figure at approximately 80%. Only about 1200 out of the 6000 inmates assigned to TCs since 1990 completed the program. Roughly, 40% are given "unfavorable terminations," 40% leave for treatment, parole or other administrative reasons, and approximately 20% complete the program. The figures for the researcher's target year of 1998 were 316 completions (State of NJ DOC 12/22/99 document).

It became clear to the researchers that a different information management system had to be developed in order to track the treatment progress of inmates in the experimental and comparison groups as they moved through the correctional process. In the DOC information

system these data were contained in myriad files, some kept by the DOC and others by the private service providers hired for various parts of the continuum of care process. Each of these data sets would have to be hand-searched presenting a daunting task for the researchers. This fact, and the early discovery that the ASI questionnaire was not capable of objectively differentiating between inmate scores of 4, 5 or 6, (or any objective score for that matter), caused the researchers to consider presenting the DOC and NIJ with an alternative methodology for the evaluation. (See page 47.)

ADMINISTRATION OF THE CORRECTIONAL PROGRAM ASSESSMENT INVENTORY (CPAI)

A key method of assessing correctional treatment programs is through the use of the Correctional Program Assessment Inventory, or CPAI, an evaluative tool developed by Drs. Paul Gendreau and Don Adams. Through structured interviews with selected program staff, this extensive questionnaire seeks responses to 76 primary questions and many supplementary questions in an effort to fully examine and determine the degree to which the correctional program follows principles associated with other successful programs within the following six areas of correctional programs:

1. The **program implementation**, specifically as a function of the influence, involvement and qualifications of the program's leadership
2. The process by which, and the manner in which, **client assessments** are conducted;
3. The **program characteristics**, including the types of treatments used and the ability of the program to target criminogenic behaviors;
4. The education, experience, involvement and training of **staff**;
5. The methods of feedback and **evaluation** currently in use in the program;

6. And a number of **"other" related considerations**, such as the stability of program funding, advisory board involvement, community support, and the adherence to ethical guidelines.

Ultimately the inventory identifies the strengths of the program, the areas that need improvement, and makes recommendations for each of the six program areas evaluated.

Research Team #2 was charged with responsibility for administering the CPAI in the TCs and select segments of the Continuum of Care treatment facilities. At a March 2000 meeting of DOC staff and the researchers, the prospect of starting the administration of the CPAI questionnaires in various components of the continuum of care was discussed [by this time the DOC had replaced its original project director with a higher-level middle management supervisor]. This extensive questionnaire would require several days to administer, and would require information that CMS had previously indicated was confidential. The new project director introduced a more current TC assessment instrument called the Scale of Essential Elements Questionnaire (SEEQ) developed by Melnick, De Leon and Bernhardt. The DOC project director indicated that she had been in touch with the authors but it was not clear at that time what use, if any, would be made of the SEEQ material. The issue of commencing the administration of the CPAI questionnaires was not resolved at this meeting. Less than a week later, it was learned that the DOC project director had hired the Center for Therapeutic Community Research (the owners of the SEEQ materials) to train DOC personnel to conduct an independent study of the therapeutic communities at the same time the researchers were engaged in the NIJ evaluation. Given this surprising circumstance, the researchers decided to defer administering the CPAI in the TCs while the DOC SEEQ project was underway, and to begin administering the CPAI in the back end of the continuum of care, i.e. the assessment centers, halfway houses and community treatment components. The project director indicated that approval was required from a higher level DOC administrator before the CPAI administration in the facilities could commence, and promised to seek it. Approval was delayed for six months until October 2000.

DEVELOPMENT OF AN ALTERNATIVE METHODOLOGY

In light of the difficulties previously reported in connection with the ASI instrument and the DOC's management information system, the researchers felt that a new methodological approach to the evaluations was indicated. In July 2000, the new methodology was suggested to both the DOC and NIJ project monitor. It was based on adopting a more scientific assessment instrument for addiction severity, drawing two new experimental and comparison groups and establishing a "real time" tracking system for monitoring inmate progress through the continuum of care protocol. The following is the draft of this proposal.

> If the New Jersey DOC adopts a new addiction severity measurement instrument and trains its ASI technicians to utilize it by September 1, 2000*, approximately 4000 inmates** will be processed through Classification by the end of the year having been tested with new instrument.
>
> Approximately 60% should test over the new standard for assignment to a Therapeutic Community (TC) (based on current DOC statistics, see Inmate Profile Reports) or approx. 2400 inmates.
>
> Approximately 50% of these will not be eligible for TCs because of:
> 1. Time factors: parole eligibility too close or too far away.
> 2. No minimum-security status.
> 3. Seriousness of charges.
> 4. Detainers.
> 5. Sex offender status.
> 6. Arsonist.
> 7. Illegal Alien status.
> 8. Referred for further psychological evaluation.
>
> By January 1, 2001 two samples (500 each) will be selected as experimental and comparison groups based on their institutional assignments. The experimental group will be tracked through the RSAT, the remainder of the Continuum of Care process, until the end of the grant (March 31, 2002). The researchers will be able to monitor their progress for 15 months. The comparison group will be similarly monitored during their confinement and while on parole.
>
> If the Outcome Evaluation Grant is extended by nine months until December 31, 2002, the monitoring of the two groups will last for 24 months. Obviously, the longer the grant is extended the more credible the outcomes.
>
> **Advantages:**
> 1. The researchers will be able to construct a special management information system to accurately control the monitoring of both inmate groups.
> 2. There will be time to settle outstanding issues with CMS relative to privacy issues.
> 3. This new methodology can probably be implemented without any increase in funding.
>
> * This may be a difficult time line to achieve. If the new ASI form is not implemented until 10/1/00, there will be 1000 less inmates in the selection pool.
> ** Classification takes place four times a week and approximately 250 inmates are processed, or 1000/month. In four months, approximately 4000 inmates will have gone through the process.
>
> - McCormack, July 2000

In addition, the researchers suggested that the data generated by the DOC's own evaluation of the TCs, using the Scale of Essential Elements Questionnaire (SEEQ), be used in place of those that would have been generated via the CPAI administration. The SEEQ material developed by Melnick, De Leon and Bernhardt was as comprehensive as the CPAI. The DOC did not accept the proposal and was not agreeable to any modification of the original methodology.

PART IV: THE DOC DECISION TO END GRANTS AND DISCUSSION

The Doc Decision to End Grants

At the end of October of 2000, one of the Co-PIs, Dr. Mario Paparozzi, became a candidate in a search for a new Chairman of the New Jersey Parole Board. As soon as the Center's research staff became aware of that fact, a search began for Dr. Paparozzi's replacement in the event that he would be selected for the position. Dr. Paparozzi was eventually chosen for the position in early in November and the DOC contacted NIJ and indicated that they wanted to close down both grants by December 31, 2000. The reason given was that it would be difficult to replace Dr. Paparozzi because of his extensive experience in corrections and that in his absence no one capable of conducting the CPAI evaluations would be available. The researchers immediately notified NIJ that they had several outstanding candidates to replace Dr. Paparozzi, and that the staff was in contact with Dr. Paul Gendreau, the developer of the CPAI instrument, to determine the plausibility of making other arrangements for CPAI administration. The grant administrator at NIJ was very receptive to both suggestions, and indicated that it was quite common for a Co-PI to leave a grant and be replaced by another. However, at a subsequent meeting with the DOC project director and staff, it became evident that they were not agreeable to either of the suggestions and were determined to cancel both the Process and Outcome Evaluation grants, effective December 31, 2000. At the urging of the NIJ grant administrator the DOC agreed to allow the Process Evaluation grant to continue through March 31, 2001 so that a final report could be prepared. The Outcome Evaluation ended on December 31, 2000.

Discussion

In retrospect, it is evident that the NJDOC was not prepared for an evaluation of their RSAT programs. After spending almost a year and a half observing the programs, it is the

researcher's opinion that executive level administrators at the NJDOC were not closely monitoring the day-to-day operations of the RSAT programs. This is not unusual in large bureaucracies where vertical communications problems often exist. Lack of communications is common, particularly in specialized treatment operations outside of the normal chain of command. Correction administrators' major concerns are custodial. The fact that the NJDOC's RSAT programs had been in effect for over ten years with little notoriety seems to have resulted in a reduced concern for extensive oversight. Responsibility for the programs' operations had been delegated to a small group of mid-level managers who, ostensibly, were achieving the program's goals of selecting, processing, treating and eventually releasing "rehabilitated" former drug-addicted inmates to the community.

On closer inspection, the researchers found that the RSAT programs had in fact been developed on a shaky foundation and had deficiencies that needed to be corrected. Perhaps the most serious and enduring problem was perpetuating the notion that the abbreviated form of the Addiction Severity Index (ASI) instrument was capable of objectively distinguishing between the various levels of inmate addiction. In many cases, use of this instrument resulted in the inaccurate assignment of inmates to TCs or to less intense treatment programs in the general correctional population. In fairness, it should be pointed out that there are few, if any, validated assessment instruments available. The researchers recommended the Texas Christian University Drug Screen (TCUDS) to the DOC project director as an alternative to the ASI. Although still in the process of validation, TCUDS is the primary screening instrument of the Texas Department of Criminal Justice. As previously noted, twelve other states have recently adopted or are considering adopting it. It includes a nine point, scorable questionnaire that discriminates between relatively severe drug related problems and those that are less severe (Institute of Behavioral Health, 1998). The flaws connected with the ASI administration were brought to the attention of DOC administrators by the researchers in early 2000 (it is difficult to believe they were not apparent before that). The

instrument continues to be used for making life-affecting decisions concerning which inmates receive or are denied appropriate levels of drug treatment while in confinement.

Another unresolved issue is the apparent lack of oversight the Department exercises over some of its service providers. These private contractors operate most of the continuum of care facilities, such as the therapeutic communities, assessment centers, half way houses and community treatment centers. Inmates selected for extensive drug treatment are assigned to the various TCs at CRAF, and unless they drop out or are removed from the program, proceed from one service provider to another until they are paroled. As indicated earlier, the position of case manager was designed to bridge the gap between the DOC and the service providers. However, these positions, perhaps 30 or 40 of them (to supervise the 1200 or so inmates in the continuum), were never created.

Research Team #1 spent most of its time in the therapeutic communities operated by Correctional Medical Services (CMS), and briefly visited the assessment centers operated by Community Education Centers (CEC). Their observations of both were indicated earlier in the report. The DOC should give serious attention to what appears to be a very high staff turnover rate among the CMS counselors in all of the TCs. Without doubt, this high turnover rate affects the quality of services, due to the disruption of relationships between the counselors and their clients, and the higher case loads among the remaining counselors. The researcher's observations indicate that in many cases the qualifications for new counselors are too low (a high school diploma in some cases), and that training for new counselors is insufficient and for the most part "on the job." This may be partially responsible for the high inmate attrition rate (about 80%) in the TCs.

After ten or more years of existence, the RSAT programs are in genuine need of evaluation. The Department should know whether service providers are in fact providing the services for which they were contracted. It needs to know which therapy programs are effective and which are not. It needs to know why one TC is more effective than another. It needs to

account for the high rate of attrition among TC inmates and determine the relapse and recidivism rates of those who complete the program. After more than a decade, the answers to these important questions elude them.

This Process Evaluation of the residential substance abuse treatment programs can be viewed as a limited success, at least in that it has resulted in an ongoing self-evaluation of those programs by the Department. The NJ DOC has been in the vanguard among states in terms of recognizing the importance of drug and alcohol treatment programs for inmates. They have made significant progress in this area and, therefore, should have been more willing to openly share both the programs' originality and limitations so that other states could benefit from their experiences.

End Notes

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Appendices

Appendix A: Addiction Severity Index (ASI) – Short Form

Appendix B: Addiction Severity Index (ASI) – Long Form

Appendix C: Texas Christian University Drug Screen (TCUDS)

Appendix D: Correctional Program Assessment Inventory (CPAI)

Appendix A: Addiction Severity Index (ASI) – Short Form

NEW JERSEY DEPARTMENT OF CORRECTIONS
RECEPTION CENTER/SUBSTANCE ABUSE DATA

Interviewers Initials

Interview Date ____/____/____ Time Begun ____ : ____ AM/PM

Institution ____ Time Ended ____ : ____ AM/PM

Satellite ____ Birthdate ____/____/____

Inmate # ____ Male/Female First Name ____

Last Name ____ City ____

Home Address ____ County ____

State ____ Zip Code ____ Last Grade School (Completed) ____ ____

Telephone (____)____ SS# ____-____-____

Race ____ Marital Status ____

ARREST / CONVICTION / SENTENCING INFORMATION

arrests prior 24 months

Total prior arrests

Total prior convictions

Total prior incarcerations

Date admitted County Jail

Date admitted Reception

Total Term ____ yrs. ____ mnths.

Man Min ____ yrs. ____ mnths.

PED or Time Goal

Actual Max

Current offense ____

SUBSTANCE ABUSE INFORMATION

Was crime drug influenced? YES NO

If drug influenced, why?

1) money to support habit
2) high at time of offense
3) both

If drug offense, was it purely for profit? YES NO NA

Primary drug use ____

Year of 1st use ____ Primary drug route use ____

Frequency use (primary drug) ____

Weekly cost of total habit $____

ADDICTION SEVERITY INDEX RATING

Severity Profile

DRUG ALCOHOL

0-1 No real problem, treatment not indicated
2-3 Slight problem, treatment probably not necessary
4-5 Moderate problem, some treatmen indicated
6-7 Considerable problem, treatment necessary
8-9 Extreme problem, treatment absolutely necessary

RACE

White - WH Black - BL American Indian - AI Alaskan Native - AN Asian Pacific Islander - API

HISPANIC: Puerto Rican - HPR Mexican - HM Cuban - HC Columbian - HCO Dominican - HDO Other - HS

DRUG/ALCOHOL USE

	Past 30 Days	30 Days Before Incarceration	LIFETIME USE Years	LIFETIME USE Months
01. Alcohol - Any use at all				
02. Alcohol - To intoxication				
03. Heroin				
04. Methadone				
05. Other opiates / analgesics Painkillers: Morphine, dilaudid, demerol, percocet, darvon, codein, etc.				
06. Barbituates Nembutal, seconal, tuinal, fiorinol, etc.				
07. Other sed. / hyp. / tranq. Benzodiazepines: Valium, Librium, etc. Phenothiazines: Thorazine, haldol, serazine, melleril, prolixin, mellaril, etc. Others: Quaaludes, chloral hydrate, etc.				
08. Cocaine "Crack", free-base, "rock"				
09. Amphetamines Mexies, crank, benzedrine, dexedrine ritalin, preludin, speed, etc				
10. Cannabis Marijuana, hashish				
11. Hallucinogens LSD (acid), green, peyote, PCP (phencyclidine), mushrooms (psilocybin), Angel Dust				
12. Inhalants Glue, solvents, carbonal				

13. More than one substance per day (include alcohol) ____ DAYS ____ YEARS ____ MONTHS

14. Which substance is the major problem? (Please code as above; or
    00 - No problem;
    15 - Alcohol & Drug: Dual Addiction;
    16 - Polydrug: when not clear, ask) ____

15. How long was your last period of voluntary abstinence from this major substance?
    (00 - never abstinent) ____ MONTHS

16. How many months ago did this abstinence end?
    (00 - still abstinent) ____ MONTHS

DRUG/ALCOHOL USE

17. How many times have you:

Had alcohol d. t. 's	
Overdosed on drugs	

18. How many times in your life have you been treated for:

Alcohol Abuse	
Drug Abuse	

19. How many of these were detox only?

Alcohol	
Drug	

19a. How many of these programs did you complete?

20. How much would you say you spent during the last 30 days, before incarceration, on:

Alcohol	
Drug	

21. How many days have you been treated for alcohol or drugs in the past 30 days? (Include N.A., A.A., psychiatrist)

22. How many days in the last 30 days (prior to incarceration) had you experienced:

Alcohol Problems	
Drug Problems	

FOR QUESTIONS 23 & 24, PLEASE ASK PATIENT
TO USE PATIENT'S RATING SCALE

23. During the past 30 days, how troubled or bothered have you been by:

Alcohol Problems ☐
Drug Problems ☐

24. At this point in time, how important is it to you to get treatment for :

Alcohol Problems ☐
Drug Problems ☐

INTERVIEWER SEVERITY RATING

25. How do you rate the inmate's need for treatment for:

Drug Problems ☐
Alcohol Problems ☐

CONFIDENCE RATINGS

Is the above information significantly distorted by:

26. Inmate's misrepresentation?

0 - No
1 - Yes ☐

27. Inmate's inability to understand?

0 - No
1 - Yes ☐

COMMENTS

Appendix B: Addiction Severity Index (ASI) – Long Form

Addiction Severity Index 5th Edition

Harold C. Urschel, III, M.D.
Jacqueline Blair
A. Thomas McLellan, Ph.D.

Remember: This is an interview, not a test.

Call QuickStart Systems at (214) 342-9020 for:
- Free copies of the Clinical/Training ASI,
- Additional information about the Addiction Severity Index,
- Certified Training in the administration of the ASI,
- The Easy-ASI software, and
- Other Treatment Tracking Software.

INTRODUCING THE ASI:

Seven potential problem areas:
Medical, Employment/Support Status, Alcohol, Drug, Legal, Family/Social, and Psychological.
All clients receive this same standard interview.
All information gathered is confidential.
There are two time periods we will discuss:
1. The past 30 days
2. Lifetime Data

Patient Rating Scale:

Patient input is important. For each area, I will ask you to use this scale to let me know how bothered you have been by any problems in each section. I will also ask you how important treatment is for you for the area being discussed.
The scale is:
0 - Not at all
1 - Slightly
2 - Moderately
3 - Considerably
4 - Extremely

If you are uncomfortable giving an answer, then don't answer.
Please do not give inaccurate information!

INTERVIEWER INSTRUCTIONS:

1. Leave no blanks.
2. Make plenty of Comments (if another person reads this ASI, they should have a relatively complete picture of the client's perceptions of his/her problems).
3. X = Question not answered.
   N = Question not applicable.
4. Terminate interview if client misrepresents two or more sections.
5. When noting comments, please write the question number.
6. Tutorial/Clarification Notes are preceded with ">".

HALF TIME RULE: If a question is interested in the number of months, you can round up periods of 14 days or more to 1 month. If the question is only interested in the number of years and not months, you can round 6 months or more up to 1 year.

CONFIDENCE RATINGS:
> Last two items in each section.
> Do not over interpret.
> Denial does not warrant misrepresentation.
> Misrepresentation = overt contradiction in information.

PROBE AND MAKE PLENTY OF COMMENTS!

HOLLINGSHEAD CATEGORIES:

1. Higher execs, major professionals, owners of large businesses.
2. Business managers & medium sized businesses, lesser professions, i.e., nurses, opticians, pharmacists, social workers, teachers.
3. Administrative personnel, managers, minor professionals, owners/proprietors of small businesses, i.e., bakery, car dealership, engraving business, plumbing business, florist, decorator, actor, reporter, travel agent.
4. Clerical and sales, technicians, little businesses (bank teller, bookkeeper, clerk, draftsman, timekeeper, secretary).
5. Skilled manual - usually having had training (baker, barber, brakeman, chef, electrician, firemen, linemen, machinist, mechanic, paperhanger, painter, repairman, tailor, welder, policeman, plumber).
6. Semi-skilled (hospital aide, painter, bartender, bus driver, cutter, cook, drill press, garage guard, checker, waiter, spot welder, machine operator).
7. Unskilled (attendant, janitor, construction helper, unspecified labor, porter, including unemployed).
8. Homemaker.
9. Student, disabled, no occupation.

LIST OF COMMONLY USED DRUGS:

Alcohol:	Beer, wine, liquor
Methadone:	Dolophine, LAAM
Opiates:	Pain killers = Morphine, Dilaudid, Demerol, Percocet, Darvon, Talwin, Codeine, Tylenol 2,3,4, Synalgos = Robitussin, Fentanyl
Barbiturates:	Nembutal, Seconal, Tuinal, Amytal, Phenobarbital, Seconbarbital, Phenobarbital, Fiorinal
Sed/Hyp/Tranq:	Benzodiazepines = Valium, Librium, Ativan, Serax, Tranxene, Dalmane, Halcion, Xanax, Miltown, Other = Chloral-Hydrate (Noctec), Quaaludes
Cocaine:	Cocaine Crystal, Free-Base Cocaine or "Crack," and "Rock Cocaine"
Amphetamines:	Monster, Crank, Benzedrine, Dexedrine, Ritalin, Preludin, Methamphetamine, Speed, Ice, Crystal
Cannabis:	Marijuana, Hashish
Hallucinogens:	LSD (Acid), Mescaline, Mushrooms (Psilocybin), Peyote, Green, PCP (Phencyclidine), Angel Dust, Ecstasy
Inhalants:	Nitrous Oxide, Amyl Nurse (Whippets, Poppers), Glue, Solvents, Gasoline, Toulene, Etc.

Just name if these are used: Antidepressants,
Lithium Meds = Zanax, Tegamet
Asthma Meds = Vanatine Inhaler, Theodur
Other Meds = Antipsychotics, Lithium

ALCOHOL/DRUG USE INSTRUCTIONS:

The following questions look at two time periods: the past 30 days and lifetime. Lifetime refers to the time prior to the last 30 days. If the client has been detained or incarcerated during the past 30 days, and this period of incarceration is less than 1 year, you would use the 30 days prior to incarceration, in answering the 30 days questions. However, if the client has been incarcerated for more than 1 year, you would only gather lifetime use information, unless the client admits to significant alcohol/drug use during incarceration. This guideline applies only to the alcohol/drugs section.

> 30 day questions only require the number of days used.
> Lifetime use is asked to determine extended periods of use.
> Regular use = 3+ times per week, 2+ day binges, or problematic irregular use in which normal activities are compromised.
> Alcohol to intoxication does not necessarily mean "drunk", use the words "felt the effects", "got a buzz", "high", etc. instead of intoxication. As a rule of thumb, 5+ drinks in one setting, or within a brief period of time defines intoxication.
> How to ask these questions?
  > How many days in the past 30 have you used....?
  > How many years in your life have you regularly used....?

Addiction Severity Index, Fifth Edition

GENERAL INFORMATION

ID No.: ☐☐☐☐☐☐☐☐☐☐☐

SS No.: ☐☐☐ - ☐☐ - ☐☐☐☐

Date of Admission: ☐☐ / ☐☐ / ☐☐

Date of Interview: ☐☐ / ☐☐ / ☐☐

Time Begun: HOUR: MINUTES ☐☐ : ☐☐

Time Ended: HOUR:MINUTES ☐☐ : ☐☐

Class: 1. Intake 2. Follow-up ☐

Contact Code: 1. In person 3. Mail ☐
2. Telephone (Intake ASI must be in person)

Gender: 1. Male 2. Female ☐

Treatment Episode No.: ☐☐

Interviewer Code No.: ☐☐

Special: 1. Patient terminated 2. Patient refused 3. Patient unable to respond ☐

Name

Address 1

Address 2

City State Zip Code

1. How long have you lived at this address? (Years/Months) ☐☐ / ☐☐

2. Is this address owned by you or your family? 0-No 1-Yes ☐

3. Date of birth: (Month/Day/Year) ☐☐ / ☐☐ / ☐☐

4. Of what race do you consider yourself? ☐
1. White (not Hisp) 5. Asian/Pacific 9. Hispanic-Other
2. Black (not Hisp) 6. Hispanic-Mexican
3. American Indian 7. Hispanic-Puerto Rican
4. Alaskan Native 8. Hispanic-Cuban

5. Do you have a religious preference? ☐
1. Protestant 3. Jewish 5. Other
2. Catholic 4. Islamic 6. None

6. Have you been in a controlled environment in the past 30 days? ☐
1. No 4. Medical Treatment
2. Jail 5. Psychiatric Treatment
3. Alcohol/Drug Treat. 6. Other: _____
> A place, theoretically, without access to drugs/alcohol.

7. How many days? ☐☐
> "NN" if Question No. 6 is No. Refers to total number of days detained in the past 30 days.

ADDITIONAL TEST RESULTS

_____ ☐☐☐
_____ ☐☐☐
_____ ☐☐
_____ ☐☐☐
_____ ☐☐
_____ ☐☐☐
_____ ☐☐☐
_____ ☐☐☐
_____ ☐☐☐

PROBLEMS	SEVERITY PROFILE									
	0	1	2	3	4	5	6	7	8	9
MEDICAL										
EMP/SUP										
ALCOHOL										
DRUGS										
LEGAL										
FAM/SOC										
PSYCH										

GENERAL INFORMATION COMMENTS

(Include the question number with your notes)

MEDICAL STATUS

1. How many times in your life have you been hospitalized for medical problems? ☐☐
   > Include O.D.'s, D.T.'s. Exclude detox, alcohol/drug, and psychiatric treatment and childbirth (if no complications). Enter the number of overnight hospitalizations for medical problems.

2. How long ago was your last hospitalization for a physical problem? ☐☐ / ☐☐ (Yrs. / Mos.)
   > If no hospitalizations in Question 1, then this should be "NN".

3. Do you have any chronic medical problems which continue to interfere with your life? 0 - No 1 - Yes ☐
   If "Yes" specify in comments.
   > A chronic medical condition is a serious physical or medical condition that requires regular care, (i.e., medication, dietary restriction) preventing full advantage of their abilities.

3b. <OPTIONAL> Number of months pregnant: ☐☐ Mos.
   > "N" for males, "0" for not pregnant.

4. Are you taking any prescribed medication on a regular basis for a physical problem? 0 - No 1 - Yes ☐
   If yes, specify in comments.
   > Medication prescribed by a MD for medical conditions; not psychiatric medicines. Include medicines prescribed whether or not the patient is currently taking them. The intent is to verify chronic medical problems.

5. Do you receive a pension for a physical disability? 0 - No 1 - Yes ☐
   > Include Workers' compensation, exclude psychiatric disability.
   If "Yes" specify in comments.

6. How many days have you experienced medical problems in the past 30 days? ☐☐
   > Do not include ailments directly caused by drugs/alcohol. Include flu, colds, etc. Include serious ailments related to drugs/alcohol, which would continue even if the patient were abstinent (e.g., cirrhosis of liver, abscesses from needles, etc.).

For Questions 7 & 8, ask the patient to use the Patient Rating scale.

7. How troubled or bothered have you been by these medical problems in the past 30 days? ☐
   > Restrict response to problem days of Question 6

8. How important to you now is treatment for these medical problems? ☐
   > Refers to the need for additional medical treatment by the patient.

INTERVIEWER SEVERITY RATING

9. How do you rate the patient's need for medical treatment? ☐
   > Refer to the patient's need for additional medical treatment.

CONFIDENCE RATINGS

Is the above information significantly distorted by:

10. Patient's misrepresentation? 0 - No 1 - Yes ☐

11. Patient's inability to understand? 0 - No 1 - Yes ☐

MEDICAL COMMENTS

(include question number with your notes)

EMPLOYMENT/SUPPORT STATUS

1. Education completed (Years/Months) ☐☐ Yrs. / ☐☐ Mos.
   > GED = 12 years, note in comments.
   > Include formal education only.
2. Training or Technical education completed: ☐☐ Mos.
   > Formal/organized training only. For military training, only include training that can be used in civilian life, i.e., electronics vs. artillery.
3. Do you have a profession, trade, or skill? 0-No 1-Yes ☐
   > Employable, transferable skill acquired through training.
   If "Yes" (specify)_____
4. Do you have a valid driver's license? 0-No 1-Yes ☐
   > Valid license: not suspended/revoked.
5. Do you have an automobile available? 0-No 1-Yes ☐
   > If answer to No. 4 is "No", then No. 5 must be "No". Does not require ownership, only requires availability on a regular basis.
6. How long was your longest full time job? ☐☐ Yrs. / ☐☐ Mos.
   > Full time = 35+ hours weekly; does not necessarily mean most recent job.
7. Usual (or last) occupation? ☐
   (specify) _____
   (use Hollingshead Categories Reference Sheet)
8. Does someone contribute to your support in anyway? 0-No 1-Yes ☐
   > Is patient receiving any regular support (i.e., cash, food, housing) from family/friend. Include spouse's contribution; exclude support by an institution.
9. Does this constitute the majority of your support? 0-No 1-Yes ☐
   > If No. 8 = "No", then No. 9 = "N" for N/A.
10. Usual employment pattern, past three years? ☐
    1. Full time (35+ hours)
    2. Part time (regular hours)
    3. Part time (irregular hours)
    4. Student
    5. Service
    6. Retired/Disability
    7. Unemployed
    8. In controlled environment
    > Answer should represent the majority of the last 3 years, not just the most recent selection. If there are equal times for more than one category, select that which best represents more current situation.
11. How many days were you paid for working in the past 30 days? ☐☐
    > Include "under the table" work, paid sick days and vacation.

How much money did you receive from the following sources in the past 30 days?

12. Employment? ☐☐☐☐☐
    > Net or "take home" pay. Include any "under the table" money
13. Unemployment Compensation? ☐☐☐☐☐
14. Welfare? ☐☐☐☐☐
    > Include food stamps, transportation money provided by an agency to go to and from treatment.
15. Pensions, benefits or Social Security? ☐☐☐☐☐
    > Include disability, pensions, retirement, veteran's benefits, SSI & workers' compensation.

EMPLOYMENT/SUPPORT COMMENTS

(include question number with your notes)

EMPLOYMENT/SUPPORT (cont.)

16. Mate, family, or friends? ☐☐☐☐
> Money for personal expenses. (i.e. clothing), include unreliable sources of income (eg. gambling). Record cash payments only, include windfalls (unexpected), money from loans, gambling, inheritance, tax returns, etc.)

17. Illegal? ☐☐☐☐
> Cash obtained from drug dealing, stealing, fencing stolen goods, gambling, prostitution, etc. Do not attempt to convert drugs exchanged to a dollar value.

18. How many people depend on you for the majority of their food, shelter, etc.? ☐☐
> Must be regularly depending on patient, do include alimony/child support, do not include the patient or self-supporting spouse, etc.

19. How many days have you experienced employment problems in the past 30 days? ☐☐☐☐
> Include inability to find work, if they are actively looking for work, or problems with present job in which that job is jeopardized.

For Questions 20 & 21, ask the patient to use the Patient Rating scale.

20. How troubled or bothered have you been by these employment problems in the past 30 days? ☐
> If the patient has been incarcerated or detained during the past 30 days, they cannot have employment problems. In that case an "N" response is indicated.

21. How important to you now, is counseling for these employment problems? ☐
> The patient's ratings in Questions 20 & 21 refer to Question 19. Stress help in finding or preparing for a job, not giving them a job.

INTERVIEWER SEVERITY RATING

22. How would you rate the patient's need for employment counseling? ☐

CONFIDENCE RATINGS

Is the above information significantly distorted by:

23. Patient's misrepresentation? 0-No 1-Yes ☐

24. Patient's inability to understand? 0-No 1-Yes ☐

EMPLOYMENT/SUPPORT COMMENTS

(Include question number with your notes)

DRUG/ALCOHOL USE

Route of Administration Types:
1. Oral 2. Nasal 3. Smoking 4. Non-iv injection 5. IV
Note the usual or most recent route. For more than one route, choose the most severe. The routes are listed from least severe to most severe.

		Past 30 Days	Lifetime	Route of Admin
01	Alcohol (any use at all)			
02	Alcohol (to intoxication)			
03	Heroin			
04	Methadone			
05	Other Opiates/Analgesics			
06	Barbiturates			
07	Sedatives/Hypnotics/ Tranquilizers			
08	Cocaine			
09	Amphetamines			
10	Cannabis			
11	Hallucinogens			
12	Inhalants			
13	More than 1 substance per day (including alcohol)			

14. According to the interviewer, which substance is the major problem?
> Interviewer should determine the major drug of abuse. Code the number next to the drug in questions 01-12. "00" = no problem, "15" = alcohol & one or more drugs, "16" = more than one drug. Ask patient when not clear.

14b. <OPTIONAL> According to the patient, which substance is the major problem?

15. How long was your last period of voluntary abstinence from this major substance?
> Last attempt of at least one month, not necessarily the longest. Periods of hospitalization/incarceration do not count. Periods of antabuse, methadone, or naltrexone use during abstinence do count. Only show periods 30 days or greater.
00 = never abstinent.
Mos.

16. How many months ago did this abstinence end?
> "NN" if question 15 = "00"
> Refers to question 15; "00" = still abstinent.
Mos.

17. How many times have you had:
Alcohol DT's?
Overdosed on Drugs?

Delirium Tremens (DT's): Occur 24-48 hours after last drink, or significant decrease in alcohol intake, shaking, severe disorientation fever, hallucinations, they usually require medical attention.
Overdoses (OD): Requires intervention by someone to recover, not simply sleeping it off, include suicide attempts by OD.

DRUG/ALCOHOL USE COMMENTS

(Include question number with your notes)

DRUG/ALCOHOL USE (cont.)

18. How many times in your life have you been treated for: Alcohol abuse? ☐☐

    Drug abuse? ☐☐

    > Include detoxification, halfway houses, in/outpatient counseling, and AA or NA (if 3+ meetings within one month period).

19. How many of these were detox only?
    Alcohol? ☐☐
    Drugs? ☐☐
    > If question 18 = "00", then question 19 = "NN"

20. How much money would you say you spent during the past 30 days on:
    Alcohol? ☐☐☐☐
    Drugs? ☐☐☐☐
    > Only count actual money spent. What is the financial burden caused by drugs/alcohol?

21. How many days have you been treated as an outpatient for alcohol or drugs in the past 30 days? (include AA/NA) ☐☐

21b. < OPTIONAL > How many days have you been treated as an in-patient for alcohol or drugs in the past 30 days? ☐☐

22. How many days in the past 30 have you experienced: Alcohol problems? ☐☐
    Drug problems? ☐☐
    > Include only: Craving, withdrawal symptoms, disturbing effects of use, or wanting to stop and being unable to.

For questions 23 & 24, ask the patient to use the Patient Rating scale. The Patient is rating the need for additional substance abuse treatment.

23. How troubled or bothered have you been in the past 30 days by these:
    Alcohol problems? ☐
    Drug problems? ☐

24. How important to you now is treatment for these: Alcohol problems? ☐
    Drug problems? ☐

INTERVIEWER RATING

25. How would you rate the patient's need for treatment: Alcohol problems? ☐
    Drug problems? ☐

CONFIDENCE RATINGS

Is the above information significantly distorted by:

26. Patient's misrepresentation? 0-No 1-Yes ☐

27. Patient's inability to understand? 0-No 1-Yes ☐

DRUG/ALCOHOL USE COMMENTS

(include question number with your notes)

LEGAL STATUS

1. Was this admission prompted or suggested by the criminal justice system? 0 - No 1 - Yes ☐
   > judge, probation/parole officer, etc.
2. Are you on parole or probation? 0 - No 1 - Yes ☐
   > Note duration and level in comments.
3. How many times in your life have you been arrested and charged with the following:

03 Shoplift./Vandal.	☐☐	10 Assault	☐☐
04 Parole/Probation	☐☐	11 Arson	☐☐
05 Drug Charges	☐☐	12 Rape	☐☐
06 Forgery	☐☐	13 Homicide/Mansl.	☐☐
07 Weapons Offense	☐☐	14a Prostitution	☐☐
08 Burglary/Larceny/B&E	☐☐	14b Contempt of Court	☐☐
08 Robbery	☐☐	14c Other: _____	☐☐

> Include total number of counts, not just convictions. Do not include juvenile (pre-age 18) crimes, unless they were charged as an adult. Include formal charges only.

15. How many of these charges resulted in convictions? ☐☐
    > If 03-14 = "00", then question 15 = "NN".
    > Do not include misdemeanor offenses in questions 16-18 below.
    > Convictions include fines, probation, incarcerations, suspended sentences, and guilty pleas.

How many times in your life have you been charged with the following:

16. Disorderly conduct, vagrancy, public intoxication? ☐☐
17. Driving while intoxicated? ☐☐
18. Major driving violations? ☐☐
    > Moving violations: speeding, reckless driving, no license, etc.
19. How many months were you incarcerated in your life? ☐☐ Mos.
    > If incarcerated 2 weeks or more, round this up to 1 month. List total number of months incarcerated.
20. How long was your last incarceration? ☐☐ Mos.
    > Enter "NN" if never incarcerated.
21. What was it for? ☐☐
    > Use code 03-14, 16-18. If multiple charges, use most severe code. Enter "NN" if never incarcerated.
22. Are you presently awaiting charges, trial, or sentence? 0 - No 1 - Yes ☐
23. What for? ☐☐
    > Refers to Q# 22. If more than one, choose most severe. Don't include civil cases, unless a criminal offense is involved.
24. How many days in the past 30, were you detained or incarcerated? ☐☐
    > Include being arrested and released on the same day.

LEGAL COMMENTS

(Include question number with your notes)

LEGAL STATUS (cont.)

25. How many days in the past 30, have you engaged in illegal activities for profit? ☐☐
> Exclude simple drug possession. Include drug dealing, prostitution, selling stolen goods, etc. May be cross checked with Question 17 under Employment/Family Support Section.

For questions 26 & 27, ask the patient to use the Patient Rating scale.

26. How serious do you feel your present legal problems are? > exclude civil problems ☐

27. How important to you now is counseling or referral for these legal problems? ☐
> Patient is rating a need for additional referral to legal counsel for defense against criminal charges.

INTERVIEWER SEVERITY RATING

28. How would you rate the patient's need for legal services or counseling? ☐

CONFIDENCE RATINGS

Is the above information significantly distorted by:

29. Patient's misrepresentation? 0 - No 1- Yes ☐

30. Patient's inability to understand? 0 - No 1- Yes ☐

LEGAL COMMENTS

(Include question number with your notes)

FAMILY HISTORY

Have any of your blood-related relatives had what you would call a significant drinking, drug use, or psychiatric problem. One that did or should have led to treatment?

Mother's Side	Alcohol	Drug	Psych.
Grandmother	☐	☐	☐
Grandfather	☐	☐	☐
Mother	☐	☐	☐
Aunt	☐	☐	☐
Uncle	☐	☐	☐

Father's Side	Alcohol	Drug	Psych.
Grandmother	☐	☐	☐
Grandfather	☐	☐	☐
Father	☐	☐	☐
Aunt	☐	☐	☐
Uncle	☐	☐	☐

Siblings	Alcohol	Drug	Psych.
Brother 1	☐	☐	☐
Brother 2	☐	☐	☐
Sister 1	☐	☐	☐
Sister 2	☐	☐	☐

0 = Clearly No for all relatives in that category
1 = Clearly Yes for all relatives in that category
X = Uncertain or don't know
-N = Never was a relative

In cases where there is more than one person for a category, report the most severe. Accept the patient's judgement on these questions.

FAMILY HISTORY COMMENTS

FAMILY/SOCIAL RELATIONSHIPS

1. Marital Status
   1-Married 3-Widowed 4-Divorced
   2-Remarried 4-Separated 6-Never Married
   > Common-law marriage = "1". Specify in comments.

2. How long have you been in this marital status (Q #1)? ☐☐ / ☐☐ Yrs. Mos.
   > If never married, then since age 18.

3. Are you satisfied with this situation? 0-No 1-Indifferent 2-Yes ☐
   > Satisfied = generally liking the situation.
   Refers to Questions 1 & 2.

4. Usual living arrangements (past 3 years): ☐
   1-With sexual partner & children 6-With friends
   2-With sexual partner alone 7-Alone
   3-With children alone 8-Controlled Environ.
   4-With parents 9-No stable arrangement
   5-With family
   > Choose arrangements most representative of the past 3 years. If there is an even split in time between these arrangements, choose the most recent arrangement.

5. How long have you lived in these arrangements? ☐☐ / ☐☐ Yrs. Mos.
   > If with parents or family, since age 18.
   > Code years and months living in arrangements from Question 4.

6. Are you satisfied with these arrangements? 0-No 1-Indifferent 2-Yes ☐
   > If with parents or family, since age 18.
   > Code years and months living in arrangements from Question 4.

Do you live with anyone who:

6a. Has a current alcohol problem? 0-No 1-Yes ☐

6b. Uses non-prescribed drugs? 0-No 1-Yes ☐

7. With whom do you spend most of your free time? 1-Family 2-Friends 3-Alone ☐
   > If a girlfriend/boyfriend is considered as a family by patient, then they must refer to them as family throughout this section, not a friend. Family is not to be referred to as "friend".

8. Are you satisfied with spending your free time this way? 0-No 1-Indifferent 2-Yes ☐
   > A satisfied response must indicate that the person generally likes the situation. Referring to Question 7.

9. How many close friends do you have? ☐
   > Stress that you mean close. Exclude family members. These are "reciprocal" relationships or mutually-supportive relationships.

9A. Would you say you have had a close reciprocal relationship with any of the following people:

Mother	☐	Sexual Partner/Spouse	☐
Father	☐	Children	☐
Brothers/Sisters	☐	Friends	☐

0 = Clearly No for all in class. X = Uncertain or Unknown,
1 = Clearly Yes for any in class. N = Never was a relative.

> By reciprocal, you mean "that you would do anything you could to help them out and vice versa".

FAMILY/SOCIAL COMMENTS

(include question number with your notes)

FAMILY/SOCIAL (cont.)

Have you had significant periods in which you have experienced serious problems getting along with:

0 - No 1 - Yes | Past 30 days | In Your Life

10. Mother
11. Father
12. Brother/Sister
13. Sexual Partner/Spouse
14. Children
15. Other Significant Family (specify)_____
16. Close Friends
17. Neighbors
18. Co-workers

"Serious problems" mean those that endangered the relationship. A "problem" requires contact of some sort, either by telephone or in person.

Did any of these people (Question 10 - 18) abuse you?

0 - No 1 - Yes | Past 30 days | In Your Life

18a. Emotionally?
> Made you feel bad through harsh words.

18b. Physically?
> Caused you physical harm.

18c. Sexually?
> Forced sexual advances/acts.

How many days in the past 30 have you had serious conflicts:

19a. With your family?

19b. With other people (excluding family)?

For Questions 20-23, ask the patient to use the Patient Rating scale.

How troubled or bothered have you been in the past 30 days by:

20. Family problems
21. Social problems

How important to you now is treatment or counseling for these:

22. Family problems
> Patient is rating his family's need for counseling for family problems, not whether they would be willing to attend.

23. Social problems
> Exclude patient's need to seek treatment for such social problems as loneliness, inability to socialize, and dissatisfaction with friends. Patient rating should refer to dissatisfaction, conflicts, or other serious problems. Exclude problems that would be eliminated if patient had no substance abuse.

INTERVIEWER SEVERITY RATING

24. How would you rate the patient's need for family and/or social counseling?

CONFIDENCE RATING

Is the above information significantly distorted by:

25. Patient's misrepresentation? 0-No 1-Yes

Patient's inability to understand? 0-No 1-Yes

FAMILY/SOCIAL COMMENTS

(Include question number with your notes)

PSYCHOLOGICAL STATUS

1. How many times have you been treated for any psychological or emotional problems:
   In a Hospital or inpatient setting? ☐☐
   Outpatient/private patient? ☐☐
   > Do not include substance abuse, employment, or family counseling. Treatment episode = a series of more or less consecutive visits or treatment days, not the number of visits or treatment days.
   > Enter diagnosis in comments if known.

2. Do you receive a pension for a psychiatric disability? 0-No 1-Yes ☐

Have you had a significant period of time (that was not a direct result of alcohol/drug use) in which you have:

	0-No 1-Yes	Past 30 Days	Lifetime
3. Experienced serious depression-sadness, hopelessness, loss of interest, difficulty with daily function?		☐	☐
4. Experienced serious anxiety/ tension-uptight, unreasonably worried, inability to feel relaxed?		☐	☐
5. Experienced hallucinations-saw things or heard voices that were not there?		☐	☐
6. Experienced trouble understanding, concentrating, or remembering?		☐	☐
7. Experienced trouble controlling violent behavior including episodes of rage, or violence? > Patient can be under the influence of alcohol/drugs.		☐	☐
8. Experienced serious thoughts of suicide? > Patient seriously considered a plan for taking his/her life.		☐	☐
9. Attempted suicide? > Include actual suicidal gestures or attempts.		☐	☐
10. Been prescribed medication for any psychological or emotional problems? > Prescribed for the patient by MD. Record "Yes" if a medication was prescribed even if the patient is not taking it.		☐	☐

11. How many days in the past 30 have you experienced these psychological or emotional problems? ☐☐
    > This refers to problems noted in Questions 3-9.

For Question 12-13, ask the patient to use the Patient Rating scale.

12. How much have you been troubled or bothered by these psychological or emotional problems in the past 30 days? ☐
    > Patient should be rating the problem days from Question 11.

13. How important to you now is treatment for these psychological or emotional problems? ☐

PSYCHOLOGICAL STATUS COMMENTS

(Include question number with your comments)

PSYCHOLOGICAL STATUS (cont.)

The following items are to be completed by the interviewer:

At the time of the interview, the patient was: 0-No 1-Yes

14. Obviously depressed/withdrawn ☐
15. Obviously hostile ☐
16. Obviously anxious/nervous ☐
17. Having trouble with reality testing, thought disorders, paranoid thinking ☐
18. Having trouble comprehending, concentrating, remembering ☐
19. Having suicidal thoughts ☐

INTERVIEWER SEVERITY RATING

20. How would you rate the patient's need for psychiatric/psychological treatment? ☐

CONFIDENCE RATING

21. Patient's misrepresentation? 0-No 1-Yes ☐
22. Patient's inability to understand? 0-No 1-Yes ☐

PSYCHOLOGICAL STATUS COMMENTS

(Include question number with your notes)

Appendix C: Texas Christian University Drug Screen (TCUDS)

TCU DRUG SCREEN

During the last 6 months before prison –

Circle Answer

1. Did you often use larger amounts of drugs (including alcohol) or use them for a longer time than you had planned or intended? ..... *0=No* *1=Yes*

2. Did you try to cut down on drugs and were unable to do it? ..... *0=No* *1=Yes*

3. Did you spend a lot of time getting drugs, using them, or recovering from their use? ..... *0=No* *1=Yes*

4. Did you often get so high or sick from drugs that it --

   a. kept you from doing work, going to school, or caring for children? ..... *0=No* *1=Yes*

   b. caused an accident or became a danger to you or others? ..... *0=No* *1=Yes*

5. Did you often spend less time at work, school, or with friends so that you could use drugs? ..... *0=No* *1=Yes*

6. In the last 6 months before prison, did your drug use often cause --

   a. emotional or psychological problems? ..... *0=No* *1=Yes*
   b. problems with family, friends, work, or police? ..... *0=No* *1=Yes*
   c. physical health or medical problems? ..... *0=No* *1=Yes*

7. Did you increase the amount of a drug you were taking so that you could get the same effects as before? ..... *0=No* *1=Yes*

8. Did you ever keep taking a drug to avoid withdrawal or keep from getting sick? ..... *0=No* *1=Yes*

9. Did you get sick or have withdrawal when you quit or missed taking a drug? ..... *0=No* *1=Yes*

10. Which drugs caused you the MOST serious problems in the last 6 months before prison? [SEE LIST BELOW]

    Worst: ..... |___| DRUG #

    Next: ..... |___| DRUG #

    Next: ..... |___| DRUG #

CHOOSE "DRUG #s" FROM THIS LIST:

0. None	*3. Marijuana*	*6. Tranquilizers or sedatives*
1. Alcohol	*4. Cocaine or crack*	*7. Hallucinogens*
2. Inhalants	*5. Other stimulants*	*8. Opiates*

11. How often did you use each type of drug during the last 6 months before prison?

	DRUG USE IN LAST 6 MONTHS				
	NEVER	ONLY A FEW TIMES	1-3 TIMES A MONTH	1-5 TIMES A WEEK	ABOUT EVERY DAY
a. Alcohol	0	1	2	3	4
b. Marijuana/Hashish	0	1	2	3	4
c. Hallucinogens/LSD/Psychedelics/PCP/ mushrooms/peyote	0	1	2	3	4
d. Crack/Freebase	0	1	2	3	4
e. Heroin and Cocaine (mixed together as speedball)	0	1	2	3	4
f. Cocaine (by itself)	0	1	2	3	4
g. Heroin (by itself)	0	1	2	3	4
h. Street Methadone (non-prescription)	0	1	2	3	4
i. Other Opiates/Opium/Morphine/Demerol	0	1	2	3	4
j. Methamphetamine/Speed/Ice/Other Uppers	0	1	2	3	4
k. Tranquilizers/Barbiturates/Sedatives	0	1	2	3	4
l. Other *(specify)* _____	0	1	2	3	4

12. In the 6 months before entering prison, how often did you inject drugs with a needle?

0. Never *1. Only a few times* *2. 1-3 times a month* *3. 1-5 times a week* *4. About every day*

13. How serious do you think your drug problems are?

0. Not at all *1. Slightly* *2. Moderately* *3. Considerably* *4. Extremely*

14. How many times before now have you ever been in a drug or alcohol treatment program? [DO NOT INCLUDE AA/NA/CA MEETINGS]..... |__|__| # TIMES

15. Do you think you need treatment for your drug use now?..... *0=No* *1=Yes**

*IF "YES":

a. How important to you is it that you get into some type of treatment program now?

0. Not at all *1. Slightly* *2. Moderately* *3. Considerably* *4. Extremely*

Scoring for the TCU Drug Screen

Page 1 of the TCU Drug Dependence Screen is scored as follows:

1. Give 1-point to each "yes" response to 1-9 (Questions 4 and 6 are worth one point each if a respondent answers "yes" to any portion).

2. The total score can range from 0 to 9; score values of 3 or greater indicate relatively severe drug-related problems, and correspond approximately to DSM drug dependence diagnosis.

3. Responses to Question 10 indicate which drug (or drugs) the respondent feels is primarily responsible for his or her drug-related problems.

There have been no composite score protocols developed for Items 11-15 on Page 2.

Appendix D: Correctional Program Assessment Inventory (CPAI)

CPAI Questionnaire

PROGRAM CHARACTERISTICS

1. Name of the Program:_____

2. Name of Contact Person: _____

3. Address, Phone # and fax # of program setting: _____

_____

4. Years in Operation: _____

5. Program Setting (e.g., community residential center, institution, probation office):_____

6. Number of residents/participants:

   # juvenile: _____

   # adult: _____

   % male/female: _____

7. Number of staff:

   # Full-time: _____

   # Part-time: _____

   % male/female: _____

8. What is the program budget?_____

9. Does this program receive all its resources from the government or is it funded by grants or contracts from other sources?

   _____

10. Is there a documented program philosophy?_____

PROGRAM IMPLEMENTATION

11. (For current program director) Were you instrumental in designing the program before it was implemented?

Yes No

12. Could you describe your educational background?

What degrees have you received?

13. Did you have any previous experience in any type of offender treatment program?

Yes No

If yes, what previous experience with any type of offender treatment program have you had?

For how long did you work with this program? _____

14. Are you directly involved in hiring and giving training to the staff?

Yes No

15. Are you involved in providing direct service delivery to the client?

Yes No

Are you involved in directly supervising the staff in the institution/program?

Yes No

16. Was there a literature search to identify relevant program materials needed to design the program?

Yes No

If yes, what was the scope or extent of the search?

17. Prior to the implementation of the formal program, was there a pilot period of the program to try to work out the practical aspects of the program and any problems?

Yes No

If there was a pilot program, how long did it last? _____

What, if any, changes were made in the program as a result of the pilot experience?

18. Was there an assessment of the need for the program in the institution or community it serves?

Yes No

If yes, describe how this assessment was done:

19. When the program began, would you say the values and goals of this program were consistent with existing values in the community? {If the program has been in existence for a long time or the director is new: are they currently consistent with the existing values in the community}

Yes No

Describe how the values and goals were either consistent or inconsistent with those of the community:

20. {Director} Is the program generally perceived by the administration and staff to be cost-effective?
{Staff} In general, do you think the program is cost-effective?

Yes No

If it is not seen to be cost-effective, what are some of the reasons why?

21. How was the program initially funded?

Was the initial funding considered to be adequate to sustain the program?

Yes No

If not, please note the concerns:

CLIENT PRE-SERVICE ASSESSMENT

22. When clients first come to the program, what kinds of problems do you most often see? (e.g., drug abuse, emotional problems, anti-social values or attitudes, sexual offending)

23. Do you feel that the type of clients that you receive are appropriate for the treatment (OR SERVICES) you provide? (explain)

24. Are there any exclusionary criteria prohibiting a client from entering the program?

Yes No

If yes, what is the basis for excluding clients?

25. When a client enters the program, do you assess his or her risk factors that would predict recidivism?

Yes No

26. If yes, what is the method used?

7. Do you assess a client's needs (dynamic characteristics) that are associated with possible recidivism?

Yes No

28. If yes, what is the method used?

29. Do you assess a client's personal characteristics, attributes, and styles of interaction? (e.g., intelligence, verbal ability, level of anxiety)

Yes No

30. If yes, what is the method used?

31. If standardized risk assessment is used, is a summary score used?

Yes No

32. If standardized needs assessment is used, is a summary score used?

Yes No

33. If standardized responsivity assessment is used, is a summary score used?

Yes No

PROGRAM CHARACTERISTICS

34. What primary changes in the person's attitudes and behaviors does the program target?
(INTERVIEWER MAY WISH TO PROMPT FOR THE FOLLOWING TARGETS LISTED BELOW:)

a) change attitudes, orientations, and values favorable to law violations and anti-criminal role models
b) change antisocial feelings
c) reduce antisocial peer associations
d) reduce problems associated with alcohol/drug abuse
e) reduce anger/hostility level
f) replacing the skills of lying, stealing, and aggression with prosocial alternatives
g) increase self-control, self-management, and problem solving skills
h) encourage constructive use of leisure time
i) improve skills in interpersonal conflict resolution
j) promote more positive attitudes/increase performance regarding school work
k) resolve emotional problems associated with intra or extra-familial child abuse
l) promote family affection/communication
m) promote family monitoring/supervision
n) improve family problem solving
o) resolve deviant sexual arousal/attitudes/behavior
p) provide low-pressure, sheltered environment for mentally disordered offenders
q) focus on harm done to victim
r) relapse prevention
s) alleviate the personal and circumstantial barriers to service (client motivation, background stressors)

: Specifically, what types of treatment that target these behaviors are provided to clients?

Theory(s):

36. If in a prison, are clients separated from rest of institution? Yes No

If in the community, are clients whereabouts and peer associations closely monitored? Yes No

37. Do you have a manual that details the types of treatment to be provided and treatment activities?

38. {Is there a schedule that clients follow on a typical day?} What is the schedule that clients follow during a typical day?
{If there is no schedule, then ask how many hours per week they spend in treatment in their program.}

Is this the same seven days a week? Yes No

If no, how does it vary?

39. Does your program vary (e.g., intensity, duration) according to the level of risk of the client?

Yes No

If yes, please provide some examples of how this is done.

40. Does the program match the type of treatment with the characteristics of individual clients? (offenders are assigned to a program that matches up best with their interests, style of learning, etc).

Yes No

If yes, please provide some examples of how this is done.

41. Does the program match the personal and professional skills of the staff with the type of treatment that they provide?

Yes No

If yes, please provide some examples of how this is done.

42. Does the program match the personal and professional skills of the treatment providers with the type of client and nature of his or her problems?

Yes No

If yes, please provide some examples of how this is done.

43. Can clients provide input into the structure and rules of the program?

Yes No

If yes, please provide some examples of changes made to the program based on client input.

44. What incentives and rewards are used to encourage program participation and compliance?

46. What disincentives and punishments are used to encourage program participation and compliance?

[Need documentation of rewards and punishers]

What is the approximate ratio of rewards to punishers?

45. Please describe the theory underlying the use of punishments. In other words, why do you punish?

47. How are punishments and disincentives administered?

When do you punish?

Once a punishment has been decided, can a client ever escape from punishment?

Do you wait until the bad behavior has been completed or do you try to intervene at the earliest point in the behavior (try to stop it)?

Is there some sort of punishment after every occurrence of deviant behavior?

Do you vary the punishment over time?

After a punishment has been administered, do you teach them a more prosocial alternative behavior?

48. Do you assess whether the punishments produce unintended negative effects?

Yes No

If yes, what reactions do you look for?

(do you look for...
emotional reactions (fear, interference with learning, disruption of social relationships), avoidance/aggression toward punishers, increase in future use of punishment by offender, production of response substitution, lacks generalization)

49. How do you determine when a client has completed the program?

Are there any instances when a client would leave the program before he/she has completed the treatment?

Are there any instances when a client would remain in the program even after completing the treatment?

50. Does this program teach the clients to monitor and anticipate problem situations?
Yes No

If yes, describe the training they receive:

51. Does the program teach the clients to plan or rehearse alternatives to problem situations? Yes No

If yes, describe the training they receive:

52. Does the program teach the clients to practice new behaviors in increasingly difficult situations?

Yes No

If yes, describe the training they receive:

53. Upon leaving the program, are clients routinely referred to other services that are relevant to the their needs?

Yes No

54. Are close relations/friends of the clients taught to provide help to the client during problem situations?

Yes No

If yes, what type of training do they receive:

55. After the client is released, is he or she brought back into the program for "booster" sessions?

Yes No

If yes, describe the booster sessions:

Name	Education	Area of Study	#yrs this job	Tx Prog>1yr*	Back ck

STAFF CHARACTERISTICS

Name	Education	Area of Study	#yrs this job	Tx Prog>1yr	Back ck

*Has the staff member worked in treatment programs with offenders for at least one year?

Note: the above information is used to score questions 56, 57, 58, and 60

STAFF CHARACTERISTICS

59. Besides training and years of experience, are there any other personal characteristics that are considered important in hiring staff?

Yes No

If yes, please list the characteristics that are important.

Are there background checks for the new staff?

61. Are staff assessed yearly on skills are related to service delivery? [on how they deliver that service?]

Yes No

If yes, are the evaluations kept in the employees file?

Yes No

Do staff receive regular clinical supervision?

Yes No

62. Could you describe how new staff are trained to work in this program.

How long does this training take? (Number of days) _____

Do all program staff participate in ongoing training programs, workshops or conferences?
Yes No

If yes, how often does ongoing training occur and how many staff participate?

6 i. Have staff been able to modify the program structure?
Yes No

If yes, please provide some examples of modifications made.

EVALUATION

64. Do supervisors provide quality assurance assessments such as a file review, clinical supervision (live or taped sessions), or other within program checks that monitor the treatment process?

Yes No

If yes, what assessments are conducted?

65. Are clients surveyed each year as to their satisfaction with the service being provided?

Yes No

66. Are there objective, periodic, standardized assessments of clients on target behaviors?

Yes No

If yes, is it located in the clients file? Yes No

67. Is reconviction data gathered on clients 6 months or more after leaving the program?

Yes No

68. Have any formal evaluations of the program been carried out?

Yes No

If yes.

Outcome or process evaluation? _____

When was the evaluation conducted? _____

Was a comparison group used? Yes No

69. Is there a document containing the details of the effectiveness of the program on file?

Yes No

70. Has an evaluation of the program been published in an edited journal?

Yes No

Journal name?_____

OTHER

71. Are client records kept in a confidential file? Yes No

(Review file: must have social history, record of presenting problem, assessment data, program progress notes, etc...)

72. Is there documentation of the ethics of intervention (e.g., least intrusive intervention etc...)? Yes No

73. Have there been any changes in the program itself in the last two years?
Yes No

If yes, to what extent has this change jeopardized the smooth functioning of the program?

74. Have there been any changes in the area of program funding?
Yes No

If yes, to what extent has this change in funding jeopardized the smooth functioning of the program?

75. Have there been any changes in community support for the program in the past two years? Yes No

If yes, to what extent has the change in community support jeopardized the smooth functioning of the program?

76. Do you have an advisory board (Board of Directors) or a consultant officially designated to oversee or advise the program in some fashion or another?
Yes No