Offender Programs Report

Social and Behavioral Rehabilitation in Prisons, Jails and the Community

Now including Vol. 15, No. 4 ISSN 1093-7439 Pages 49 – 64 November/December 2011

Offender Substance Abuse Report
CORRECTIONS • COURTS • TREATMENT • LAW

Increasing Male Offenders' Readiness for Change: In-Program Outcomes and Implications for Reentry

by Ralph Fretz, Scott Cone, and Christopher Petrozzi

Introduction

Enhancing offenders' motivation to change their antisocial lifestyle is an important component of an effective continuum of care model that strives to reduce recidivism and enhance public safety. The need for effective correctional programming comes at a time when the number of individuals incarcerated and under community supervision in the United States continues to increase, growing nearly fivefold between 1980 to 2008 (Glaze & Bonczar, 2009; West, 2010). Throughout this period, the largest increase has been in the probation population, followed by the prison population, the parole population, and the jail population. In 1980, the prison population was 319,598; by 2008, this figure had reached 1,518,559. Concomitantly, the corrections budgets for the U.S. counties, states, and the federal government have skyrocketed. Monies that could have been allocated to other needs, including education and building infrastructure, have been diverted into correctional budgets. Besides being a drain on the economy, the unprecedented growth of incarcerated individuals has affected countless lives, particularly with respect to minorities (Glaze & Bonczar, 2009). Possible causes for the significant increase in the U.S. incarceration figures have been posited, including the U.S. decision to take a "get tough on crime" approach and implement the "war on drugs." These approaches to crime have swelled the prison population numbers, yet public safety does not seem to have been enhanced, because the returning offenders have high rates of recidivism, with 67.5% being rearrested within three years (Langan & Levin, 2002).

As this increase of prisoners and parolees has strained many state and federal prisons beyond capacity, correctional treatment has evolved from the 1970's "nothing works" in correctional programming to "what works" and "evidence-informed" methods in correctional treatment today (Bonta, 2010). An important component of effective correctional treatment has been the development of a continuum of care model for offenders as they reenter society (Friedmann et al., 2009; Taxman, 1998; Taxman et al., 2002). A number of components make for a successful continuum of care model, including assessing the offender using a reliable and valid instrument, using the assessment results to drive

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Treatment Behind Bars: Substance Abuse Treatment in New York Prisons, 2007–2010

by Cindy Eigler, Jack Beck, and Jaime Kringstein

The Benefits of Successful Treatment

Substance abuse is a daunting problem for many incarcerated individuals both nationally and in New York State. The majority of individuals in prison come from urban communities characterized by poverty, unemployment, crime, and substance use. The devastation that often accompanies substance abuse places notoriously heavy demands on the criminal justice, correctional, and substance abuse treatment systems, as well as on inmates, their families, and their communities. The prison system has the unique potential to provide effective drug treatment to this population, and a substantial body of research documents that treatment is, on the whole, more effective than incarceration alone in reducing drug abuse and criminal behavior among substance abusers and in increasing the likeli-

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treatment planning, and continuously evaluating the progress and functioning of the offender as he or she moves along the continuum. A seamless transmission of information as the offender moves through the phases of the continuum is another critical factor.

Because the initial phase of the continuum of care lays the foundation for other, subsequent phases, it is particularly critical to the current and future success of the offender's reentry process. Offenders at the initial phase require a structure that is flexible, with graduated sanctions that become more stringent as the offender becomes acclimated to the program (Lowmaster et al., 2010). However, the titration of the flexibility and increase in sanctions for the offender during the orientation phase needs to be guided by the individual assessment of that offender's risk and needs factors (Andrews & Bonta, 2010). For example, an offender with a panic and anxiety disorder may need to be approached differently from an offender without this disorder.

Vital to this initial phase of the continuum of care is the proper assessment of the offender's motivation for changing his or her antisocial behaviors. Although other criminogenic needs are also identified during the initial phase, motivation for treatment must be determined, because offenders with low motivation for treatment should have this area targeted first. Because most offenders are mandated to some form of treatment, much of their initial reason for engaging in treatment is extrinsically motivated. A key component of a successful treatment program is using the assessment results, including motivational levels, to move the offender from a primarily extrinsic motivational mindset to a more intrinsically motivated attitude toward treatment. The use of motivational enhancement techniques, rather than persuasion tactics, increases the offender's movement along from the extrinsic to intrinsic motivation for change

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Offender Programs Report™

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Offender Programs Report (ISSN 1093-7439) is published bimonthly by Civic Research Institute, Inc., 4478 U.S. Route 27, P. O. Box 585, Kingston, NJ 08528. Periodicals postage paid at Kingston, NJ and at additional mailing office (USPS #016-795). Subscriptions: $165 per year in the United States and Canada. $30 additional per year elsewhere. Vol. 15, No. 4, November/December 2011. POSTMASTER: Send address changes to Civic Research Institute, Inc., P.O. Box 585, Kingston, NJ 08528.

For information on subscribing or other service questions call customer service: (609) 683-4450.

STATEMENT OF OWNERSHIP, MANAGEMENT AND CIRCULATION (Required by 39 U.S.C. 3685). 1. Title of publication: Offender Programs Report 2. Publication No. 1093-7439. Date of filing: September 30, 2011 4. Frequency of issue: Bimonthly 5. No. of issues published annually: 6 6. Annual subscription price: $179.95 7. Complete mailing address of known office of publication: 4478 U.S. Route 27, P.O. Box 585, Kingston, NJ 08528 8. Complete mailing address of headquarters or general business office of publisher: same 9. Complete mailing address of publisher, editor, and managing editor: Publisher, Mark E. Peel, 4478 Route 27 Ste 202, Kingston NJ 08528; Editor, R Immarigeon/Kevin Knight/David Farabee, 353 West 48th Street, 4th Floor New York, NY 10036; Managing Editor, Deborah J. Launer, 353 West 48th Street, 4th Floor New York, NY 10036 10. Owner: Civic Research Institute Inc., Fred Cohen, 9771 E. Vista Montanas, Tucson, AZ 85749; William C. Collins, P.O. Box 2316, Olympia, WA 98507; Deborah J. Launer, 216 W. 89th St., #7D, New York, NY 10024; Mark Peel, P.O. Box 450, Kingston, N.J. 08528; Lois Rosenfeld, 330 W. 72nd St., New York, NY 10023; F. Rosenfeld, 175 N Tigertail Rd, Los Angeles CA 90049. 11. Known bondholders, mortgagees, and other security holders owning or holding 1 percent or more of total amount of bonds, mortgages, or other securities: None 12. For completion by nonprofit organizations authorized to mail at special rates: Not applicable 13. Publication name: Offender Programs Report 14. Issue date for circulation data below: September/October 2011 15. Extent and Nature of Circulation. Average No Copies Each Issue During Preceding 12 Months: 15a. Total Number of Copies (Net Press Run): 500. 15b(1) Mailed Outside County Paid Subscriptions: 37; 15b(2) Mailed In-County Paid Subscriptions: 0; 15b(3): Paid Distribution Outside Mail: 0; 15b(4): Paid Distribution by Other Classes of Mail through USPS: 0; 15c. Total Paid Distribution: 156; 15d. Free Distribution by Mail: 15d(1) Free or Nominal Outside-County Copies included on PS Form 3541: 0; 15d(2) Free or Nominal In-County: 0; 15d(3) Free or Nominal Copies Mailed at Other Classes through USPS: 14; 15d(4) Free or Nominal Rate Distribution Outside the Mail: 0; 15e. Total Free or Nominal Rate Distribution: 14; 15f. Total Distribution: 208; 15g: Copies not Distributed: 292; 15h.Total 500; 15i. Percent Paid: 75%. No copies of Single Issue Published Nearest to Filing Date: 15 a. Total Number of Copies (Net Press Run): 500. 15b(1) Mailed Outside County Paid Subscriptions: 0; 15b(2) Mailed In-County Paid Subscriptions: 0; 15b(3): Paid Distribution Outside Mail: 0; 15b(4): Paid Distribution by Other Classes of Mail through USPS: 120; 15c. Total Paid Distribution: 120; 15d. Free Distribution by Mail: 15d(1) Free or Nominal Outside-County Copies included on PS Form 3541: 0; 15d(2) Free or Nominal In-County: 0; 15d(3) Free or Nominal Copies Mailed at Other Classes through USPS: 14; 15d(4) Free or Nominal Rate Distribution Outside the Mail: 0; 15e. Total Free or Nominal Rate Distribution: 14; 15f. Total Distribution: 179; 15g: Copies not Distributed: 321; 15h.Total 500; 15i. Percent Paid: 67%. 16. Publication Statement of Ownership will be printed in the November 2011 issue of this publication. 17. I certify that the statements made by me above are correct and complete: (Signed) Mark Peel, President.

Worth Reading

by Stacy Calhoun*

Accelerated Vaccinations

Vaccination Against Hepatitis B Among Prisoners in Iran: Accelerated vs. Classic Vaccination

by Ali Asli, Mohsen Moghadami, Nima Zamiri, Hamid Tolide-ei, Seyyed Heydari, Seyed Alavian, and Kamran Lankarani
100(2–3) *Health Policy* (2011) 297–304.

In 1993, Iran implemented a nationwide Hepatitis B virus (HBV) vaccination program for newborns. Recently, the country implemented another nationwide HBV vaccination program to reach 17 year olds who were not included in the 1993 vaccination program, as well as teenagers born between 1989 and 1992. Even though the vaccination programs have been widely successful in reducing the prevalence of HBV infection in Iran, HBV infection and its related complications, such as cirrhosis, still remain a major health concern for the country. Prisoners are one group that remains especially vulnerable to contracting HBV due to the many high-risk behaviors in which they have been known to engage, such as injection drug use or unsafe sex. Prisons provide a unique opportunity to increase the coverage of HBV vaccinations among this high-risk group by creating a vaccination program for individuals entering prison. But the transient nature of the prison population poses a challenge in that many prisoners may not be in custody long enough to complete the traditional vaccination schedule (three doses at 0, 1, and 6 months). Thus, an accelerated vaccination program is something that has been proposed for this population. The authors of this article evaluate the effectiveness of an accelerated HBV vaccination schedule in providing sufficient seroprotection against HBV in an incarcerated population.

Study Methods. The study was conducted from June 2006 to July 2007. Participants were recruited from three prisons and correctional facilities in Shiraz, Iran, and randomly assigned to either the accelerated schedule (Group A) or the classic schedule (Group C). A total of 250 individuals were assessed for eligibility and told about the nature of the study. Of the 250 who were assessed, 180 agreed to participate in the study and were randomized to one of the groups. Each group consisted of 90 participants.

Interviews were conducted with the study participants in order to obtain demographic information as well as information about previous HBV vaccinations and HBV infections. Participants were excluded from the study if they had a history of HBV vaccination or HBV infection. They were also excluded if they tested positive for antibody against Hepatitis B core-antigen (anti-HBc) or Hepatitis B surface-antigen (HBsAg) or had positive titers of antibodies against Hepatitis B surface-antigen (anti-HBs). Five individuals in Group A and six individuals in Group C were excluded from the study because they tested positive for HBsAg, anti-HBc, or anti-HBs at baseline.

Those who were assigned to Group A received four doses of the HBV vaccine over a two-month period. The first dose was administered at baseline, the second dose one week later, the third dose at four weeks and the last dose at eight weeks. Participants in Group C received three doses of the HBV vaccine over a six-month period. The first dose was administered at baseline, the second dose one month later and the third dose at six months. Participants in both groups received 20µg of recombinant Hepatitis B vaccine at each dose.

Blood samples were obtained from each participant at baseline and at one, two, six, and eight months and tested for anti-HBs and HBsAg. Anti-HBc was assessed at baseline and at eight months in order to detect acute HBV infection. The vaccination was considered a failure if the participant tested positive for anti-HBc or HBsAg at the eight-month assessment. Seroprotection was defined as an anti-HBs titer of 10 IU/L or more. A compliance rate was calculated based on the proportion of participants in each group who received the required number of doses for their group. Using an intent-to-treat analysis, the success rate was calculated for each group based on the proportion of participants who achieved seroprotection in each group.

The transient nature of the prison population poses a challenge in that many prisoners may not be in custody long enough to complete the traditional vaccination schedule.

Participant Characteristics. The participants in this study were male, with a mean age of 34 years. About 31% of the participants in Group A and 38% of the participants in Group C had a prior history of incarceration. With regard to injection drug use, approximately 7% of Group A and 9% of Group C reported prior injection drug use. Although there were no significant differences in age, incarceration history, and injection drug use history, there were significant differences in marital status and history of unprotected sex. A larger percentage of participants in Group A were married (55%) than in Group C (30%), and a larger percentage of participants in Group C reported engaging in unprotected sex (13%) than in Group A (4%).

Study Findings. The participants in Group A had a significantly higher compliance rate than the participants in Group C. All of the participants in Group A completed their vaccination schedule in the required two-month period. In contrast,

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hood that they will remain drug and crime free (Fletcher & Chandler, 2006).

The benefits of successful treatment, moreover, go beyond the recovery of participants to both enhancing the quality of life within the prison itself and heightening public health and safety in the greater community. Successful substance abuse treatment programs can lead to increased safety for inmates and prison staff by decreasing prison violence associated with inmate drug use and trafficking and can foster positive attitudes and behaviors that frequently result in increased participation in educational, vocational, and other prison-based programming. Additionally, successful prison-based treatment reduces drug use by formerly incarcerated individuals on the outside, leading to reductions in crime and the decrease in the spread of many injection-related chronic health conditions such as HIV and Hepatitis C. Effective treatment can ultimately lead to more productive and healthy lives for the individuals involved, for their families, and for other members of their community.

The New York State Department of Correctional Services

As of April 2010, the New York State Department of Correctional Services (DOCS) operated 68 facilities, with 57,650 inmates under custody. In its 2007 report, DOCS stated that 83% of the state's prison population, or approximately 47,850 inmates, were "in need of substance abuse treatment" (NYS DOCS, 2008b; this is the percentage of inmates DOCS had identified with its screening process as of December 31, 2007—not the percentage of inmates in New York State prisons with a diagnosis of substance/alcohol abuse or dependence; DOCS has not provided an updated percentage since this 2008 report). Sixty of the state's correctional facilities operated 119 substance abuse treatment programs, making DOCS the single largest provider of substance abuse treatment in New York State. These programs comprised approximately 10,000 treatment slots, and about 34,000 inmates were enrolled in these programs annually. The 2009 reforms to the New York State Rockefeller drug laws called for change, requiring the New York State Office of Alcoholism and Substance Abuse Services (OASAS) to guide, monitor, and report on DOCS substance abuse treatment programs (*A156-B Budget Chapter 56*, 2009).

Given the inmate population's considerable need for treatment and the large number of inmates participating in treatment programs, it is crucial that these programs be effective. Successful prison-based treatment is realized only when that treatment is based upon sound strategies carefully matched to the needs and strengths of program participants and delivered by competent, committed staff. The DOCS substance abuse treatment programs have historically been subject to little analysis or outside monitoring. As a result, in 2007, the Correctional Association of New York's Prison Visiting Project (PVP) launched a multi-year study to evaluate the needs of inmates with substance abuse problems as well as to review the treatment programs in New York State's prisons that responded to their needs.

The Correctional Association of New York and the Prison Visiting Project

The Correctional Association of New York (CA) is an independent, nonprofit organization founded in 1844 by citizens concerned about prison conditions and the lack of services for inmates returning to their communities. The New York State Legislature granted the CA authority to inspect prisons and report on its findings. Through monitoring, research, public education, and policy recommendations, the CA strives to make the administration of justice in New York State more fair, efficient, and humane.

PVP is one of four projects that the CA administers and is the one that carries out the CA's unique legislative authority to monitor conditions in the male prisons. In addition to its general prison monitoring, PVP conducts in-depth studies on specific corrections issues and publishes comprehensive reports of findings and recommendations. Most recently, PVP published *Treatment Behind Bars: Substance Abuse Treatment in New York Prisons, 2007–2010*, the result of the multi-year study described above.

For this project, PVP visited 23 correctional facilities that included more than half of DOCS treatment slots. PVP staff met with DOCS treatment staff and facility management; interviewed treatment participants, experts, prison officials, and correction officers; observed treatment sessions; visited housing units set aside for treatment participants; and reviewed treatment case records and system-wide data provided by DOCS. More than 2,300 surveys were collected from inmates who were, or had been, in prison treatment programs as well as from those waiting to enroll in such programs.

The review of all of the above information resulted in a number of system-wide findings. The principal findings fall into the following six categories:

1. Screening and assessment;
2. Program admission and placement;
3. Treatment programs, content, and structure;
4. Staffing;
5. Aftercare and reentry; and
6. Monitoring and oversight.

Screening and Assessment

The CA's evaluation found that, in general, DOCS had an overly broad and unclear screening process, and there was no clear definition of what constitutes a need for substance abuse treatment. For example, important factors such as the types of drugs used, the severity of the drug use, the history of the drug use, the consequences of the drug use, or prior participation in community-based treatment were not necessarily taken into consideration when determining need. Although many inmates have struggled with addiction for years prior to their incarceration, and many have participated in prison- and community-based treatment programs before their current sentence, they were still placed in a treatment program even though they had been successful in their recovery for a significant period of time.

DOCS assessed inmates at reception to determine their need for substance abuse treatment using nationally recognized screening instruments, including the Michigan Alcohol Screening Test (MAST) and the Simple Screening Instrument (SSI). However, the scores used to make this evaluation were set at a low threshold so that inmates with even a limited history of substance use were designated to need treatment. These instruments were designed primarily to screen inmates for a potential substance abuse problem and to determine who should be further evaluated for potential treatment, leaving a final determination of severity of substance abuse and treatment needs to be made only after completion of a more comprehensive assessment by a qualified substance abuse professional. An experienced clinician can distinguish

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between substance abuse and substance dependence, a procedure recommended by the Substance Abuse and Mental Health Services Administration (SAMHSA; Peters et al., 2005). DOCS does not conduct such a follow-up comprehensive assessment, and every individual with positive scores on the screening tests will have substance abuse treatment added to his or her required program list, regardless of need.

Although substance abuse treatment is not mandated, if an inmate refuses to participate in a program on his/her required program list, the consequences are extremely negative and can result in a loss of good time or merit time and of being denied early release by parole. Many inmates expressed feeling forced to complete a treatment program or face spending more time in prison. In addition, individuals may be designated to need treatment based upon any drug-related information included in their pre-sentence report. Finally, there was no DOCS training or requirement for specific experience in treatment assessment for the staff involved in the process, resulting in inconsistent application regarding who was required to enter a substance abuse treatment program.

As a result of this screening process, DOCS identifies approximately 83% of the inmate population as having a "substance abuse problem" and needing treatment (NYS DOCS, 2008a). The casting of such a wide net not only has the potential to overwhelm the existing treatment resources, but also dilutes the treatment available for those with more severe need. Substance abuse treatment programs offered by DOCS are primarily a "one size fits all" approach. Treatment matching requires that individuals with substance abuse are placed in the least restrictive, but clinically appropriate, programs available that best match their level of need. Most experts consider this kind of continuum of care not only to be most cost effective, because individuals are matched to the most appropriate level of services, but also to improve the overall effectiveness and quality of services offered (Peters et al., 2005). This type of treatment matching generally does not occur in DOCS.

Program Admission and Placement

Largely due to the aforementioned lack of treatment matching, the CA observed significant variation in substance abuse histories and needs among treatment participants in the same program. Mixed together in the sessions that were observed were:

- Inmates who had active substance abuse histories with substances such as heroin or crack;
- Inmates who reported using only marijuana occasionally;
- Inmates who had previously had substance abuse problems but had been abstinent for many years; and
- Inmates who were drug dealers but who asserted they never used drugs themselves.

Common criticisms from inmates included that they often could not relate to some of their fellow participants and felt pressure from their peers and the treatment staff to admit to more drug use than they had actually done. They also reported that some of the subjects covered in group sessions were either not specific or comprehensive enough to address their needs or were about topics that were not applicable to them. In response to such assertions, DOCS officials suggested that individuals who sold drugs but did not use them could still benefit from treatment that addresses the issues of individual responsibility, life skills, addictive behavior, and criminal thinking.

The DOCS treatment programs prioritize admission to the program based on the inmate's proximity to his or her earliest release date—not based on an active or immediate substance abuse problem. Inmates facing lengthy incarcerations may therefore not receive any treatment for many years, regardless of demonstrated need. At most prisons, inmates must be within one year of their potential release dates before they are offered treatment.

The CA understands the challenges associated with completing a substance abuse treatment program soon after beginning one's incarceration. For example, the inmates would then have to complete their sentences and continue recovery within the general population, where continued recovery support is limited and the chance of relapse is high—a factor that also has a negative impact on prison management and safety. Moreover, at the beginning of one's prison term, it is more difficult to plan appropriate continuity of care for eventual discharge to one's community. Inmates generally need treatment support toward the end of their incarceration to prepare them for returning to the community.

The CA is nevertheless concerned about the inmates entering DOCS custody with an immediate need for treatment. Many of these inmates end up using drugs in prison and thus becoming subject to considerable disciplinary sanctions. Inmates found possessing or using drugs or alcohol are routinely given disciplinary sentences of several months to a year or more and are placed in a special housing unit (SHU), where they spend 23 hours of their day in lockdown and are generally denied any meaningful substance abuse treatment. In addition to being disciplined, inmates using drugs are simultaneously moved to the back of the waiting list for substance abuse treatment and still have to wait for treatment until one to two years before their release.

Treatment Programs, Content, and Structure

Although there are a variety of DOCS treatment programs, the most widely used program is the Alcohol and Substance Abuse Treatment Program (ASAT). ASAT is a six-month program with rolling admission aimed at providing education and counseling through a competency-based curriculum. Although there are other programs for some special populations (two DWI programs, four CASAT programs, 13 programs for individuals with co-occurring disorders, three programs for the special needs or sensorially disabled population, and four programs for inmates residing in regional medical units), representing approximately 16% of all treatment slots, those programs follow similar curricula as the ASAT program, with additional topics being discussed (e.g., mental health) and an extended length of time spent to complete the curriculum in order to accommodate different learning abilities. Other DOCS substance abuse treatment programs, such as the four shock, boot-camp-style programs, the Willard Drug Treatment Campus, and the Edgecombe Residential Treatment Facility, accept individuals based not necessarily on treatment needs, but on length of sentence and other factors.

Throughout the study, it became clear that a great deal of variability existed among substance abuse treatment programs, especially with regard to content and structure. The absence of a detailed

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curriculum with supporting documents in the treatment manual resulted in much of the variation observed and left program staff without adequate direction. The CA observed some effective presentations and program sessions but also saw sessions that were poorly planned and lacked coherent and substantive content. Each prison, and often each staff member within a prison, collected and maintained different handouts, worksheets, and other materials. Although we commend staff for going above and beyond the curriculum, there was limited to no guidance from the DOCS central office regarding what resources were effective, resulting in treatment programs that were inconsistent.

Program structure varied a great deal as well. Most of the DOCS treatment programs were designed as modified therapeutic communities (TCs; the original TC uses a model that is highly structured and hierarchical, and it focuses its treatment approach on the entire individual. Members of the treatment group live and work together, so that the community is the primary therapeutic agent. Modified TCs often integrate aspects of other approaches, such as cognitive behavioral treatment and social learning techniques). The DOCS ASAT Manual did not provide detailed guidance as to clinical content or treatment modalities and loosely stated that programs could utilize various techniques, such as cognitive behavioral therapy, within their programs. Although most DOCS treatment programs used some components of a TC (cognitive behavioral therapy and the 12-step approach), the degree to which these were used and the fidelity to the traditional models varied among facilities. The amount of skills training in areas such as anger management, stress management, and communication skills also varied among programs.

Group sizes in most treatment programs ranged from 20 to 60 inmates, with typical groups comprising 25 to 30 participants. This group size is more appropriate for educational or informational lectures and is generally considered too large by experts for effective group therapy. In a significant number of the programs visited, classes rarely divided up to work in smaller groups. Treatment participants also said they spent a considerable amount of the program time listening to educational presentations or watching informational videos and much less time talking about their own substance abuse issues. Because most programs use some variation of a modified TC, there was some type of community meeting, but, again, these sessions differed in length, frequency, and format, with the typical program having group meetings once a week. The variability from program to program and within programs did not appear to reflect differences in the population or program design, but, rather, to reflect differences in the style and preference of the individual treatment staff.

Additionally, individual counseling was limited, yet varied widely across programs. There was no clear requirement for significant one-on-one counseling beyond monthly meetings that served as the basis for the monthly evaluations. Some of these monthly meetings lasted only a few minutes or less per inmate. Some treatment staff reported, however, that they did have frequent informal individual meetings with program participants who requested them, but these sessions were not documented in participants' treatment records.

Regarding individuals' treatment records, they also varied in content from program to program, and documents in the records provided no real indication or detail about individuals' treatment needs, substance abuse history, or treatment objectives. Overall, the treatment records were not sufficiently individualized, and it appeared that no clinical supervisors reviewed the charts.

Finally, the role of inmates in the treatment programs varied significantly. At some programs, inmate hierarchy members facilitated a significant portion of the group sessions; at other prisons, staff took a more direct role. Although treatment staff were often present as inmates facilitated part or all of some sessions, at some facilities, the treatment staff would leave the group and allow the inmates to facilitate on their own. This was also reported to us by treatment participants at some facilities. Many inmates have a significant amount to offer to other participants regarding their own experiences with substance abuse and recovery, but they rarely possess the clinical background, training, or expertise necessary to provide a full range of treatment services. Being a facilitator can be an important learning experience for the inmate and a meaningful leadership opportunity to model behavior and develop self-esteem. This type of development can be accomplished only with the assistance and supervision of qualified treatment staff.

In a TC program, hierarchy is defined as a system that allows for positions of increasing responsibility and associated privileges through commitment to and mastery of TC and counseling concepts. Although many of the treatment programs had some type of modified hierarchy structure in place, the hierarchy roles were not generally associated with an increase in privileges, nor were all members of the community given a role in the hierarchy structure. Many treatment programs that were observed had a more punitive response for failure to conform to the rules. The CA did not witness or learn about incidents in which individuals were rewarded for their progress. Both sanctions and incentives serve as equally important functions in a structured hierarchy and can help build self-esteem, model appropriate behavior, and develop important social skills. In most cases, it seemed that occupying one of the multiple hierarchy positions was often based on staff preferences or inmate volunteerism rather than upon actual progress in the program.

Staffing

Substance abuse treatment program staff are very important to the success of inmates in their rehabilitation efforts. The CA found that the staffing ratio at most treatment programs was inadequate to meet the needs of the participants. Most ASAT programs were staffed with only one ASAT corrections counselor and two program assistants (PAs) for every 120 program participants, with the PAs facilitating most of the group meetings. At several prisons, there were not only a large number of staff vacancies, but also a high level of staff turnover. It appeared that some professionals used the PA position as an entry-level job and then sought promotions once they had met the minimum standards for advancement. In the current economic environment, most facilities are not being granted the authorization to fill vacancies, resulting in treatment program staff being stretched beyond capacity and inadequate treatment attention often being given to program participants.

Wide variations were also apparent in competence and skills among DOCS treatment staff. Some treatment staff had extensive substance abuse training and experience working in community-based treatment

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programs, while others possessed considerably less experience and training. Very few treatment staff possessed higher level degrees, and only 23% of the treatment staff with whom the CA spoke reported being credentialed alcoholism and substance abuse counselors (CASACs). Although all treatment staff participated in the mandatory 40 hours of training required by DOCS, they received minimal training on substance abuse topics such as new counseling techniques and preparation for working with special populations. The DOCS Office of Substance Abuse Treatment Services provided limited professional training, focusing on an average of two or three different topics per year. It appeared that training on TCs was the only topic offered on a more regular basis by this office. OASAS has an extensive training catalogue on a variety of topics, but participation in this training was not a requirement for DOCS treatment staff. The CA observed significant variation in answers among staff when asked if they had participated in OASAS trainings. In addition, when asked about trainings they had participated in during the past two years, a number of staff were unable to recall the topics covered in the training session.

There was also wide variation in staff's commitment to the program. The CA observed substance abuse staff who were enthusiastic and engaged with the participants in their classes, evidencing a commitment to the program and to the success of its participants. Also observed were some substance abuse staff who appeared to be indifferent to the daily activities of the treatment program. These staff members often exhibited a lack of concern about the need for updated materials and innovative approaches for engaging participants in the treatment process. Many survey respondents were highly critical of the staff's efforts and did not believe they were receiving effective support for their recovery. Satisfaction with such key services as providing treatment plans and general counseling varied considerably at some facilities.

Finally, staff/inmate relations varied from facility to facility and were often marked by inmate distrust of staff and frustration with the power many staff held over participants. Inmates spoken with often felt that staff were not sincere in their efforts to help them and that they did not appear to be invested in the treatment program. Several inmates also reported that some staff would use their ability to remove them from the program as a means of intimidation. This was found to be true in that some of the facilities visited removed nearly as many participants as they graduated from the program.

Aftercare and Reentry

Most substance abuse treatment programs did not require or provide assistance to inmates in developing specific in-prison aftercare recommendations for program graduates. Treatment staff frequently did not emphasize the importance of participation in voluntary programs such as Alcoholics Anonymous or Narcotics Anonymous.

Discharge planning was minimal as well, and many of the staff responsible for this task lacked the expertise and resources to execute it effectively. The treatment staff who had worked with the inmates for a minimum of six months and were in the best position to assess an individual's readiness for, and make recommendations to, appropriate community-based treatment programs, were not charged with the responsibility of developing a detailed discharge plan for continuum of care, even for those participants who were nearing release. Discharge planning for inmates with substance abuse problems is the responsibility of the DOCS Transitional Services (TS) unit and the New York State Division of Parole. The discharge planning process for inmates with substance abuse problems varied greatly among the prisons visited. The TS units were primarily staffed by inmate program assistants, with varying degrees of professional staff oversight. The Division of Parole created a special unit of parole substance abuse counselors called ACCESS who are responsible for interviewing, assessing, and referring many individuals who are required to participate in community treatment and are being released in New York City. Although this effort is a positive one, it focuses exclusively on New York City, so inmates discharged to other parts of the state are not provided with these important services.

Monitoring and Oversight

Program monitoring is an integral component of effective programs because it allows for strengths and weaknesses within a program to be identified, holds staff and administrators accountable for program quality, and serves as the foundation upon which future program changes are built (Peters et al., 2005). However, on most of the CA's visits, prison administrative staff reported that they typically performed limited monitoring of the program, generally visiting the program area and reviewing grievances and complaints from participants. At some facilities, the supervising corrections counselor, who was directly responsible for the program, had expertise in the area, but there was no protocol defining the official's duties in managing and monitoring the program. There appeared to be very little clinical supervision in the daily operations of the treatment program, particularly in terms of observing sessions, case consultations, and chart reviews.

Only recently has there been any outside monitoring of DOCS substance abuse treatment services. Language was included in the Rockefeller drug law reforms passed in April 2009 that required OASAS to monitor prison-based substance abuse treatment programs, develop guidelines for the operation of these programs, and release an annual report assessing the effectiveness of such programs. The first report by OASAS on DOCS Addiction Services, published in December 2009, laid out plans for 2010 that included site visits to eight to 10 facilities as well as the development of new basic operating guidelines for both the ASAT and CASAT (Paterson & Carpenter-Palumbo, 2009). In December 2010, OASAS released its second annual report, which included guidelines requiring enhanced program oversight, clinical supervision, documentation, and staff training (Paterson & Carpenter-Palumbo, 2010). Additionally, concrete steps were initiated to improve aftercare and reentry services. Although pleased with these important steps, the CA was concerned with the absence of recommendations addressing the overall screening process for individuals entering DOCS custody, the matching of individuals to varying levels of care, and the development of a formalized removal policy for individuals in the treatment programs.

Before April 2009, the only external oversight of DOCS substance abuse treatment services was provided at the Willard Drug Treatment Campus and the Edgecombe Residential Treatment Facility, both of which were OASAS certified. The expansion of OASAS's role in prison-based treatment has led to the certification of five additional DOCS substance abuse treatment programs (Arthur Kill, Hale Creek, Taconic, Albion, and Gowanda; Paterson & Carpenter-Palumbo,

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2010) and the commitment to eventually certify every program. The CA commends DOCS and OASAS on moving toward developing more effective substance abuse treatment services and hopes to work with both agencies in the future to ensure the success of these efforts.

Principal Recommendations

As mentioned above, OASAS outlined a number of promising developments and future plans for improving DOCS substance abuse treatment programs. Although these plans are positive and necessary first steps in improving the current substance abuse treatment offered in New York State prisons, the following recommendations build upon and further develop many of these points:

1. Implement a Comprehensive System of Screening and Assessment to Identify the Severity of Each Inmate's Substance Abuse and Corresponding Treatment Needs. Using a more comprehensive assessment tool for individuals who screened positive for substance abuse and developing a clearer and more formal definition of who should receive treatment would be beneficial not only for the inmates, but also for DOCS. It would:

- Reduce the number of individuals being inappropriately placed into treatment programs;
- Ensure that individuals are being placed in the program that most accurately reflects their level of need;
- Be most effective in reducing risk of relapse and recidivism due to drug use; and
- Make the best use of limited staffing and financial resources.

2. Develop a Continuum of Treatment Options, From Education to Intensive Residential Treatment, and Match Each Inmate to the Program That Best Addresses His or Her Needs. To create a successful therapeutic environment, inmates with similar types and severity of substance abuse issues should be placed together to maximize the effectiveness of the treatment and to make the best use of treatment staff resources. Correctional facilities in Colorado (Colorado Department of Corrections, 2009) and Maine have had success with treatment matching; these programs could serve as models for a similar approach in New York State.

Additionally, inmates with a significant need for substance abuse treatment at admission to DOCS or who repeatedly receive disciplinary sanctions for drug use inside prison should be prioritized for substance abuse treatment services regardless of the length of their prison sentence. Although individuals will still be required to participate in a substance abuse treatment program toward the end of their incarceration, the state should explore the creation of a separate, voluntary substance abuse treatment program for individuals first entering the prison system who need treatment services more urgently, and for those receiving misbehavior reports for use or possession of drugs. It is important to note that SAMHSA also recommends that inmates with significant substance abuse needs and high recidivism risk should be prioritized for initial placement into a substance abuse treatment program (Peters et al., 2005).

3. Develop a More Consistent and Comprehensive Curriculum for Each Program and Adjust the Program Structure to Better Fit the Needs of the Participants. Standardizing program content and materials can assist in making certain that all treatment information is current and includes up-to-date evidence-based practices and approaches. Efforts should also be taken to ensure that key elements of TCs and a cognitive behavioral approach are more fully integrated into the program. This approach includes placing a greater focus on role playing and skills development, as well as use of incentives and privileges in the community.

The treatment participants would also benefit from reducing the size of group sessions, because large groups do not create an appropriate environment for open communication, sharing, and discussion, which are all essential for proper rehabilitation. Breaking into smaller groups more regularly would help facilitate a more effective dialogue among peers. The curriculum should also include a greater frequency of individual counseling sessions so that participants have a chance to address more personal and sensitive issues that they might hesitate to discuss in a group setting.

4. Improve the Quality and Skill Levels of Treatment Staff. Treatment staff should meet the necessary requirements and qualifications as outlined by OASAS, resulting eventually in a substantial portion, if not all, of treatment staff having some type of outside credential or license, such as CASAC. Additionally, treatment staff should be provided with more thorough and frequent training that is available on an ongoing basis. Greater participation may be encouraged by providing monetary support, approved absences, and other incentives or by requiring a mandatory set of training hours in a given time frame. Finally, all DOCS-authorized substance abuse treatment staff positions should be promptly filled, and staff-to-participant ratios should be in accordance with OASAS community regulations.

5. Enhance and Coordinate Discharge Planning to Connect Inmates With Appropriate Community-Based Treatment and Other Support Services Upon Release. To promote successful reentry for individuals graduating from prison-based substance abuse treatment programs, the state should develop a prison-based, reentry-oriented, integrated process that includes input from, and coordination with, treatment staff, parole, and community-based organizations. The state should create a more detailed discharge plan that includes specific recommendations for the type and length of treatment program or services that would most benefit the individual. These programs should range in level of intensity from outpatient services to halfway houses and inpatient treatment programs. In addition, each facility should provide every individual leaving prison with documentation from the treatment staff outlining the treatment services he or she received while incarcerated. This information would enable community-based treatment staff to provide a more effective and appropriate continuity of services.

In addition to coordinating a discharge planning policy, the CA also recommends that aftercare services be implemented for inmates who complete substance abuse treatment but still remain incarcerated. Suggestions include creating an aftercare dorm for inmates completing residential substance abuse treatment programs and continuing to make services from treatment staff available to the graduated inmates. The CA also recommends that DOCS allows inmates to run Alcoholics Anonymous and Narcotics Anonymous programs when volunteers from the outside community are not available.

6. Implement an Effective System of Monitoring Programs and Overseeing Staff. To address the significant variation

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among programs, DOCS and OASAS should establish formal policies requiring quality assurance and utilization review plans. In addition, documents should be developed for monitoring purposes to effectively rate treatment plans and records, program sessions and participant satisfaction, and to collect outcomes data.

The CA also recommends that clinical supervision should be provided to all treatment staff by a qualified clinical supervisor in accordance with OASAS community standards. A clinical supervisor should regularly monitor all individual treatment plans and records. If a qualified clinical supervisor is not available at the facility, DOCS should employ a consultant to offer clinical supervision to treatment staff two to four times per month in person or through teleconferencing.

Discussion

Because 27,000 individuals—nearly 40% of the New York State prison population—return home each year, how well these inmates are prepared in prison to transition back into their communities has a considerable effect not only on their individual chances for successful reentry, but on the disadvantaged communities to which they will return.

If the recommendations described above and the many more included in the CA's full report, *Treatment Behind Bars: Substance Abuse Treatment in New York Prisons, 2007–2010,* are enacted, it would not only make the best use of limited resources during tough economic times, but would also be the right thing to do for inmates, for communities, and for the state. Inmates would benefit from an improved quality of treatment, increasing their chance of rehabilitation and reducing their risk of recidivism; communities would benefit from increased public safety; and the state would benefit from providing a greater quality of care with fewer resources and from being a model for other states' prison-based treatment.

This article summarizes the many findings and the 33 specific recommendations that are made in the full report. Further elaboration on the CA's findings, which include more topics than covered in this article, and the full list of recommendations are included in *Treatment Behind Bars: Substance Abuse Treatment in New York Prisons, 2007–2010*, which is available on the publications tab of the CA's website at *www.correctionalassociation.org*.

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continuum. The Cheyenne Mountain Reentry Center (CMRC), located in Colorado and the site of the current research, uses motivational enhancement techniques within its milieu. A more detailed description of the CMRC is provided in another section of this paper.

Research on Motivation and Program Compliance

Hiller et al. (2002) reported that motivation for treatment predicts whether individuals engage and remain in treatment. The authors described the three cognitive phases in the Texas Christian University (TCU) Motivation Model in the following manner:

1. Problem recognition: The individual realizes that his or her problems are causing serious consequences in his/her daily life and that stopping these behaviors (substance abuse, criminal activities) might help;
2. Desire for help: The individual realizes that he/she has to deal with his/her issues; and
3. Treatment readiness: The individual makes a decision to actively participate in the treatment process.

Hiller and colleagues studied a group of 419 felon probationers who were mandated to treatment as part of their sentences. Consistent with the TCU Motivation Model, the researchers found that motivation for treatment "influenced the entire treatment episode as well as post-treatment outcomes" (Hiller et al., 2002, p. 71). Hiller et al. also reported that motivation for treatment played an important role in the development of the therapeutic relationship between counselor and offender, and they noted that pre-treatment motivation played an indirect role in post-treatment outcomes. The authors suggest that programs that focus resources on low-motivation offenders will have better treatment outcomes than programs that neglect to address this issue.

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Sung et al. (2004) studied 150 addicted felony offenders to determine what factors predict treatment compliance. The researchers tested five hypotheses that predict noncompliance with treatment:

1. Physical prime hypothesis: Male and younger offenders will be more likely to be noncompliant;
2. Conventional social involvement hypothesis: The offender with more involvement in conventional social activities will be more compliant;
3. Supportive social network hypothesis: The stronger the offender's prosocial network of support is, the more cooperative he or she will be with treatment;
4. Treatment motivation hypothesis: The level of internal motivation for treatment will affect the level of compliance; and
5. Risk-taking syndrome hypothesis: The more the offender has engaged in risky behaviors (non-drug-related), the less likely the offender will be to comply with the treatment rules.

Sung and colleagues found support for all five hypotheses playing a role in predicting noncompliance, with motivation having one of the strongest associations with levels of compliance. The authors reported that motivational measures "demonstrated interesting predictive strength in the analyses" (p. 24). Based on their findings, Sung et al. recommended that correctional treatment providers should continually reinforce the offender's recognition of his problems in his own life and the lives of others in order to assist him in committing himself to the rigors of intensive treatment.

Lowmaster et al. (2010) evaluated 729 offenders who were court mandated to a substance abuse treatment program. The group used the Texas Christian University Correctional Self-Rating Form-Intake (TCU CSF-Intake) to assess the offenders' characteristics, including treatment motivation, psychological functioning, and social functioning. The researchers analyzed the relationship between offender characteristics and treatment completion and major rule infractions. They found that offenders with high motivation for treatment were more likely to complete the program and less likely to engage in rule infractions while in the program. The authors recommended that the offenders with low motivation be identified using an instrument similar to the TCU-CSF. Low pre-treatment motivation should be an initial target of intervention to enhance the treatment process for the offender.

The Cheyenne Mountain Reentry Center

The Cheyenne Mountain Reentry Center (CMRC) is designated as a 750-bed medium-custody correctional facility. CMRC functions as a community reentry facility that services a wide variety of offenders who arrive at the facility with divergent emotions, motivations, and behaviors. The process of motivating residents to assimilate within a prosocial program culture as opposed to a traditional custodial correctional setting frequently results in "cultural disorientation."

CMRC provides a variety of programs and services within the therapeutic culture, including:

- Lifeskills/reentry/employment classes;
- Anger management classes;
- Strategies for self-improvement and change;
- Self-discovery classes;
- Peer awareness groups;
- GED classes; and
- Reentry education classes.

CMRC's program milieu mirrors a modified therapeutic community (TC). As such, the program is designed to assist in the development of a prosocial lifestyle and change in personal identity (DeLeon et al., 2000). Incremental change is engineered within the context of a social learning environment through use of phase-based competencies, shared norms and values, awareness training, motivational interviewing techniques, participant roles, and feedback, as well as structures and systems that support responsible living. The essence of this approach is that the community (i.e., residents) serves as the agent of change. The personal transformation within the context and method of the CMRC culture is preparatory for the social, interpersonal, and behavioral expectations of successful living in the community.

The Community Education Centers' Continuum of Care Model

Community Education Centers (CEC), a privately owned and operated correctional treatment company that collaborates with public entities, has developed an evidence-based continuum of care model that begins with in-prison treatment through community reentry and aftercare. This model is based largely on social learning theory, and other empirically supported approaches, such as the TC principles as defined by DeLeon in his writings (1997; 2000) and the risk-need-responsivity (RNR) model developed by Bonta and Andrews.

The CEC model includes a comprehensive risk/needs assessment that drives individualized treatment planning and competency-based phase progression toward the successful attainment of the mutually established reentry goals. This model has been used successfully across genders and with varied ethnic and demographic groups, including females, Native Americans, inner-city minorities, and rural populations.

A discussion of the efficacy of the CEC's continuum of care includes an article written by Cone (2008). Using a New Jersey population of 730 male state prisoners, Cone assessed treatment effectiveness while offenders were at a CEC assessment and treatment center (ATC). In New Jersey, the ATC was developed as a "step down" program for state offenders as they move along a continuum of care that starts in prison and continues through return back to the community. While at the ATC, "residents" (the term for the offenders in the ATC) are involved in a comprehensive assessment of their risk factors and treatment needs along with an orientation to treatment. After analyzing the sample's pre- and post-treatment scores for the Client Evaluation of Self in Treatment (CEST), Cone found that residents who were classified as having a low level of treatment motivation (scored low in "Problem Recognition") at intake showed a statistically and clinically significant increase in treatment motivation at post-treatment as defined by their "Desire for Help" pre- and post- scores. Cone's findings indicated that the ATC orientation to treatment program was quite successful at increasing the motivation of those residents who were initially not motivated to engage in the treatment process.

Outcome research on the CEC continuum of care model found a lower rate of recidivism in a CEC treatment group than in a control group, whose members did not receive the CEC continuum of care (Fretz et al., 2004). In 2008, Heilbrun et al. found

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a 50% lower recidivism rate in female offenders who completed the CEC continuum of care than in a control group. Other outcome research on the CEC continuum of care by White et al. (2011) found that the model played a significant role in the reduction of recidivism of different populations, including for technical parole violators. White and colleagues estimated that the state avoided $1.3 million in cost per 100 technical parole violators who participated in the CEC continuum of care.

The Current Study

The current study was designed as an exploratory analysis of archival data and as a replication of prior research. Of interest was whether resident responses on various indices of treatment motivation and psychological and social functioning changed from intake to post-treatment. Differences in all of the CJ CEST subscale scores were analyzed from intake to post-treatment to assess whether the application of the CEC treatment model at CMRC resulted in a greater-than-chance associated change in the psychological constructs assessed by the CJ CEST.

Another goal of the study was to replicate Cone's (2008) findings that the CEC treatment model enhances treatment motivation in a male incarcerated population that entered treatment with very low self-reported problem recognition scores. Specifically, the study analyzed the differences in the "Desire for Help" and "Treatment Readiness" scales in residents who scored in the lowest third on "Problem Recognition" at intake using the CEST. The study was designed to replicate this prior research with another population in a distinct geographical area that had also participated in CEC programming.

Study Participants, Measures, and Procedures

The study participants were 378 male offenders sentenced to the Colorado Department of Corrections. The sample was drawn from offenders housed at the CMRC for the 21-month period from December 2007 through May 2009. The average length of stay at the CMRC was 143 days. The average age was 41 years, with a racial breakdown of 45% Caucasian, 28% African American, and 27% Hispanic. In terms of current offense, 19% were incarcerated for a violent offense, and 81% were incarcerated for a nonviolent offense.

The study used client evaluation tools developed for a criminal justice population by the TCU Institute of Behavioral Research (Garner et al., 2007). The participants were asked to score the CEST items along a five-point Likert scale that ranged from "Disagree Strongly" to "Agree Strongly." Research has found that the CJ CEST has favorable psychometric properties, including strong reliability and validity (Garner et al., 2007). Garner and colleagues reported test-retest reliability of the CJ-CEST scales correlations ranging from 0.74 ("Desire for Help") to 0.88 ("Treatment Readiness"), with an average test-retest correlation of 0.81. The test is group administered within 14 days of admission and then four months into the resident's stay at the facility. The CEST results are included in the assessment report, which is sent to community corrections boards for those residents under consideration for placement at a residential community corrections facility.

Two versions of the CJ CEST were used, one at intake (CJ CEST-Intake) and a second version approximately four months later that included treatment progress variables (CJ CEST). The CJ CEST-Intake is an 80-item test measuring:

- Treatment motivation (Problem Recognition, Desire for Help, Treatment Readiness, and Pressure for Treatment);
- Psychological functioning (Self-Esteem, Depression, Anxiety, and Decision Making); and
- Social functioning (Childhood Problems, Hostility, and Risk Taking).

The CJ CEST, administered approximately four months after the CJ CEST-Intake, is a 115-item test that contains most of the variables measured at intake and also includes measures of treatment progress (Treatment Participation, Treatment Satisfaction, Counselor Rapport, Peer Support, and Social Support). It is relevant to note that an increase in some subscales (Treatment Readiness, Decision Making) indicates an improvement, whereas a decrease in some subscales (Anxiety, Depression) indicates an improvement.

There were 2,222 administrations of the CJ CEST-Intake and 556 administrations of the CJ CEST. The reasons for the decrease of the original sample size from 2,222 to 556 ranged from residents' sentence completion or transfer to another program before the second administration of the CEST, to medical discharges, parole discharges, and disciplinary returns to custody. Of the remaining 556 CJ CEST records, 40 records were dropped (20 blank, five duplicate residents, and 15 with no corresponding CJ CEST-Intake data), leaving 516 completed records. From these remaining 516 records, 129 parole violators were separated out of the sample to keep the sample as a homogenous prerelease population. Nine additional records were dropped from the sample due to excessive (more than 20) missing values. The files from the remaining 378 residents were analyzed in the current study.

The primary purpose for the administration of the CESTs was to provide information for the assessment report as part of a packet of information that was sent to the community release boards.

The database recorded a date for all corresponding records based on when the test was scored, not necessarily when it was administered, resulting in some outliers in the range of dates between test administrations. Although this is a limitation, a reasonable estimate of the time frame of test administrations was calculated by excluding the outside 10% of dates (i.e., outliers that were less than 30 days or more than 190 days) in our sample. The resulting descriptive statistics on the number of days between the scoring of the tests is a mean of 110.8 days (SD = 27.78), with corresponding ranges from December 31, 2007, to March 9, 2009, for the pre-treatment tests and March 24, 2008, to May 12, 2009, for the post-treatment test. Members of the assessment staff, employees with a master's degree in a behavioral science, administered the tests. The primary purpose for the administration of the CESTs was to provide information for the assessment report as part of a packet of information that was sent to the community release boards.

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Table 1: Mean Differences on the CJ CEST (N = 378)

Treatment Motivation								
	Pressure for Treatment		Desire for Help		Treatment Readiness			
	Intake	Post	Intake	Post	Intake	Post		
Mean	22.530	23.200	30.940	35.520	31.128	35.443		
SD	8.208	6.843	9.994	7.450	9.933	8.474		
SE mean	0.422	0.352	0.514	0.383	0.511	0.436		
Mean difference	0.670		4.581		4.315			
SD of difference	7.465		8.006		9.368			
SE mean difference	0.384		0.412		0.482			
T	1.745		11.123		8.956			
Df	377		377		377			
Sig (2-tailed)	0.082		0.000		0.000			
Effect size	0.090		0.572		0.461			
Psychological Functioning								
	Depression		Self-Esteem		Anxiety		Decision Making	
	Intake	Post	Intake	Post	Intake	Post	Intake	Post
Mean	19.018	17.348	38.906	42.547	19.477	18.922	37.741	41.897
SD	7.666	6.128	8.051	6.001	8.089	6.817	6.137	4.742
SE mean	0.394	0.315	0.414	0.309	0.416	0.351	0.316	0.244
Mean difference	–1.669		3.641		–0.555		4.156	
SD of difference	6.906		7.086		6.815		5.688	
SE mean difference	0.355		0.364		0.351		0.293	
T	–4.700		9.989		–1.583		14.203	
Df	377		377		377		377	
Sig (2-tailed)	0.000		0.000		0.114		0.000	
Effect size	–0.242		0.514		–0.081		0.731	
Social Functioning								
	Hostility		Risk Taking					
	Intake	Post	Intake	Post				
Mean	19.051	17.245	26.669	23.955				
SD	7.197	5.213	7.727	7.131				
SE mean	0.370	0.268	0.397	0.367				
Mean difference	–1.806		–2.714					
SD of difference	6.324		7.008					
SE mean difference	0.325		0.360					
T	–5.551		–7.531					
Df	377		377					
Sig (2-tailed)	0.000		0.000					
Effect size	-0.286		–0.387					

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Study Results

Two-tailed, paired sample t-tests with alpha set at 0.05 were used to analyze the mean differences between the pre- and post-treatment scores on the nine subscales of the CJ CEST for the entire sample (see Table 1). The effect size, calculated using Cohen's *d,* is also provided for all mean differences. The changes in all of the scales were in the direction suggestive of treatment benefits, and seven of the nine mean differences were statistically significant. Modest to high effect sizes were observed for three of the statistically significant differences (e.g., Desire for Help, Self-Esteem, and Decision Making).

The sample was then separated into three groups at the 33rd and 66th percentiles based on participants' responses on the Problem Recognition scale at intake. Two-tailed, paired sample t-tests with alpha set at 0.05 were used to analyze the mean differences between the pre- and post-treatment scores on the Desire for Help and Treatment Readiness subscales of the CJ CEST for each level of Problem Recognition (see Table 2 and Figure 1). The effect size, calculated using Cohen's *d,* is also provided for all three mean differences. The mean difference in Desire for Help and Treatment Readiness was greatest in the Low Problem Recognition group, modest in the Moderate Problem Recognition group, and very small in the High Problem Recognition group. The mean difference in these treatment motivation scales was statistically significant in the low and moderate group, with corresponding high and moderate effect sizes.

Discussion and Recommendations

The study results indicate that residents report a variety of positive gains on multiple psychological constructs as measured by a respected client evaluation tool for a criminal justice population. Further, these results replicate the findings by Cone (2008), lending additional support to the hypothesis that offenders who enter treatment reporting low recognition of problem behavior can make notable gains on indicators of treatment motivation.

As indicated in Table 1, results from the entire sample show the overall trend of mean differences in the direction of positive gains on all measured constructs. More noteworthy is the finding that seven of the nine mean differences are not likely to be interpreted as chance fluctuations in the data and three of the nine differences (Desire for Help, Self-Esteem, and Decision Making) had modest to high effect sizes greater than 0.5. Focused only on these last three variables, the study does indicate that the participants sampled reported an increase in their motivation for treatment, feelings of self-respect and self-worth, and an increase in making sound decisions and considering the consequences of their actions. These findings encourage further research to identify the antecedents associated with these gains and an elaboration on which offenders appear to be making the most substantial advances.

The second analysis was consistent with Cone's (2008) findings that the gains in treatment motivation scales of Desire for Help and Treatment Readiness were most pronounced in those residents who entered programming with the lowest recognition or admission of their problem behavior. These findings lend further support that the CMRC milieu is associated with enhanced treatment motivation in initially resistant residents. A number of factors influence outcomes from correctional-targeted interventions. Offenders vary considerably in their motivation to engage in prosocial change, particularly with respect to the mandated programming that characterizes programs such as the CMRC. Further research is needed to compare CMRC offenders with a randomly assigned control group in order to isolate this intervention as the likely causal agent for this change. As described above, Lowmaster et al. (2010) found that successful and nonsuccessful program completers who had been sentenced to court-mandated residential treatment were differentiated by their scores on the Problem Recognition, Desire for Help, and Treatment Readiness scales of the TCU Correctional Residential Self-Rating Form (TCU CR SRF; an alternate version of the CEST). This highlights the importance of the present research for contributing to the field's understanding of methods that enhance treatment motivation.

The changes observed in this study in treatment motivation in the Low Problem Recognition group were noteworthy, with effect sizes of 1.23 for Desire for Help and 0.83 for Treatment Readiness. As is highlighted in Figure 1 and Table 2, the increase from a mean of 21.06 to 30.61 for Desire for Help and from a mean of 28.05 to 31.81 for Treatment Readiness is a clinically significant finding. At intake, the average response for this group was "disagree" on questions related to wanting and receiving help and being prepared to change. Following treatment, the average response for this group was "uncertain" on these same questions. A randomized controlled design is needed to draw any firm conclusions.

The change in treatment motivation for the Low Problem Recognition subgroup is consistent with the transtheoretical model of change because this group moved from a pre-contemplation stage to the contemplation stage (Prochaska & DiClemente, 1986). This change may suggest that the CMRC staff effectively used motivational

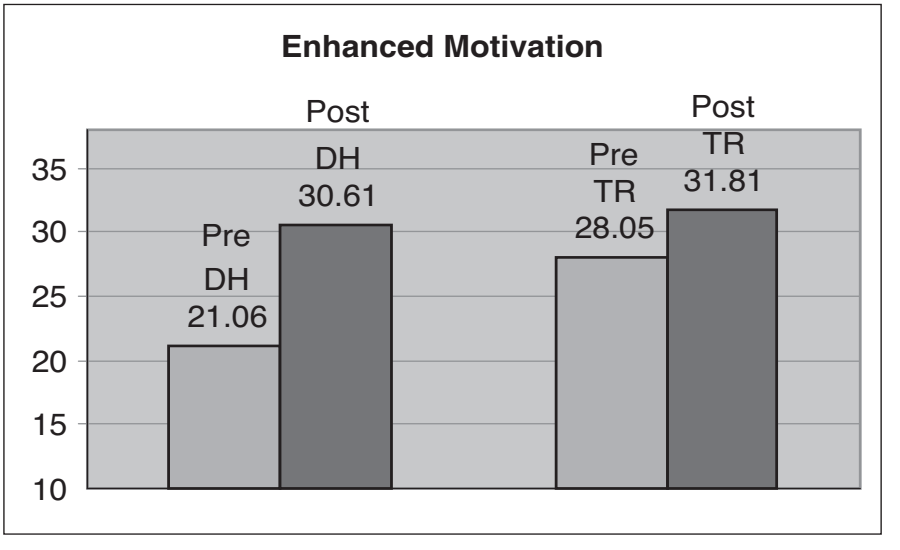

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Table 2: Mean Differences on the CJ CEST at Each Level of Problem Recognition (N = 378)

	Low		Moderate		High	
	128	33.77%	119	31.40%	131	34.56%
Desire for Help						
	Pre	**Post**	**Pre**	**Post**	**Pre**	**Post**
Mean	21.06	30.61	30.77	35.48	40.74	40.36
SD	5.99	7.28	5.3	5.74	6.01	5.64
	$t(127) = 13.9, p < 0.001$		$t(118) = 7.4, p < 0.001$		$t(130) = 0.76, p = 0.446$	
Effect size	1.23		0.68		0.07	
Treatment Readiness						
	Pre	**Post**	**Pre**	**Post**	**Pre**	**Post**
Mean	28.05	31.81	33.66	35.19	38.86	37.10
SD	7.16	6.85	6.41	5.71	6.96	5.99
	$t(127) = 5.1, p < 0.001$		$t(118) = 2.4, p < 0.05$		$t(130) = -2.8, p < 0.05$	
Effect size	0.449		0.218		0.244	

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enhancement techniques consistent with the CEC treatment model, thus encouraging a shift to becoming more intrinsically motivated. The CMRC residents come to the program having been extrinsically motivated to attend the program, because the criminal justice system has mandated their involvement. During incarceration, offenders' conformity to institutional rules is achieved primarily through extrinsic measures. Yet, when offenders reenter society, they are expected to accommodate and assimilate to conventional norms and values, based primarily on intrinsic motivation. In other words, the prison system reinforces an external locus of control, but society reinforces and expects ex-offenders to act from an internal locus of control. The gains observed in this study suggest that the CMRC therapeutic process may be a factor in assisting residents in developing a more internal locus of control, thus preparing them for their eventual return to society.

These results can be interpreted in terms of the RNR model, in that the CMRC program may have been responsive to residents with low problem recognition in a manner that increased their motivation for treatment. Motivation as a barrier to treatment is a critical responsivity factor that, in many ways, precludes other treatment goals, because a resident who is not aware that he has a problem and is not motivated for treatment is not likely to complete a program successfully (Hiller et al., 1999). For the low problem recognition subgroup, the need to increase motivation for treatment was critical, because their treatment motivation scores suggested that they were in the pre-contemplative stage of change entering the program, with minimal recognition that they had any problems requiring treatment services. As prior research has shown, this group was the most likely to fail to complete treatment and more likely to commit rule infractions (Lowmaster et al., 2010).

The CMRC's use of a reliable and valid instrument (CJ CEST) to assess residents' self-evaluation of their change in a therapeutic program milieu is consistent with the CEC treatment model and standards of evidence-based practices in the correctional treatment field. Surveys of programs across the country have found that practically half of all prison-based programs do not use an assessment instrument (Taxman et al., 2007). Although the administration of the assessment instruments is primarily for treatment planning purposes (Latessa et al., 2002), an analysis of the aggregated data is helpful in identifying positive trends and developing hypotheses for more difficult, costly, yet tightly controlled, randomized trials.

Results of the current study suggest that CMRC staff use the assessment information gathered at intake to formulate program plans that target the residents' specific criminogenic and responsivity needs. The positive results, particularly with the low motivation subgroup, are consistent with a program curriculum, service provisions, and staff training that reflect current evidence-based principles of offender rehabilitation.

Study Limitations

Unequivocal conclusions regarding the causal agents associated with these observed changes would be premature given the study design, particularly in the absence of a control group to compare and contrast with the treatment group. The results of this archival data analysis do point to some positive trends—particularly for those who enter programming reportedly unmotivated—and lend support to more aggressive and comprehensive research where subjects may be randomly assigned to treatment and control groups.

Other limitations of the current study are the potential selectivity of the sample and the possibility that the changes in the scores, particularly for the high-risk group, reflect a regression to the mean. A large number of those residents who were tested at intake were not given a post-treatment test. This is explained chiefly by the later start of the administration of the post- version of the CJ CEST and the number of residents who were not slated to remain at CMRC consistent with a 180-day length of stay or were not part of the pre-release population of interest. An analysis of the treatment motivation scales of the entire intake sample vis-à-vis the experimental sample (387) was calculated to determine if there were any differences in the groups on this dimension. The analysis yielded no statistically significant differences between the two groups. This lack of statistical differences along the treatment motivation scales suggests some similarities in the two groups. Given that demographic data such as age and race were not calculated between the groups, due to difficulties with data retrieval, the selection bias threat cannot be ruled out as a confounding variable. Future studies will need to be more deliberate in the data collection process to be able to assess for any differences between the groups who were administered the test both at intake and following treatment and those who failed to complete a post-treatment test.

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Finally, the study did not include follow-up data to assess whether the enhanced motivation for treatment and other positive gains continued through the phases of the participants' reentry into society. It would be useful to evaluate the potential impact that these treatment gains may have on recidivism. The use of a self-report instrument alone without other corroborating data may limit the findings.

Summary

This study analyzed archival data related to offenders' evaluation of their self and treatment using the CJ CEST, which was collected for assessment purposes at the CMRC. Results indicate that the CEC program model may reinforce prosocial behaviors, attitudes, and feelings in offenders. The findings also served as a form of quality assurance and evaluation for the CMRC, because the results provided evidence that the quality and fidelity of the CMRC programming is consistent with its mission to enhance public safety by preparing its residents for their return to society by increasing their motivation for treatment and for social and psychological functioning. As the work of Hiller et al. (2002) and DeLeon et al. (1997; 2000) has noted, the positive changes in motivation and other clinical domains for the residents in this study have been correlated with improved post-treatment outcomes.

The current study is a replication of prior research about the effectiveness of the CEC continuum of care model. The current findings also cross-validate prior work on the CEC treatment process, because this second study was conducted on a population that is demographically more diverse than that examined in previous work. Thus, the generalizability of prior research has been enhanced by this current research. Overall, the findings from the current study serve as another example of the potential effectiveness of the CEC continuum of care model in treating offenders for their risk and needs factors that may ultimately translate into enhanced public safety, cost avoidance, and savings for the public entities partnering with CEC.

Results indicate that the CEC program model may reinforce prosocial behaviors, attitudes, and feelings in offenders.

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only 91% of the participants in Group C completed their vaccination schedule. There were no new cases of HBV infection among the participants during the trial. With regard to the seroprotection rate, Group A had a significantly higher rate (22%) than Group C (5%) at one-month post-baseline. This significant difference remained at two months post-baseline, when approximately 61% in Group A achieved seroprotection compared to 44% in Group C. However, by the end of the study (eight months post-baseline) the rate of seroprotection was significantly higher in Group C (93%) than in Group A (79%). When looking at differences in the anti-HBs titer, the authors found that the mean anti-HBs titer was significantly higher in Group A at one month, but the antibody titer increased at a higher pace in Group C after six months.

Conclusions. Even though the findings show that the classic schedule resulted in statistically higher rates of seroprotection in inmates at the end of the study, the accelerated schedule may still be a better option for correctional settings where low compliance is common. Generally, HBV vaccination programs are considered successful if they reach at least 85% seroprotection. However, the authors believe that achieving at least 75% seroprotection within a correctional setting is a more reasonable target goal for this population, considering the low compliance in study and the transitory nature of the population. Using the 75% target goal as a measure of success, the 79% seroprotection that was achieved in this study shows that the accelerated program can be an effective and feasible way of providing HBV vaccination to an incarcerated population, especially for inmates who have short sentences of six months or less. ■

The 79% seroprotection that was achieved shows that the accelerated program can be an effective way of providing HBV vaccination to an incarcerated population.

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