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FLORIDA ADULT S.T.O.P. PROGRAMS:

Screening, Assessment, Treatment, Followup and Evaluation for Drug Involved Offenders

125120

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Prepared by
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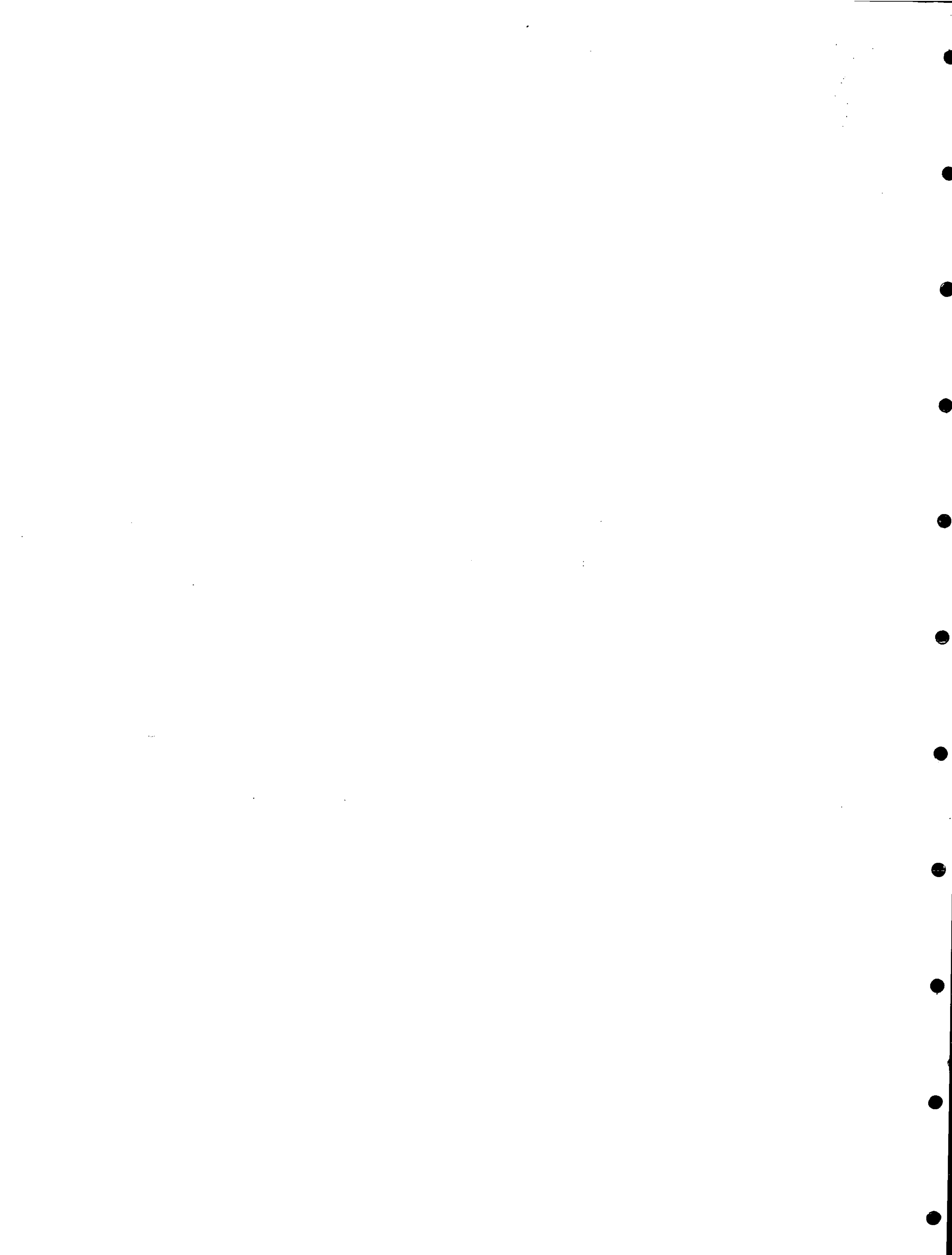
February, 1990



FOREWORD

This report describes a proposed program for adult drug-dependent offenders whose criminality is causally linked with drug abuse. This program design is intended to be responsive to the Florida's STOP (Serious Targeted Offender Programs) legislation and follows from the contract between the Florida Joint Legislative Management Committee and the Florida Mental Health Institute.

Development of the Adult STOP Program

Design

Staff from the Florida Mental Health Institute have undertaken several activities pursuant to developing designs for screening and assessment components of the STOP program. These include: (1) a literature search on current drug treatment approaches, correctional treatment programs, and evaluation of drug treatment program effectiveness, (2) examination of current substance abuse programs within DOC, (3) identification of national experts in drug abuse assessment and treatment to consult with the Florida Mental Health Institute on the STOP program, (4) consultant meetings held at the Florida Mental Health Institute to discuss the STOP program design including national, HRS, DOC, and Florida Alcohol and Drug Abuse Association (FADAA) consultants, (5) the hosting of a statewide conference on the "Critical Challenge of Drug Abuse" held coincidentally to the STOP program but focusing on related issues of drug abuse as impacting Florida, its criminal justice system and its treatment providers, and (6) identification of procedures for the implementation of drug abuse assessment and treatment programs. Although the results of these activities are described within this report, the following section will address the process of involving consultants in the design of the STOP program.

Procedure

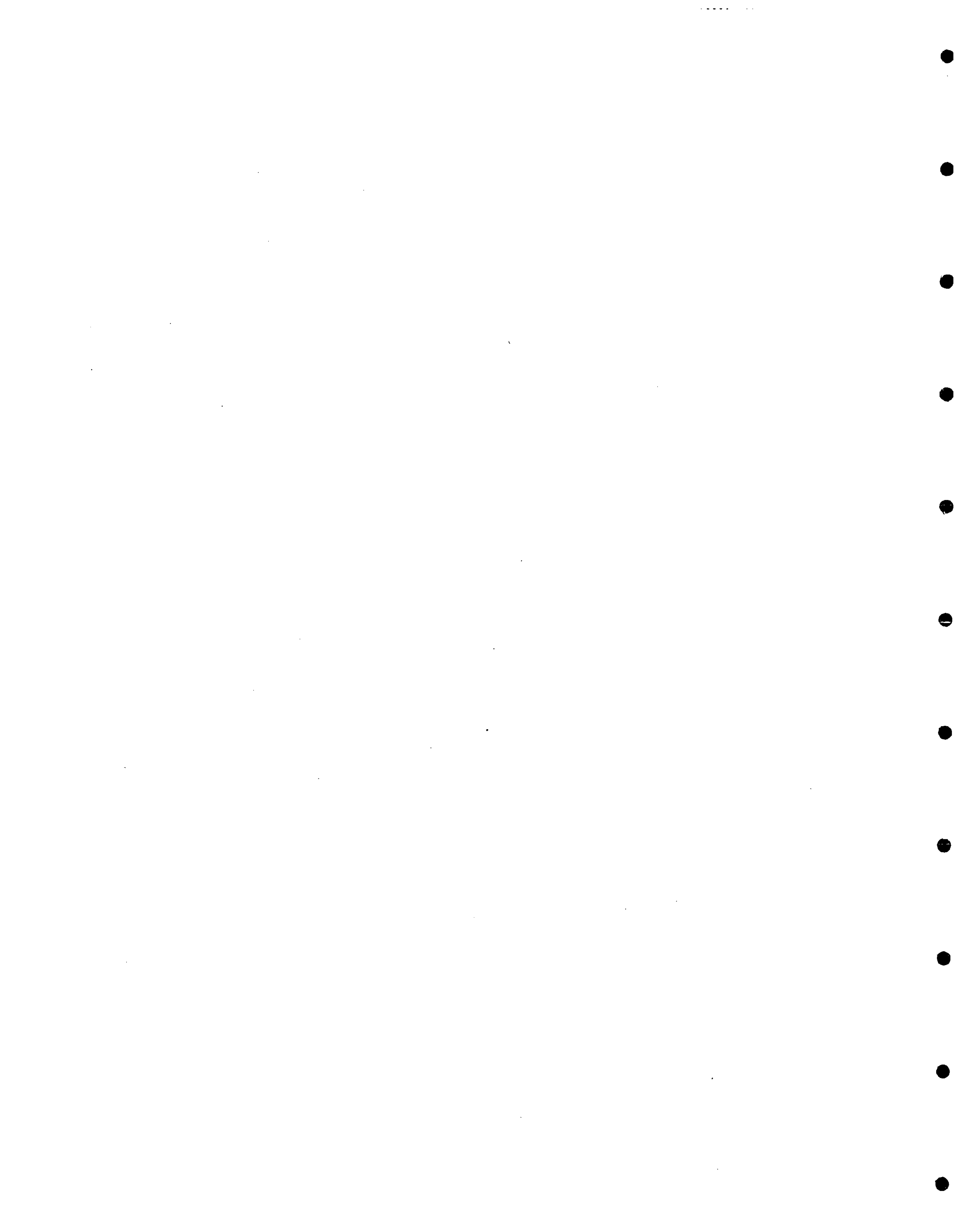
Following a search of prominent experts in the area of drug abuse assessment and treatment, several were identified, and invited to attend consultant workshops at the Florida Mental Health Institute. Three such workshops were convened, during October 16-17, 1989, November 13-14, 1989, and December 12, 1989. Experts participating in these activities were as follows: Dr. James A. Inciardi, Professor and Director, Division of Criminal Justice, University of Delaware; Dr. A. Thomas McLellan, Research Professor, Substance Abuse Treatment Center, University of Pennsylvania; Dr. Gary Field, Director, Cornerstone Program, Oregon Department of Human Resources and Corrections; Dr. Robert Hubbard, Senior Social Psychologist, Center for Social Research and Policy Analysis, Research Triangle Institute; Dr. Richard Dembo, Professor of Criminal Justice, University of South Florida; and Dr. Gary Whittenberger, Federal Bureau of Prisons. Meeting with these experts were several FMHI staff, in addition to Jim Mitchell, Ben Williams, and Bob Kriegner, of the Florida Department of Corrections; Pam Peterson of the Florida Department of Health and Rehabilitative Services; and Jay Schrader, representing the FADAA. A final STOP program workshop was held on January 5, 1990, involving community drug treatment providers identified by FADAA from throughout the state, and staff from HRS and from DOC. This workshop served as a forum to discuss effective procedures for implementing the STOP program, and proposed assessment and treatment approaches. Additional consultation in review of the STOP program design was provided by Dr. Harry Wexler, of the Narcotics and Drug Research, Inc., and Dr. Eric Wish, Visiting Fellow at the National Institute of Justice.

Richard M. Swanson, Ph.D., J.D., the Chair of the Florida Mental Health Institute's Department of Law and Mental Health, directed the development and writing of this proposal. Dr. Roger Peters, Ph.D., Assistant Professor in the Department of Law and Mental Health served as project coordinator of the FMHI STOP team and as liaison between the STOP team and the program consultants. Major portions of the report were authored by Drs. Swanson and Peters. Other team members were Dr. William Kearns and Ms. Mary Murrin who participated in project activities and contributed to the report.

Dr. Katurah Jenkins-Hall served as consultant on the STOP Quality-assurance plan and contributed to the writing of that chapter. Dr. John Platt served as consultant on educational and vocational training and contributed to the writing of that section of the chapter on specific treatment interventions.

Richard Brown of ACTS in Tampa, Jay Schrader and Harvey Landress of Operation PAR in Pinallas County, Bonnie Christiano of DACCO in Tampa, and Harry Dodd, Director of Probation and Parole Services, Department of Corrections all generously contributed to the implementation plan and budgeting issues of this STOP program proposal.

Mr. John D. Williams served as senior word processor and graphics specialist in producing this document.



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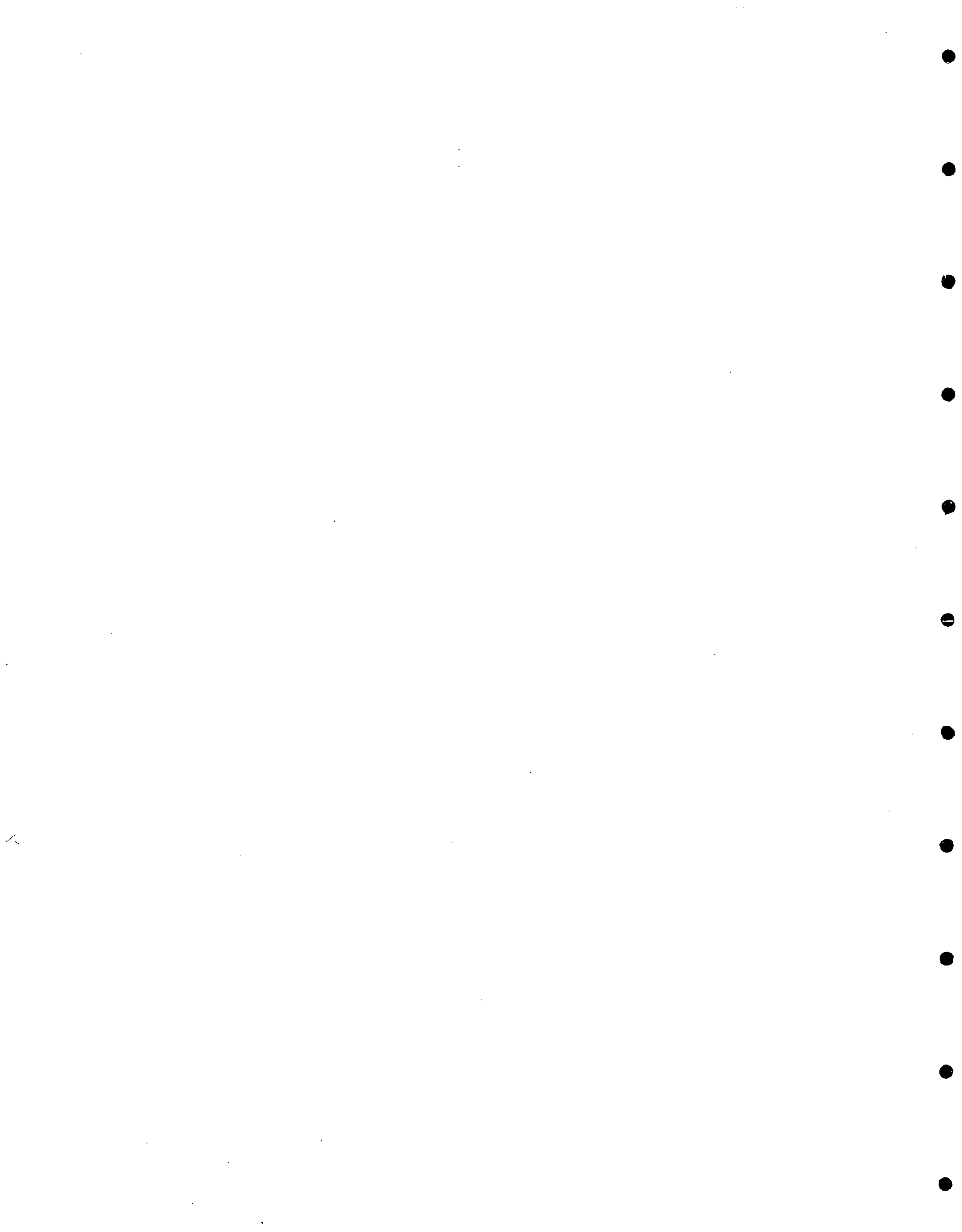

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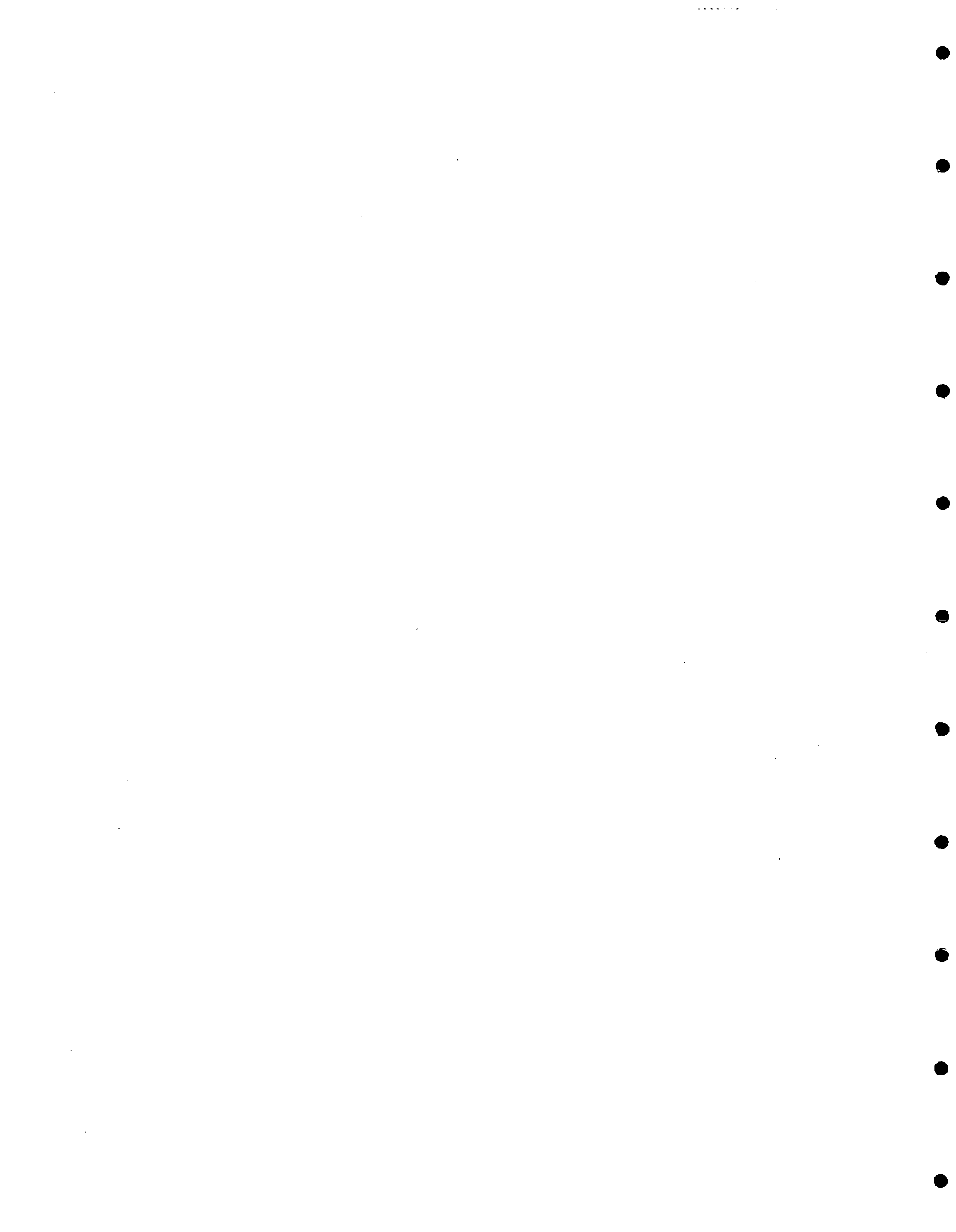

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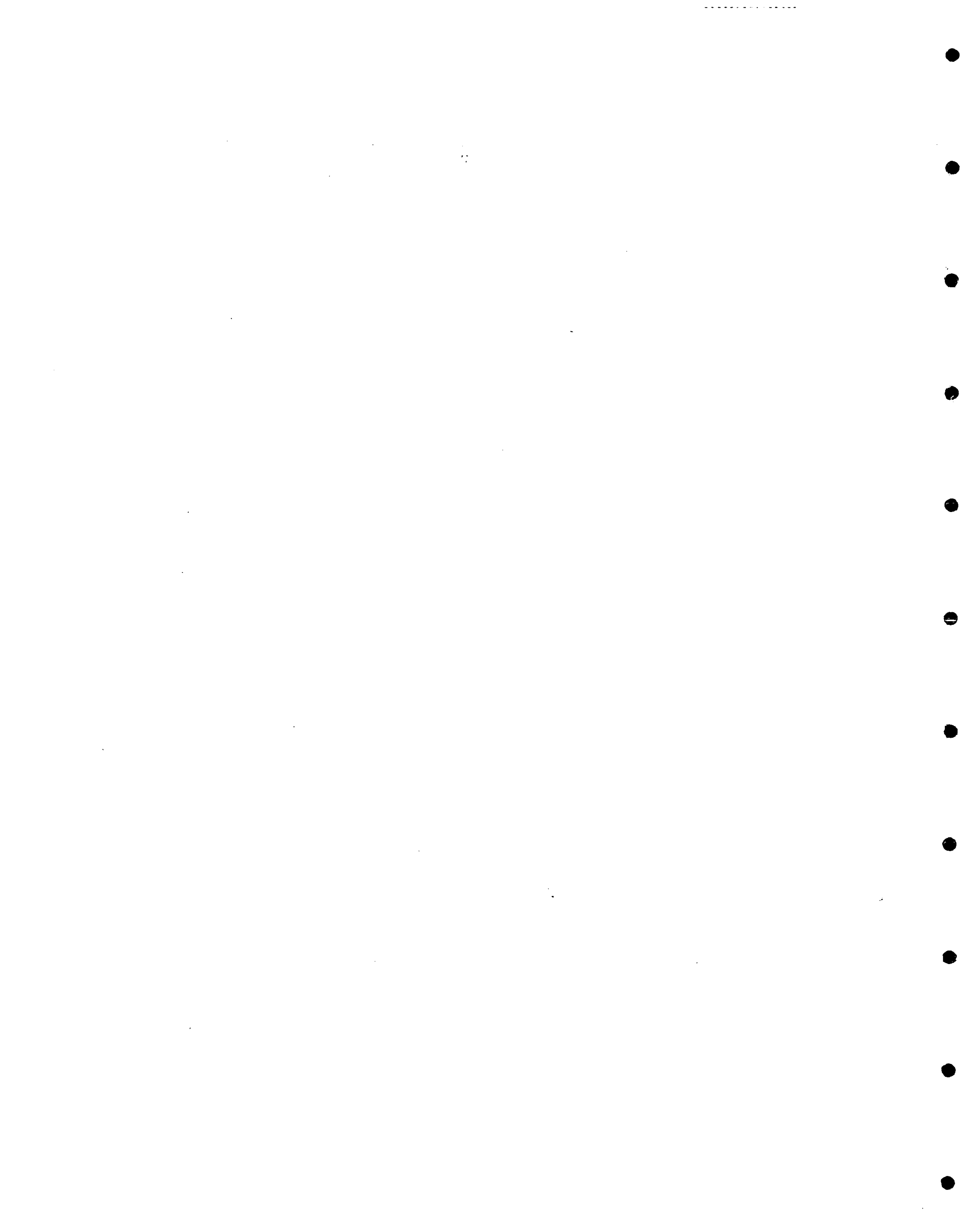

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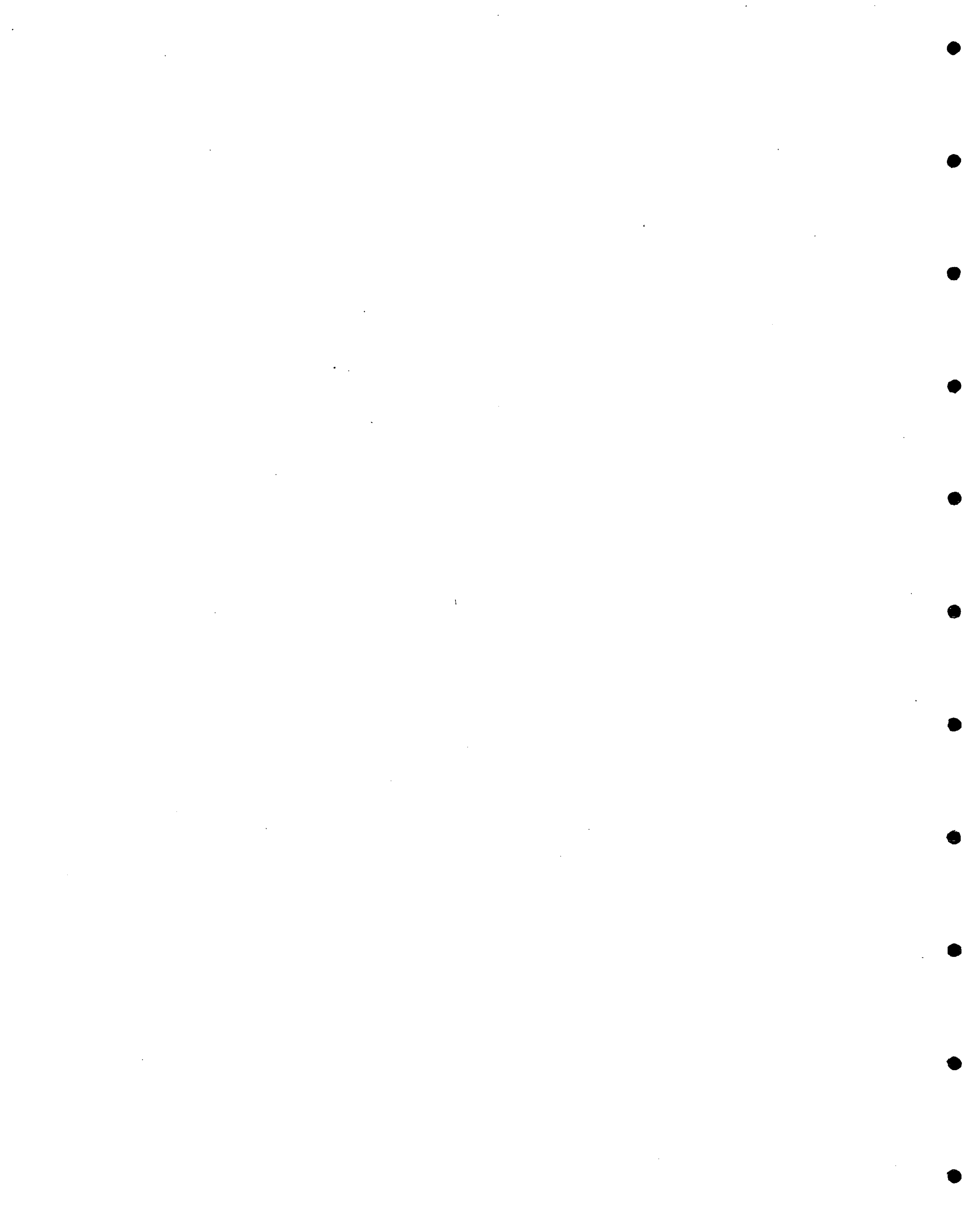


Chapter 1

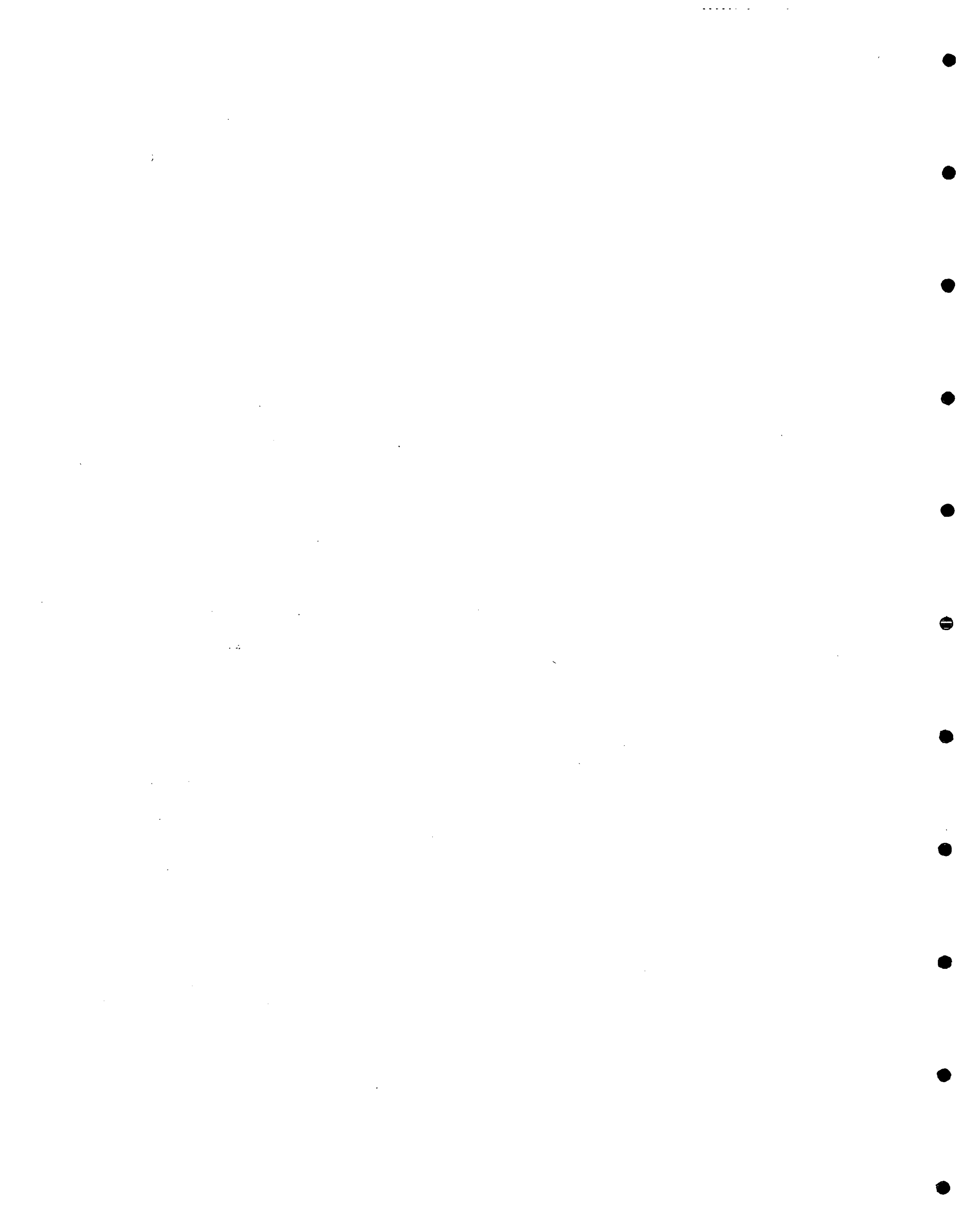
INTRODUCTION

The 1989 Florida Legislature enacted the Serious Targeted Offender Program (STOP) to select populations of offenders, identified as exacerbating Florida's problems of prison overcrowding, who are also amenable to effective interventions to develop constructive alternatives to criminal careers. The two populations seen as potential career criminals and crucial to Florida's future are: 1) serious habitual young offenders likely to graduate to Florida's Department of Corrections adult institutions and 2) Florida's drug involved offenders whose criminal behaviors are attributable to drug dependence.

The legislature selected two of Florida's state universities to assist in the design of state of the art programs to intervene in the destructive criminal careers of these two targeted populations: the Florida Atlantic University's Center for Youth Policy was selected to address programs for the serious habitual young offender and the University of South Florida's Department of Law and Mental Health at the Florida Mental Health Institute was selected to address programs for the drug-dependent adult offender.

Adult Drug-Dependent Offenders

This report addresses the design of a state of the art drug treatment program for adult offenders who show a causal link between their abuse of drugs and their criminal activity. Following the mandates of the STOP legislation and the Joint Legislative Management Committee, The Florida Mental Health Institute designed screening, assessment, treatment, quality assurance and evaluation programs to implement the adult STOP legislation.



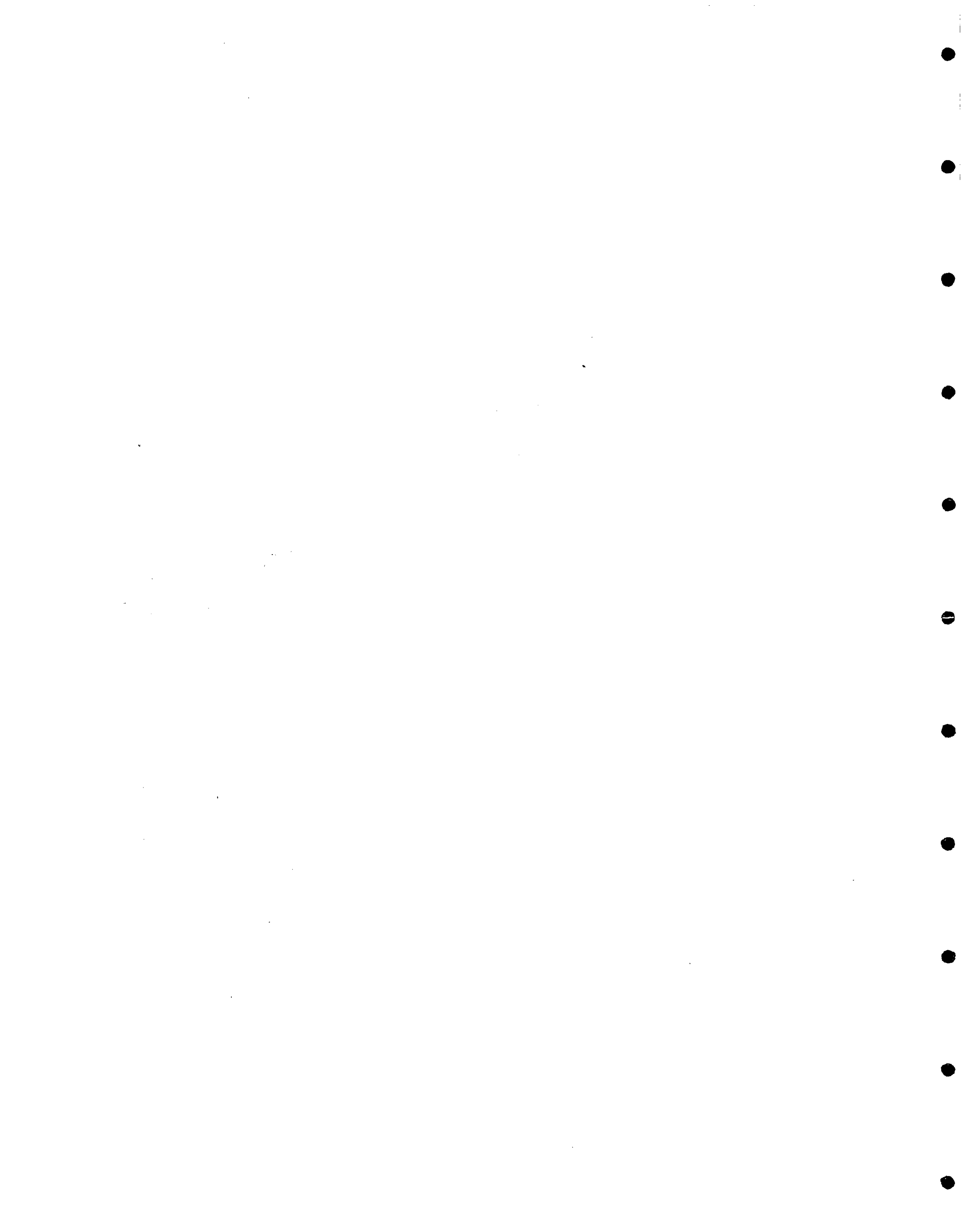
Primary considerations in developing this proposal were:

* Reducing crime in Florida.
* Developing a cost-effective approach to intervening in the lives of drug-dependent offenders with severe problems and a range of needs.
* Making use of what has been shown to be effective in the clinical and research literature.
* Exploring new treatment techniques to keep the state on the leading edge of treatment innovations with drug-dependent offenders.
* Developing a more intensive treatment approach for drug-dependent offenders than is currently available through outpatient treatment in the community.
* Providing alternatives to prison for those drug involved inmates not appropriate for less restrictive community alternatives.
* Diverting offenders from Florida's overcrowded prisons who are amenable to treatment.
* Effectively utilizing scarce community supervision resources by targeting offenders whose criminality is attributable to drug dependence.
* Providing a mechanism to guarantee at least the minimum time in treatment sufficient to expect lasting therapeutic impact.
* Building on the effective strategies already developed by the Florida Department of Corrections.

The FMHI approach also considered the program design in the context of Florida's current treatment efforts in the community and current treatment efforts in the Florida Department of Corrections (DOC).

Current Treatment Efforts

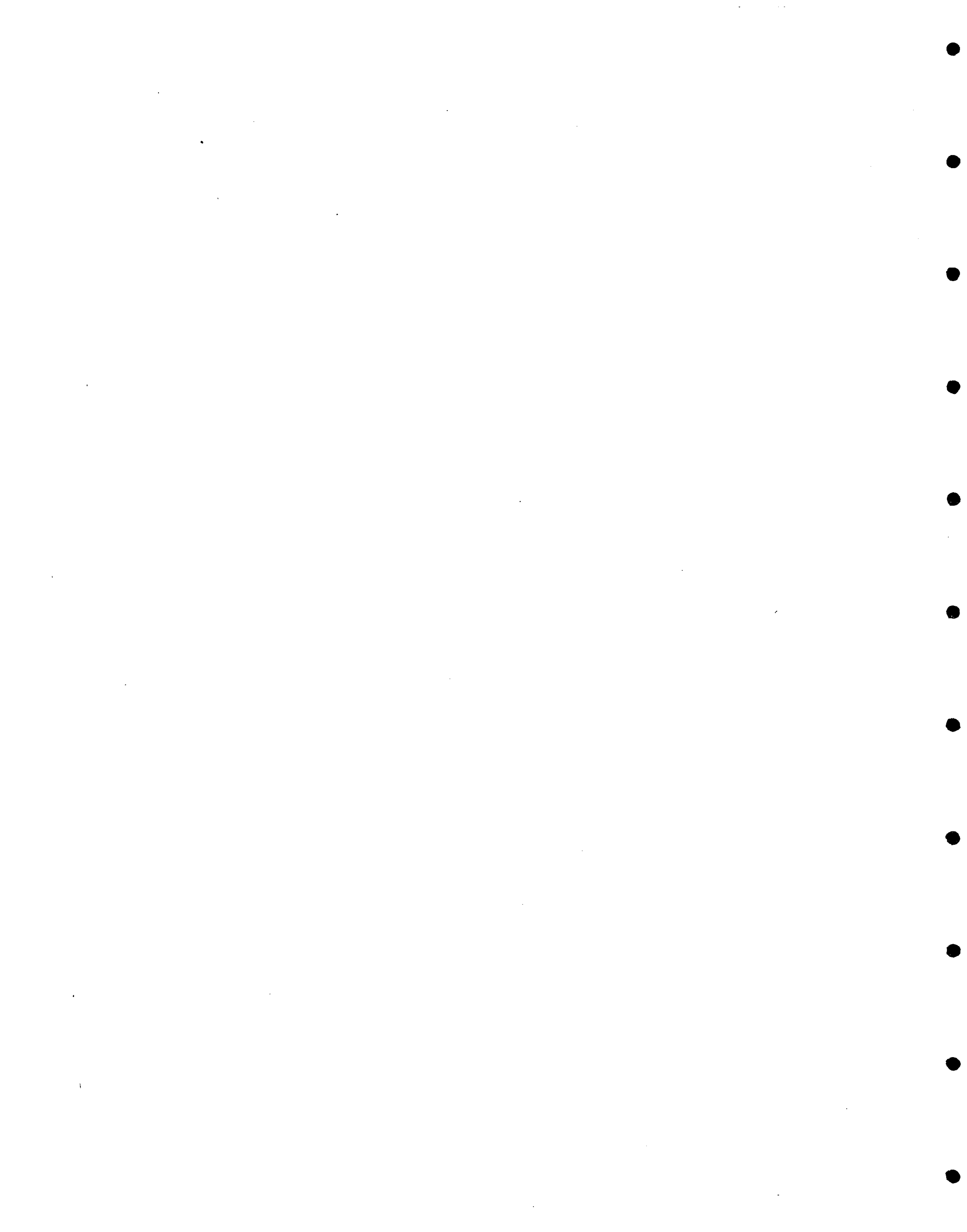
Florida's efforts to address the problems of drug abuse and crime are impressive but have not kept pace with the need for treatment. Community efforts are not only extensive but currently reflect many aspects of state of the art approaches. However, these efforts are largely inadequate as they are



overwhelmed by the magnitude of demand and the complexity of the problem. More drug-dependent persons need treatment for their addictive behaviors than can be helped with existing resources. Pre-trial diversions, alternatives to incarceration and other community programs are plagued by overwhelming demand for slots yielding impossible waiting times for admission which diminish possible treatment impact. Many people motivated to seek services are unable to gain timely admission to programs or are unable to pay for expensive private treatment programs. Many people with drug problems lack the motivation to change, despite the destructiveness of the drug problem, as they do not perceive or appreciate the likelihood of criminal justice sanctions until too late.

While the Department of Corrections has implemented an extensive five tier program (see Appendix A), the treatment efficacy is severely limited by an overcrowded system that cannot be structured by an individual's treatment needs, but rather is driven by the system's needs to match sentence with crime and to release inmates to relieve overcrowding. With continuing Federal court intervention restricting the number of inmates in the system, most of Florida's offenders are serving decreasing proportions of their sentences. Actual time served is decreasing from a third of their sentence to a fourth. As current drug treatment experts agree, effective treatment programs share several tenets: 1) recovering from drug addiction requires fundamental cognitive and behavioral changes in the drug-dependent person, 2) treatment efforts must begin with intensive and long term interventions separated from the temptations of continued drug use and 3) an intensive first stage of treatment must be followed by extensive support and aftercare activities.

Florida's prison system is limited in its treatment efficacy by the following characteristics: 1) most inmates needing drug treatment who are amenable to intervention efforts are not in DOC's custody for sufficient time to accomplish the necessary initial objectives of breaking the cycle of drug dependence, 2) drugs are readily available within most prison communities which reduces treatment effectiveness, and 3) Florida's corrections system can not provide for the necessary followup surveillance or aftercare services necessary to maintain positive drug treatment outcomes. (Under current Florida law the vast majority of Florida's inmates return to the community without parole supervision.)

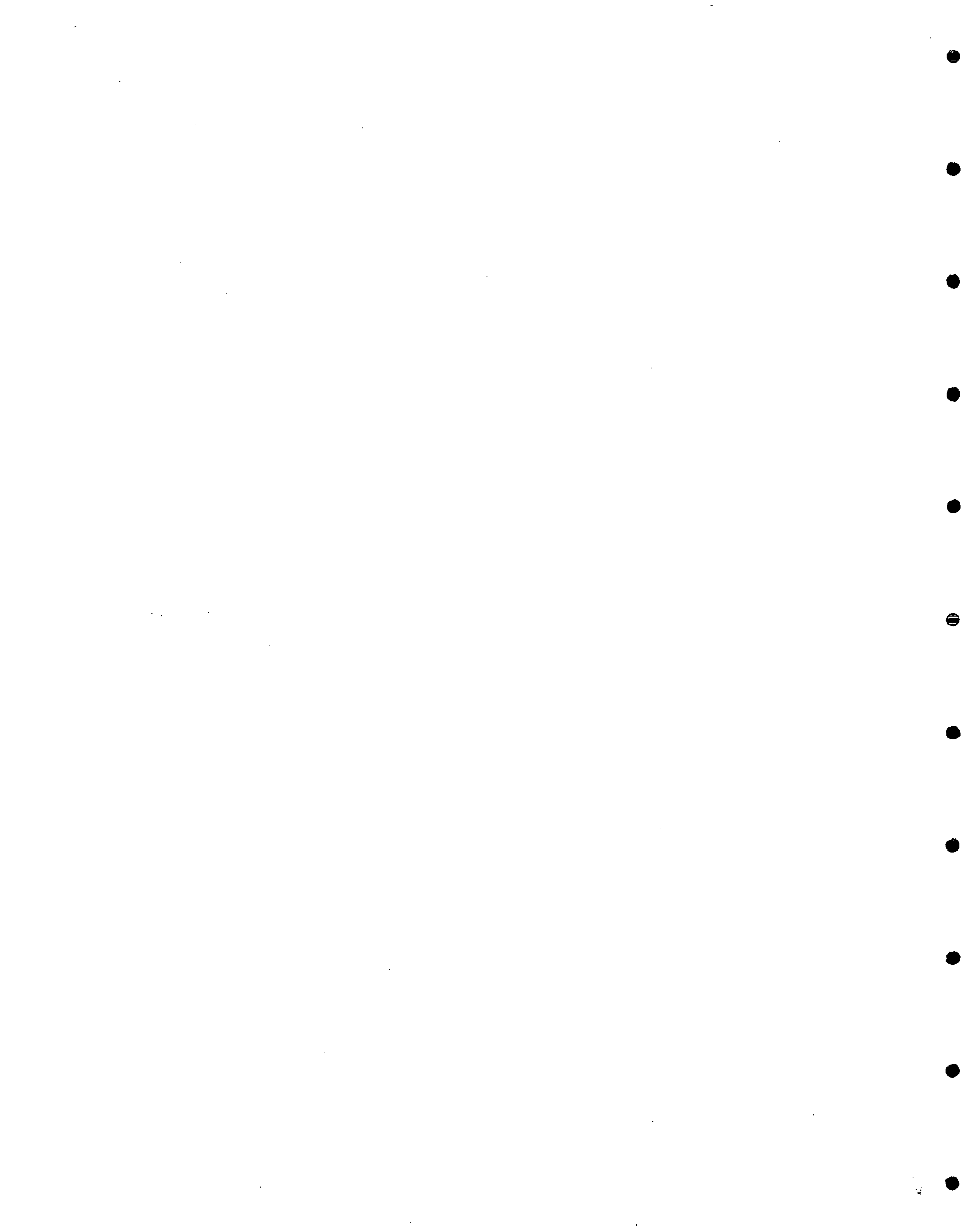


Consequently, the three characteristics of effective treatment are not capable of implementation in a prison-based treatment approach under current Florida law.

Target Treatment Population

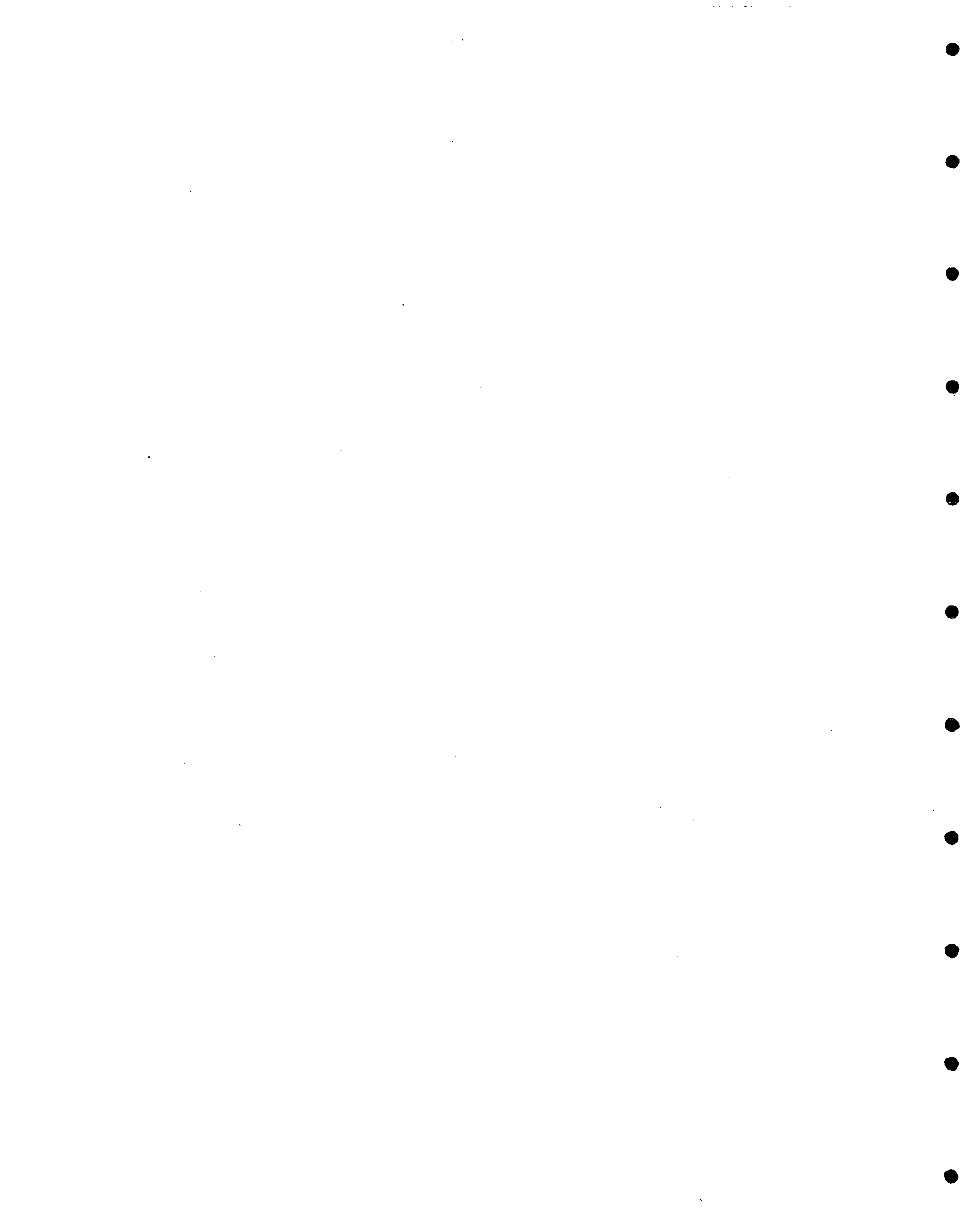
While DOC is severely constrained in its management of prison-based drug treatment programs, it participates in a number of community-based programs that serve drug-dependent offenders under the auspices of probation. Currently more than 87,000 offenders are under community supervision of Florida's probation and parole system. Of these, 69,200 are probationers which includes an overwhelming majority that are seen as drug-dependent (Department of Corrections Annual Report, 88-89). At a recent statewide conference addressing Florida's "Challenge of Drug Abuse" members of Florida's judiciary and law enforcement communities concluded that Florida lacks structured, secure, and effective drug treatment programs for offenders with chronic drug abuse problems. They further observed that drug treatment programs are needed that provide for the safety of the community and should include systematic sanctions for continuing drug involvement e.g. "do drugs, do time." Such programs should work to motivate persons to deal with the root of their criminal activity, their need for drugs (see Critical Drug Abuse Challenge Conference Proceedings, 1990).

FMHI's STOP program design targets probationers and persons under community control status who are not effectively managing their drug dependence, who are not able to address their problems within the available community programs under traditional probation supervision and who do not require relocation to prison if a more secure alternative is available to the courts. The intent of this proposal is to target probationers who without a STOP program face revocation of probation and transfer to a DOC institution. These probationers are currently in the community, engaging in drug abuse, and are found with "dirty urines" (urines testing positive for drug abuse). Their dirty urines are largely tolerated because of the lack of available prison beds, but many such probationers are eventually revoked from probation and admitted to Florida's prison system. Between July and November, 1989, of 25,496



probationers tested for drugs, 7,228 were tested positive (28%). Of those tested, more than half tested positive for cocaine. Between July and November, 1989, of 6,683 probationers referred to treatment, only 70% were accepted into treatment (the remaining 30% were placed on waiting lists due to a lack of available treatment slots) and another 21% of those accepted were subsequently reported as unsuccessful in treatment (Department of Corrections unpublished research data, 1990).

Florida's current approach lacks a secure alternative between community outpatient treatment and Florida's prison system. This alternative should be available to the courts for drug-dependent offenders assessed by treatment professionals as: 1) amenable to treatment, 2) not conducive to lesser restrictive community alternatives and 3) not requiring commitment to the Department of Corrections prison system. Such a program should operate to treat the drug-dependent offender and also to protect the community, while reserving prison beds for those presenting a danger to the community and not amenable to drug treatment. Such an approach will provide both primary diversion for incarceration by avoiding the first commitment to DOC, and secondary diversion by diverting drug-dependent offenders from criminal careers who would otherwise begin a revolving door association with Florida's prison system. Correct assessment procedures would preclude net widening and reserve the STOP program to those probationers at high risk of revocation of probation and disposition to a Florida prison bed.



Chapter 2

REVIEW OF THE CORRECTIONAL DRUG TREATMENT LITERATURE

Overview

State prison populations have increased significantly in the past five years due in large part to an influx of drug-dependent inmates, many of whom are repeat offenders who serve their sentence but are released without treatment (Wexler, Lipton, and Johnson, 1988). In Florida, there were 7,441 state prison admissions with a history of cocaine offenses in FY 87-88, an increase of 863% from admissions in FY 85-86 (Florida Department of Corrections Annual Report, 87-88). Although an estimated 70 to 80% of state prison inmates are in need of substance abuse treatment (National Conference of State Legislatures, 1989), a Bureau of Justice assistance report (National Criminal Justice Association, 1988), indicates that only 8% of grant funds from the Anti-Drug Abuse Act of 1986 were spent to treat offenders. In a recent survey only 25% of prison inmates reported involvement in any substance abuse treatment (Bureau of Justice Statistics, 1986).

The need for drug treatment for offenders was addressed by Nicholas Demos, former Program Manager for Corrections with the Bureau of Justice Assistance in a recent monograph published by Project REFORM (1988):

> "The more serious the drug problem of the inmate, the deeper the level of intervention must be both in the institution and in the community. . . . The cost for all this will be substantial but the benefits are much greater".

History and Effectiveness of Correctional Treatment

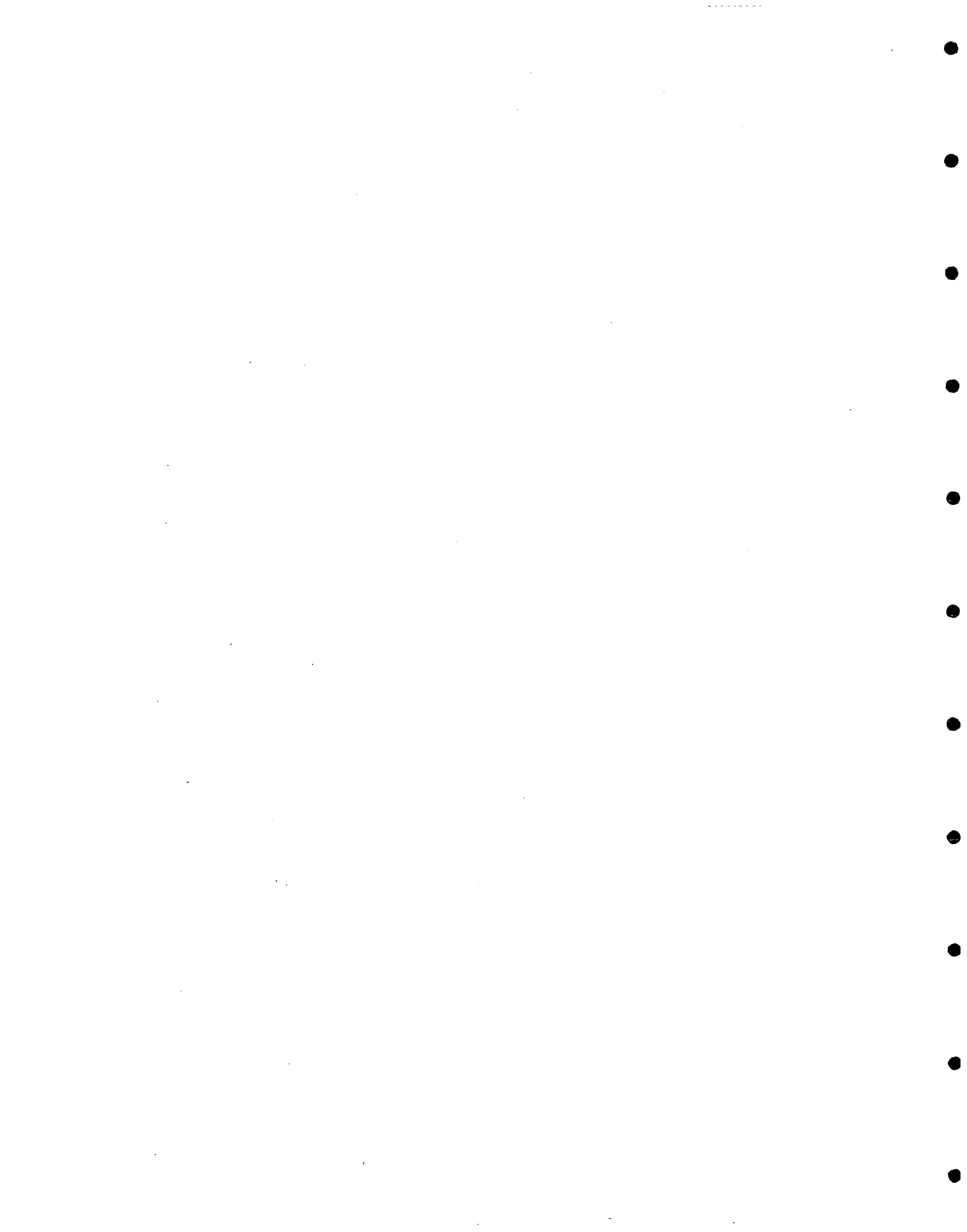
The first organized public effort to combat crime by treating drug abuse was the initiation of the U.S. Public Health Service's hospital in Lexington, Kentucky in 1935 to care for federal offenders who were addicted to drugs. A second facility opened in 1938 in Fort Worth, Texas. Treatment in these facilities lasted from 4-6 months and consisted of detoxification, psychotherapy and supervised activities. Success in this early study was measured by the length of time to initial relapse to drug use. The only treatment interventions that consistently led to long-term abstinence were programs that lasted longer than eight months and that were followed by more than one year of parole (Maddux, 1988; Vaillant, 1966). A twelve year follow-up of 100 offenders released from drug treatment programs found that 30% of offenders became totally abstinent for three years or more and had not been arrested in four years. Major shortcomings of early correctional treatment interventions included the absence of followup treatment in the community (Kramer, 1971).

In the mid-1950's the Special Narcotics Project, implemented in New York City, provided intensive parole supervision for drug-dependent offenders (Diskind, 1960; Inciardi, 1988). Early results indicated that 45% of offenders abstained from drugs while under supervision (Diskind and Klonsky, 1964a,b). However, subsequent investigation revealed that many offenders were not effectively tracked and that the program failed to report detected cases of recidivism (Inciardi, 1988). By the 1960's the civil commitment approach was developed and implemented in New York and California, involving a large proportion of offenders. Since earlier programs reported that addicts were not enrolled in treatment for a sufficient length of time, civil commitment to state hospitals was routinely ordered for periods of 5-10 years. Upon commitment clients were placed in facilities such as the California Rehabilitation Center for 7-15 months and were then eligible for release on outpatient status. In a random sample of 289 admissions, only 67 clients (23%) had successfully completed the program (McGlothlin, Anglin and Wilson, 1977).

Sells, DeMarre, Simpson, Joe and Goruch (1977) reported that prior to the 1960's drug treatment was largely confined to psychiatric hospitals and clinics. Although most programs were not routinely evaluated, available data indicates only marginal treatment effectiveness. After federal funding was introduced in the 1960's, four basic treatment strategies were developed: methadone maintenance, therapeutic communities, drug-free outpatient counseling, and short-term detoxification. The most thorough cross-modality comparison of the four treatment types was the Drug Abuse Reporting Program (DARP), a network of 52 programs initiated in 1969 (Simpson, 1984; Simpson, Joe, and Bracy, 1982; Simpson, Savage, Lloyd, and Sells, 1978). Approximately 44,000 clients admitted to these programs between June 1, 1969 and March 31, 1973 were followed bi-annually until March 31, 1974, and samples of the population were followed for up to twelve years. At the one-year followup (Simpson, et al., 1978), several long-term interventions (methadone maintenance, drug-free outpatient counseling and therapeutic communities) were found to be more effective in reducing rearrest and in improving employment outcomes. All treatment interventions were effective in reducing opioid use.

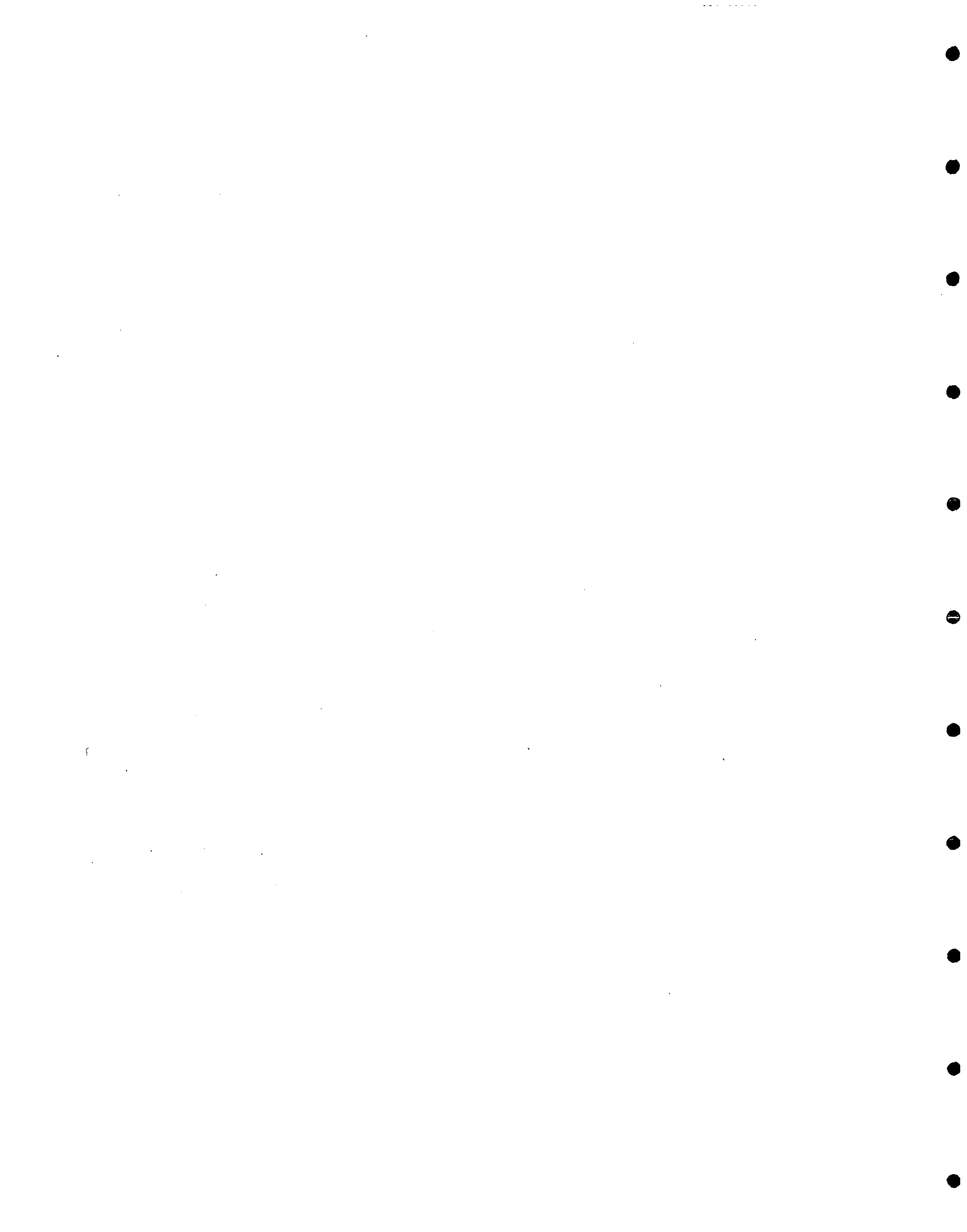
Long-term outcome data from the DARP sample (Simpson, et al., 1982) indicates that while approximately 60% of the initial sample returned to treatment within five years, each return to treatment was associated with increasingly favorable outcomes (Simpson, 1984). Of the 61% who had achieved at least one year of abstinence, 75% had become abstinent while actively engaged in some treatment activity (Simpson et al., 1982). At the twelve year followup 63% of the sample had been abstinent for a period of at least three years. The best predictor of favorable outcome at the 12-year followup was the social adjustment levels obtained at the time of six-year followup, indicating that interventions that enhance social adjustment have more lasting effects (Simpson and Marsh, 1986). The study also revealed that treatment of less than 90 days duration is of extremely limited benefit. After 90 days, increased duration of treatment leads to increasingly favorable outcomes (Simpson, 1984).

Although there have been few well-controlled studies evaluating the effectiveness of prison-based drug treatment programs, the available research indicates a potential for favorable outcomes in reducing recidivism. One of the few prison drug treatment programs that has been extensively evaluated



is the "Stay-N-Out" program in New York (Wexler, Lipton, and Falkin, 1990). This program was developed in 1977, and is a modified therapeutic community (TC) that is isolated from the general prison population. Major features of the Stay-N-Out program are: 1) a highly structured schedule of daily activities, 2) positive reinforcement of good conduct through provision of progressively greater responsibilities to inmates, 3) hierarchical organization of inmate jobs and social roles according to progress in the program, and 4) extensive interaction with non-prison TC's (e.g., halfway house programs). Findings from the followup of 376 offenders participating in the Stay-N-Out program indicate that 80% of inmates completing nine months of treatment had no subsequent parole violations, compared with a 50% parole violation rate for inmates who dropped out before completing three months of treatment, a 56% parole violation rate for long-term residents of other less intensive prison-based TC's, and a 47% parole violation rate for inmates receiving long-term counseling. Results showed that only 27% of Stay-N-Out participants were arrested following treatment during a followup period that ranged from one to five years, compared to a 35% arrest rate of other TC program participants, a 42% arrest rate of inmates placed in waiting list groups, and a 50% arrest rate of inmates treated in counseling groups. During the followup period, offenders participating in the Stay-N-Out program remained in the community without rearrest for an average of nearly twice as long as offenders receiving other types of treatment. (Wexler, et al., 1988; see Appendix C for a description of the program).

Vigdal (in press) evaluated a sample of 67 offenders released from prison after completing drug treatment within the Wisconsin Department of Corrections Drug Abuse Treatment Unit (DATU) between 1982 and 1989. The DATU program is a long-term therapeutic community that encourages lifestyle change, promotes pro-social behaviors, and includes a major focus on identification and correction of criminal thinking patterns. Offenders selected for the DATU program have an extensive history of polydrug use, a lengthy criminal history, and are often classified as character disordered or sociopathic. Despite the profile of chronic drug abuse and criminal behavior among inmates selected for treatment, evaluation results indicate that the DATU program is quite effective in reducing recidivism. After two years of discharge from the program, only 6% of program participants returned



to Wisconsin state prisons, compared to 33% of untreated state prison inmates. DATU inmates were significantly less likely to be reincarcerated (22%) in the five years following release from prison in comparison to untreated inmates (42%).

Field (1985) evaluated a sample of 220 offenders discharged from the Cornerstone program, a comprehensive 6-18 month residential program for drug-involved state prison inmates in Oregon (see Appendix D for a description of the Cornerstone program). The Cornerstone program provides comprehensive treatment services with a focus on development of basic social skills, life skills, and modification of criminal values and patterns of thinking. Treatment is provided through group and individual counseling and includes interventions for specific social, psychological, and interpersonal problems identified through an individualized treatment plan. Inmates selected for the Cornerstone program have a chronic history of drug abuse, with an average age at initial drug use of 12.5. Treated offenders average almost 14 adult arrests and over seven years of adult incarceration. Within three years of release only 29% of offenders completing the Cornerstone program were rearrested, compared to a 37% rearrest rate for untreated drug involved parolees released in 1974,[1] and a 74% rearrest rate for inmates who dropped out of the Cornerstone program after completing less than 30 days of treatment. A later evaluation of 1983-1985 Cornerstone graduates (Field, 1989) showed that over a three-year post-release period only 26% of program graduates returned to state prison, compared to 85% of offenders discharged from the program in the first 60 days of treatment. During the post release followup period, a significantly lower proportion (63%) of program graduates were rearrested, compared to a 92% rearrest rate for offenders who had been discharged before completing 60 days of treatment.

An evaluation conducted by the Washington State Department of Corrections (1988) examined the effectiveness of a short-term drug treatment program (5-9 weeks) and found only 21% of inmates receiving short-term correctional drug treatment were rearrested during a two-year followup period. This reflected only a slight improvement over the 29% of untreated inmates who were rearrested.

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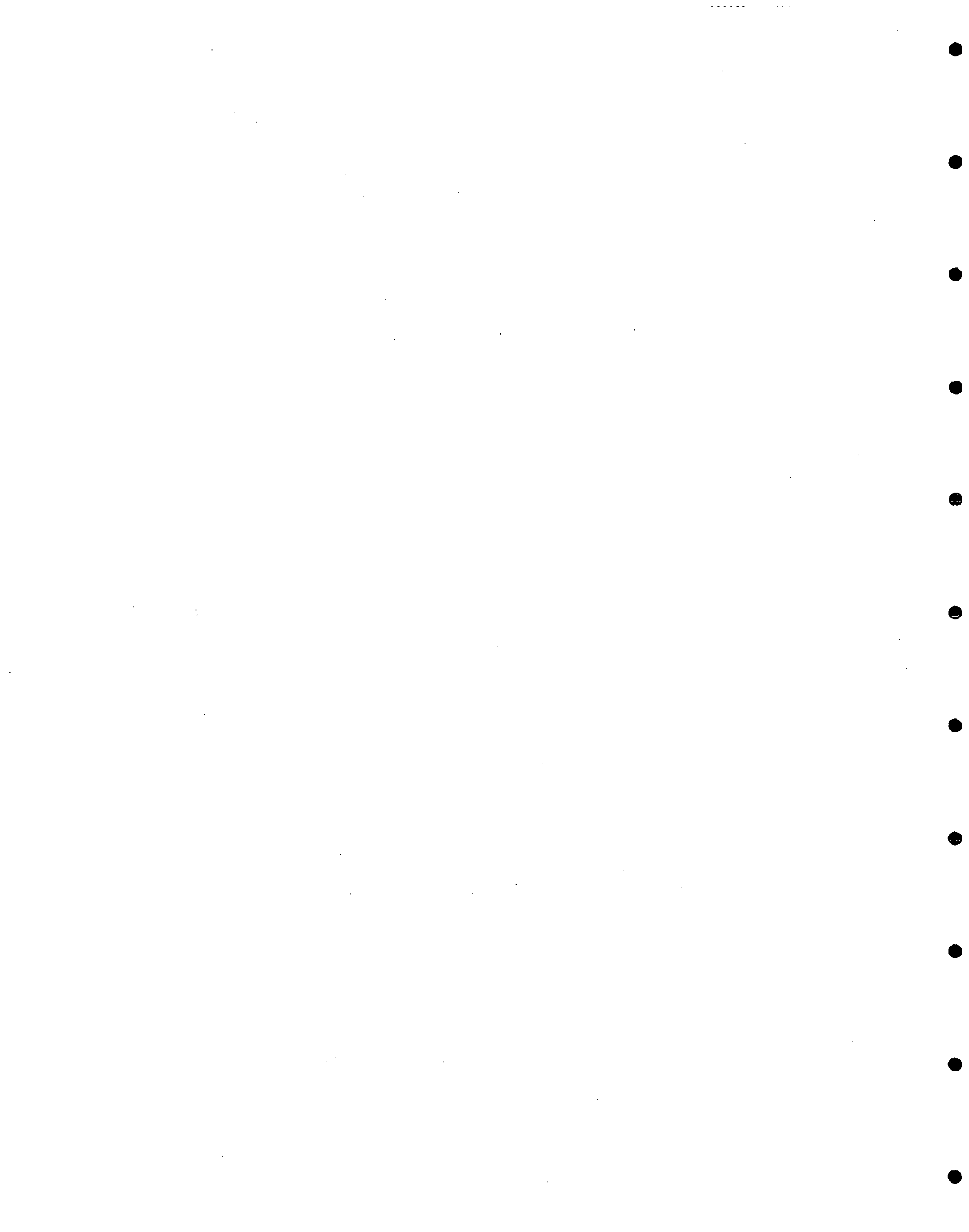
[1] A comparison group of untreated drug-involved parolees in Michigan were also tracked and showed a rearrest rate of 50%.



Principles of Effective Correctional Treatment

Several intensive drug treatment research reviews evaluate correctional treatment program effectiveness for offenders and provide guiding principles for the design of treatment programs for the drug-involved offender. Based on a review of 400 studies of drug treatment, criminal rehabilitation, and juvenile programs of six months to three years in duration, Gendreau (1989) concluded that 40-70% of the programs reduce recidivism depending upon the type of program reviewed. Reductions in recidivism range from 10% to 50%. Findings from the survey indicated that correctional programs matched to inmates' risk levels, needs and abilities are generally successful in reducing recidivism and increasing positive outcomes.

Gendreau's research reviews are consistent with similar studies conducted by Garrett (1985), Davidson, Gottschak, Geesheimer, and Mayer (1984). A research review conducted by Izzo and Ross (in press) found, in addition, that cognitive-behavioral programs achieved overall treatment gains that were twice that of other programs and that community-based programs reported greater levels of success than institutional programs. Work conducted by Bandura (1979), Millon (1981), and Yochelson and Samenow (1976) also indicate that learned behavior, thoughts, and beliefs can be positively changed through cognitive-behavioral treatment in a structured correctional setting. Gendreau (1989) notes that the most successful correctional treatment programs use multimodal treatment approaches that are primarily cognitive-behavior in nature, have a foundation in social learning theory, and include clearly specified goals, procedures and program interventions. Maxine Stitzer, medical research chief in the Department of Psychiatry at the Francis Scott Key Medical Center in Baltimore, echoes these findings in a recent edition of the American Psychological Association Monitor (1990):

> ". . . a multimodel approach may be the most practical, because the problems of the drug abuser will be addressed from a variety of perspectives, one or more of which may be effective in promoting change in a given individual".

Comprehensive surveys of correctional treatment programs (Andrews and Kiesling, 1980; Gendreau and Ross, 1984; Wexler, et al., 1988) indicate the following guiding principles for effective treatment:

1. Provide clear consequences for behavior. Structures exist within the program to clearly describe positive and negative consequences for behaviors within the treatment unit. Program rules, regulations and guidelines are reinforced through formal and informal sanctions.

2. Isolate offenders in drug treatment from the general inmate population. An isolated treatment unit within a correctional setting removes the offender from the criminal influences of the general prison population, and provides a milieu in which pro-social behaviors are strictly enforced and constantly modeled through a peer support network. The social environment of the treatment program is seen as equally important to the types of interventions presented (Field, 1989).

3. Encourage anti-criminal modeling and reinforcement of pro-social behaviors. Program staff provide clear models of anti-criminal behavior and reinforce pro-social behaviors, thoughts, and cognitions, helping to re-orient the inmates's criminal value system.

4. Promote the development of problem-solving skills. This type of intervention assists inmates to learn effective pro-social behaviors to deal with interpersonal and social problems.

5. Reinforce use of cognitive-behavioral strategies. Offenders are instructed in self-management techniques, including self-monitoring and restructuring of criminal thinking and other maladaptive thoughts. Ample opportunities are provided to rehearse and overlearn these techniques.

6. Utilize multimodal treatment approaches. Effective programs work to remediate and address the multiproblem lifestyle of the offender and multiple skills deficits (e.g. vocational, interpersonal, psychological) that inhibit successful recovery from drug dependence. Diverse treatment strategies are necessary and appear to be complimentary in addressing the complex problems of the drug-dependent offender.

7. Employ a group treatment format. Most effective drug treatment programs rely heavily on group treatment, in addition to individual counseling and didactic interventions. Not only is this format cost-effective, but the group support and confrontation are critically important in removing barriers of denial and resistance during the recovery process.

8. Provide a highly structured treatment milieu. Addicted offenders perform best with a wide variety of structured activities and a full weekly schedule. An intensive program of services encourages commitment to treatment and self-discipline and is crucial in addressing the many skill deficits and areas of dysfunction among this population (Field, 1989).

9. Allow for intensive and lengthy involvement in treatment. Results of the Drug Abuse Reporting Program indicate that outcomes for individuals in treatment for less than 90 days are similar to those for individuals who received no treatment. Success rates in methadone maintenance, therapeutic communities, and outpatient programs all increase

linearly as a function of length of treatment (Simpson, 1984; DeLeon, Wexler, and Jainchill, 1982). The Bureau of Justice Assistance recommends placing drug abusing inmates in treatment for 9-12 months prior to release on parole (Wexler, et al., 1988).

10. Provide a graduated reentry to the community. Successful drug treatment programs assist the inmate in the transition to the community to ensure adherence to the recovery plan (Field, 1989; Wexler and Williams, 1986). Based on data from the California Civil Addict Program, Anglin (1988) concluded that the most effective format for drug treatment involves several months of residential treatment coupled with a lengthy followup period that includes frequent monitoring and drug testing. Aftercare services are also strongly recommended by the Bureau of Justice Assistance, in the guidelines for in-prison treatment programs (Wexler, et al., 1988).

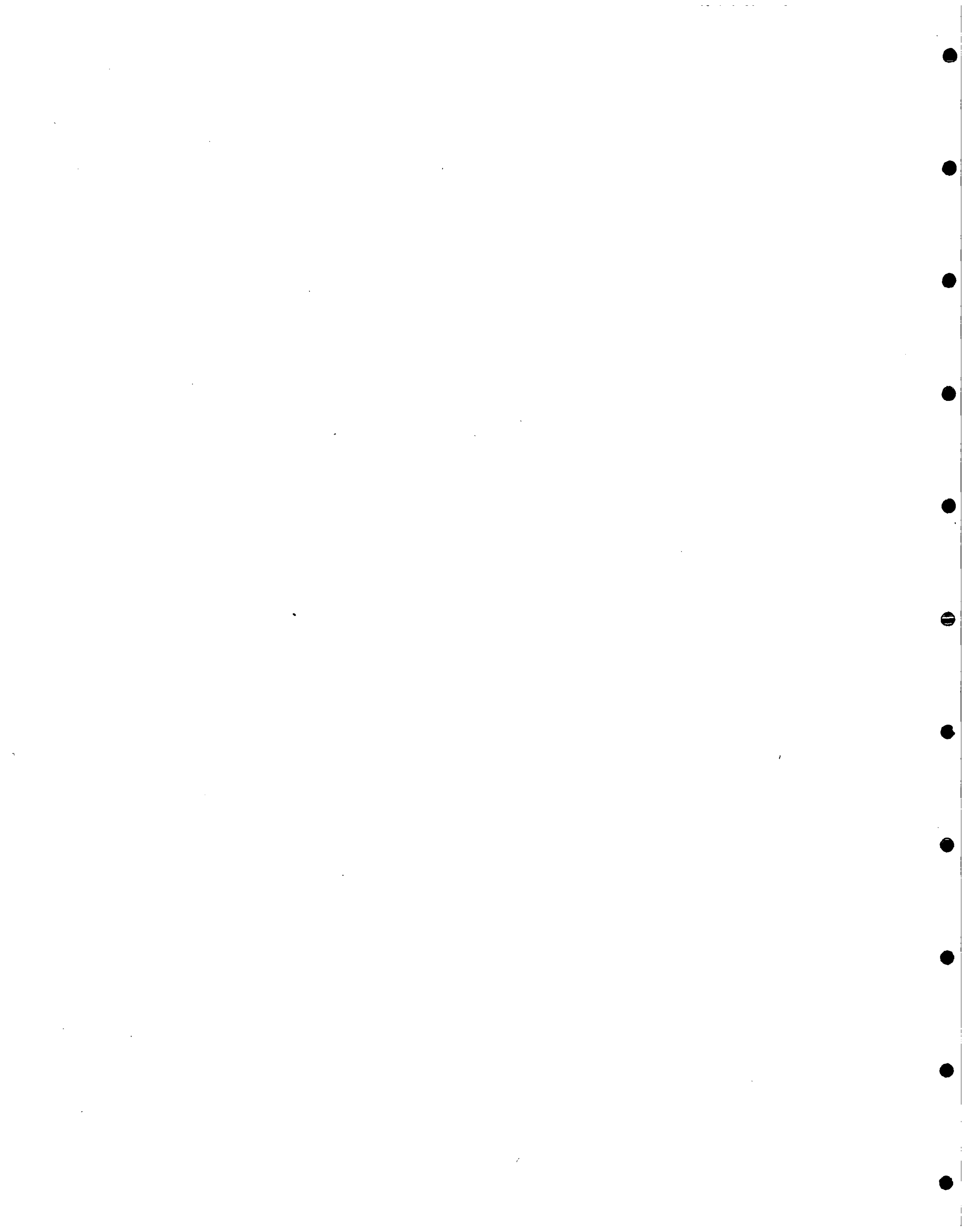
Effective Drug Treatment Interventions

In addition to the principles of effective correctional treatment described above, several specific interventions appear to enhance the effectiveness of drug treatment programs for offenders. The following interventions are consistently cited in the drug treatment literature as essential components of effective treatment, and should be addressed in developing a comprehensive drug treatment program for STOP offenders:

1. Assessment. Barton (1982) states that baseline assessment enhances inmate accountability and facilitates classification, problem identification, and needs assessment. Since drug abuse affects cognitive processes, an in-depth assessment is required to evaluate the offender's mental state and any concurrent psychiatric problems (Craig, 1988). Washton (1987) recommends an extensive history of all previous drug-related behaviors and consequences in order to counteract resistance and denial in treatment.

2. Drug/AIDS Education. Drug education is a primary goal during the first 30 days of many inpatient and outpatient drug treatment programs. Understanding the nature of chemical dependency and the stages of recovery can help the offender evaluate his progress and to avoid potential relapse due to misconceptions about urges and cravings. Knowledge of high risk AIDS behaviors can also help deter drug use (Becker and Joseph, 1988; Des Jarlais and Friedman, 1988). The majority of U.S. prison-based treatment programs (76%) include a drug education component (Tims, 1981).

3. Skills-Based Interventions. Highly structured programs designed to encourage the acquisition and rehearsal of problem-solving, stress management, urge coping, interpersonal and other skills appear to hold considerable promise in the treatment of drug-dependent offenders (Kadden, Cooney, Getter, and Litt, in press). This study



suggests that skills-based interventions may be more effective than traditional group therapy approaches for drug abusers with anti-social characteristics.

4. Relapse Prevention. Development of relapse prevention skills is an important component of drug treatment, and serves to enhance the maintenance of drug-free behaviors following completion of treatment (Brownell, Marlatt, Lichtenstein, and Wilson, 1986). In developing such skills, Washton (1987) recommends examination of predictable behavioral antecedents that occur prior to relapse, and development of coping skills to help avoid and manage high risk situations for relapse.

5. Urinalysis. Frequent urinalysis provides a strong deterrent to relapse for substance abusing offenders. The Bureau of Justice Assistance guidelines for prison-based drug treatment programs recommend urinalysis upon arrest, during treatment, and during aftercare (Wexler et al, 1988). Findings from the California Civil Addict program indicate that frequent urinalysis was commonly the most important intervention in maintaining successful recovery from drug dependence (Anglin, 1988).

Chapter 3

ASSESSMENT PROGRAM

Overview and Rationale

Assessment for the STOP program will include multitiered screening designed to select offenders whose criminal activity is directly linked to habitual drug use and who are amenable to drug treatment. The initial stage of assessment involves probation officers or judges who screen for eligibility using criteria described in CS/CS/HB 1810.[1] Eligible candidates are assessed after referral for a more extensive evaluation by a community assessment provider.[2] This assessment uses objective instruments to determine which offenders are amenable to, and would benefit from treatment in the STOP program. Assessment providers ensure that initial eligibility requirements have been met. The assessment examines evidence of early and serious drug abuse and of clear association between drug use and criminal behavior. The assessment program will target offenders for whom less restrictive community drug treatment has been unsuccessful, or for whom needed drug treatment is unavailable in their community, and who do not present evidence of serious mental illness, violent or disruptive behavior. Evidence of exposure to the AIDS virus or of pregnancy at the time of initial screening or of eligibility assessment will not prevent a probationer's admission to the STOP program unless specialized medical services appear to be required. The final assessment report issued by the provider will guide the

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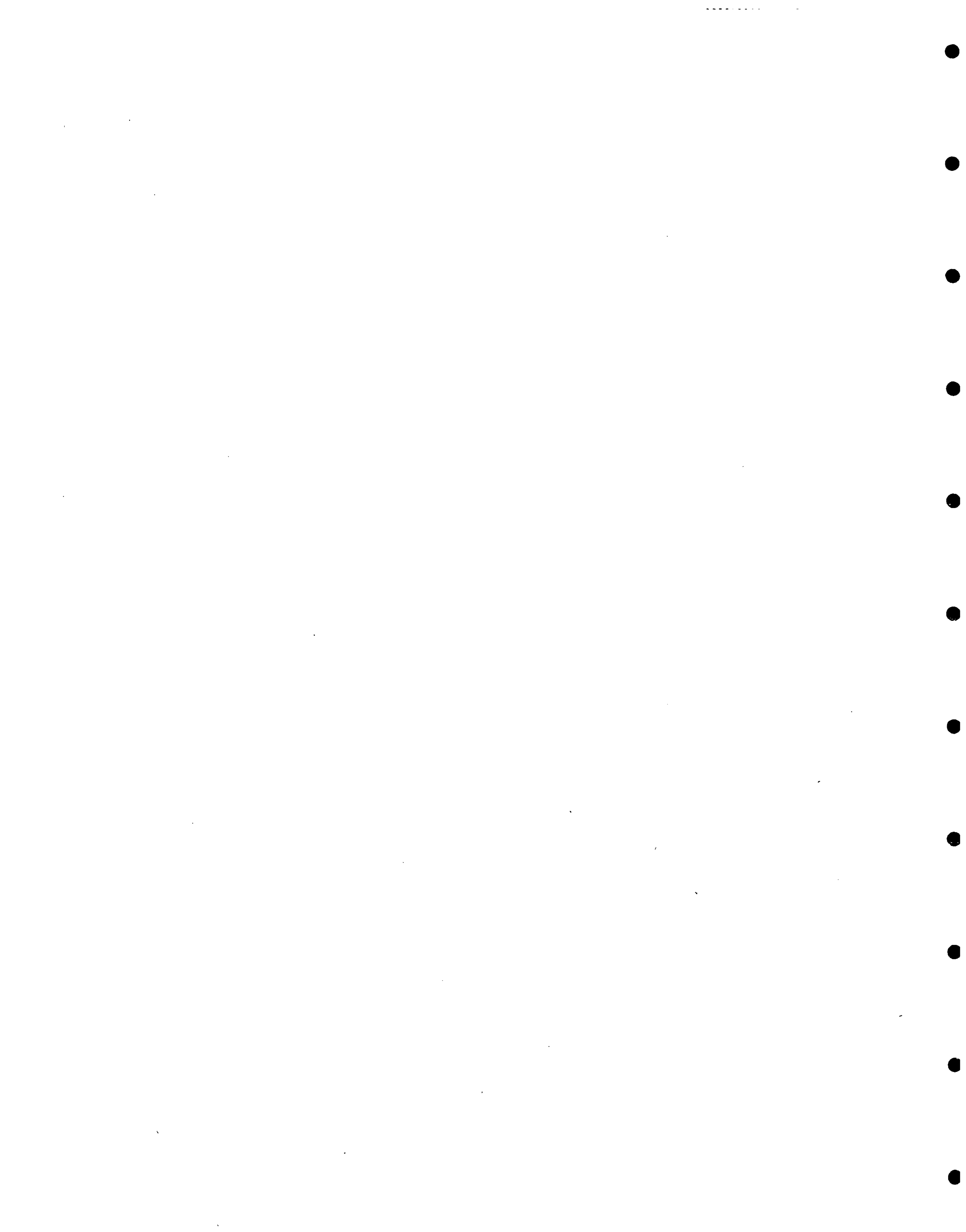
[1] "Adult STOP offender" means an adult felony offender who is not classified as a youthful STOP offender pursuant to subsection (1) and who is sentenced to the state correctional system and who meets the following criteria: (a) has been convicted for three or fewer felony offenses, none of which constitutes a capital or life felony or results in classification as a mentally disordered sex offender, and has not served more than a total of 19 months in a state correctional facility; and (b) has been convicted of a violation of chapter 893 or s. 316.193. Is believed by the court, based upon reasonable grounds, to have engaged in criminal activity due to habitual substance abuse; or has voluntarily admitted to the habitual use of a controlled substance or the abuse of alcohol and has requested treatment."

[2] Due to the potential conflict of interest of treatment providers selecting the clients admissible to the STOP program, the STOP legislation requires that assessment providers not be the same vendors who provide STOP treatment. Such a conflict of interest can also be controlled by careful quality assurance monitoring.



probation officer and court in modifying terms of probation to admit an offender to the STOP program. Admission to the STOP program requires a recommendation to admit a probationer to a STOP facility.

Assessment Goals

Specific goals of the STOP assessment program include:

(1) Identification of probationers that are likely to benefit from drug treatment due to an early onset of drug abuse and dependence and a pattern of intense and/or chronic drug use.

(2) Identification of individuals who present the greatest risk of recidivism to the criminal justice system due to a history of crime attributable to drug abuse.

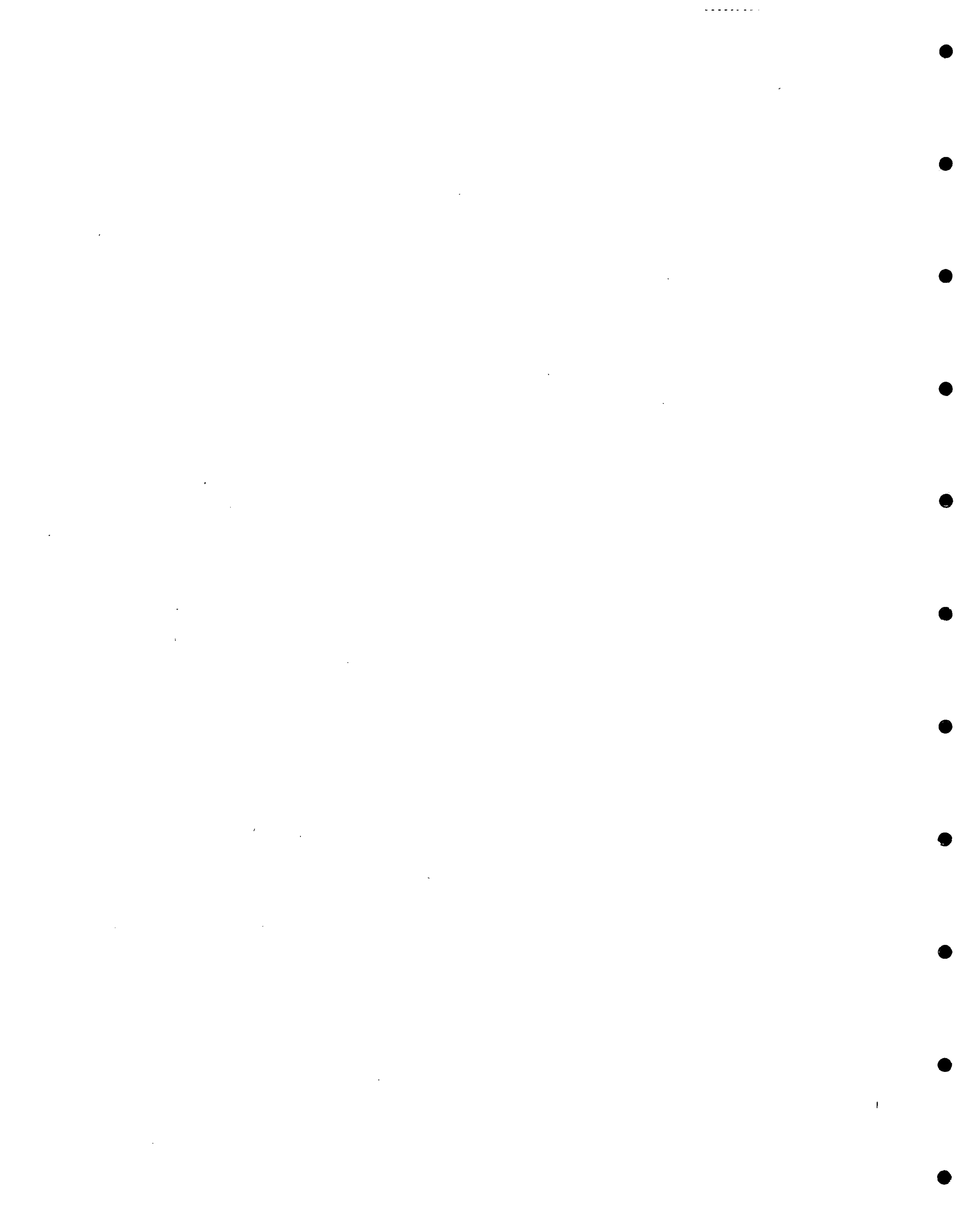
(3) To discourage admission of violent offenders and/or sex offenders who present an unreasonable threat to the community if diverted from a prison bed to the STOP program.

(4) To prevent admission of drug-involved offenders who can be treated in a less restrictive program.

(5) To provide diagnostic information and psychosocial history to identify potential behavior problems and other need areas for treatment staff that should be assessed in more detail during program intake and treatment planning.

(6) To identify probationers who would be committed to a Florida Correctional Institution if not for assessment as eligible for the STOP program.

(7) To provide a timely and informative report to probation officers and the court describing STOP eligibility status and recommendations for drug treatment.



Procedures

Initial Screening

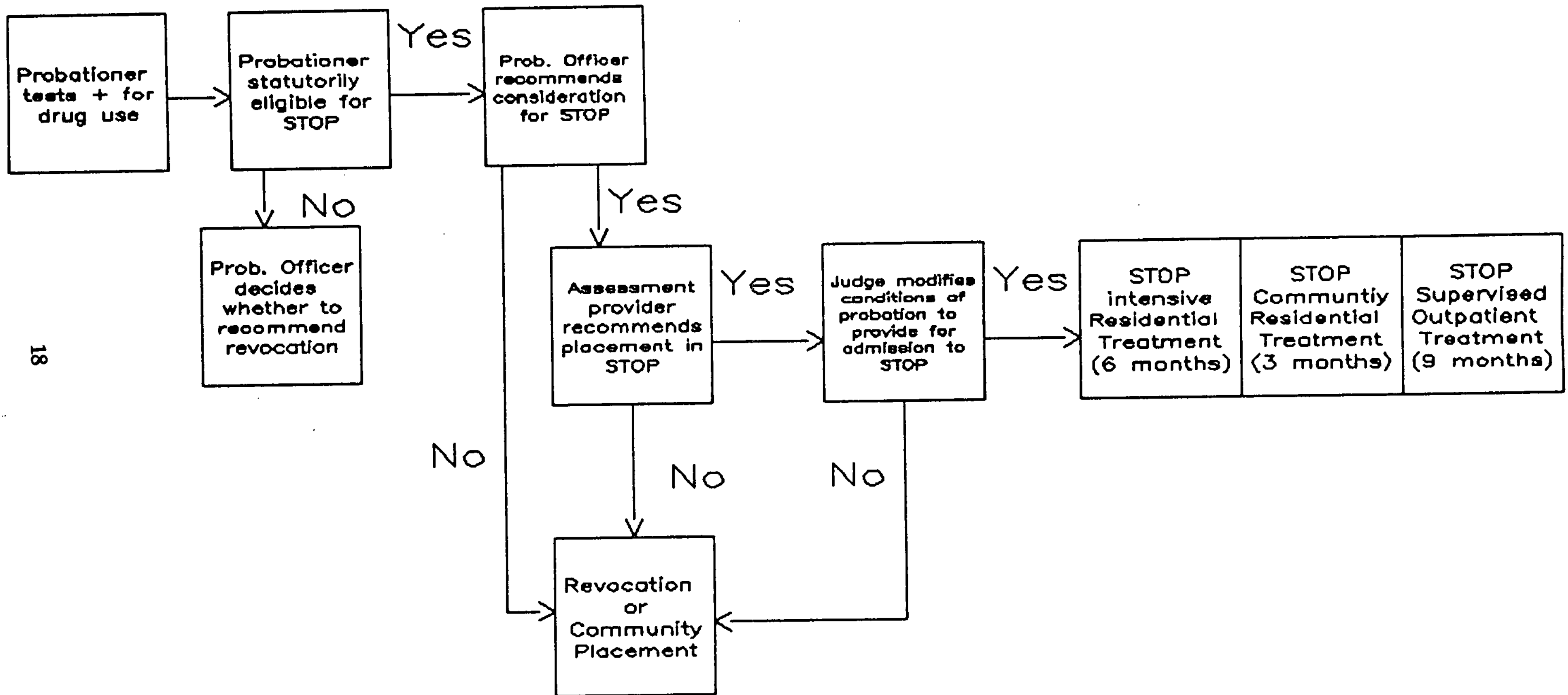
Probation officers or judges having an opportunity to review probation status and disposition for a probationer believed to have violated conditions of probation due to continuing drug use shall conduct an initial screening for the STOP program (see Figure 1). A STOP screening instrument (see Appendix E) is completed as part of the initial screening. This instrument reviews statutory criteria for STOP eligibility, including guidelines regarding prior felony convictions, prior prison time served, and evidence of criminal activity related to habitual substance abuse or voluntary admission of habitual substance abuse. In addition, the screening instrument requires probation officers or judges to review and enumerate the presence of a drug-related probation violation, the potential of at least 18 months of supervision remaining if the violation is substantiated, and obstacles to placing the probationer in a less restrictive community drug treatment program.

Referral

All probationers determined to be eligible for the STOP program will be referred for comprehensive assessment. The assessment provider will be located within the judicial circuit of the referring probation officer or court. Whenever possible, several assessment providers (or providers) will be appointed within a circuit in order to provide flexibility in responding to assessment referrals and to ensure that reports are returned in a timely manner. It is recommended that at least three assessment providers be selected by the Department of Corrections in highly populous judicial circuits. Assessment offices will be established by the STOP provider accessible to probation offices in each circuit. Whenever possible, several assessment offices will be maintained by the provider in densely populated judicial circuits. Assessment providers will have the capability of conducting assessments in county jails

Figure 1:

SERIOUS TARGETED OFFENDERS PROGRAM



or at other acceptable sites within the circuit when it is determined that the probationer is unable to travel to the assessment office.

Requests for STOP assessment will be accompanied by a copy of the STOP screening instrument. All available records describing the offender's substance abuse, psychosocial, and criminal histories, including urinalysis results, prior participation in drug treatment, arrest records, probation violations, and any other pertinent Department of Corrections records will be provided. If, in the initial screening for the STOP program, it is determined that necessary drug treatment in the community is unavailable or inappropriate, the request for STOP assessment will be accompanied by a description of drug treatment facilities that were considered and judged to be inappropriate. Additional information may be requested from the referral source by the assessment provider.

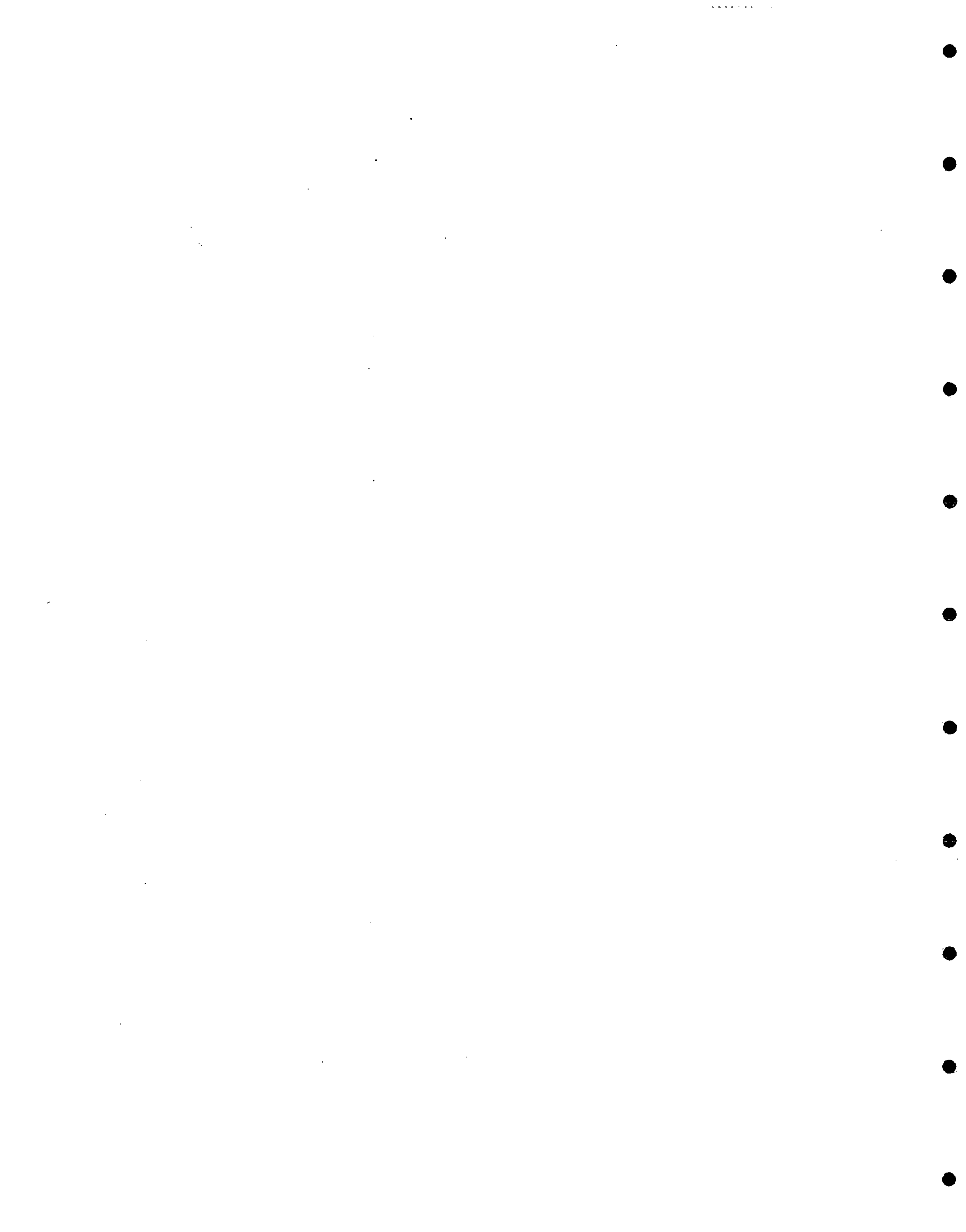
Each STOP assessment report will be completed and delivered to the probation officer or court within 72 hours (three working days) of receiving the request, unless waiver of this time limit is authorized.[3] The rapid response to a request for STOP assessment will allow the court to modify the conditions of probation for probationers accepted to the program at the hearing. The STOP assessment will include an interview and diagnostic testing as deemed necessary by the provider. Assessment staff may also contact collateral sources of information (e.g. family members, previous treatment counselors, etc.) after obtaining a release of information from the probationer.

Content Areas

The STOP assessment will address, at minimum, the following areas:

1. History of drug use and dependency. The examiner will assess the severity of past drug use and the relative risk of drug relapse. Information will be gathered to determine age at first drug use, age first used drugs regularly, number of years of drug use, present age of the offender, the pattern of drug use in the month prior to the last

[3] Such a time line is seen as necessary to avoid adding to local jail overcrowding problems and to ensure timely feedback to the courts.



arrest, and the type, amount (e.g. quantity ingested per week) and frequency of past drug use including use of cocaine or polydrug use in the month prior to the last arrest. Assessment staff will also attempt to determine if the probationer has administered drugs intravenously within the previous two years. Symptoms of drug dependency will be assessed including evidence of a compulsive pattern of drug use, loss of control over drug use, and adverse effects of drugs on physical or psychosocial functioning.

2. History of crime related to drug use. The examiner will attempt to gauge the effect of drugs on criminal behavior. Information obtained will include use of drugs at the time of the last arrest and during probation, history of drug use during past offenses, history of crime to support drug use, the duration of time between the first felony arrest (including juvenile arrests) and the first period of regular drug use, the number of felony arrests prior to the first period of regular drug use, and the number of prior probation violations related to drug use in the past year.

3. History of drug treatment. The assessment will describe the course of any previous drug treatment (of greater than one week) received in the community, especially while placed on probation.

4. Mental health symptoms. The examiner will conduct an assessment for depression, thought disorder, and other mental health symptoms or disorders that might interfere with participation in the 18-month STOP program. A treatment plan will be recommended for dually diagnosed probationers, only when such treatment is seen as manageable in the STOP program.

5. Recent violent or aggressive behavior. The assessment will determine whether a probationer presents an imminent risk of disrupting STOP treatment activities. If recent violent or aggressive behavior is indicated, the examiner will describe the behavior and the presence of recent threats or acts of violence by the probationer which might interfere with participation in the STOP program.

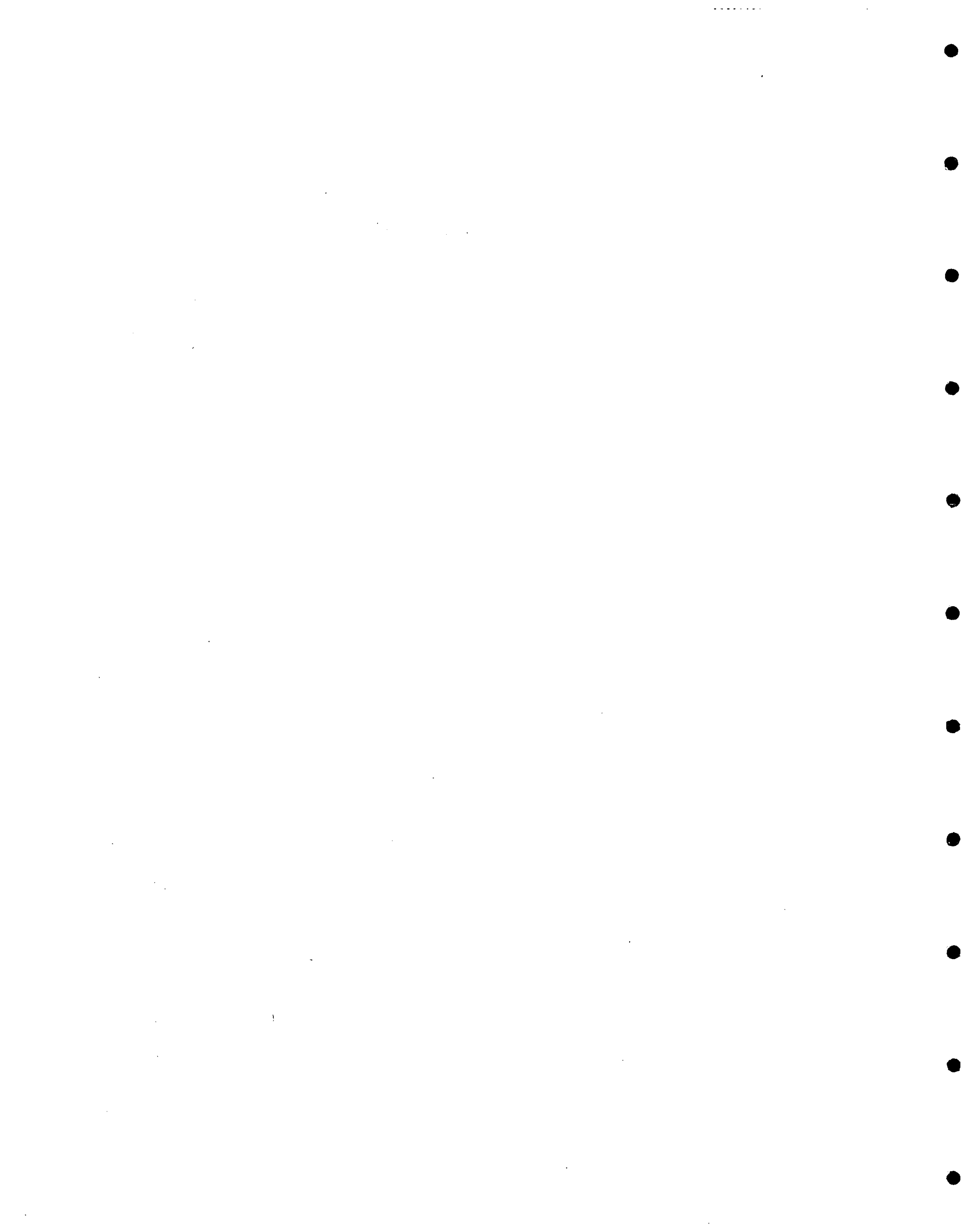
Assessment providers are required to use standardized assessment instruments in evaluation of probationers referred as eligible for the STOP program. Assessment staff are recommended to use the Addiction Severity Index (ASI) or the U.C.L.A. Natural History Interview Form to gather information regarding history of drug use and dependency, history of crime related to drug use, and the history of drug treatment (see areas 1, 2, and 3 above). These instruments should be modified as needed to include assessment of intravenous drug use, involvement in drug treatment while on probation, and response to treatment. Assessment staff are recommended to use the Minnesota Multiphasic Personality Inventory (MMPI, or MMPI-2), the SCL-90, or the Referral Decision Scale (RDS) to assess mental health symptoms likely to impact on treatment (see area 4 above). All recommended instruments are included in Appendix F. Use of standardized testing should be supplemented by a focused interview

with the probationer to evaluate each of the five key areas described above to verify or elaborate responses provided during testing and to examine inconsistencies observed in these responses.

When a probationer is determined to be withholding information requested or is significantly distorting such information, the assessment staff may elect to terminate the evaluation. The staff member will inform the probationer of the rationale for termination of the assessment and will provide the referral source with a written description of this decision. Staff choosing to continue the assessment after determining that information is being withheld or is false will document these observations and may proceed to complete the STOP eligibility assessment protocol on the basis of adjunctive information provided from probation records and other collateral sources.

Eligibility Assessment Instrument

Assessment staff will be required to complete a STOP eligibility assessment instrument for each probationer evaluated. A sample instrument is included in Appendix G and provides an example of recommended content areas to be assessed. These areas will be weighted in scoring to enhance objective evaluation of eligibility for the STOP program. The instrument provides an objective method for evaluating amenability and need for treatment in each of the critical areas described above. In addition, the instrument ensures that vital areas of information are consistently and comprehensively examined during each assessment. The instrument also provides a method for examiners to identify and evaluate additional assessment findings that support or detract from the probationer's eligibility for treatment in the STOP program. Critical areas of information to be included in the eligibility assessment instrument will be reviewed and modified as needed by the STOP advisory board prior to program implementation. The instrument will also be field tested with a probation sample to determine weighted scores for each content area and an appropriate range of cutoff scores for eligibility to the STOP program. This cutoff range will be periodically revised and modified by the evaluation and quality



assurance staff in consultation with the advisory board, based on the research findings from the Quality Assurance program. In completing the STOP eligibility assessment instrument, assessment staff will evaluate several content areas (e.g. history of drug use) and the research staff will provide a weighted score for each area. As an example of a weighted scoring procedure, a score of five on the sample instrument in Appendix G reflects the greatest need for drug treatment and the least risk of behavior likely to interfere with treatment. A score of one reflects the lowest need for drug treatment and the greatest risk of behavior likely to interfere with treatment.

Assessment staff will compile an overall eligibility score for each probationer based on the STOP eligibility assessment. This score will reflect the sum of all weighted scores provided on the eligibility assessment instrument. A normative range of scores will be provided to the assessment staff to help guide recommendations for STOP admission. Assessment providers will ordinarily follow objective scoring guidelines and will use designated cutoff scores in making recommendations for STOP admission. Assessment staff will be required to provide a rationale for recommending admission to the STOP program in all cases in which objective scoring guidelines are not followed. If the assessment provider recommends against STOP admission, the assessment report will describe recommended drug treatment modalities and settings in the community for additional services that are needed to promote recovery from drug dependency. Other relevant factors that should be considered by the court, probation officers, or treatment providers in determining appropriate placement in drug treatment will be reported.

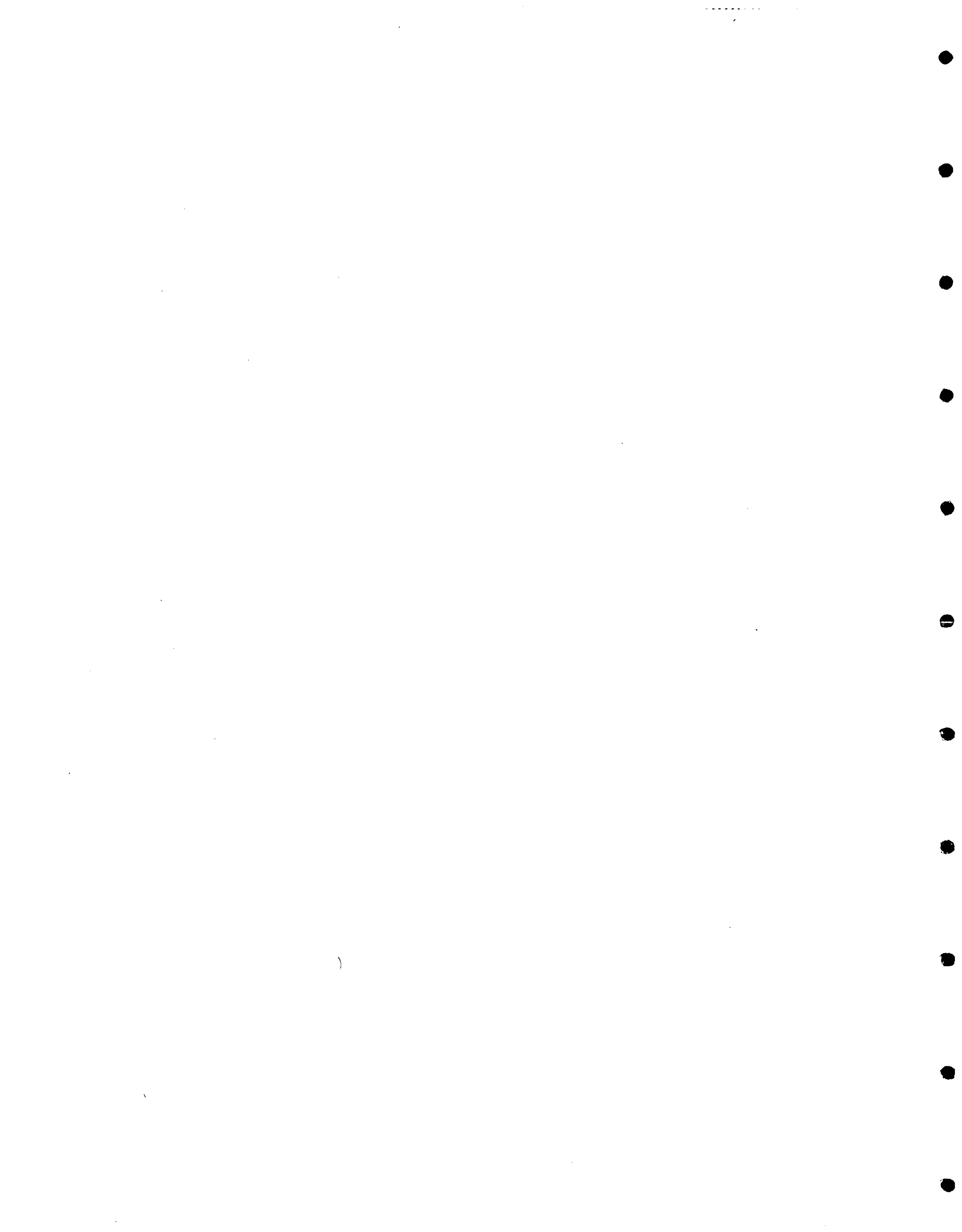
The completed STOP assessment report will describe date(s) of assessment, names of examiners, procedures used during the assessment, and all sources of information relied upon including probation records and reports, diagnostic instruments, and probationer and collateral interviews. A copy of the STOP eligibility assessment instrument will be attached to the report. All conclusions reached regarding amenability for treatment, drug dependence, and the presence of mental health symptoms or violent behavior that is determined to present a risk of disrupting treatment activities will be supplemented by a full description of how these conclusions were reached. The assessment staff will

send the report to the designated probation officer and will supply additional information or materials requested. When necessary and requested by the court, the assessment staff will travel to judicial/revocation hearings to offer testimony regarding the recommendations.

Probationers will be admitted to the STOP program only upon recommendation by a STOP assessment provider. In cases in which probation officers or judges disagree with these recommendations, a written request for review of the STOP eligibility determination may be submitted to an Assessment Review Committee and will detail the basis for disagreement with recommendations made in the STOP assessment report. This committee will make the final determination whether the probationer is eligible for admission to the STOP program. The Assessment Review Committee will consist of the STOP Quality Assurance Coordinator, the STOP Research Coordinator staff and at least one staff member each from an assessment provider, from the Department of Corrections, and from the Department of Health and Rehabilitative Services.[4]

Assignment to the STOP treatment program will occur following a probation revocation hearing in the Circuit Court. The court will review the results of the STOP assessment and other available information. For probationers determined by the assessment provider to be eligible for the program, the court may modify conditions of probation to provide for participation in the STOP program. The court will issue a standard order modifying conditions of probation to require the probationer to enter, participate fully in, and to successfully complete the STOP treatment program. Probationers ordered to receive treatment in the STOP program will be transported by probation staff in a timely manner to a STOP treatment facility within the same judicial circuit. If there is not an available bed in an existing STOP facility within the circuit, the probationer may be placed on a waiting list, and will be admitted

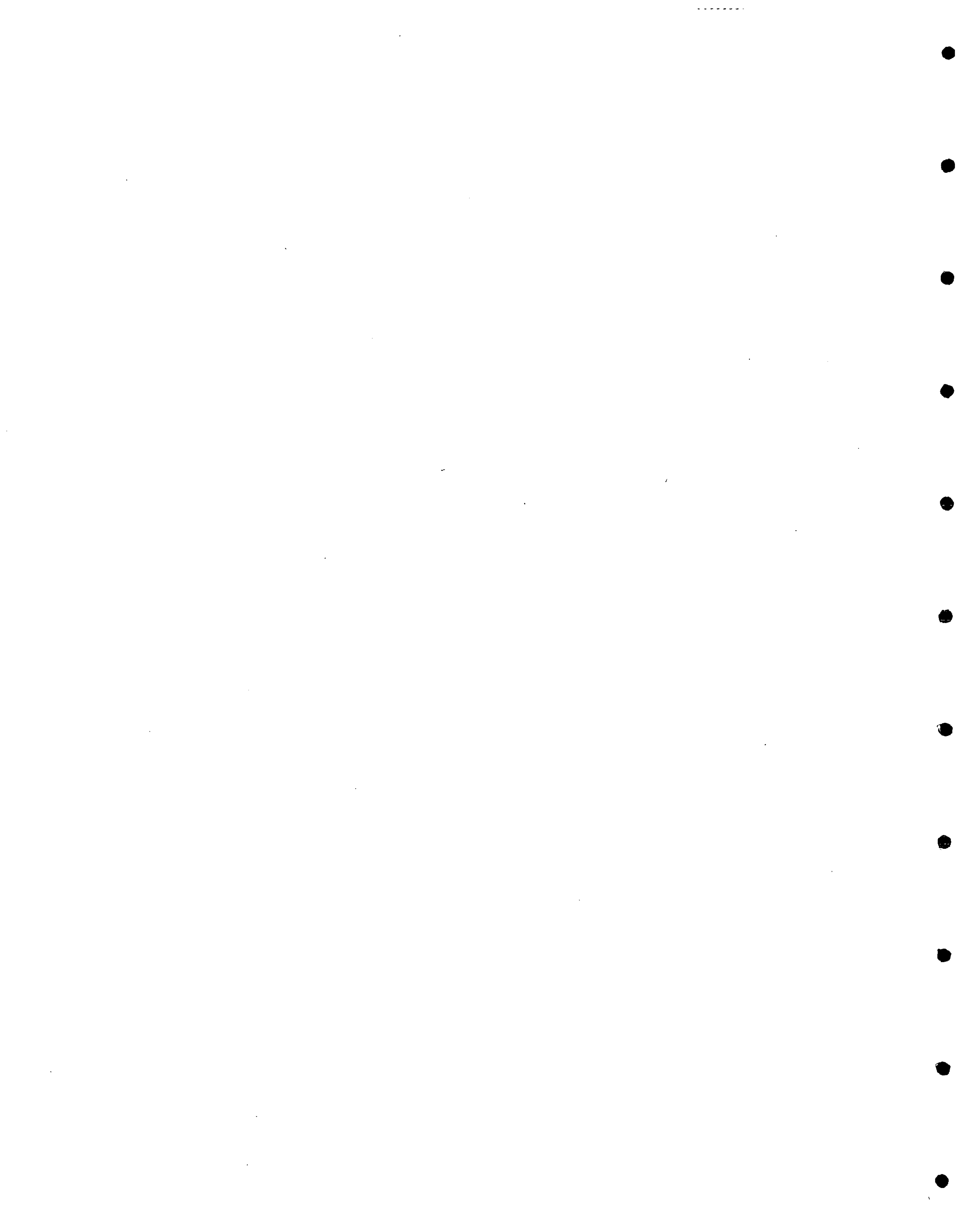
[4]Based on the results of these reviews, the quality assurance and research staff will issue updates to probation staff, the court, and STOP assessment providers indicating changes to, or clarification of criteria, and further elaborating guidelines based on the experience of the vendor staff and treatment outcomes.



to a STOP institution at the earliest possible date. Where revocation of probation is the only alternative to the STOP program, the person can be placed in the custody of DOC as part of a split sentence and transferred to a STOP facility when space is available. This option is with the court, and is possible when the expected waiting time is less than three months and is appropriate to the offender's needs as part of a shock probation approach where no less restrictive alternative is available.

Staffing Pattern

STOP assessment will be conducted by vendor staff within the community. Assessment will be conducted by staff with at least a Bachelor's degree and experience in assessment and treatment of drug-dependent clients. A STOP assessment coordinator who is licensed or license eligible as a mental health counselor, psychologist, or psychiatrist, or who is a "Qualified Supervisor" according to Florida Administrative Code 10(E)(16.003) will supervise assessment activities. The assessment coordinator will review each completed STOP assessment report to ensure comprehensive coverage of minimum content areas (see following section). The assessment coordinator will sign all completed reports. Qualification of STOP assessment staff will be reviewed by quality assurance staff prior to assessment program startup, and as needed thereafter.



Chapter 4

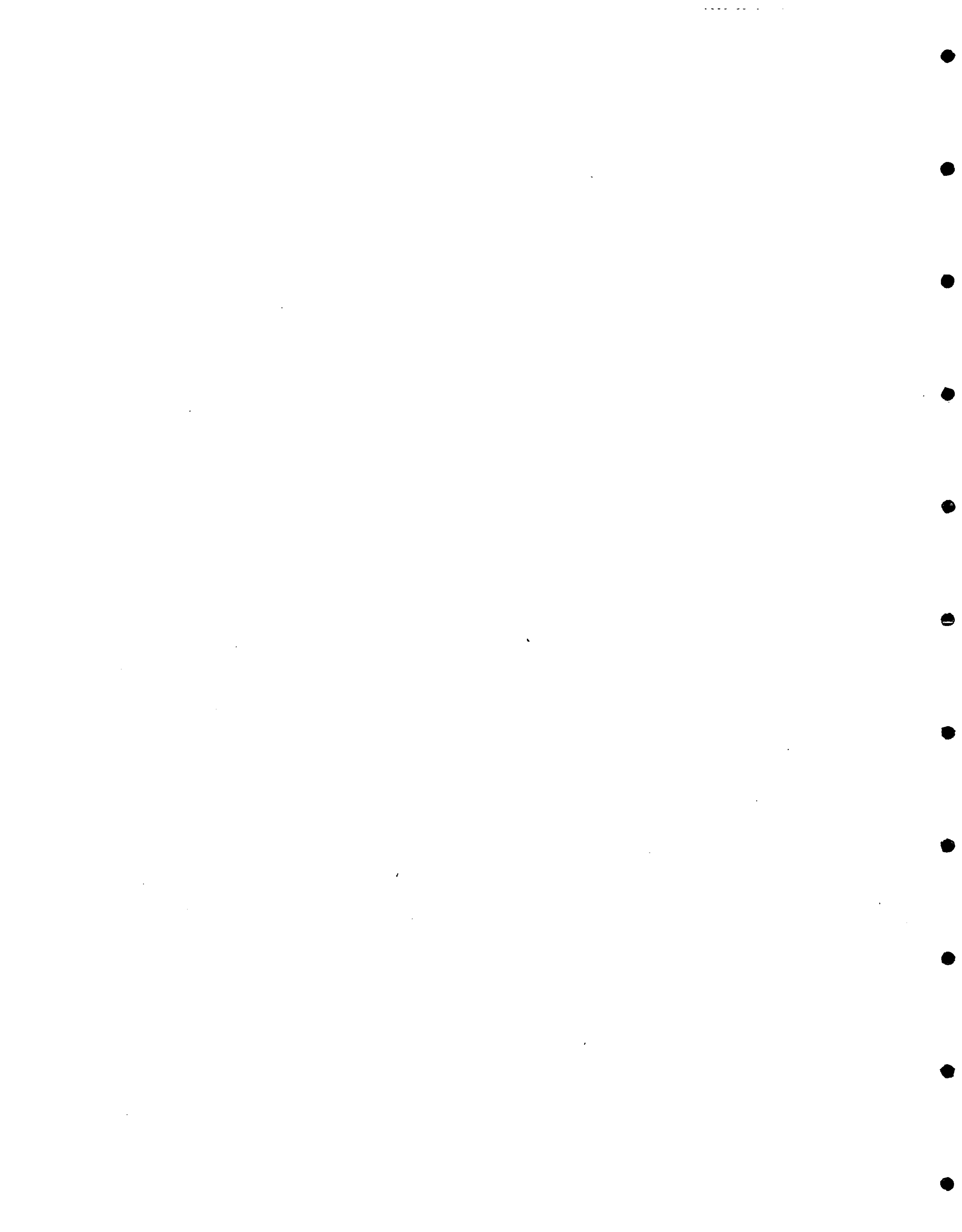
TREATMENT PROGRAM

Overview and Summary

The 1989 Florida Legislature enacted CS/CS/HB 1810, the Serious Targeted Offender Program (STOP) to target particular populations of offenders for either secure placement or for treatment programs to reduce rates of criminal recidivism. The Department of Law and Mental Health of the Florida Mental Health Institute has developed the following plan to address the needs of adult drug-involved offenders who show a causal link between their abuse of drugs and their criminal activity.

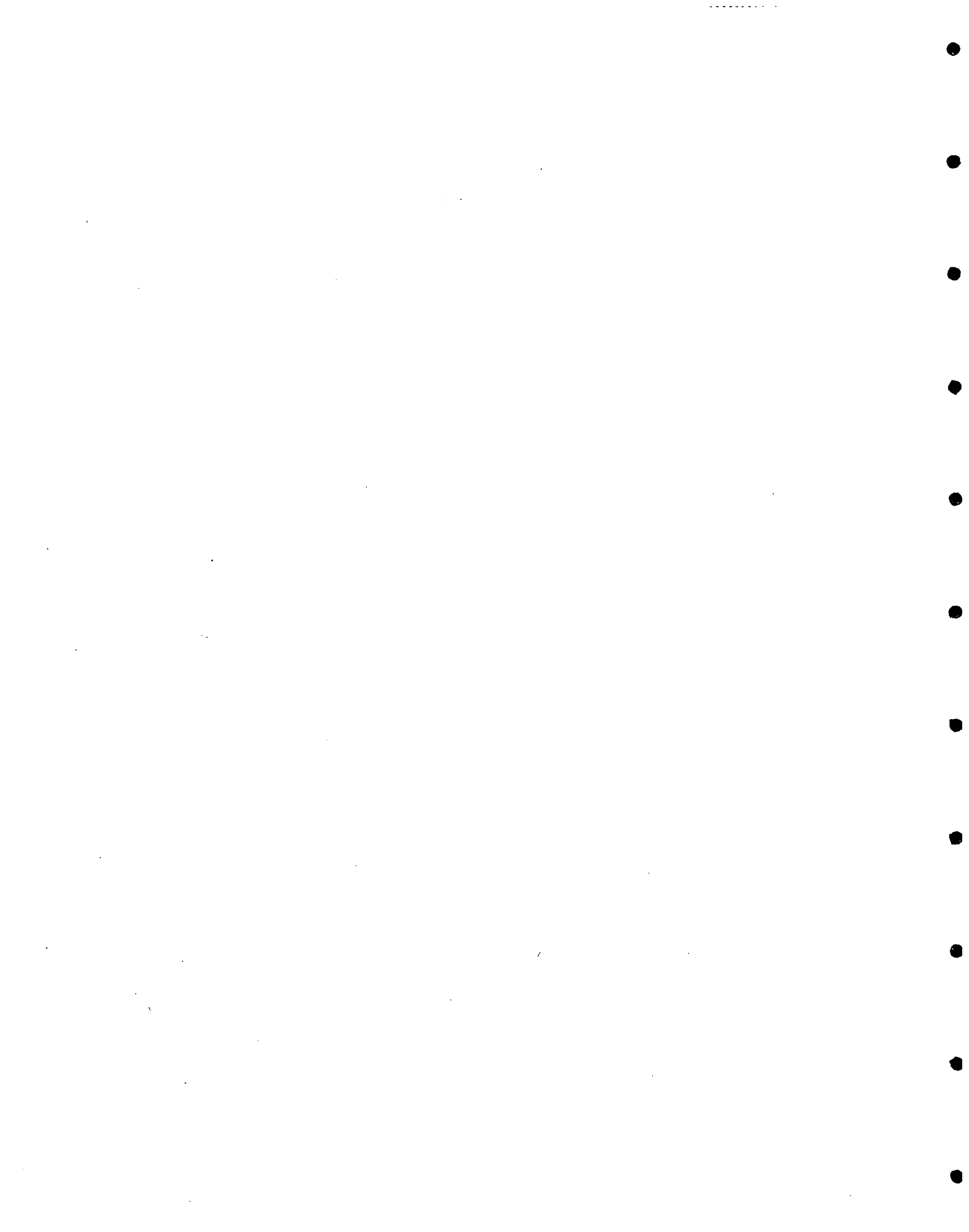
Briefly, FMHI proposes the following program for identified drug-dependent probationers who are in need of long-term, intensive treatment:

* Phase I: Six months of intensive residential treatment in a modified therapeutic community located at a STOP institution. Phase I institutions will house up to 140 probationers in a 20 bed intake unit and three 40 bed residential units.
* Phase II: Three months of employment experience and transition work in a community residential, reentry setting. Phase II facilities will house up to 40 probationers.
* Phase III: Nine months of supervised community outpatient treatment that decreases in intensity as the probationer responds to treatment and becomes established in the community.



The primary considerations in developing this proposal were:

* Reducing crime in Florida.
* Developing a cost-effective approach to intervening in the lives of drug-dependent offenders with severe problems and a range of needs.
* Making use of what has been shown to be effective in the clinical and research literature.
* Exploring new treatment techniques to keep the state on the leading edge of treatment innovations with drug-dependent offenders.
* Developing a more intensive drug treatment approach for offenders returning to the community that does not rely exclusively on referral for outpatient treatment.
* Providing alternatives to prison for drug-involved inmates who are not appropriate for less restrictive community alternatives.
* Diverting offenders from incarceration in Florida's overcrowded prisons who are amenable to treatment.
* Effectively utilizing scarce community supervision resources by targeting offenders whose criminality is attributable to drug dependence.
* Providing a mechanism to guarantee at least the minimum time in treatment sufficient to expect lasting therapeutic impact.
* Building on the effective strategies already developed by the Florida Department of Corrections.



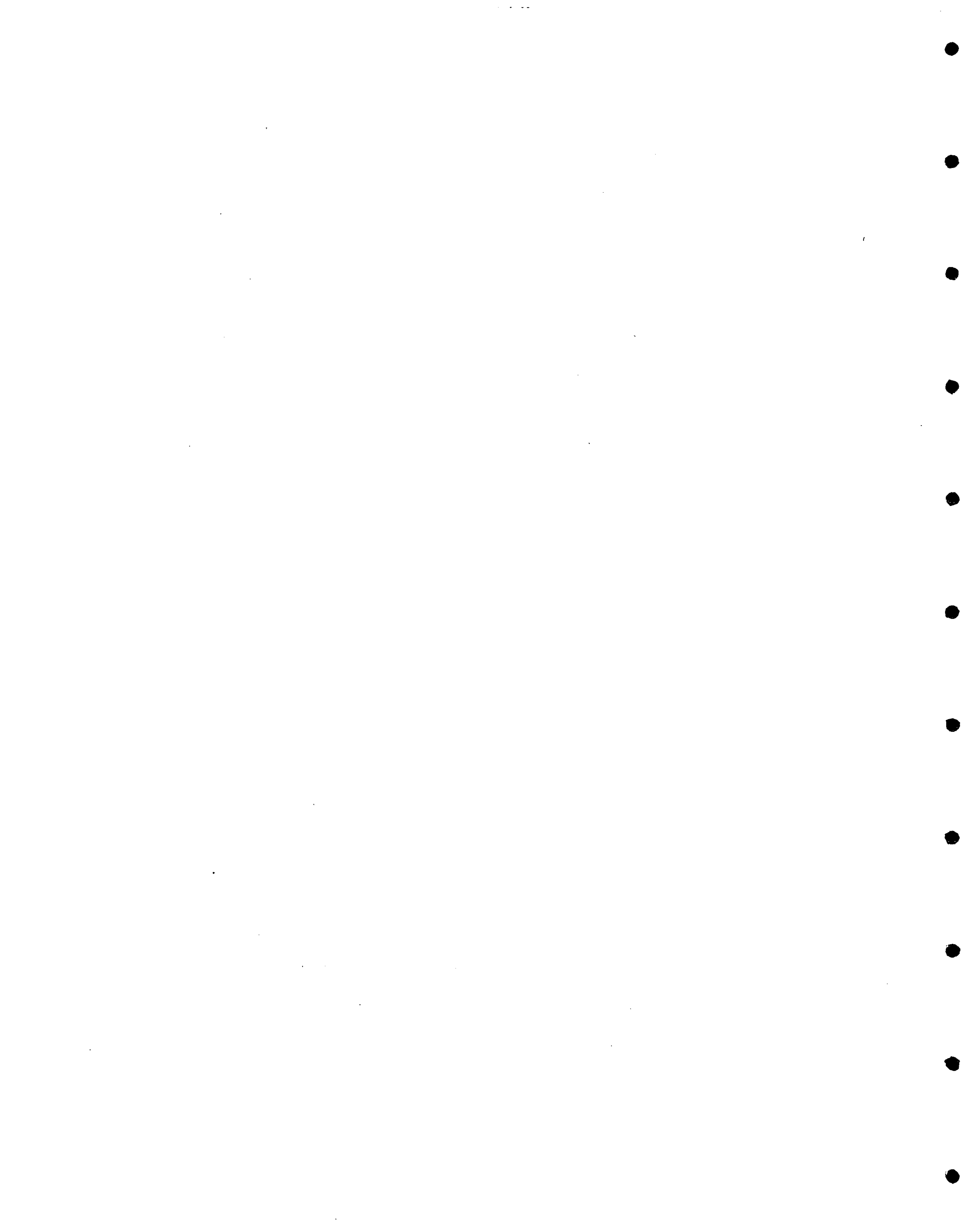
Treatment Goals

Underlying the STOP Program are the basic assumptions that drug abuse is a major health and social problem in Florida; that crime in Florida and its social costs are unacceptably severe; that drug abuse exacerbates the crime problem; that treatment of substance abuse can be effective; and that treatment of drug-dependent offenders is a crucial part of the solution to the drug and crime problem in Florida. With those assumptions, the STOP Program offers the following goals:

1. Reduction of criminal recidivism.
2. Reduction of substance abuse (with abstinence as the goal for each individual offender).
3. Development of employment skills and attainment of employment by STOP clients.
4. Development of a positive peer support network and on-going participation in services to maintain treatment gains.
5. Enhancement of education, self-care, and parenting skills to improve role functioning such as employee, spouse, or parent.

Treatment Facilities

STOP treatment facilities (Phase I & II) will be designed to accomplish the dual purposes of providing security for the community and effective drug treatment programming for drug involved offenders. STOP facilities will be designed and sited by the Department of Corrections with guidance from the STOP advisory board (see page 58 infra.) regarding specific program needs for STOP activities. Phase I facilities will provide a secure locked environment in which the institutional walls serve as perimeter security. Phase II facilities will allow for restricted access to the community. Twenty-four hour security will be provided by vendors at all Phase I and II facilities. Security procedures will be supervised by probation staff from the Department of Corrections.



Phase I STOP institutions include an intake unit with a capacity of up to 20 probationers and may include as many as three treatment units housing up to 40 probationers per unit. Phase I treatment units may be designed for co-ed programming, according to the need for treatment slots within the judicial circuit. A Phase I STOP institution will house a maximum of 140 probationers. Phase II STOP facilities will house up to 40 probationers and will also be designed so that females may be sequestered from other offenders in a section of the facility and allow for co-ed programming. These facilities should be co-located on Phase I STOP institution sites whenever possible to promote continuity of casemanagement and treatment services and to maximize access to employment and educational opportunities in the community. STOP facilities are deemed inappropriate for probationers with more than routine health care needs.

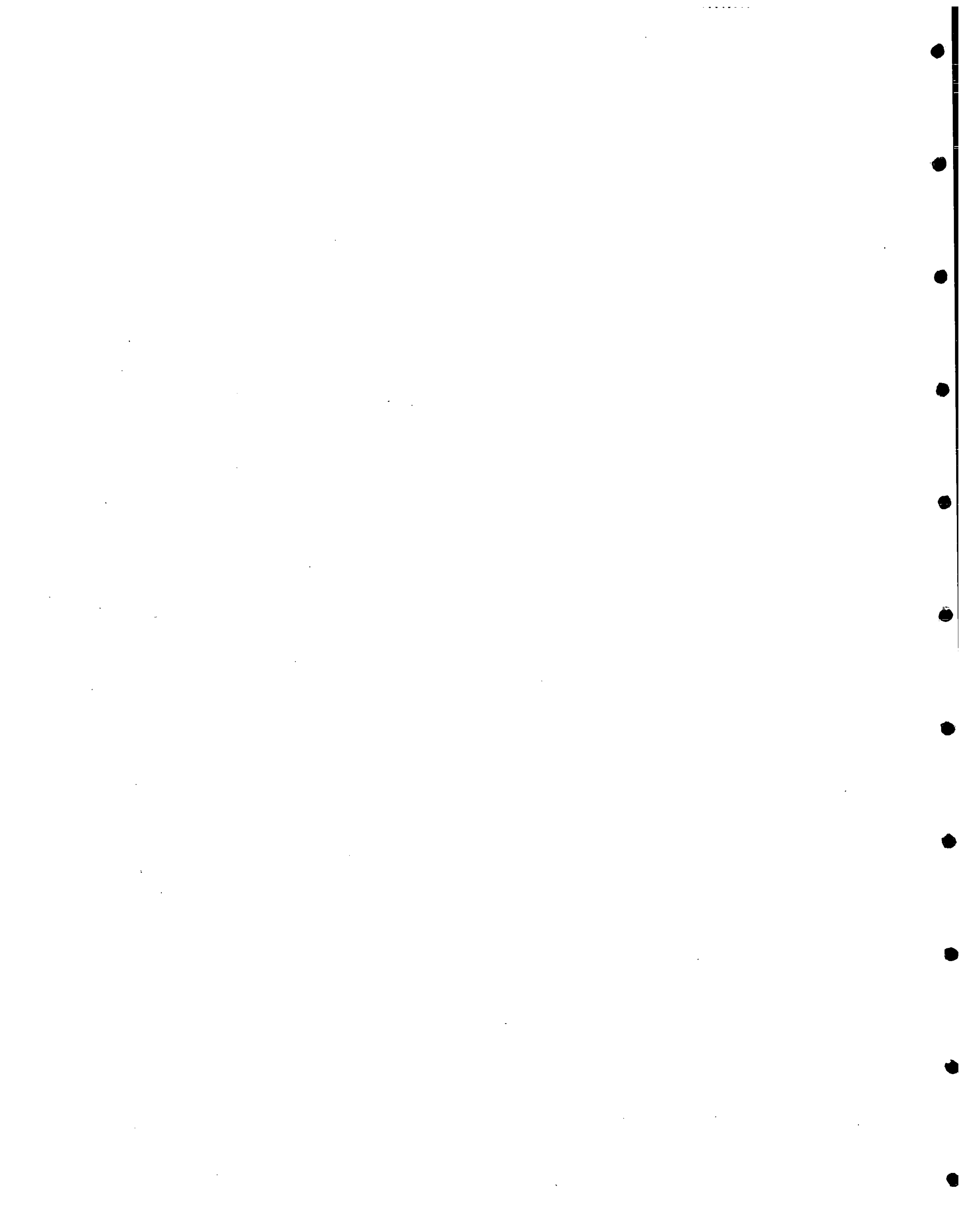
Procedures

Treatment Program Intake

For offenders receiving positive assessment for admission to the STOP program, the Court may modify terms of probation to order participation in treatment. A copy of the assessment report, and probation and court records describing required participation in the STOP program will be forwarded to intake staff at the STOP institution prior to the probationer's admission. The probation officer will send the STOP institution additional materials, as necessary, describing past participation in drug treatment, results of urinalysis, and other relevant probation records.

Offenders admitted to STOP treatment will be housed in a separate intake unit for the initial two weeks in the program. Each Phase I STOP institution will include an intake unit that accommodates 20 individuals which seems the size necessary to feed three 40 bed treatment units.[1] An

[1] Based on vendor experiences a treatment facility of 120 will be adequately served by a 20 bed intake unit.



intake counselor from the assigned program meets with the probationer upon arrival at the institution and provides a brief orientation to intake and treatment activities. The intake counselor obtains, in the presence of another staff member, a full and informed consent from each individual to participate in the program. The informed consent procedure includes a description of all potential risks and benefits associated with participation in the STOP program and the consequences of withdrawal from the program. A sample informed consent protocol is included in Appendix I.

The probationer receives a full medical examination within 48 hours of entering the STOP intake unit. Medical examination includes AIDS testing, to be performed according to universal precautions and guidelines established for invasive procedures by the Centers for Disease Control, and the Department of Health and Human Services, and as specified by the State of Florida Department of Health and Rehabilitative Services. All probationers are to receive counseling services prior to AIDS testing to describe the purpose and consequences of testing, and counseling services following the test, to include assistance in understanding and interpreting AIDS test results. Each offender is also screened for evidence of mental illness and of suicidal thoughts or behavior. The medical examination will evaluate the presence of severe or chronic disorders that would prevent effective participation in treatment. Probationers who are determined to have a disabling medical disorder (e.g. AIDS), or who develop such a disorder during the course of the STOP program will be reviewed for termination by the treatment team.

STOP offenders participate in a series of orientation activities during the first week in the intake unit. These activities provide basic information regarding program rules, regulations and sanctions, responsibilities to attend treatment activities, guidelines for participation in group activities, confidentiality of information, including limits to confidentiality, criteria for termination from the STOP program, and criteria for successful completion of the program. Orientation includes a thorough discussion of the full scope of treatment activities to occur in all phases of the program.

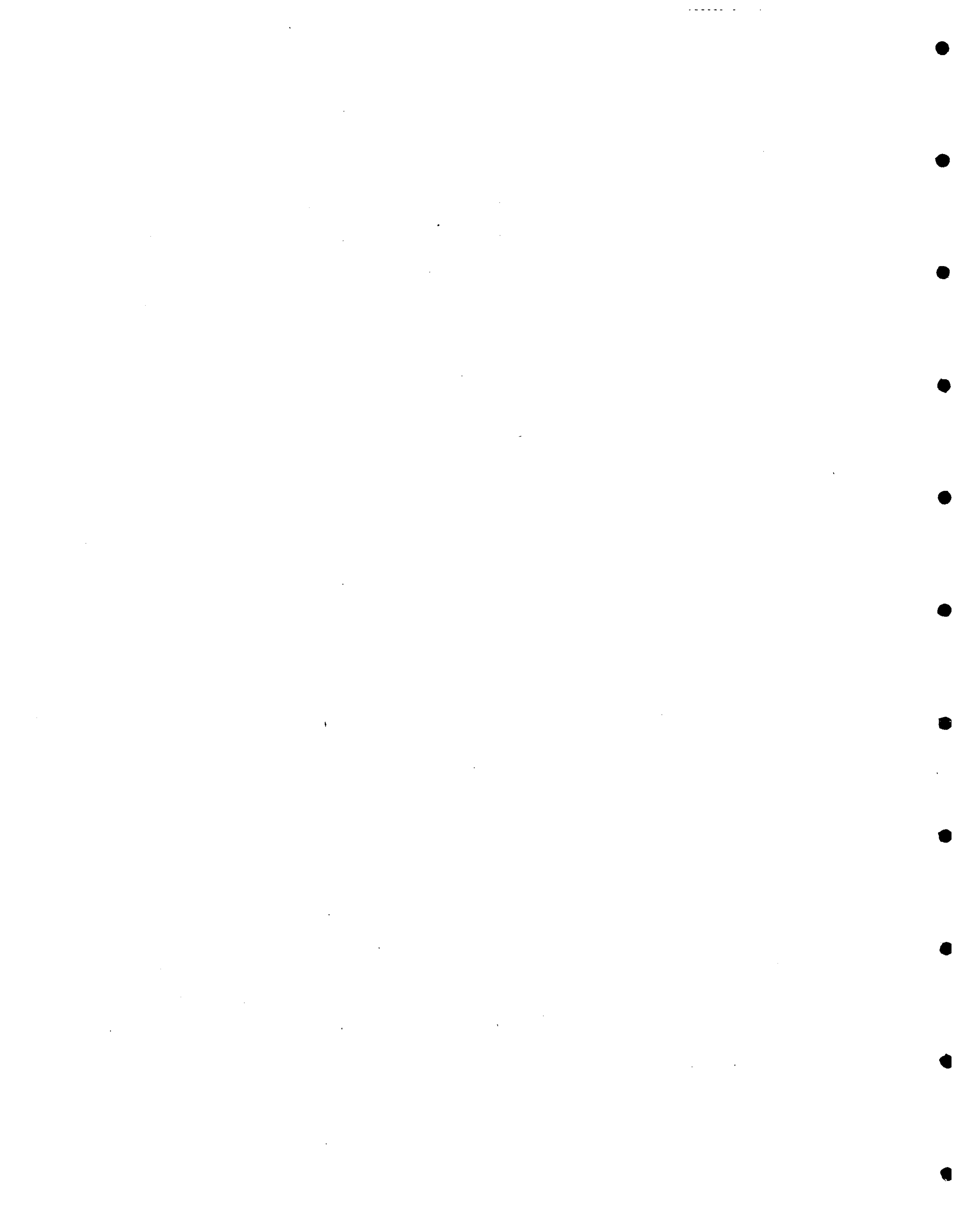
All STOP participants are required to participate in group treatment sessions during the first two weeks of intake. These groups will focus on key issues involved in the first stages of treatment

including acceptance of responsibility for involvement in substance abuse, means of counteracting denial and of mobilizing commitment to change, development of trust in treatment staff and other group members, and identifying the several stages in the recovery process. Sample materials to be presented in the orientation group are provided in Appendix J.

The assigned intake counselor administers all intake assessment instruments during the first two weeks in the STOP institution. Several evaluation instruments are administered to assist in the evaluation of program effectiveness. These include the Addiction Severity Index (ASI), the Hopkins Symptom Checklist (SCL-90), the Tennessee Self-Concept Scale, measures developed to assess knowledge of key concepts covered during the course of treatment, and competencies in handling high risk situations for relapse to drug use. These instruments establish a baseline of inmate functioning at the time of intake in key areas such as psychological/emotional status, self-esteem, social adjustment, motivation to receive treatment, self-efficacy, knowledge of effects of drug abuse, frequency of drug urges and cravings, and drug coping skills. Instruments are readministered during the course of treatment to gauge individual progress in the STOP program (see Chapter 8). STOP treatment providers shall enter into agreement to share client and program information with the STOP quality assurance and program evaluation staff as well as the probation staff.

Treatment Planning

At the conclusion of intake and within the first week of admission to each phase of the STOP program, a treatment team will meet to develop a coordinated plan of treatment activities. The treatment team may include an intake counselor, a primary treatment counselor, the unit or facility supervisor, consulting psychologists or psychiatrists, and other multidisciplinary team members. The treatment team will develop an individualized treatment plan, will monitor the probationer's progress during each phase of the STOP program, and will review all critical incidents or requests for termination that may arise during the course of involvement in the program. The STOP offender and assigned



probation officer are included in developing the treatment plan whenever possible. The treatment plan describes measurable goals for each individual, and specific treatment interventions recommended to meet each goal. For each STOP participant the treatment plan will include measurable behavioral criteria for successful completion of the respective Phases of the STOP program. Criteria will address minimal requirements for attendance and participation in treatment activities, achievement of satisfactory monthly progress ratings by the treatment counselor, and other behaviors that are determined by the treatment team to be critical to the offender's recovery from drug dependence. The treatment plan will also describe dates of treatment provided, staff responsible for monitoring treatment activities and dates of anticipated treatment plan review. Treatment plans are to be reviewed at least once monthly by the treatment team. Monthly progress ratings are to be provided by the primary treatment counselor for each critical problem area identified within the treatment plan (see Appendix K) and are reviewed regularly by the treatment team. A separate treatment plan is developed for each phase of the STOP program. All treatment records, including assessment results, progress notes, and the treatment plan follow the probationer through the three phases of the STOP program.

Treatment Activities

Phase I - Intensive Residential Treatment. Following completion of intake and development of a treatment plan, STOP offenders are to complete the six-month program of comprehensive drug treatment and are assigned to a treatment management unit of no more than 40 individuals.

In order to reduce negative peer influences and to encourage a structured treatment environment, the STOP treatment unit will involve a relatively small modified therapeutic community with a high staff/inmate ratio. Experts on the drug therapeutic community recommend small treatment units. An ideal treatment unit size is seen as twenty, but an effective unit should not exceed forty. This recommended number is imprecise and represents the balance between the tenet that small numbers are ideal and large numbers provide the economy of scale. There have been no controlled

studies examining the treatment unit size as it influences effectiveness of treatment. As the STOP Phase I facilities are designed to be secure from negative community influences, the larger size of forty is seen as manageable. This limited size also assumes a unit management system allowing for individualized treatment programming and sanctions tailored for each individual. When host facilities are allowed to grow over one hundred participants, the concentration of such a large number of individuals increases the likelihood of the breakdown of individualized treatment communities and is conducive to the deindividualization of individuals and increasing participant alienation. Phase I facilities are therefore set at a maximum size of 140 with 3 treatment units of no more than 40 and an intake unit of no more than 20.

Entry and exit from the facility will be electronically monitored and will be supervised by unarmed program staff. As the STOP clients are under probation status, the purpose of security is to control and monitor entry and exit, not to physically prohibit escape. Escapes will be considered violations of conditions of probation. For probationers participating in Phase I of treatment, the controlled movement represents a significant restriction of liberty in comparison to other probation programs. STOP is a restrictive alternative to incarceration, but is not the equivalent of prison.

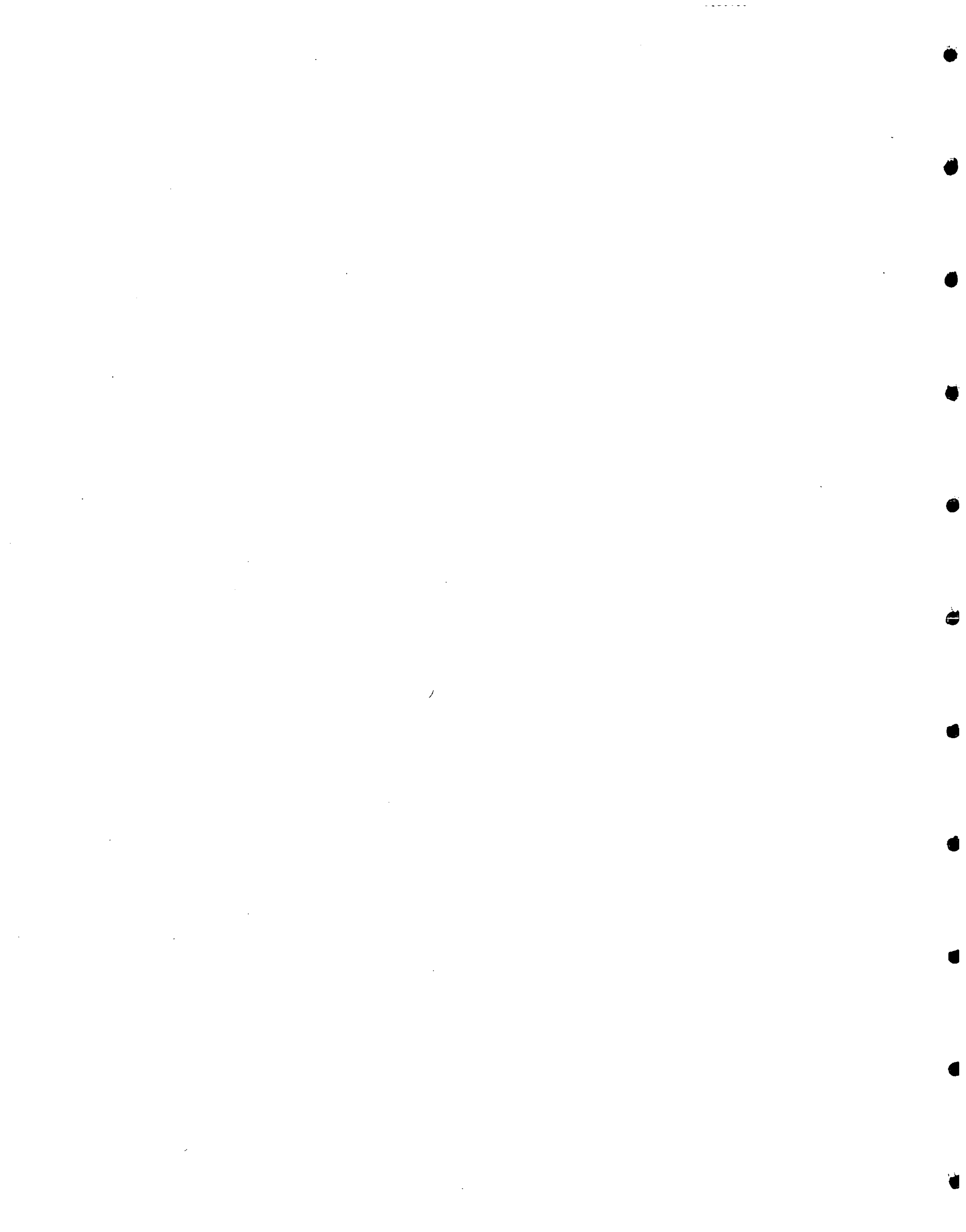
Each treatment unit is organized according to the Unit Treatment Review (UTR) approach. Under this approach each treatment unit functions semi-autonomously, with administrative duties assumed by a unit administrator. All case review and treatment planning activities are conducted within the unit. One probation officer is assigned to supervise a maximum of 140 offenders within a Phase I STOP institution. This probation officer will monitor security provided by the Phase I vendor and will serve as the court liaison officer for the Phase I facility.

All probationers complete a series of "core" treatment activities within the assigned unit during the course of the six-month STOP institutional program. Probationers also participate in several "supplemental" treatment activities that may include individuals from other treatment units. The content of treatment activities for probationers in Phase I and Phase II of the STOP program are described in a following section entitled "Specific Treatment Interventions". Each probationer will

participate with the primary treatment counselor in developing a weekly schedule of Phase I treatment activities according to the treatment plan. The treatment program will involve a structured plan of activities from 8 A.M. to 9 P.M., and will include programming seven days per week. The STOP treatment schedule developed by the probationer and assigned counselor includes both core and supplemental activities. Appendix L provides a sample schedule of Phase I treatment activities. The probationer and assigned counselor are to review criteria for successfully completing each treatment module. Criteria for completion of each module include observable and measurable behaviors that are expected to occur over the course of treatment. Counselors supervising each treatment group record weekly progress notes for each individual in the group.

Treatment activities (other than individual counseling, diagnostic assessment, casemanagement, and vocational, educational, recreational activities) are conducted in groups of eight to 15 offenders, and are led by a team of two counselors whenever possible. Activities are ordinarily scheduled for one to two hours. Several ongoing treatment groups (as many as five at one time) in a particular core area are to be provided within the treatment unit, allowing probationers entering the unit to begin treatment as quickly as possible. Probationers will not be allowed to join a core treatment group that has progressed beyond the first three weeks of the curriculum and will be assigned to the next group that begins in the same core area. Random urinalysis will be conducted at least once weekly during Phase I of treatment.

All core and supplemental group treatment activities in Phase I and II of the program are conducted with the assistance of treatment manuals. A participant manual shall be developed for each of the core and supplemental areas of treatment during the first year of the STOP program operation by a qualified vendor in consultation with FMHI and the advisory board. Manuals will include goals and objectives for each treatment session, exercises, didactic material, and homework assignments. Another manual shall be developed to assist staff in presenting materials to the treatment group. A sample curriculum treatment manual developed by FMHI for an outpatient offender treatment program is presented in Appendix M to provide an example of the format of manuals to be used by group counselors in each core treatment area of the STOP program. Manuals in each core treatment area will



be reviewed and recommended for DOC approval by the STOP advisory board based on consistency with STOP program goals and program design.

Offenders will meet at least once monthly with their assigned treatment counselor to review progress and unmet treatment goals for the STOP program. This counselor has responsibility for liaison with the probation officer regarding the offender's progress and changes in treatment status including disciplinary actions. Probationers are required to meet all criteria for assigned treatment modules before graduating to the reentry component of the STOP program. A probationer may request a review of unmet criteria before the treatment team. A probationer that does not cooperate in completing treatment objectives for assigned treatment modules may be considered in violation of the conditions of probation and may be considered for revocation of probation and possible judicial hearing for transfer to a traditional DOC institution to complete his/her sentence.

The primary treatment counselor will provide casemanagement services following completion of intake. This counselor meets at least once monthly with the probationer during the first three months of treatment and at least once weekly during the final three months of the Phase I program to review progress toward successful completion of the institutional program and to develop a treatment plan for the reentry portion of the STOP program. This treatment plan will be completed prior to the last month in the institutional phase of the program. Casemanagement responsibilities are transferred to a primary treatment counselor from a community provider agency during the Phase III of the program.

Additional casemanagement counselors will have primary responsibility for ensuring continuity of care between Phases I, II, and III areas of educational, vocational, and treatment programming. Casemanagement staff are to develop a catalogue/reference library of materials describing available treatment, vocational, and other adjunctive services for probationers at each STOP facility. Staff will take reasonable measures to assure that services identified (particularly treatment services) are structured to address content areas, goals and objectives that are consistent with those expressed within the STOP program. Casemanagement counselors assist in the following activities: (1) introducing the inmate to reentry counselors and community self-help groups prior to completion of Phase I of the

program, (2) tracking a probationer's progress during the transition to Phase II to ensure that he/she is enrolled in recommended activities, and (3) providing treatment records and information requested from the reentry counselor.

Phase II - Graduated Reentry. Reentry treatment facilities should be designed to accommodate approximately 40 STOP offenders. This size treatment facility is recommended for two reasons: 1) experts in the drug treatment community indicate that treatment units should not exceed 40 individuals, particularly during a reentry phase of treatment in which program participants will require individualized counseling to develop and rehearse relapse prevention strategies, and 2) this size reentry facility will accommodate the estimated flow of STOP offenders successfully discharged from a Phase I facility. Three probation officers are assigned to supervise a maximum of 40 offenders within a Phase II STOP facility. Following transfer to a Phase II program, the probationer is assigned a primary treatment counselor. This counselor assists the casemanagement counselor to develop a treatment plan, and monitors the probationer's progress. Major goals for Phase II of the STOP program are to continue refinement of the relapse and recovery plan developed in the first six months of treatment.

The primary counselor works with the offender to develop a schedule of activities that includes at least eight hours of work or vocational training, five days per week, and a range of treatment activities that include continuation of several core activities from Phase I of the program and several new supplemental treatment activities. Appendix L provides a sample schedule of Phase II treatment activities. Treatment activities are provided throughout the day, in two shifts (10 AM - 2 PM, 6 PM - 10 PM) to allow flexibility in probationer work schedules. Intensive treatment activities are also provided during weekend hours in Phase II of the program. Treatment is conducted in groups of no more than 14 individuals, to facilitate interaction, self-disclosure, and rehearsal of relapse prevention/recovery skills. Groups are led by co-therapists whenever possible. Random urinalysis is conducted twice weekly during Phase II of treatment.

During Phase II of treatment, a casemanagement counselor identifies vocational training and employment opportunities, housing, and other support services available in the community. In the two months prior to completion of the Phase II program, the casemanagement counselor begins to develop a treatment plan for the followup phase of the STOP program in consultation with the probationer, the probation officer, the Phase II treatment counselor, and the primary treatment counselor assigned from a community provider agency. This plan identifies outpatient or other transitional drug treatment services that include a major emphasis on relapse prevention and recovery programming, consistent with the treatment provided in the first two phases of the STOP program.

At least 30 days prior to completion of Phase II treatment, the casemanagement counselor identifies an outpatient counselor from a designated STOP provider agency that is responsible for delivering at least nine months of followup treatment during Phase III of the program. This outpatient service is to be delivered in close proximity to the offender's place of residence. Whenever possible, the outpatient counselor is to participate in treatment planning activities during the last month of reentry and prior to the completion of Phase II. The outpatient service provider receives a copy of the aftercare plan from the casemanager for the supervised outpatient phase of treatment. The aftercare plan includes a narrative description of the following areas: (1) treatment goals and key areas of difficulties identified at the onset of Phase II of the program, (2) treatment activities completed by the offender, (3) the course of treatment including major areas of progress and disciplinary actions, (4) present status of the offender in treatment, and (5) remaining treatment goals that should be addressed in Phase III of the program in the least restrictive setting in which these goals can be accomplished.

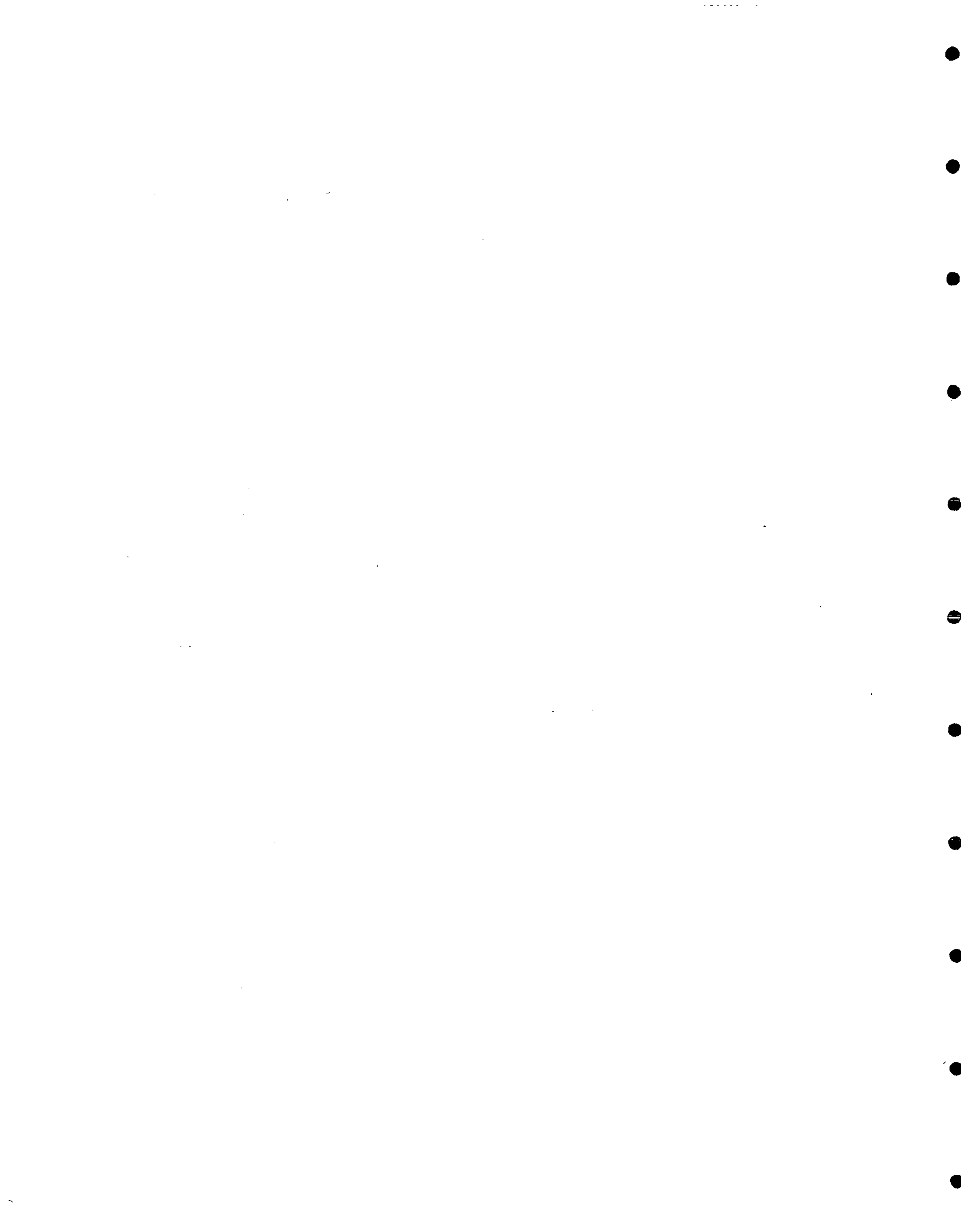
Whenever possible, the casemanagement counselor, the primary treatment counselor, and/or the assigned probation officer accompanies the probationer to the designated outpatient facility for Phase III of the treatment program in order to provide initial contact with the outpatient treatment group and counselor. If this supervised visit can not be arranged, the outpatient treatment counselor (or another designated staff from the provider agency) is to visit the reentry facility during the month prior to release to review the aftercare plan with the probationer, the primary treatment counselor, and

casemanagement staff and to describe the course of outpatient drug treatment activities to be provided during Phase III of the program.

Phase III - Supervised Outpatient Treatment. After successful completion of the Phase II program, the probationer is assigned to a probation officer with a specialized caseload of approximately 15 STOP offenders (to provide the support and surveillance necessary to maintain a drug free lifestyle) and is placed in a nine-month followup treatment program. During this phase of treatment, the probationer will reside in his/her own home. However, the probation officer maintains a minimum of three face-to-face contacts, and one collateral contact with the probationer each week. In addition, random urinalysis is conducted at least twice weekly. The probation officer will monitor attendance in the outpatient treatment group, self-help groups, and other required activities. During the followup phase of treatment, the probationer is expected to participate in full-time employment or vocational training. Major treatment goals for Phase III of the STOP program include: (1) rehearsal and refinement of relapse prevention strategies, (2) continued work towards the recovery plan, and (3) maintenance of behavior change achieved during the first nine months of treatment.

Whenever possible, the community drug treatment provider will develop specialized outpatient groups that consist of STOP offenders who have successfully completed the first two phases of the STOP program. This will enable outpatient treatment to focus on more advanced recovery issues and to reinforce specific relapse prevention, cognitive, and life skills developed earlier in the program. Each probationer participates with the primary treatment counselor and probation officer to develop a treatment plan and a weekly schedule of treatment activities for Phase III of the STOP program. (Appendix L provides a sample schedule of Phase III treatment activities). Programming during Phase III involves five days of structured work, training, and treatment activities and additional activities as needed on weekends.

Followup treatment provides three levels of graduated intensity to ensure adequate monitoring and support in the transition to independent living: (1) for the first three months, attendance in a

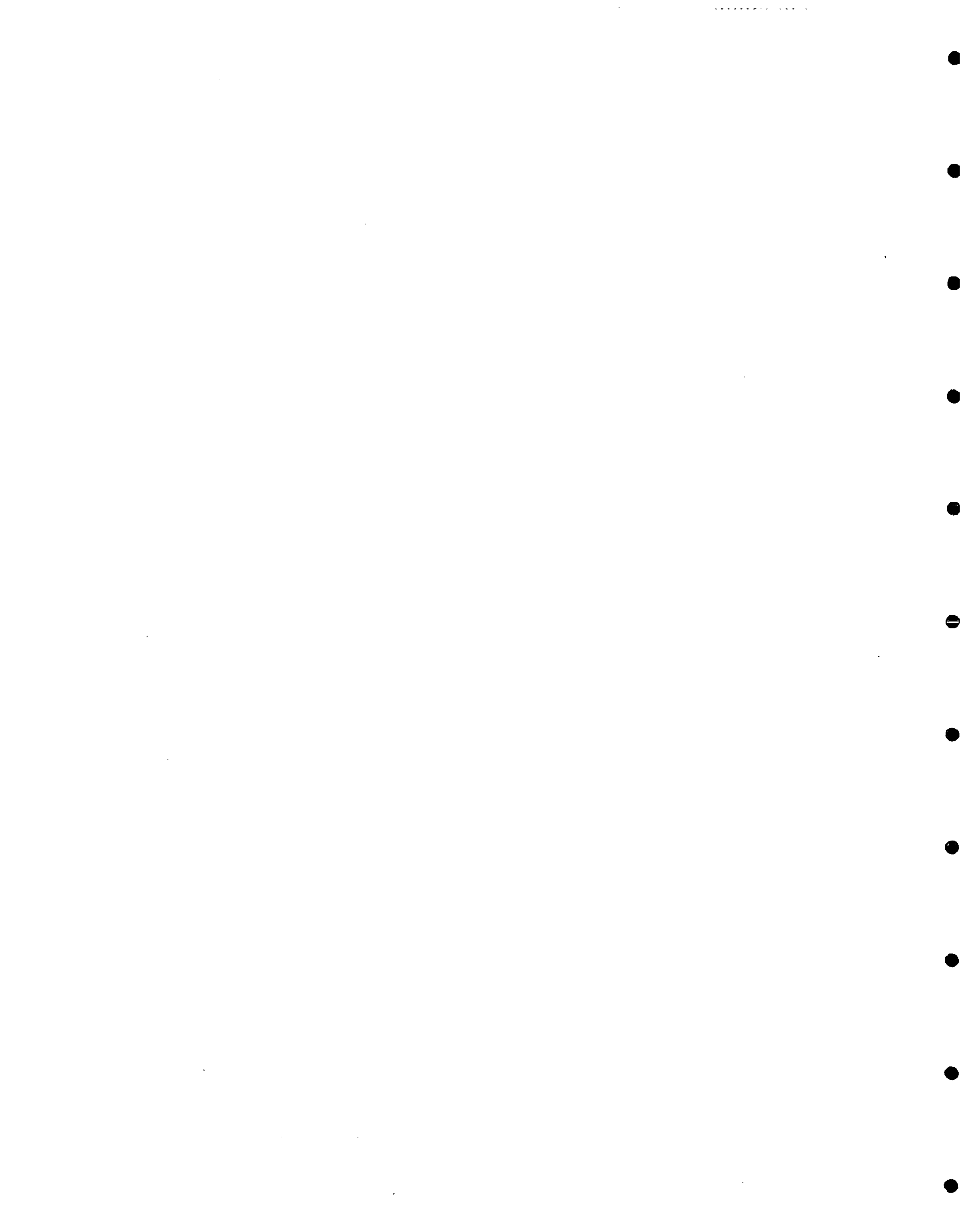


minimum of three weekly group treatment sessions and two self-help groups, Alcoholics Anonymous (AA), Narcotics Anonymous (NA), and Cocaine Anonymous (CA), (2) for the next three months, a minimum of attendance in two treatment sessions and one self-help group each week, (3) for the final three months, a minimum of attendance in one treatment session and one self-help group each week. Phase III treatment sessions are ordinarily conducted in an outpatient setting and involve a group of 8-12 probationers. Treatment groups are jointly co-led by a team of two counselors whenever possible. Group treatment sessions will consist of two hours and are augmented by individual counseling held once weekly during the first three months of Phase III treatment, and once every two weeks for the last six months of the program.

During the followup phase of treatment, casemanagement responsibilities are assumed by the primary treatment counselor. This counselor prepares a report for the probation officer, once monthly (or as determined by the probation officer) describing attendance in treatment, results of urinalysis, achievement of measurable treatment goals, and any change in treatment status, or indications of relapse to drug use. Treatment counselors are required to immediately report missed treatment sessions or violent or disruptive behavior to the probation officer. The probation officer will meet at least once monthly with the counselor to review the probationer's progress towards completion of treatment goals. Within one month of completion of the followup program, the treatment counselor prepares a termination summary that includes progress in outpatient treatment and recommendations for further drug treatment, counseling, or other social or rehabilitative services.

Termination Criteria

The Department of Corrections is authorized, at any time during participation in the STOP program, to recommend revocation of a probationer who presents a security risk within the institution or in the community. Probationers may also be terminated from the STOP program by the treatment



provider, with notification to the offender's probation officer, under the following circumstances (which would be considered violations of the conditions of probation):

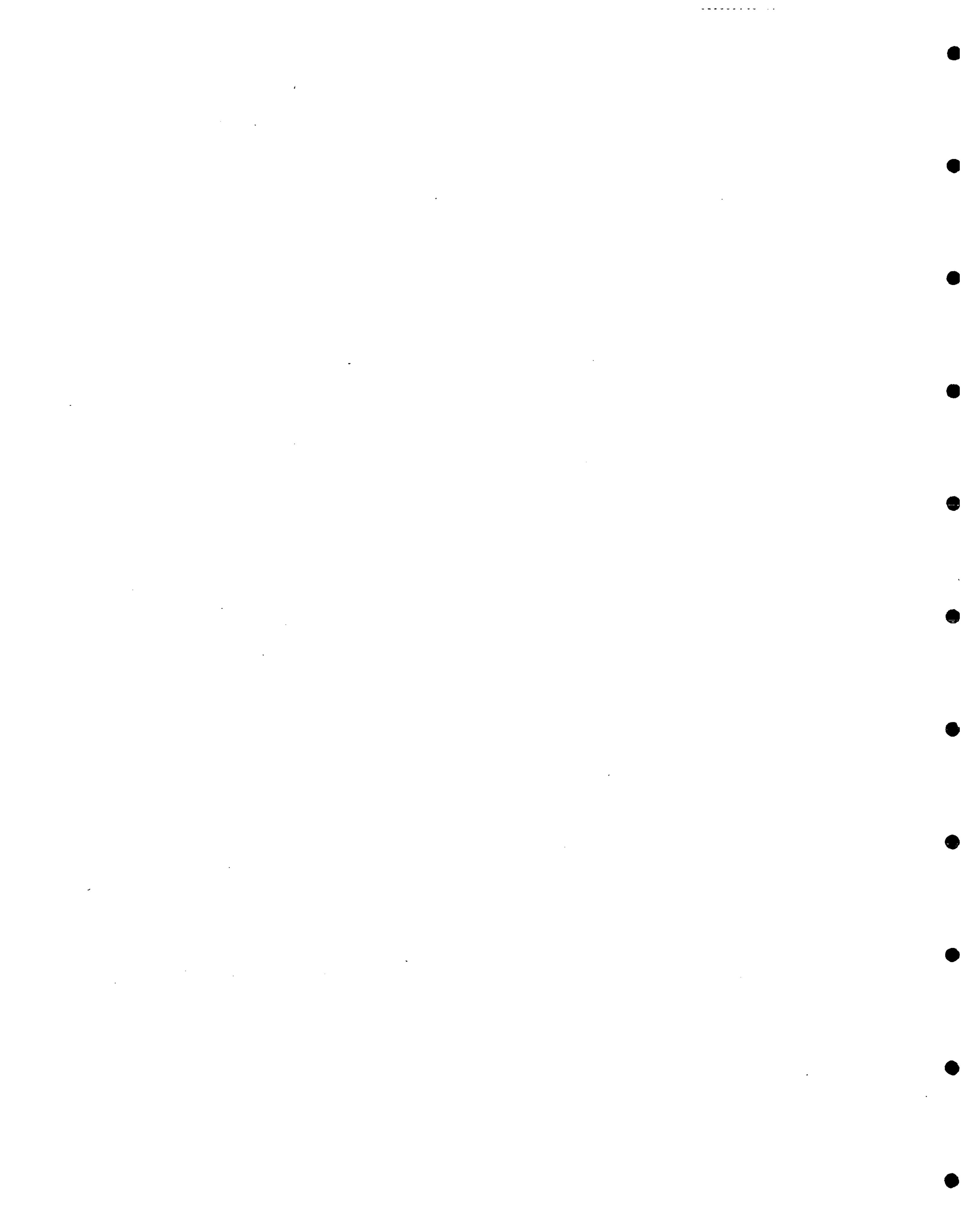
1. Violent behavior directed towards self or others while in the STOP program.
2. Continued refusal to participate in intake or treatment activities.
3. Frequent non-participation in treatment activities.
4. Threats to staff or other program participants, or other behavior that significantly disrupts treatment activities.
5. Psychological decompensation that requires continued psychotropic medication or segregation from other inmates such that the individual cannot benefit from the STOP program or is disruptive of the treatment program.
6. Possession or use of controlled substances as determined through urine monitoring or other means.

A series of graduated sanctions for infractions during Phase I, II, and III of treatment will be developed by the FMHI, reviewed by the STOP advisory board, and approved by DOC prior to program startup. Policies and procedures will describe progressive levels of treatment supervision, more restrictive conditions of treatment, and loss of privileges for probationers who do not comply with program guidelines. Graduated sanctions will enhance accountability to the larger treatment community and will ensure that probationers not committed to full participation in the treatment program will be identified and considered for revocation.

All offenders and staff members will be alerted to procedures for reviewing an individual's treatment status upon the determination of substance abuse within the STOP program. Graduated sanctions for possession or abuse of controlled substances may include more frequent urine monitoring, reinvolvement in orientation groups to mobilize commitment to treatment, and enhanced correctional supervision. For a second offense, a probationer would receive additional institutional sanctions or may be terminated from the STOP program.

In circumstances in which an offender does not appear to be benefitting from drug treatment, does not attain behavioral criteria, or is interfering with treatment program activities, the treatment provider may initiate procedures for termination from the STOP program, or for transfer to the previous (more restrictive) phase of STOP treatment. In the case of termination, the treatment provider will be required to document the lack of progress towards treatment goals and efforts made to address and remedy this problem. All termination decisions will be made by the treatment team in consultation with probation staff and will be reviewed periodically by quality assurance staff.. The supervising probation officer and court are notified immediately of an offender who has absconded from, or has been terminated from the treatment program. The supervising probation officer and court receive a written report from the treatment provider within 24 hours (one working day) of an offender's termination from the STOP program. This report will describe the course of treatment and reasons for termination. Such events would be considered as violations of the conditions of probation.

A treatment provider may initiate transfer of a probationer to a more restrictive Phase of the STOP program (e.g. from Phase II to Phase I) after review by the treatment team and by the host facility administrator. Use of negative transfer will be limited to cases in which the treatment team determines that the probationer is likely to benefit from brief re-exposure to a more restrictive and structured therapeutic setting. An individualized treatment plan will be developed within 48 hours of the negative transfer. This plan will describe specific behavioral criteria and contingencies governing successful completion of the program and progression to the next phase of treatment. Such a transfer will be effected only if there is a treatment slot available in the more restrictive facility. STOP offenders shall not be transferred from Phase III to a Phase I facility. A STOP facility or unit shall be comprised of no more than 10% of probationers negatively transferred from another facility. A negatively transferred STOP offender will stay a maximum of one month in the more restrictive facility, at which time the treatment team determines whether the probationer will proceed to the next phase of treatment or will be terminated from the program. Use of negative transfers within the STOP program will be periodically reviewed by quality assurance staff.



Summary of Treatment Elements

STOP program effectiveness is seen as dependent on program intensity, program length and program size. Treatment efficacy as reported by empirical evaluation and research results depends upon separating the drug dependent person from the environment associated with drug abuse. This requires a seven day a week structured treatment program that separates the probationer from the cues associated with drugs, substitutes productive activities for destructive ones, and develops long-term therapeutic goals.

In order to expedite the transition between the first two phases of treatment, to facilitate casemanagement activities, and to encourage efficiencies derived from development of single facility sites and from sharing external staff consultants and program resources (e.g. staff with specialized training, transportation) it is strongly recommended that Phase I and Phase II facilities be co-located on a single site. Reentry units co-located with Phase I facilities should be capable of programmatic and physical separation from Phase I facilities. The size of the Phase II facilities should be no more than forty, consistent with the treatment unit size of Phase I. It should be noted with STOP organized as a probation program, the STOP facilities can be operated with both men and women probationers. The facility design should permit segregated housing separating men and women, but would allow for co-educational programs. STOP programs would then be available for both sexes within any judicial circuit.

Phase III requires the use of contract services from approved STOP community providers where probation offices are budgeted to purchase services from the list of approved community drug treatment providers to follow-up the Phase I and Phase II programs. These services are designed to include at least three, two-hour sessions per week but could vary according to the individual's needs and treatment plan. Supervising compliance to this treatment plan are specialized STOP probation officers carrying a reduced caseload of no more than fifteen STOP probationers per officer. As the STOP offender will be dealing with the inevitable temptations to lapse or relapse to drug use in the community, the

probation officer must be able to intensely supervise this STOP offender to support efforts to avoid drug use and to impose sanctions where appropriate. A range of sanctions including revocation are seen as appropriate and necessary. Lapse to drug use should be sanctioned but not necessarily lead to revocation. Phase III is seen as lasting at least nine months but can be extended where appropriate and possible to meet the needs of the STOP offender and to protect the public. During Phase III the STOP offender is expected to seek and hold employment. Restitution and program reimbursement payments are seen as appropriate throughout Phase III to reduce taxpayer costs and to repay victims as required in the STOP legislation. Urine testing should continue on a frequent and random basis throughout all phases of the STOP program.

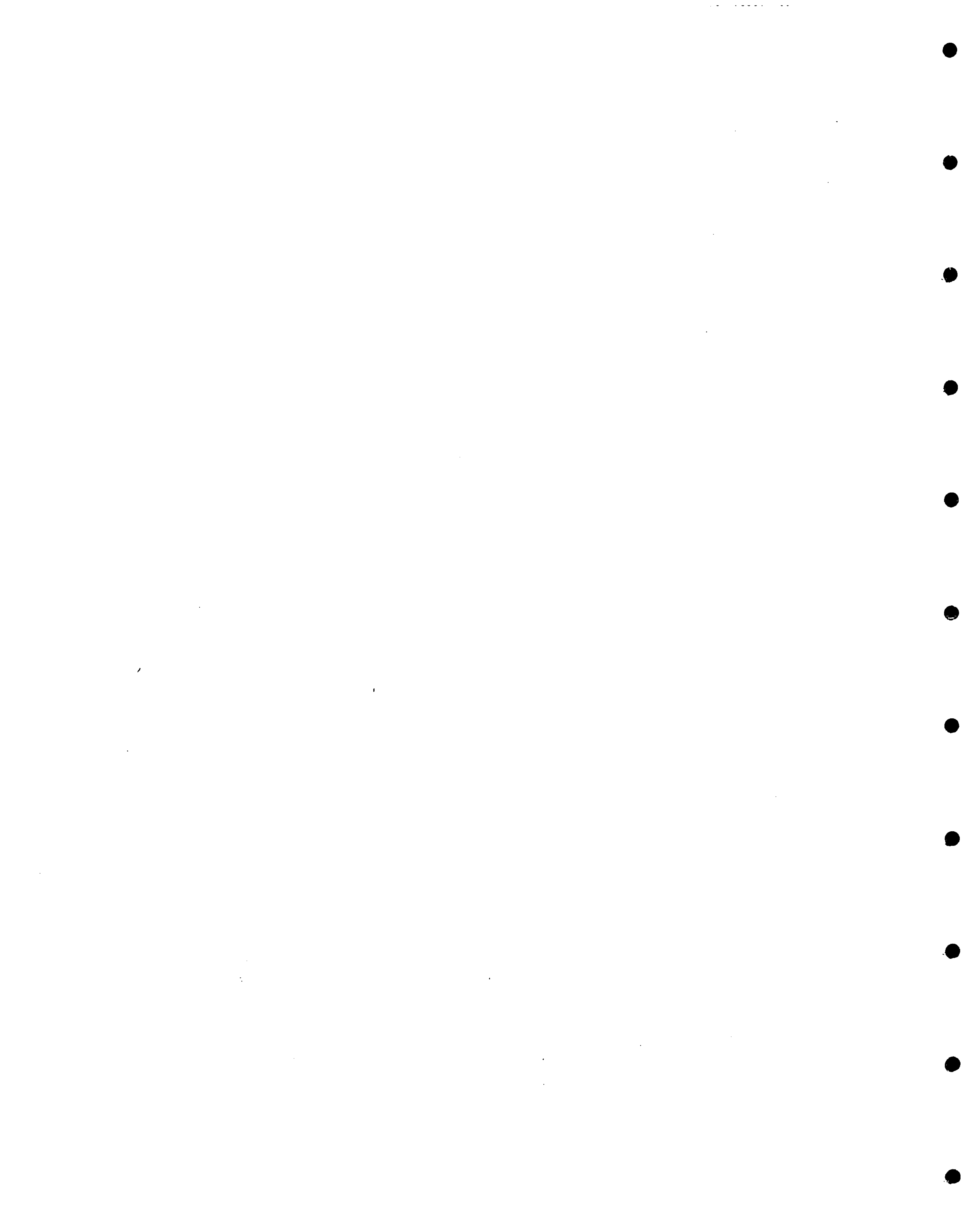
Staffing Pattern

The following section describes a recommended staffing pattern for each phase of the STOP treatment program. Corresponding state employee classification codes, pay grades, and yearly salaries are described in Appendix H.

Phase I

Administrative and Support Services. A Phase I treatment facility administrator will coordinate all program activities. The administrator will have a terminal degree[2] in social or behavioral sciences with experience in providing drug treatment services for offenders and in program administration. The administrator will supervise a full time records clerk and administrative secretary and will maintain direct liaison with each Phase I treatment unit supervisor within the facility. Each Phase I institution will have on-site medical services available, supervised by a consulting senior physician or psychiatrist. Two

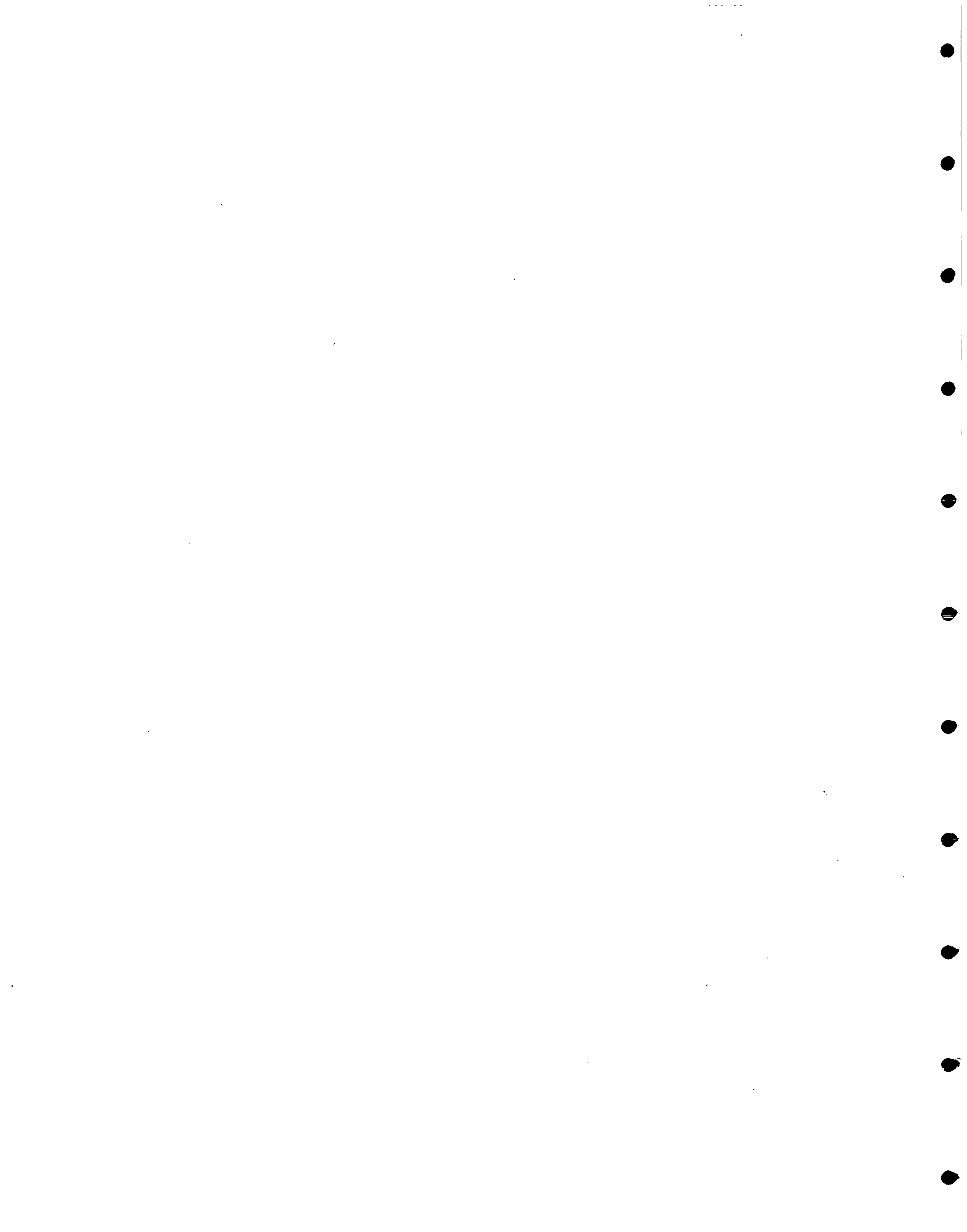
[2] A terminal degree is the practicing degree for a particular discipline, e.g. Social work is M.S.W., psychology is Ph.D or Psy.D., etc.



full time registered nurses will staff the medical unit and will provide routine care. Medical staff will be assisted by a clerk typist and a medical technologist who will supervise drug testing activities. Two casemanagement counselors are assigned to each STOP facility to coordinate transfer of probationers from Phase I to Phase II of treatment. These individuals will have at least a Bachelor's degree and experience in providing or coordinating drug treatment services for drug dependent offenders. Other support personnel include recreation counselors, food services staff, night counselors, and facility maintenance staff.

Educational and Vocational Services. Educational and vocational services will be coordinated by a program director with at least a Master's degree in Education or Rehabilitation and experience in adult education or vocational training. The program director will be assisted by a clerk typist and will supervise three vocational instructors and several Adult Basic Education teachers. Vocational instructors will have at least a Bachelor's degree and experience in vocational training in a rehabilitation setting. Counselors will have specialty training in vocational assessment. Adult Basic Education teachers will be provided by the local school board. A staff development and training manager will assist the program director in obtaining training and teaching resources, in developing curriculum, and in monitoring educational and vocational services. This individual will have at least a Master's degree in education or an allied field with experience in adult education and two years of work in curriculum development.

Intake Unit. The Phase I intake unit supervisor will meet all qualifications required as a "Qualified Supervisor" under Florida Administrative Code 10(E)(16.003). The intake unit supervisor will be assisted by a clerk typist and an intake records clerk. The supervisor will coordinate the activities of four intake counselors, including two primary counselors and two counselor aides. These staff will be responsible for providing orientation and treatment services during the first two weeks of the STOP program. All counselors will have experience in drug abuse assessment. Counselors will have at least a Bachelor's degree from an accredited university and experience working with drug-dependent clients.

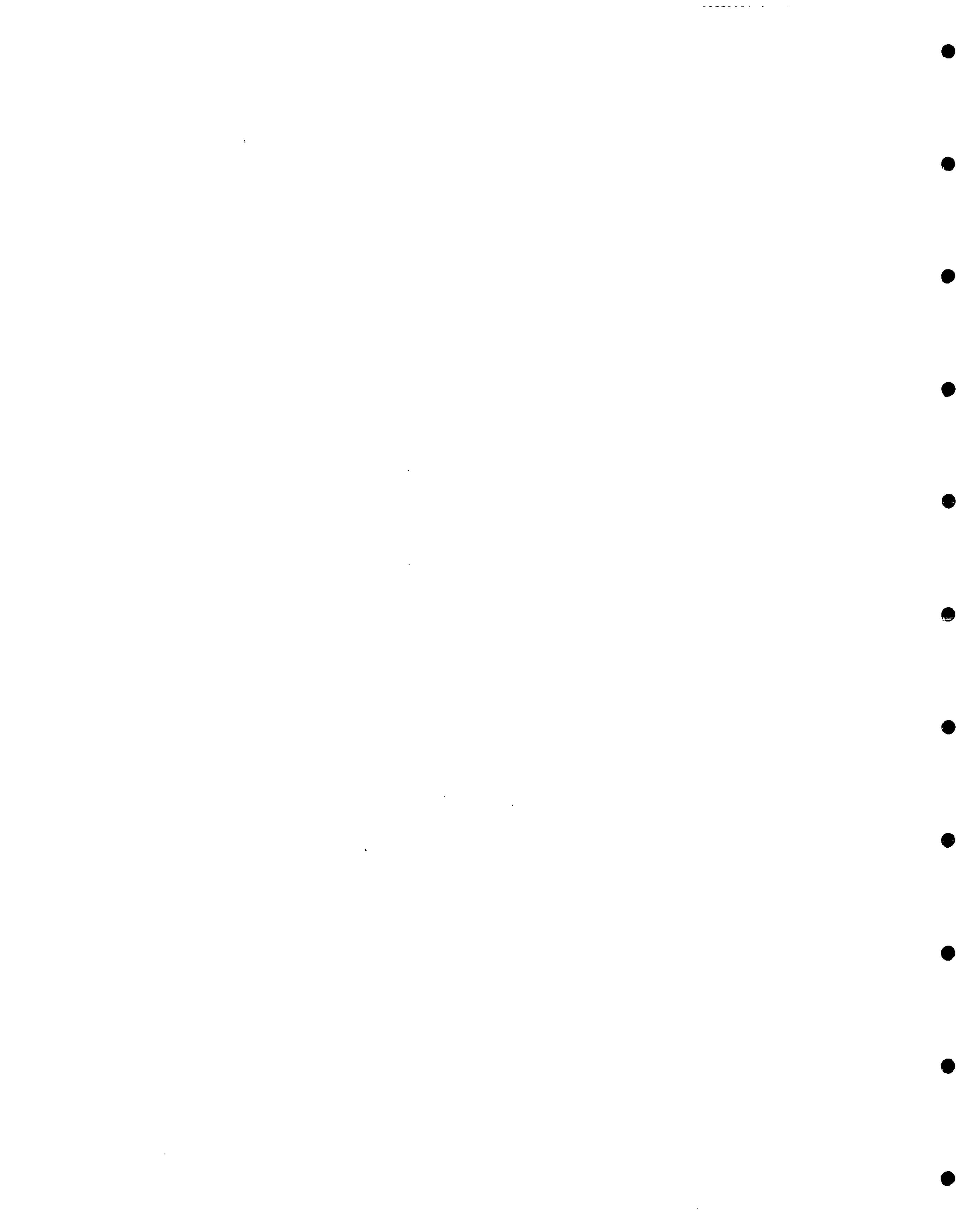


Treatment Services. All Phase I treatment units are coordinated by a unit supervisor. The supervisor will meet all qualifications required as a "Qualified Supervisor", under Florida Administrative Code 10(E)(16.003) and will have experience in program administration. The unit supervisor is assisted by a clerk typist and will coordinate activities of five primary counselors and six counselor aides. Counselors will have at least a Bachelor's degree and experience in working with drug dependent clients. All counselors will assist in providing core and supplemental treatment interventions and in coordinating group meetings and other activities.

Curriculum Development and Training. During the first year of program implementation several consultants will assist in designing treatment manuals in core areas (e.g. relapse prevention, general group counseling, treating errors of criminal thinking) and supplementary areas of treatment. Consultants will provide a pre-service training workshop for treatment staff from Phase I facilities.

Phase II

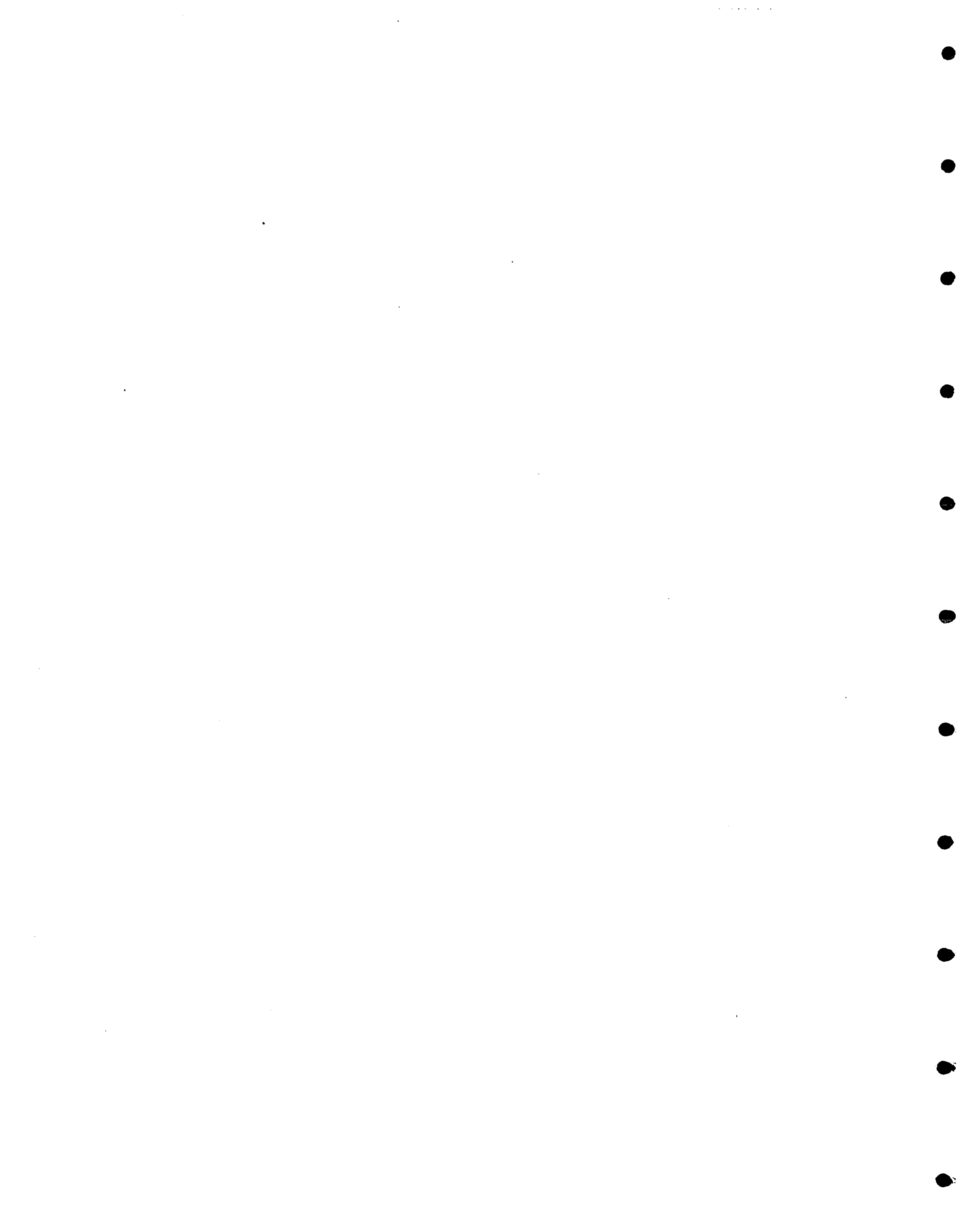
All Phase II unit activities are coordinated by a unit supervisor who will meet all qualifications required as a "Qualified Supervisor" under Florida Administrative Code 10(E)(16.003) and will have experience in treatment of drug-dependent offenders and program administration. The supervisor is assisted by a clerk typist and a records clerk. Phase II units will be staffed by four primary counselors and five counselor aides who will provide direct treatment services. A primary treatment counselor may be designated to assist the unit supervisor in providing clinical supervision to other staff if the counselor meets all qualifications as a "Qualified Supervisor" under Florida Administrative Code 10(E)(16.003). All counselors will have at least a Bachelor's degree and experience in providing drug treatment services. A vocational training specialist with experience in offender rehabilitation will assist in coordinating job and vocational training placements. Adult Basic Education will be provided by the local school board and may be offered in the Phase II facility in local community colleges or in other settings. A



casemanagement counselor will be assigned to each Phase II facility and will assist in coordinating the transfer of probationers to Phase III treatment services. The casemanagement counselor will have at least a Bachelor's degree and experience in providing or coordinating drug treatment services for offenders. A consulting physician will provide routine medical services for Phase II probationers. Other support staff will include a recreation counselor, a food service coordinator, a night counselor, and a transportation coordinator.

Phase III

Phase III treatment services will be provided by treatment providers in a community setting by experienced counselors with at least a Bachelor's degree and experience in working with drug-dependent individuals. Phase III treatment counselors will be supervised by experienced clinical staff who will meet all qualifications required as a "Qualified Supervisor", under Florida Administrative Code 10(E)(16.003).



Chapter 5

SPECIFIC TREATMENT INTERVENTIONS

All STOP offenders are required to complete a series of core treatment activities during the initial six-month institutional program in accordance with the provisions established by Florida statute, Chapter 953. These critical areas include substance abuse interventions and mental health services. In addition, F.S. 953 includes the following range of activities in the STOP program: (1) Diagnostic evaluation, (2) individual and family therapy, where appropriate, (3) independent living skills, parenting skills, and self-sufficiency planning, (4) prevocational and vocational services, including job training, placement, and employability skills training, (5) educational services, including special education and pre-GED literacy, (6) recreational activities, (7) victim restitution, where appropriate, and (8) casemanagement services and graduated reentry into the community. Core treatment activities, and supplemental activities to be provided in each phase of the STOP program are described in the following section (see Figure 2). All core and supplemental group treatment activities in Phase I and II of the program are conducted with the assistance of treatment manuals developed during the first year of the STOP program. The following section describes goals, procedures, topics covered, and the duration and sequence of each treatment intervention. Several examples of treatment curricula are provided in appendices, as indicated for each of the specific treatment interventions below.

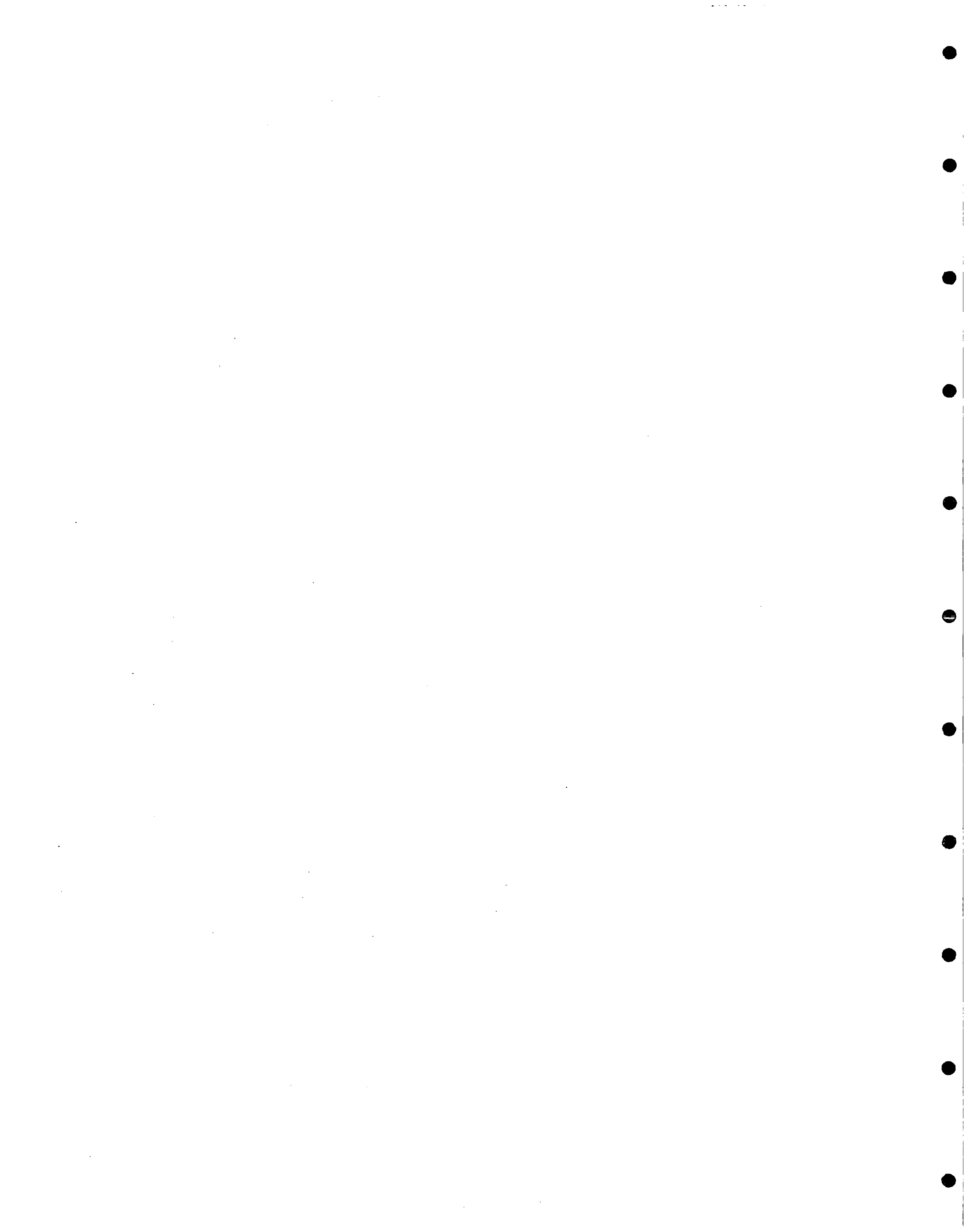


Figure 2: STOP TREATMENT INTERVENTIONS

CORE ACTIVITIES	PHASE I	PHASE II	PHASE III
General Group Counseling	X	X	
Relapse Prevention Group	X	X	
Treating Criminal Thinking Errors	X	X	
Skills of Daily Living	X	X	
Leisure Skills	X	X	
Self-Help Groups	X	X	X
Drug Testing	X	X	X
AIDS Education and Prevention	X	X	
Drug Education	X		
Individual Counseling	X	X	X
Outpatient Treatment Group			X
Relapse Prevention Peer Support Group	X	X	
VOCATIONAL & EDUCATIONAL ACTIVITIES			
GED/Educational Program	X	X	X
Vocational/Educational Assessment	X		
Vocational Training	X	X	X
Institutional Employment	X	X	
Community Employment		X	X
SUPPLEMENTARY ACTIVITIES			
Anger Management	X	X	
Problem-Solving Skills	X	X	
Stress Management	X	X	
Parenting Skills	X	X	
Communication Skills	X	X	
Assertiveness Skills	X	X	
Recreation	X	X	
Community Meetings	X	X	
Restitution Planning	X	X	X

Core Treatment Activities

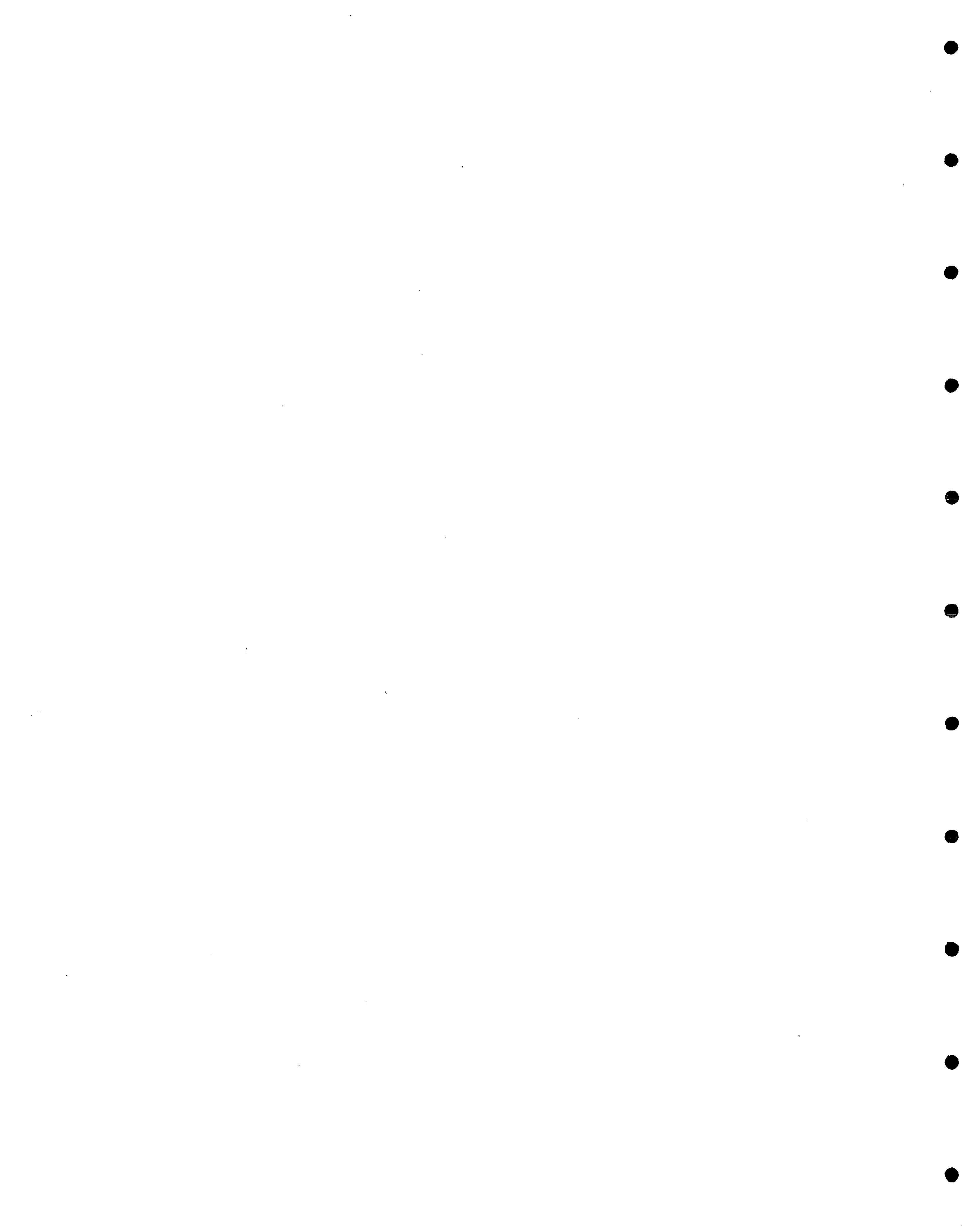
General Group Counseling

Program-focused group counseling will be held three times weekly during Phase I and II of the program and will consist of two to three hours per session. This group provides a forum to discuss and review several core treatment issues. These include topics related to drug and alcohol use and criminality, but also include peer review of individual treatment plans, issues of program business, special seminars by staff and inmates, and conflict resolution. As an example of this latter function, the group will process and resolve instances of verbal threats or hostility between two offenders in the treatment unit.

Group counseling sessions are designed to help offenders learn new skills by experiencing support for prosocial behavior and confrontation of antisocial behavior by peers and staff alike. This group, in large part, forms the therapeutic community and culture of the STOP program. The experience of therapeutic community programs has shown that such an environment is a necessary element of successful drug treatment. Based on the research review reported in Chapter 2, the group treatment format is not only an important element of successful programs, but is also cost effective. General group counseling sessions serve as a vehicle for offenders to take responsibility for their behavior and to individually and collectively develop a commitment to change.

Relapse Prevention

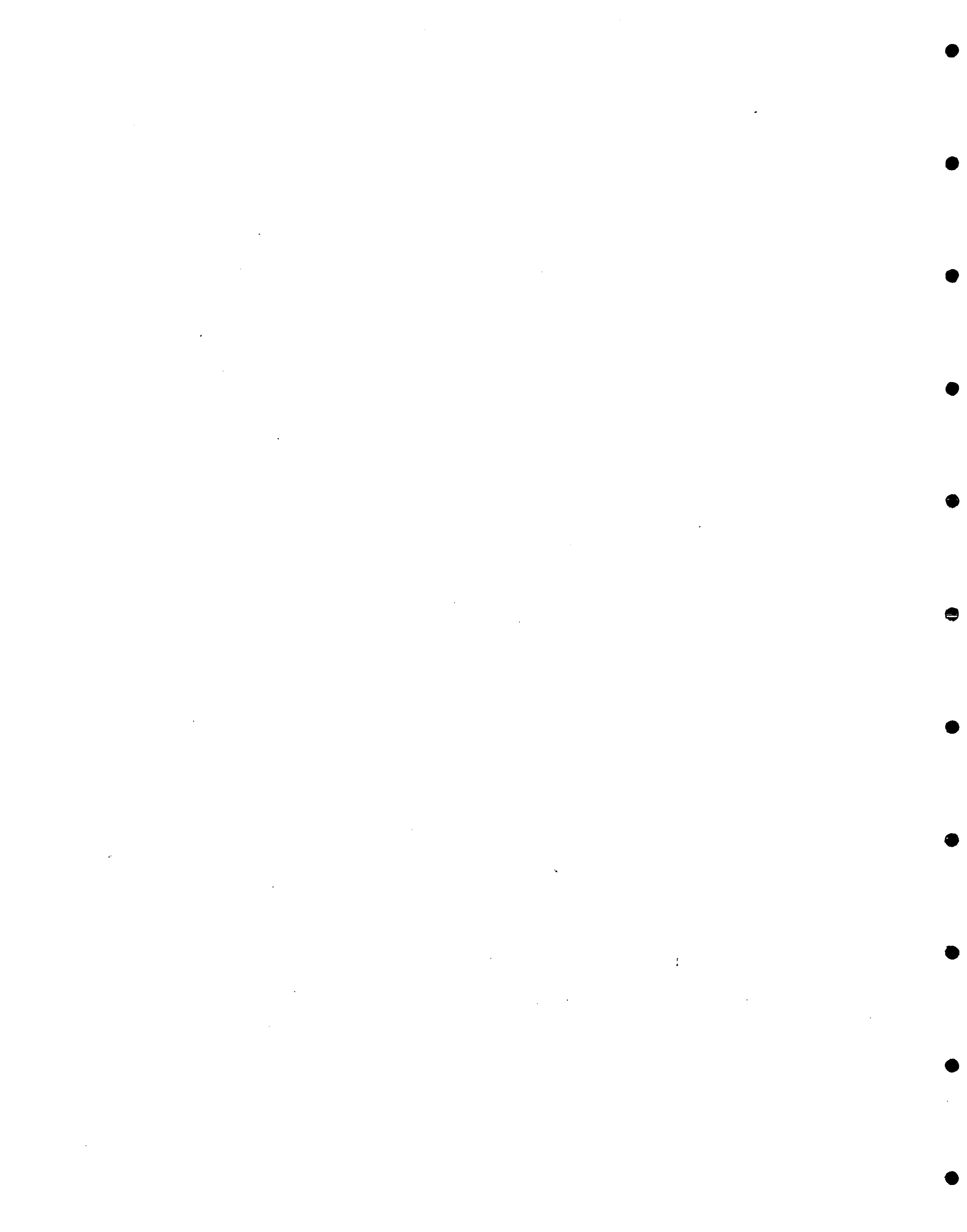
Relapse Prevention groups provide STOP offenders with a series of coping skills to maintain a drug-free lifestyle during the important transition to the community. These skills will be particularly important for rehearsal in the last month of Phase I and during Phase II and III of the STOP program.



During the first three months of Phase I treatment, relapse prevention groups are held three times a week. For the final three months of Phase I treatment, these groups will meet five times per week. Relapse prevention groups are provided three times a week in Phase II of the STOP program. Groups will consist of two hours per session. A relapse prevention peer group will be held three times weekly for one hour during Phase I of the program and at least once weekly for two hours during Phase II. This group will review homework and discuss common strategies for avoiding high risk situations using coping skills and preventing drug relapse.

The relapse prevention approach has been successfully applied to a wide variety of addictive disorders and combines elements of lifestyle change, cognitive interventions, and behavioral skill training designed to enhance self-control in the maintenance of patterns of reduced substance abuse (Brownell, et al., 1986). Relapse prevention groups begin by assisting each probationer to identify and understand specific antecedents which lead to their substance abuse. Individuals are asked to describe events, feelings, or experiences which represent their high risk situations for relapse. These situations include: (1) cravings and urges to use drugs, (2) interpersonal conflict, (3) overt or implied social pressure to use drugs, (4) negative emotional states such as boredom, depression, or anger, (5) situations in which the individual is feeling good and wants to feel better, and (6) external cues, often including sights or sounds associated with past drug use. Probationers learn how these high risk situations prompt rationalizations or irrational thoughts which support the use of drugs. Each individual is taught to recognize maladaptive thought patterns and to rehearse strategies to replace these thoughts with more rational or adaptive thoughts. Finally, probationers learn specific coping skills to help deal with high risk situations, including drug refusal skills, stress management, and strategies for handling unpleasant emotions such as depression, anger, frustration or disappointment.

An important aspect of relapse prevention is learning how to deal with a slip, or single instance of drug use. Individuals are taught to use specific coping skills if a slip occurs and to return to abstinence with a minimum of guilt and self-blame. Such negative emotions often contribute to drug relapse. Probationers are taught to view a lapse as a mistake and as a signal that coping skills need to be



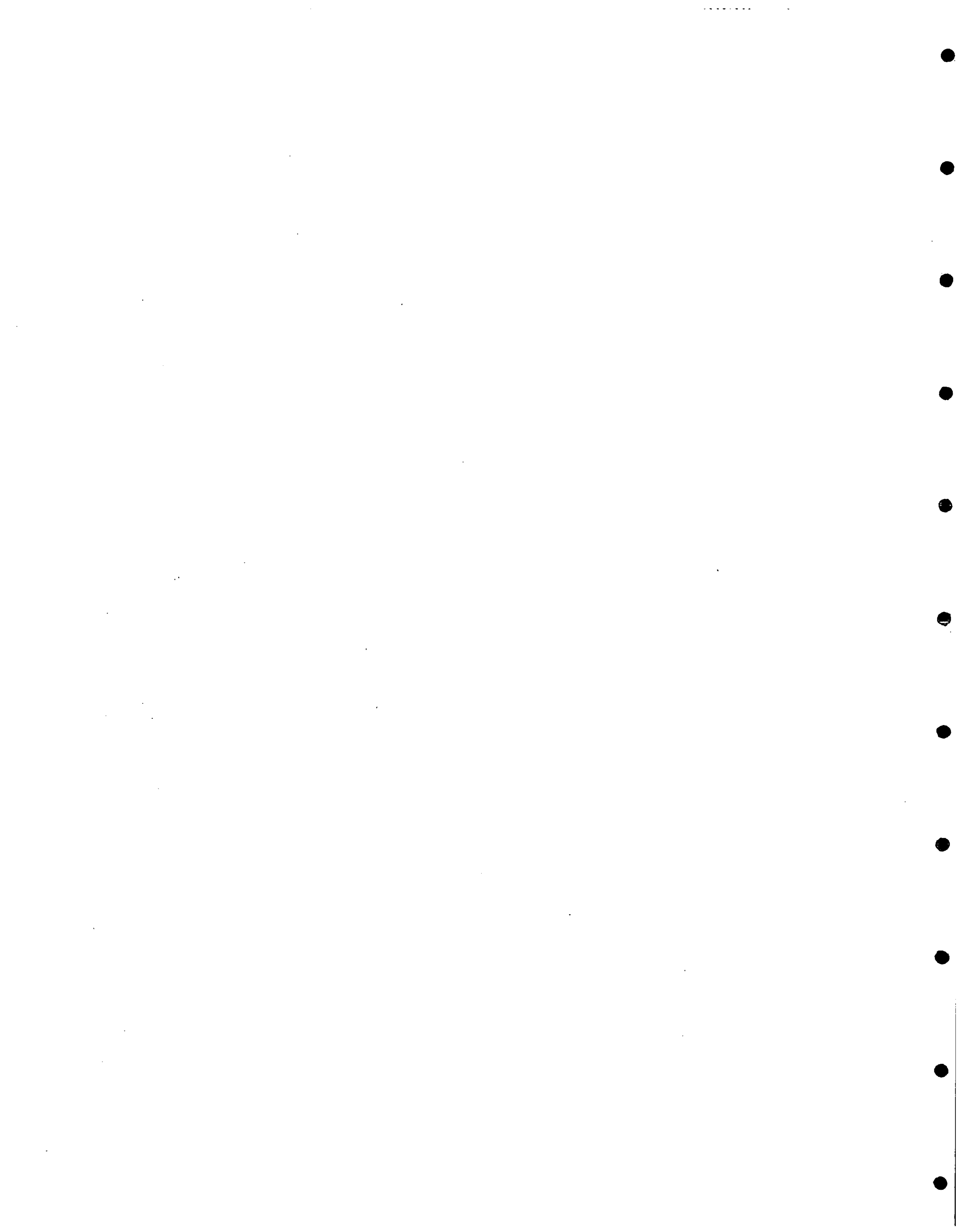
strengthened, rather than as an indication of failure or weakness. Probationers also participate in relapse rehearsal exercises where they begin to anticipate the many ways in which relapse occurs and develop specific coping strategies to counteract relapse.

Other treatment activities include building a drug-free social network, developing a balanced lifestyle, developing alternative sources of positive reinforcement, and building a long-term plan for recovery. Issues of motivation and commitment to the recovery process are addressed throughout this treatment module. A sample relapse prevention curriculum is presented in Appendix N.

Treating Criminal Thinking Errors

Drug abuse or addiction among inmates is closely linked with criminal thinking patterns, a criminal lifestyle, and criminal values. Criminal thinking is much like the distorted thinking of addiction and can be described by denial, minimalization and self- centeredness; but is presented in a different context. For example, inmates often blame the victim of their crime rather than accepting responsibility for their actions. Treatment consists of reorienting the offender's thinking and values by providing instruction to recognize and intervene with distorted thinking patterns. Specific treatment includes an introductory class, completion of thinking logs, review of thinking logs with a counselor, and group treatment that is focused on review and modification of criminal thinking. Appendix O contains sample exercises and information provided during treatment.

The introductory class includes four to eight hours of instruction on the meaning and impact of criminal thinking. Following basic instruction on terms and concepts, offenders individually list and share the tactics and errors they have most frequently used in the past and at present. "Thinking reports" are written daily (at times hourly) and require one to two hours of work outside the treatment group. The "thinking reports" are a device for probationers to track and explore their thinking process and to examine how that process leads to a destructive lifestyle. Each probationer meets for an hour,



once weekly, with their counselor to review their thinking log. This is necessary because the individual will begin to confuse thinking and feeling, and will otherwise lose focus of the assignment.

Probationers participate in group treatment sessions twice weekly, two hours per session, during Phase I of treatment, and once weekly during Phase II. Group sessions include review of methods to identify criminal thinking patterns and intervention strategies for criminal thinking and tactics. Much of this work consists of review of behavior grids for critical incidents (such as an angry outburst that may have occurred earlier in the week) in which the probationer presents his thinking, feelings and resultant actions as well as alternative thoughts, feelings, and behavior.

Skills of Daily Living

Many drug-dependent offenders have lost, or may never have had, basic life skills such as budgeting, cooking, or maintenance of health and personal hygiene due to their extensive drug use. These offenders often deny the absence of these skills due to embarrassment. The STOP program will assure that program participants are sufficiently knowledgeable and skilled in these areas to successfully live in the community. The STOP program includes two hours weekly for twelve weeks of instruction and practice in the basic skills of daily living during Phase I of the treatment program. Offenders are involved in one hour of daily living skills training per week in Phase II of treatment. Program participants are given pre-tests to identify skill deficits and post-tests to document improvement in skills and proficiency levels.

Leisure Skills

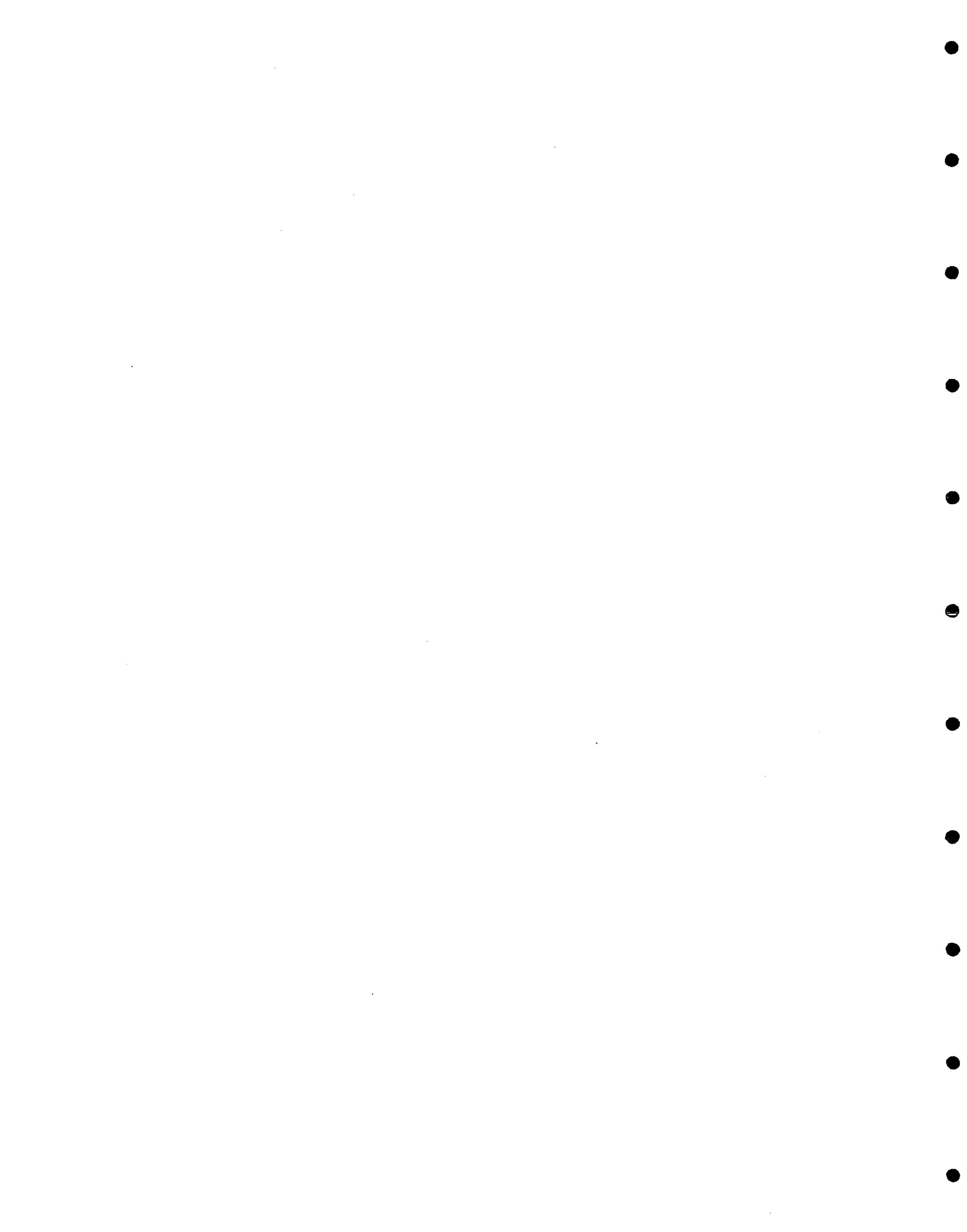
STOP participants are seen as entering the program with a history of recreational and social interactions focused around drug use. Typically, when asked what activities they enjoy other than drug use, drug offenders may indicate one or two hobbies (e.g. "fishing") but when asked further, disclose

that these activities occurred several months or years ago. As offenders return to the community, the presence of boredom and drug urges will often lead to relapse unless the individual has alternative pleasurable activities in his/her repertoire. Leisure skills training is a major component of several successful and comprehensive drug treatment programs for offenders, including the Cornerstone and Stay-N-Out programs described in Chapter 2. Involvement in a leisure skills program during the early stages of drug treatment provides an effective means to integrate leisure activities within the daily routine and provides a consistent source of self-reinforcement for pleasurable non-drug activities (Field, 1986). Leisure skills training begins by developing a regimen of healthy physical exercise that can be continued in the community. Offenders will be assisted in developing a variety of non-drug activities that are self-sustaining and reinforcing. In addition to learning new leisure skills, probationers will receive supervision in planning and scheduling weekly activities, and to carry out these activities. Leisure skills training is provided for approximately two hours per week during Phase I and II of treatment.

Self-Help Groups

Alcoholics Anonymous (AA) and/or Cocaine Anonymous (CA) or Narcotics Anonymous (NA) self-help groups are available at least five nights per week in Phase I and II of the STOP program. These groups are arranged through community affiliates of AA, NA or CA, and last from one and a half to two hours per group. All probationers are required to attend a minimum of three self-help groups per week during each phase of treatment. Self-help groups are based on the principles of AA and are oriented towards developing long-term rehabilitation. These groups are particularly effective in breaking down the self-centered and exploitative habits and values of cocaine abusers and encourage a more altruistic value system.

Self-help groups use peers as role models to encourage motivation and commitment to treatment and realistic hope for change to a drug-free lifestyle. These groups provide practical advice and information in the recovery process and bridge the gap between residential and outpatient treatment



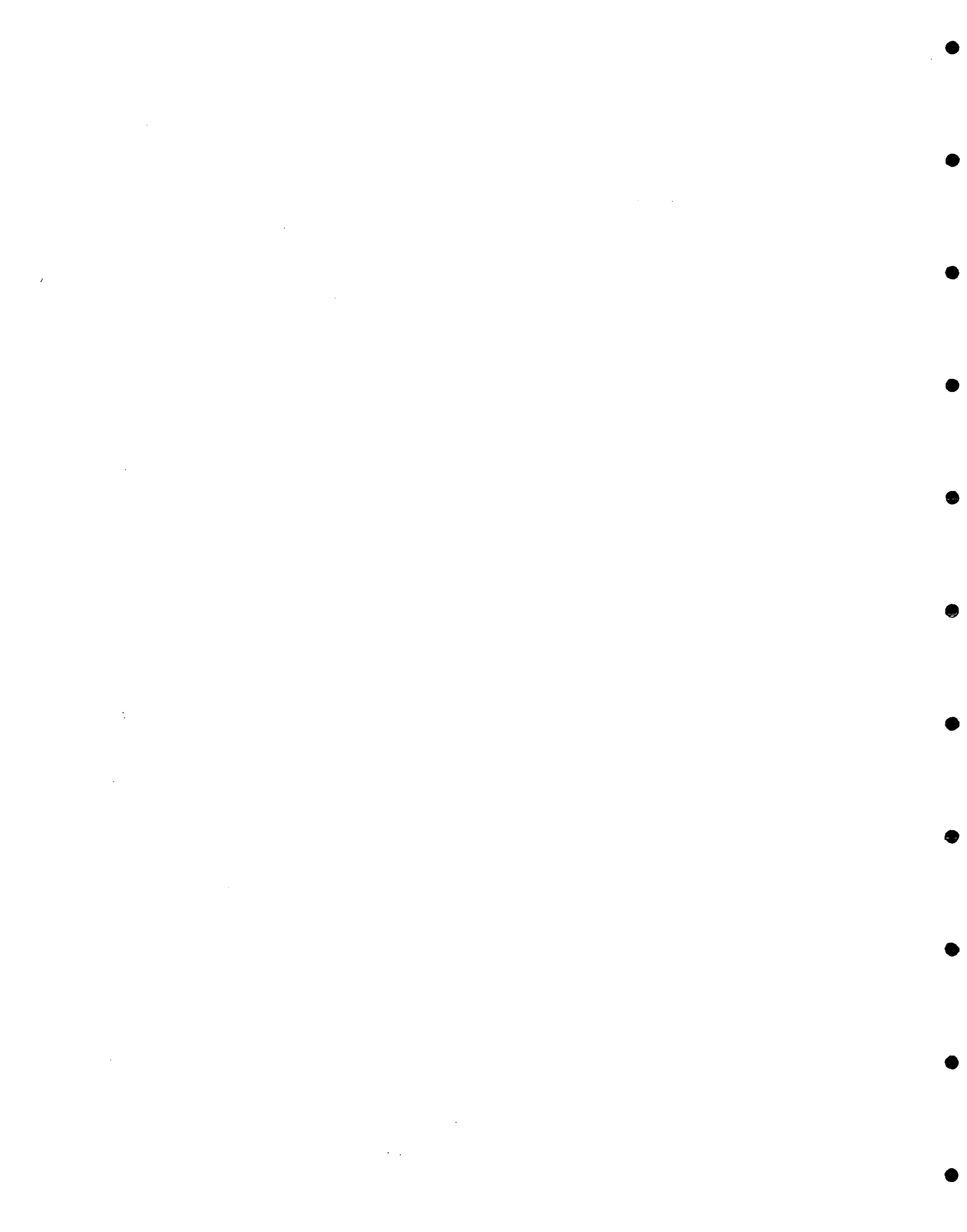
settings. The twelve-step model used in these groups is premised on the belief that addiction is a primary, chronic, progressive illness that is responsive to treatment but cannot be cured. Self-help groups provided in STOP are structured according to the following principles:

1. Addiction impairs normal physical, emotional, social, economic and spiritual functioning.
2. Recovery is a life-long developmental process wherein the individual, while maintaining abstinence, continues to learn and develop more effective life skills.
3. Treatment must be tailored to the unique circumstances of each individual, and each individual must ultimately accept personal responsibility for his/her own recovery.
4. Active association with the self-help fellowship is an integral component of recovery.
5. Abstinence from alcohol and other mood-altering drugs is essential to recovery and well-being.

Topics covered in self-help sessions include: introduction to the principles of AA/NA/CA, review of the disease/addiction process and the 12 steps to recovery, assessment of denial of drug addiction, and identification of other defense mechanisms presenting barriers to recovery (educational exercises related to consequences of drug abuse, honesty and empathy in recovery, manipulative relationships, structured group exercises including peer confrontation, and use of self-help and recovery groups in the community). Involvement in self-help activities during the followup phase of the STOP program focuses more on developing leadership and responsibility in planning for an abstinent lifestyle and developing a personal program of recovery. Sample exercises and materials to be presented in self-help groups are provided in Appendix P.

Drug Testing

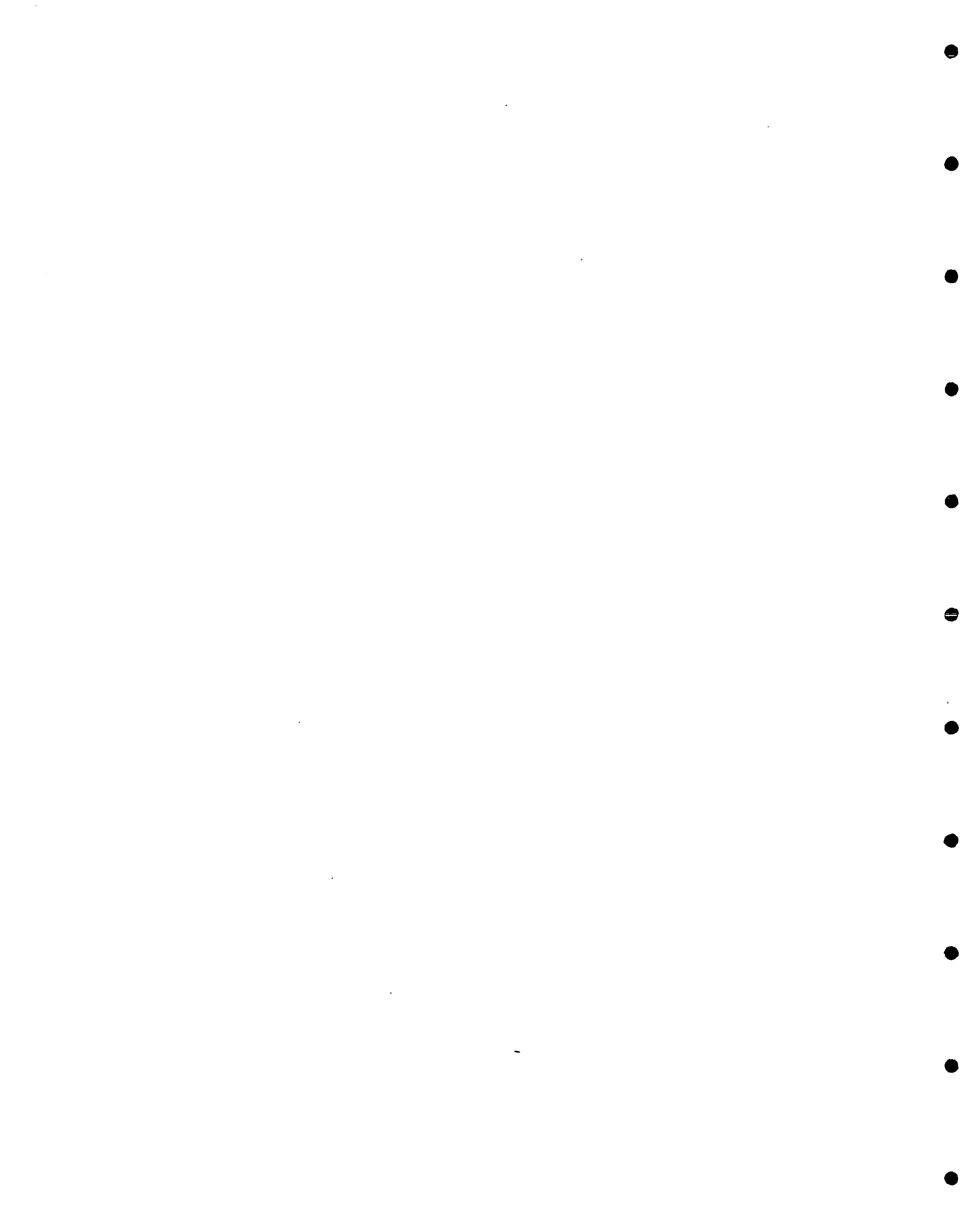
Random drug testing of STOP offenders is conducted by treatment counselors in all three phases of the program. Drug testing serves as a deterrent to the introduction of contraband to STOP



facilities and provides evidence of drug relapse throughout the program. Counselors administer drug testing on an average of at least once weekly during Phase I of the program and twice weekly during Phase II. Random urinalysis will be conducted by probation officers at least twice weekly during Phase III of the program. Urine samples are processed within 48 hours by a health care laboratory using the Enzyme Multiplied Immunoassay Technique (EMIT), the most widely accepted method of testing used within the criminal justice system. The treatment provider administers drug testing to evaluate abuse of the following substances (at minimum): cocaine, marijuana, alcohol, amphetamines, methamphetamine, opiates, and barbiturates. The provider may test for additional substances as appropriate.

Confirmation of challenged urine test results are obtained by gas chromatography/mass spectrometry (GC/MC) procedures, recommended by the National Institute on Drug Abuse as the preferred means of identifying false-positive results. Chain-of-custody procedures are established for legal purposes, and additional measures are taken to prevent probationers from invalidating urine specimens. Safeguards will be implemented to assess specific gravity and temperature of specimens to reduce false negative results.

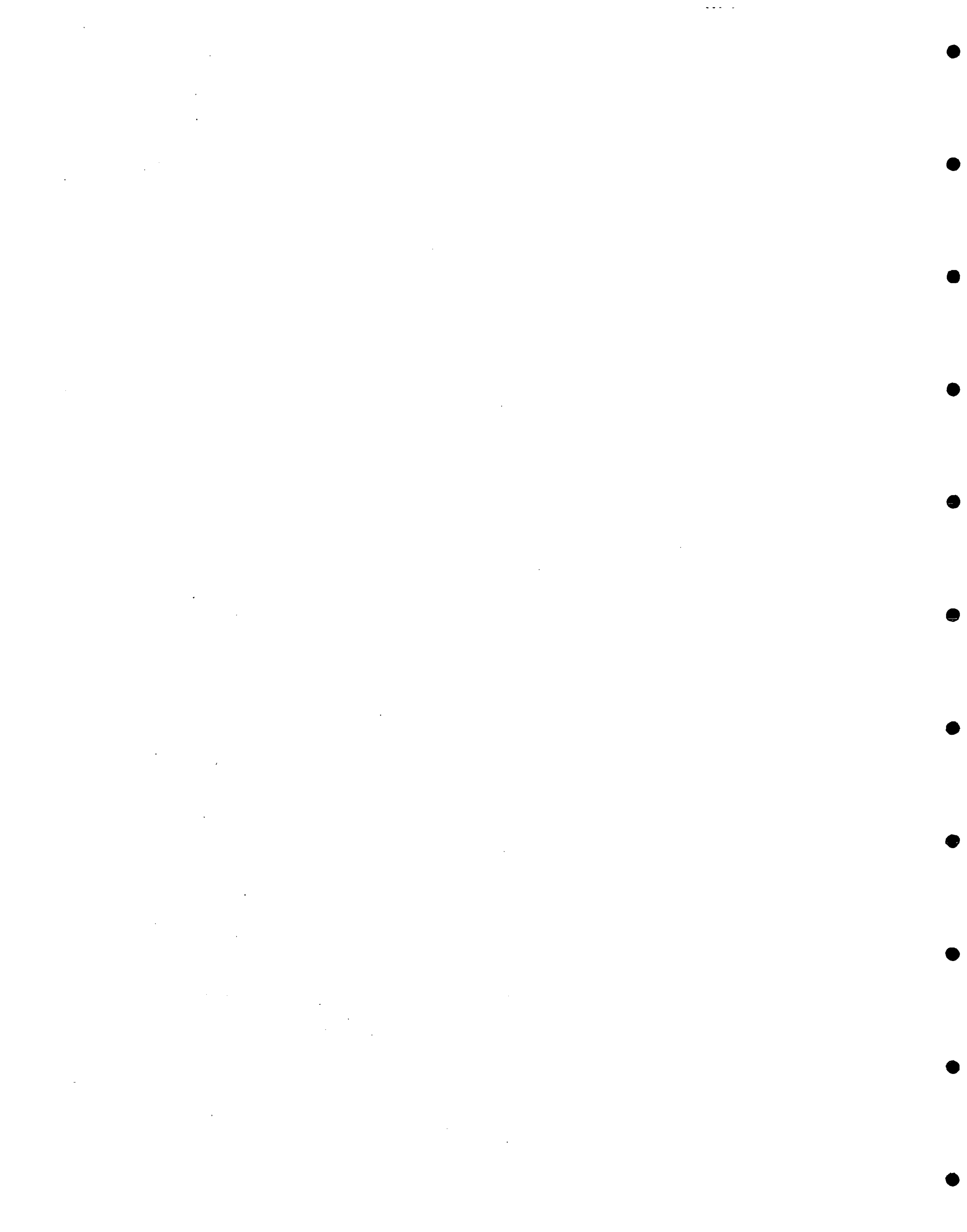
In the event of a positive drug test, the treatment counselor is required to contact the supervising probation officer and to convene a meeting of the treatment team to discuss sanctions to be applied. The treatment team reviews a series of predetermined graduated sanctions for each Phase of the program to be used if positive drug test results are obtained. The probationer is ordinarily confronted with evidence of drug use, receives enhanced supervision and more frequent drug testing. The individual may also be required to attend additional treatment activities and may lose program privileges. Frequent positive drug test results provide grounds for termination from the STOP program and possible revocation of probation.



AIDS Education and Prevention

As drug abusers are at high risk for AIDS through unsafe sex and/or I.V. use, AIDs education and prevention training is provided during Phase I and II of the treatment program. Eight sessions of training are presented to probationers, including six sessions of educational and skill-building exercises during Phase I, and two sessions of peer support exercises during the reentry phase. The program outline for each AIDS education and prevention session is included in Appendix Q. AIDS education and prevention sessions focus on three areas: (1) AIDS information, including how the virus works to immobilize the immune system, and methods of transmission, (2) health promotion, with foci on: (a) identifying and reducing unsafe sexual and drug abuse behaviors, (b) positive strategies to reduce risk of infection and to maintain good health (e.g. nutrition, exercise, stress management), and (c) increased sensitivity to bodily symptoms of disease, and (3) reducing tolerance for attitudes and behaviors associated with substance abuse, including an emphasis on encouragement and support from the group to reduce denial and rationalization supporting substance abuse.

Within each of these areas of emphasis, several prevention strategies are utilized: (1) awareness of staff and group attitudes consistent with reduction of substance abuse and recognition that prevention of AIDS-risk behaviors requires ongoing monitoring of attitudes and behaviors, (2) education in means of reducing exposure to HIV infection and support to apply new information, (3) integration of newly learned material regarding AIDS-risk behaviors including an awareness of the immediacy of the AIDs threat to one's own life, identification of risks that are currently being taken, and means of applying risk reduction in daily living, (4) skill-building and strategy development in avoiding and managing high risk situations for sharing needle works and for practicing unsafe sex including rehearsal of new skills, (5) peer support in challenging perceptions that there are no alternatives to unsafe behaviors in handling relationships or social interactions that promote continued drug and needle use, and in interacting assertively with sexual partners to explore safer sex practices.

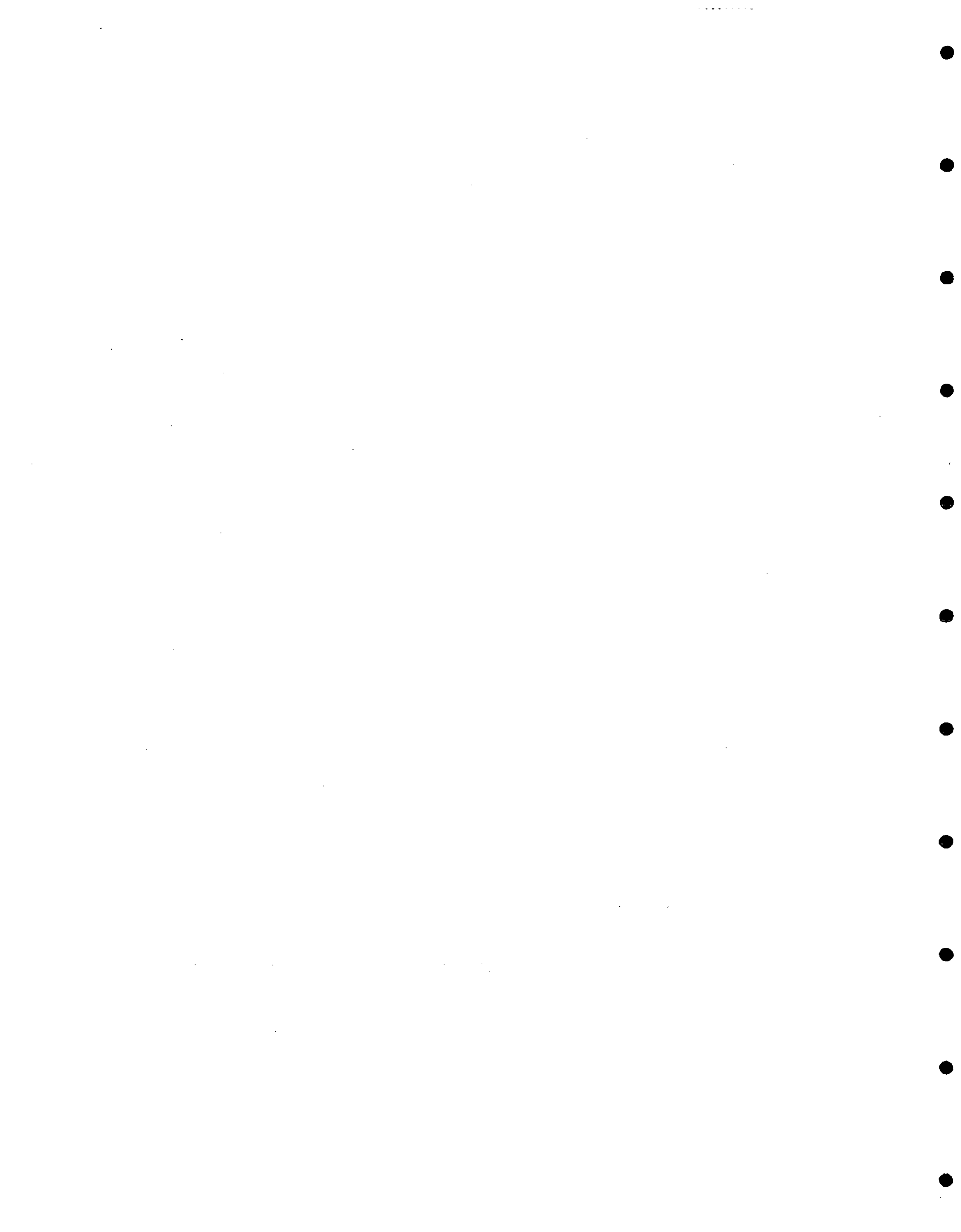


Initial AIDS sessions conducted during Phase I of treatment review barriers and fears associated with discussion of AIDS issues, the epidemiology of AIDS, the link between AIDS and I.V. drug use, definitions of high risk behaviors, and values clarification regarding attitudes about sexual behavior. Each probationer completes a comprehensive AIDS-risk assessment during this treatment module. Subsequent sessions focus on encouraging drug-free attitudes, contact with limited sexual partners, and condom use. Treatment also addresses the rationale for and benefits of AIDS testing, the importance of information provided by the test, and physical health issues including nutrition, exercise, and stress management.

Drug Education

Offenders are involved in drug education for one hour per week for the first 16 weeks of Phase I treatment. A drug education curriculum is to be developed in the first year of STOP program operation that assists probationers to: (1) identify stages of recovery from drug addiction, (2) recognize and understand the psychological and physiological effects of cocaine, methamphetamine, and other commonly abused drugs, (3) understand the development of addictive behaviors including compulsive patterns of abuse and denial of drug dependency, (4) understand the dysfunctional lifestyle of the drug user, and (5) understand how relapse affects recovery from drug abuse.

Each offender participates in several self-assessment exercises designed to enhance awareness of the severity of their own drug dependence, the frequency and severity of past cocaine use, and the impact of drug abuse on family members, employment, financial status, physical health and self-esteem. Additional assessment exercises encourage probationers to identify precursors to past drug relapse. Drug education also focuses on the importance of developing motivation and commitment to change to a drug-free lifestyle, means of enlisting support from friends, assisting others that are abusing drugs, and goals of community drug treatment programs, such as self-help groups.



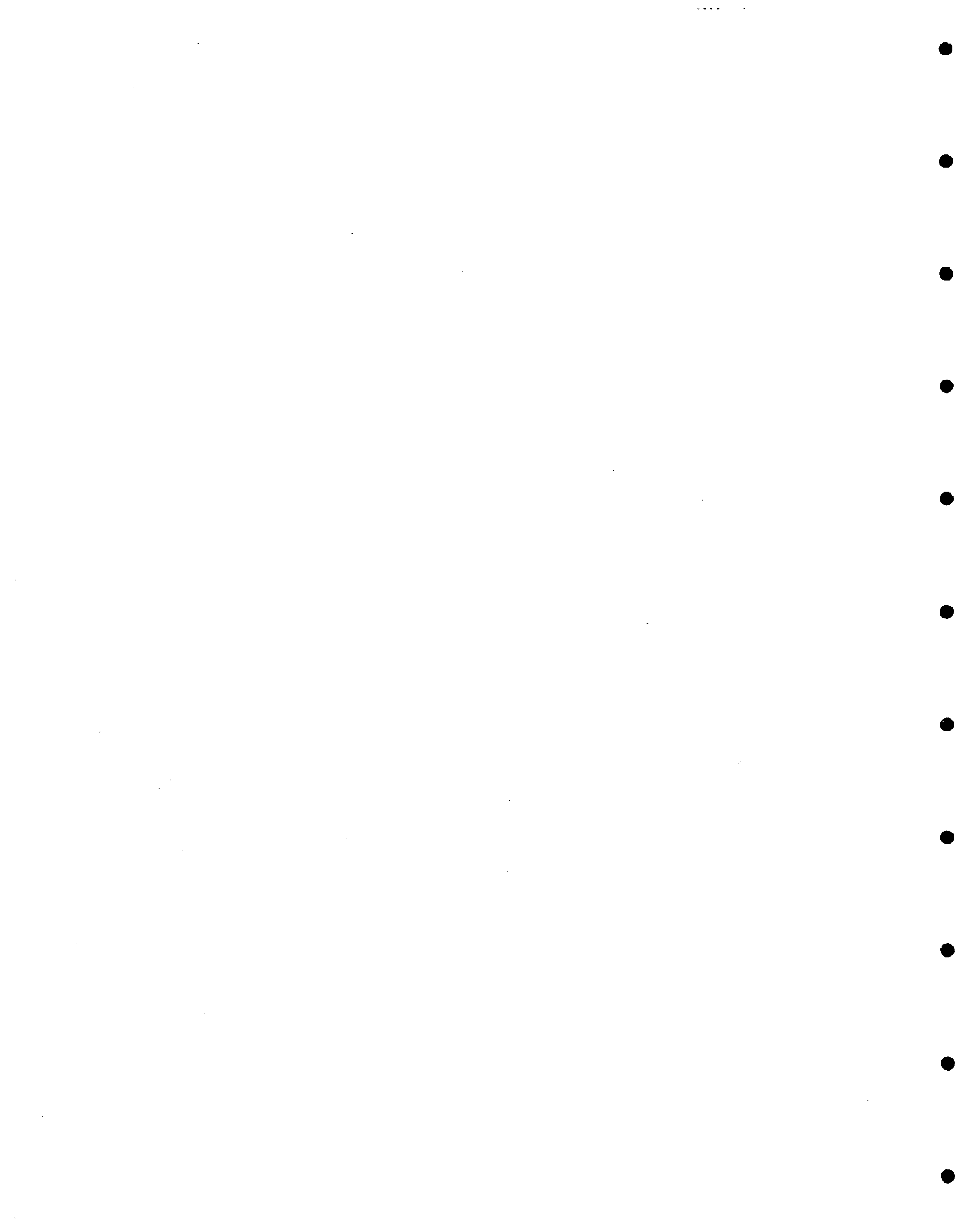
Individual Counseling and Psychiatric Consultation

Individual counseling is provided for offenders in each Phase of the STOP program. The primary treatment counselor will schedule individual sessions with the offender, ordinarily to be provided once a week during the first month of developing a treatment plan, and at least once monthly thereafter during each phase of the STOP program. The focus of individual counseling is on the individual's progress towards treatment plan goals, any conflict between the offender and other program participants or staff, development of prosocial attitudes and behaviors, and areas of personal growth.

Individual counseling and psychiatric consultation is also available for offenders with depression, suicidal thoughts, excessive anxiety, or other disorders requiring psychotropic medication. Mental health interventions will be ordinarily recommended in cases where psychopathology interferes with participation in designated treatment activities. All psychological or psychiatric consultations will be approved by the treatment team. Treatment counselors with expertise in mental health assessment and treatment are designated within each unit. Individual counseling sessions will be scheduled as often as needed and will be conducted in private counseling facilities, segregated from other program areas. Individuals requiring inpatient mental health care, extended crisis counseling or medication monitoring will be reviewed by the treatment team for termination from the STOP program and possible transfer to another DOC institution, as another community provider. Recommendations for transfer will be provided the court by the probation staff.

Supplemental Activities

Supplemental treatment activities are included in the treatment plan during Phase I and II of the STOP program according to the probationer's needs and interests and as determined by the treatment team. These activities are ordinarily presented for one to two hours per session, several times a week, for a period of six to eight weeks. Each supplemental activity will ordinarily be offered at least



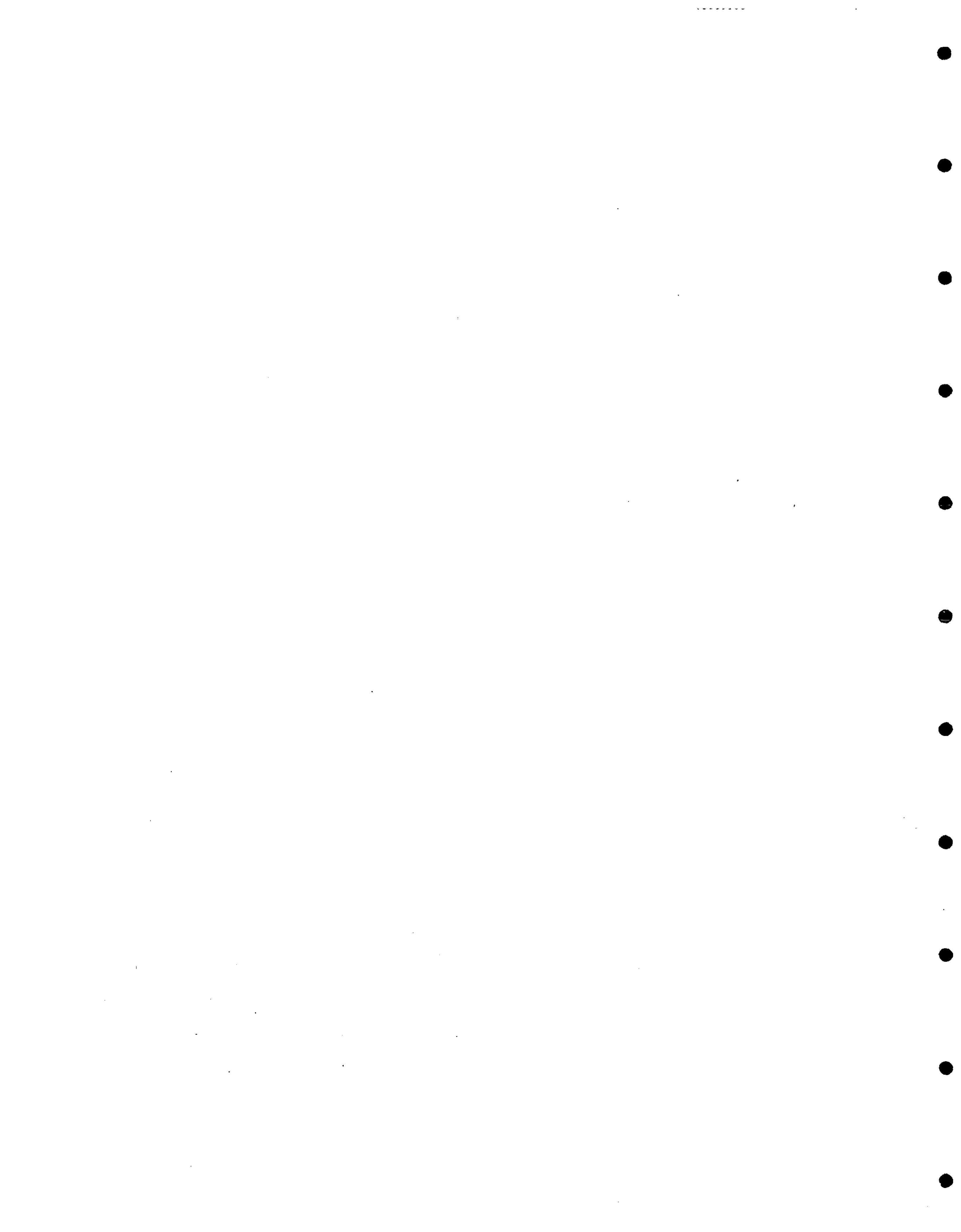
once every other month during Phases I and II of the STOP Program. Supplemental group activities will involve from eight to 25 offenders, according to the topic area. Treatment curricula for supplemental activities shall be developed in the first year of the STOP program operation. Curriculum manuals are to be developed by a qualified vendor to be selected by DOC in consultation with the STOP advisory board. Examples of treatment curriculum for several supplemental areas described below are presented in Appendix R. The following supplemental treatment activities are to be provided in STOP institutions:

1. Anger management. This treatment activity assists offenders to identify direct and indirect "trigger" events that precede anger and destructive consequences of anger, particularly those related to drug use. Offenders learn to restructure their thoughts to use coping self-statements, to detach themselves from the anger-provoking situation, and to reduce tension in these situations.

2. Problem-solving and decision-making skills. Offenders are often confronted by difficult situations that lead to impulsive behavior or inaction. These situations may involve drug use or may lead to drug use due to the desire to find an easy solution to the problem. This module provides techniques to recognize and identify difficult situations that may trigger drug use, to consider a range of approaches to resolve the situation, to select the most effective problem-solving approach, and to evaluate the outcome of the problem-solving approach selected.

3. Stress management. Long-standing difficulties in managing stress or tension can result in negative physical consequences such as insomnia, cardiac problems, or headache, or may result in alcohol or drug abuse. Stress and anxiety experienced by STOP offenders represent significant high risk situations for relapse to drug use. This module provides instruction to recognize signals of stress and to prevent buildup of stress before it leads to drug use. Offenders learn to use three basic relaxation skills involving reduction of muscle tension, breathing exercises, and relaxation imagery, and to rehearse these skills in situations that otherwise would lead to drug urges, cravings, or abuse.

4. Parenting skills. The majority of drug-involved offenders come from single-parent or dysfunctional family units and have not learned necessary skills to manage difficulties that arise due to discipline of children and marital conflict. The development of skills to maintain an intact family unit results in an important measure of stability and support for individuals working towards recovery from drug dependence. This module assists the probationer to identify sources of family conflict, to provide effective reinforcement and discipline in the home, and to develop skills in communicating, negotiating and compromising with their spouse. The offender also receives information regarding counseling resources and support groups available in the community to assist in the event of marital or family discord that is not easily resolved.

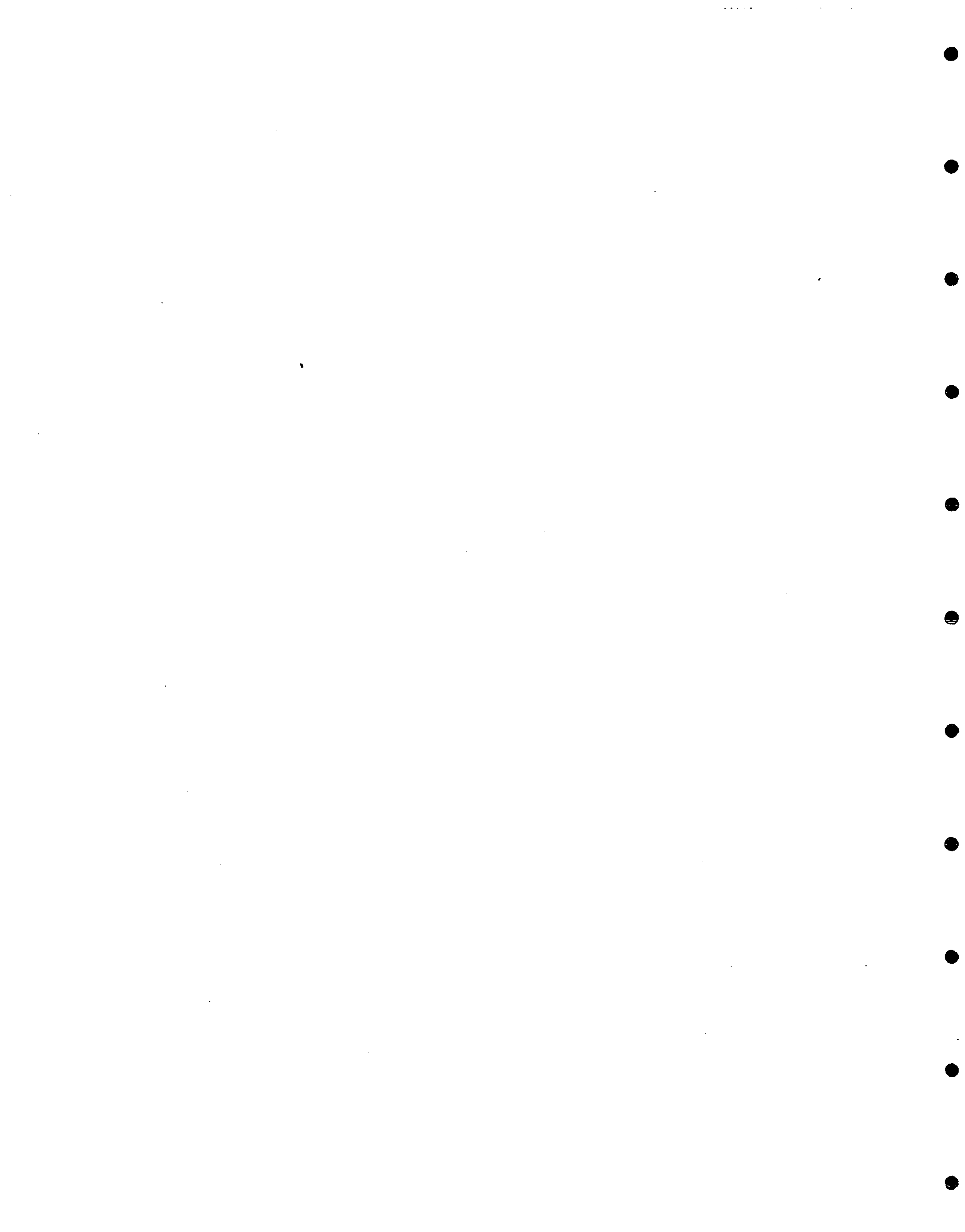


5. Communication skills. Communication skills often provide the means to develop supportive and intimate relationships with others. Drug-involved offenders frequently do not have well-developed communication skills, preventing them from giving and receiving positive comments from others, receiving constructive criticism, expressing feelings, and listening attentively to others. Many offenders attempt to self- medicate negative feelings (e.g. frustration, anger) through use of drugs and also indicate that drug use is one of the few ways they know to express positive emotions. Development of communication skills provides an opportunity to express positive and negative emotions more effectively and to prevent the resulting buildup of stress and anger that leads to drug abuse. STOP offenders learn to use active listening skills, to be aware of non-verbal behaviors that enhance communication, and to make effective use of positive feedback from others.

6. Development of assertiveness skills. Offenders often behave passively or aggressively in interpersonal situations with family members or drug-using friends. The absence of assertive responses to these situations leads to difficulties in communicating with others, in receiving social and emotional support, and to anxiety, frustration and anger; all increasing the likelihood of relapse to drug abuse. Passive behavior in dealing with drug-using family members and friends is also closely linked to relapse to use of drugs (Monti, Abrams, Kadden, and Cooney, 1989). In this module STOP offenders learn techniques to communicate clearly and directly with others, to identify and express negative emotions, and to propose compromises or alternative courses of action in conflict situations. Offenders also rehearse skills used to give and receive criticism related to substance abuse, and drug refusal skills.

Education and Vocational Training

A comprehensive educational and vocational rehabilitation program within the STOP program includes a range of skill development opportunities to enable each offender to obtain skills commensurate with his interest and abilities. Goals of educational and vocational programs are to enhance basic life skills, to develop marketable vocational skills, and to improve educational skills to allow the offender to maintain benefits from treatment and to gain employment in the community. Specific objectives include development of fundamental reading skills, placement of each offender in employment and/or vocational training during Phase II and III of the program, and achievement of the GED by completion of Phase III of the STOP program. In the pursuit of these goals, a comprehensive educational/vocational program is developed for each offender during intake. This will consist of: (1) basic literacy skills, (2) GED completion, (3) employability skills and (4) vocational skills. These



activities are supported by several supplemental treatment activities available during Phase I and II of the STOP program, including problem-solving skills, communication skills and skills of daily living. Appendix H provides a recommended staffing pattern for educational and vocational programs.

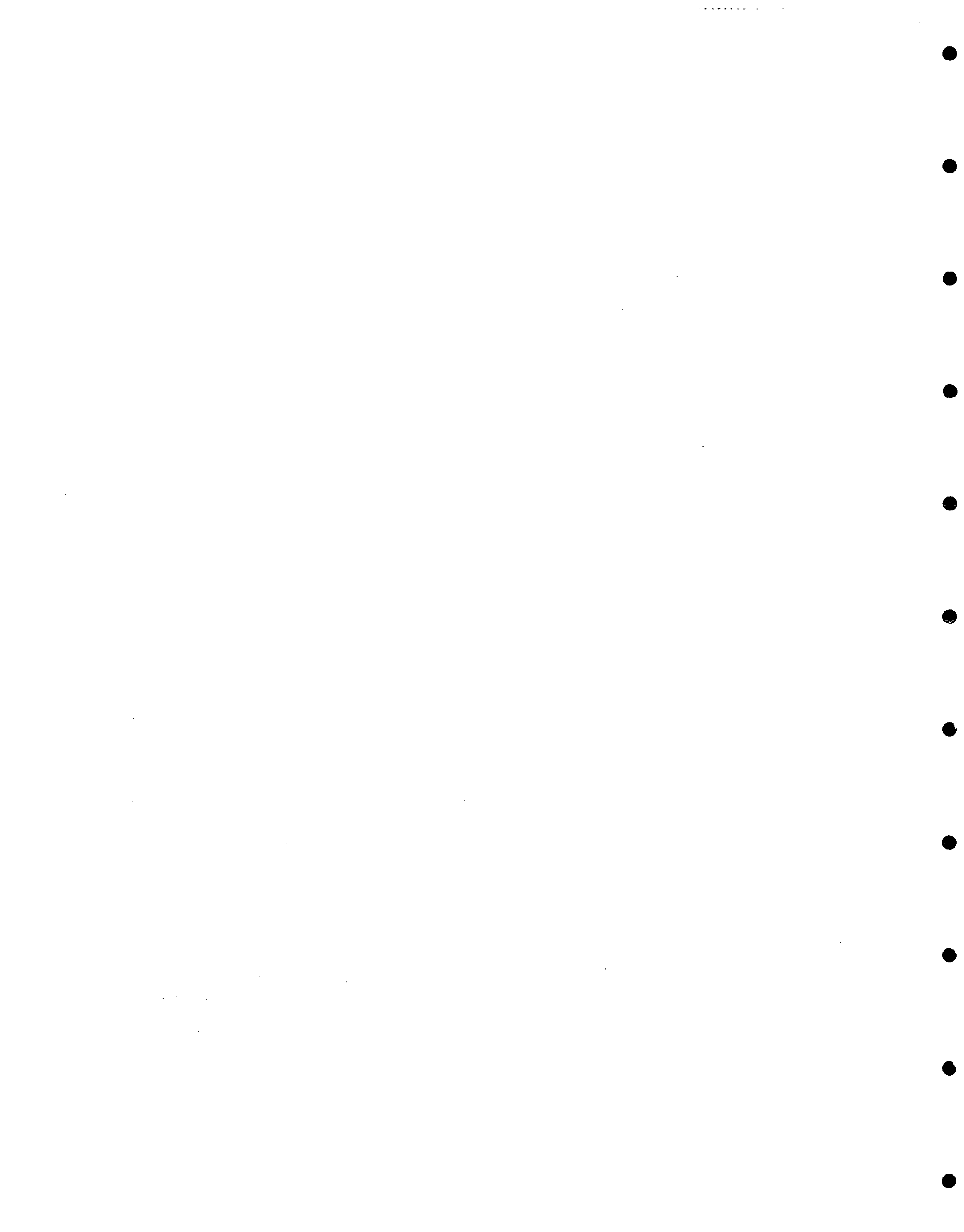
Each of the four components of the educational/vocational program involve assessment, individualized program planning, participation in educational and vocational activities and post- program placement. Each of these program components shall be staffed by professional educators or trainers with demonstrated competency in educational and vocational training. Staff development activities are recommended during the first year of program operation to ensure that staff have demonstrated competencies in areas of educational/vocational training.

Educational/Vocational Assessment

STOP offenders are evaluated during Phase I of treatment to assess specific skills in each of the identified educational and vocational curriculum components. Assessment will be a continuous process throughout each phase of the program. Pre and post-testing assessment measures will be taken in areas of vocational and employability skills to evaluate the impact of vocational programs. The following areas of assessment will be provided during the program:

1. Academic Skill Assessment. A criterion test of basic skills is used to evaluate each offender's skill level in the areas of word identification, comprehension, computation and use of algorithms. Information regarding literacy skills provides the basis for assessment of vocational interest and abilities, and vocational counseling.

2. Vocational Assessment. An essential component of the program includes assessment of vocational interests and aptitudes. Each probationer receives a vocational evaluation, consisting of a vocational aptitude and interest measure. The results of these measures are used to indicate a number of vocational options for the probationer. Offenders are provided individual vocational counseling, to assist in identifying a specific area for further vocational training. Monitoring will be conducted to determine the appropriateness of, and progress in, vocational training relative to local norms. Additional vocational assessment is conducted through work samples, situational assessment and task analysis.



3. Employability Skills Assessment. The importance of employability skills such as the ability to follow directions, punctuality and dependability are among the most important for success in entry level positions. These skills are evaluated by use of a specific skills checklist completed by staff, such as the San Francisco Street Survival Checklist. Job acquisition skills are also assessed through objective measures and mock interviews. Probationers are evaluated for current GED status through administration of the GED prediction test. This instrument surveys each of the five GED subtest areas and has a predictor coefficient of $r = .8$.

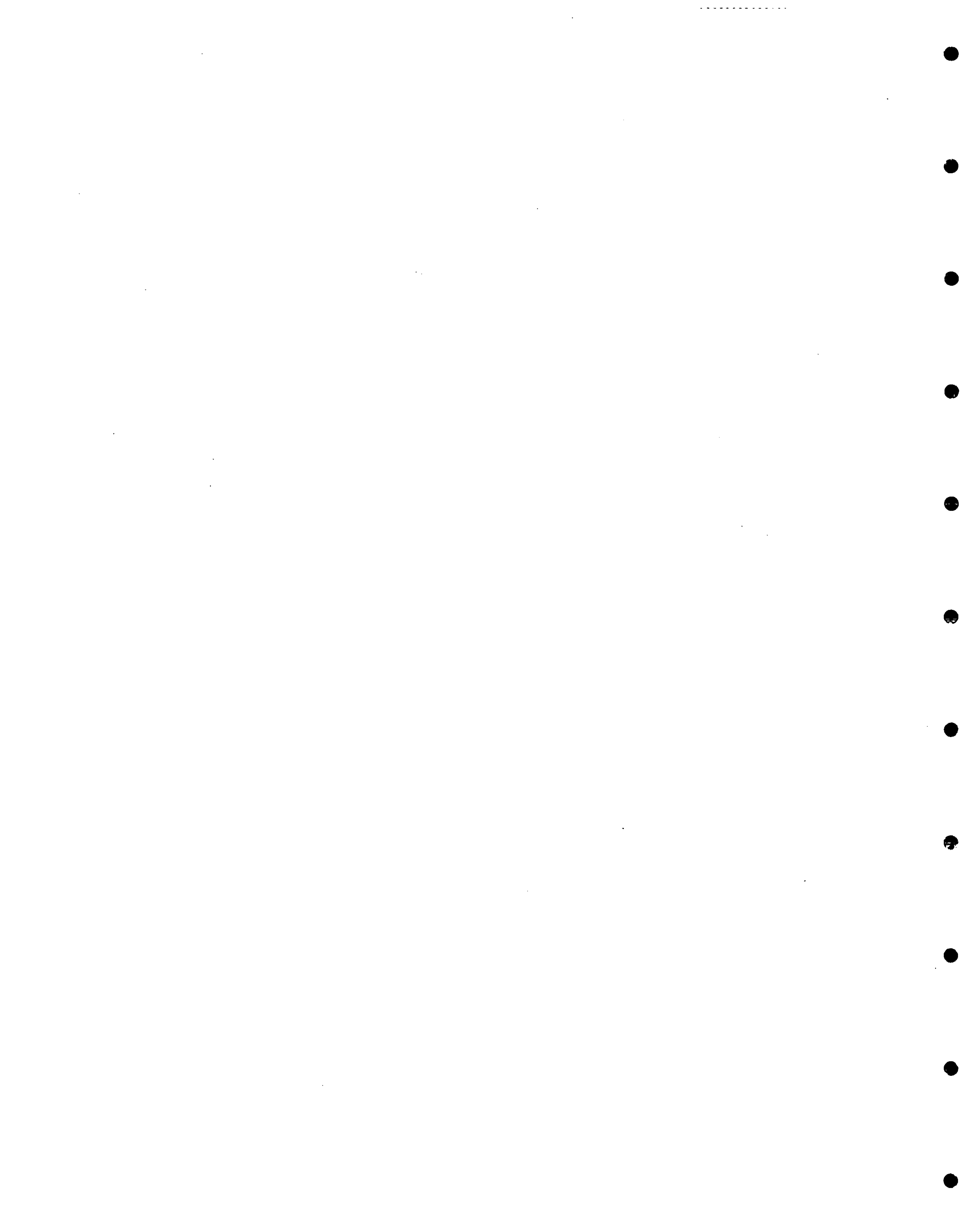
Educational and Vocational Activities

Educational and vocational interventions provided during each phase of the STOP program will assist probationers to acquire functional skills, thereby increasing the likelihood of social adjustment during reentry. The STOP educational and vocational program is designed to address the needs, abilities and interests of each probationer, using the most current curricula and teaching techniques. The STOP program will provide the following educational and vocational interventions:

1. Basic Literacy Intervention. Basic literacy programs will be individualized for each offender, with specific skill assessment leading to interventions related to identified deficits in vocational training and life skills. This program is designed to improve literacy and to facilitate acquisition of content knowledge. This approach maximizes participant motivation and accomplishes basic goals related to functional achievement.

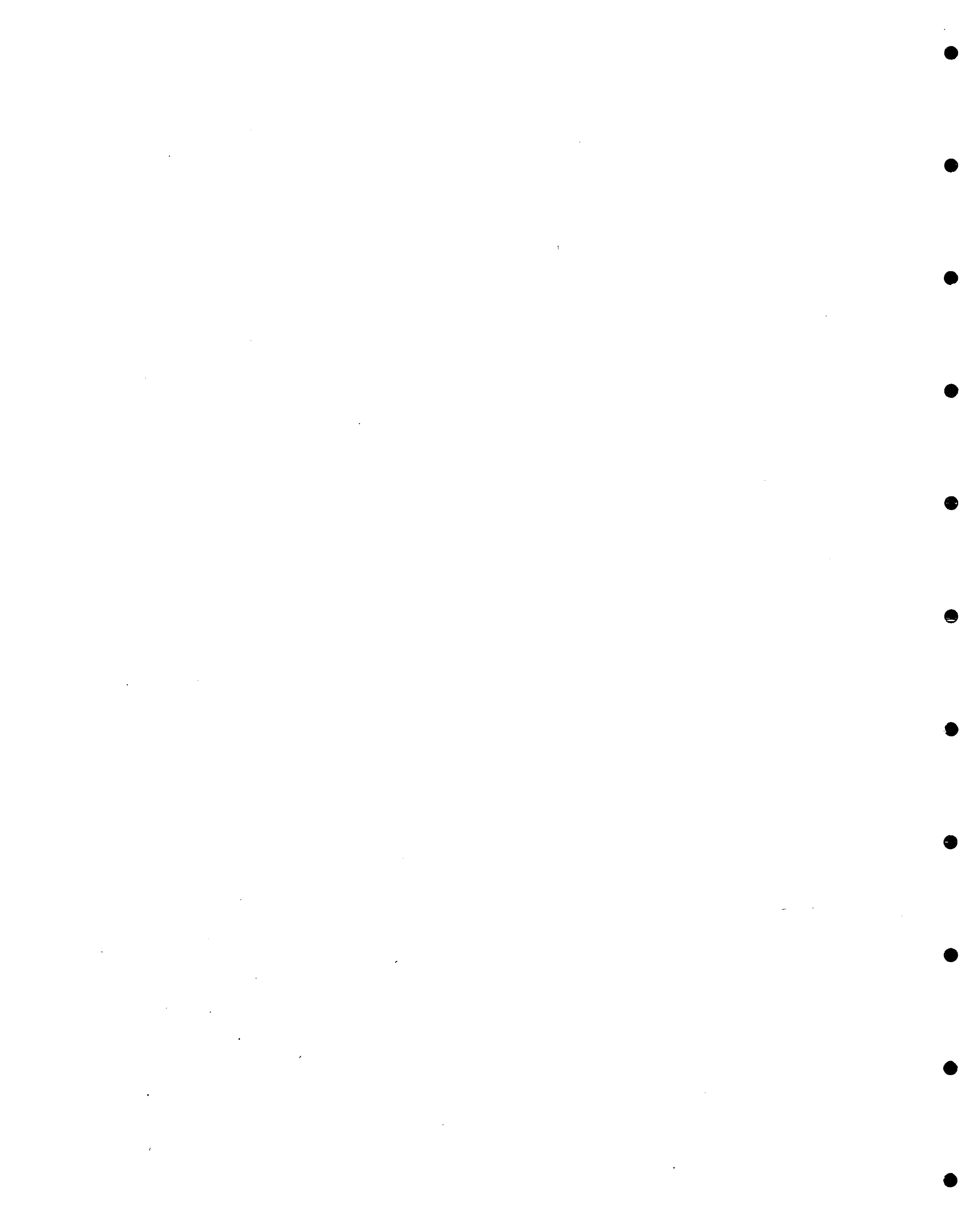
2. GED Completion. GED training will be provided to assist offenders in completing the GED. Training will include use of existing materials developed to address specific skill sequences which correspond with the five subtest areas of the GED. Individualized programs to develop literacy skills and to work towards completion of the GED will be provided at least five times weekly for one hour per day during Phase I of treatment and at least twice weekly during Phase II. Casemanagement staff will work with probationers as needed to continue GED classes in the community during Phase III of the STOP program.

3. Vocational Training. Vocational training provides an opportunity to increase employability and community involvement during Phases II and III of the STOP program. Vocational staff at STOP facilities are to encourage community involvement in the development of vocational training programs and job placement committees. This maximizes job training and placement sites available and facilitates more rapid assimilation of the STOP offender to the community. All STOP offenders who are assessed as needing vocational skills will be expected to participate in intensive vocational training during Phase I of treatment. This training will be provided at least three times weekly for one hour per session and will be supplemented by institutional



work placements. Each STOP offender will participate in a full-time (40 hours per week) supervised vocational training program or job placement during Phase II and III of the STOP program.

4. Employability Skills Training. Employability skill training includes development of job seeking and retention skills that are critically important to successful community adjustment following completion of the STOP program. Employability skill training is accomplished in both academic and vocational settings to increase opportunities for skill acquisition and generalization. These activities will be offered during each Phase of the STOP program.



Chapter 6

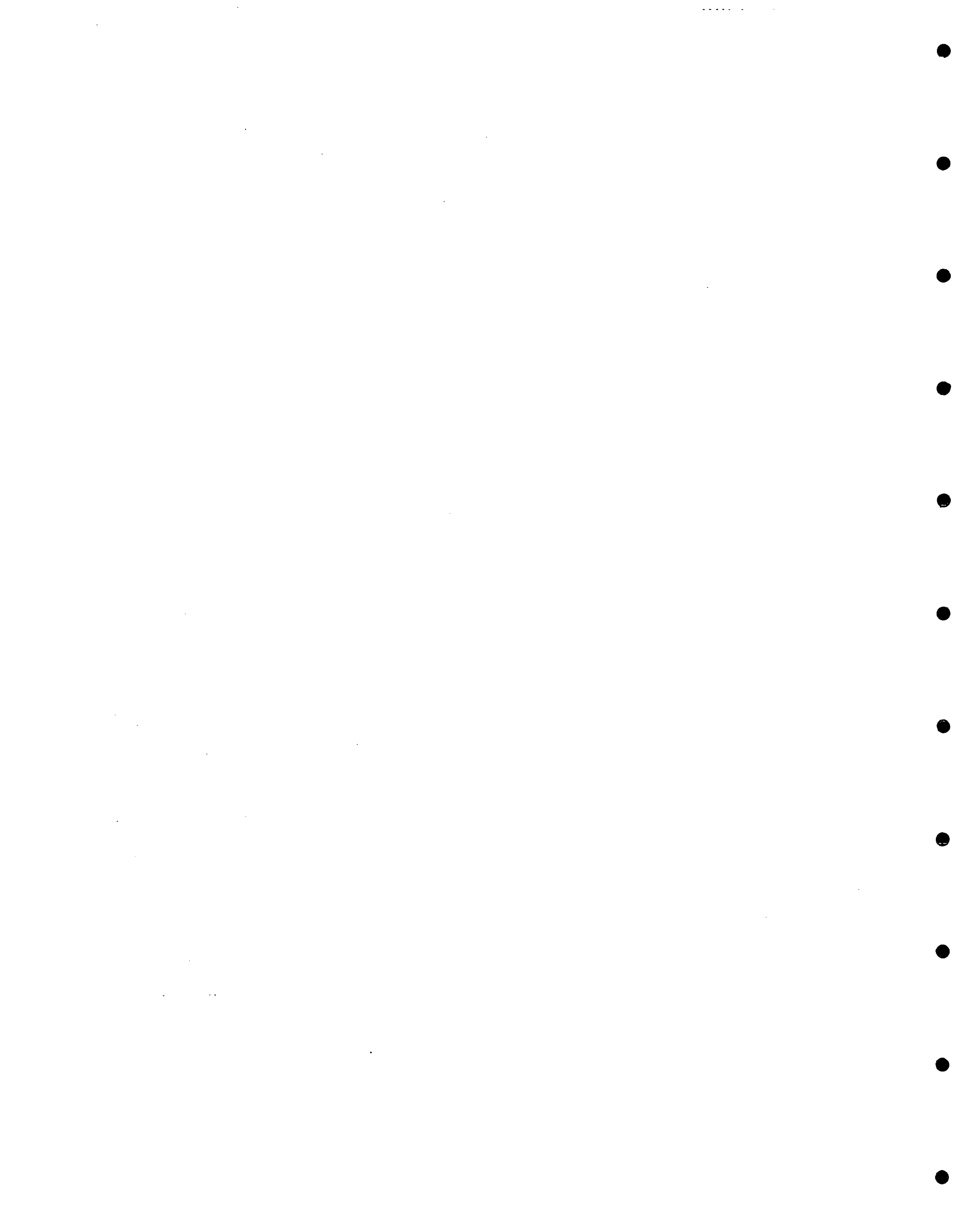
PHASED IMPLEMENTATION

Nearly 2,000 probationers and community controllees are violated each month in the state of Florida for violation of conditions of probation (Department of Corrections, Research Division, January, 1990). Conservatively, 20% are estimated as appropriate for the STOP Program and would, without the program be committed to a Florida prison bed. Of 4800 potential assessments, 25% are estimated to qualify for STOP for 1200 diversions from a prison bed each year. Our estimates suggest that for 1989, adult STOP programs would have required at least six Phase I facilities designed for 140 probationers each.

Currently Florida's drug program vendors are not seen as capable of bringing six major STOP facilities into operation in one year with each facility offering three treatment units of 40 probationers each and six intake units of 20 each. The STOP consultants advised that other states have attempted to implement drug treatment programs without consideration of the limited numbers of trained drug treatment specialists and the need for systematic staff development to accompany phased implementation. In addition, six reentry facilities are required statewide with the associated specialized probation aftercare caseloads in the affected DOC regional probation offices.

Five Year Implementation Schedule

Because of the limited number of certified drug treatment professionals, the limited number of supplementary professionals acquainted with the treatment of drug offenders, and the anticipated impact on probation officer caseloads, phased implementation is recommended. The first implementation phase is recommended to bring into operation one STOP program the first year. This



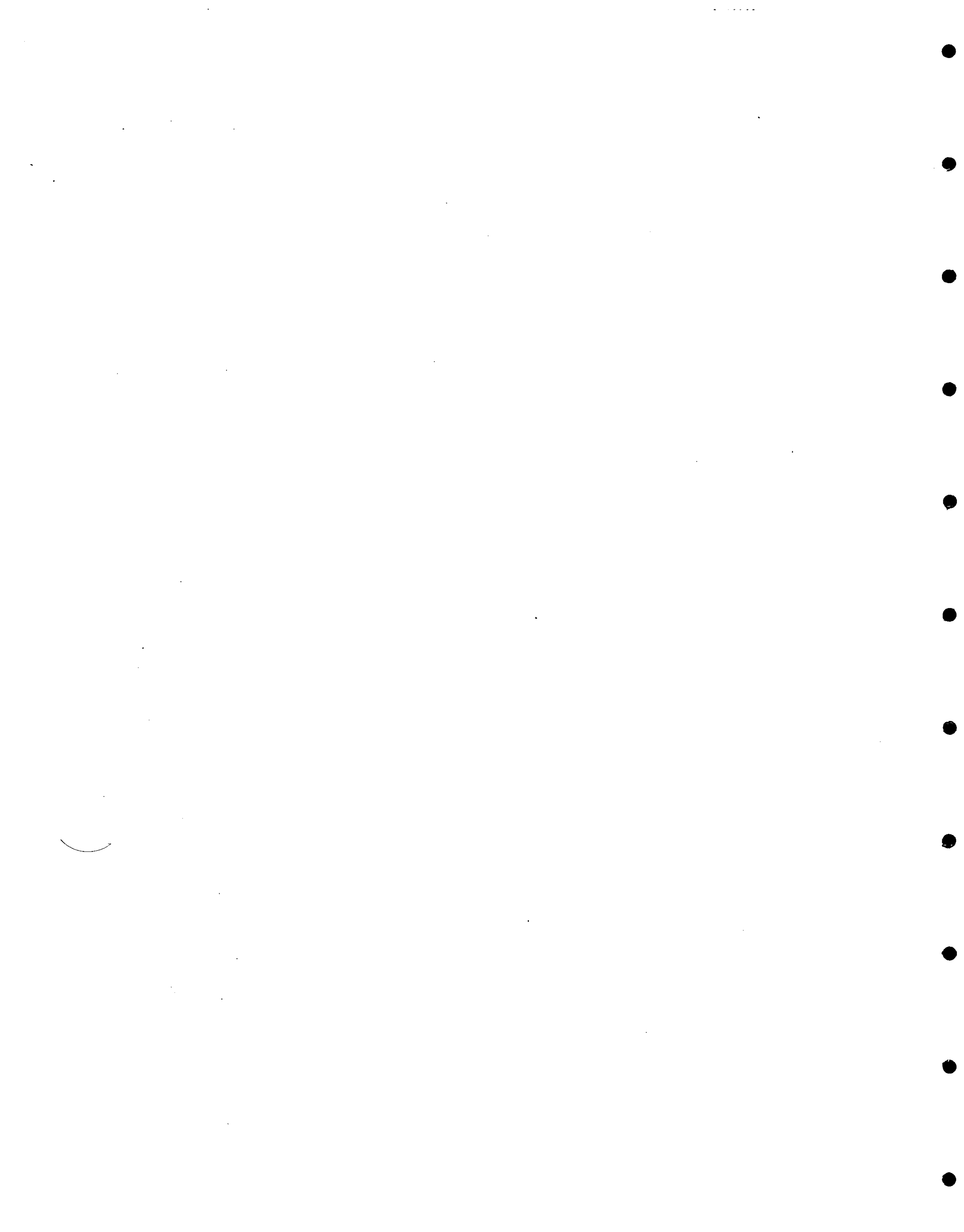
STOP facility would be accessible to only one judicial circuit, and should be a circuit with a large population of drug-involved offenders currently under probation supervision potentially eligible for a STOP program.

The second year two additional STOP programs are brought into operation serving two additional circuits in urban areas having large populations of drug-involved probationers.

Years three through five would add sufficient STOP facilities to provide STOP services to the remaining seventeen circuits. A needs assessment survey will be conducted by the Department of Corrections working with FMHI during year one of STOP implementation. This needs assessment will be reviewed by the STOP advisory board. This survey will evaluate the need for STOP facilities in each of the remaining judicial circuits, based on numbers of drug-involved probationers, drug-related probation violations, and other statistics. The number and location of the remaining STOP facilities will be determined on the basis of results from the needs assessment survey.

The three circuits that are the top major contributing circuits committing inmates to the Department of Corrections are Broward, 17th Judicial Circuit, (16.7% of FY 88-89 commitments), Hillsborough, 13th Judicial Circuit, (10.7% of FY 88-89 commitments) and Dade, 11th Judicial Circuit, (10.3% of FY 88-89 commitments). These figures are based on data from the DOC annual report, 1988/1989. These three counties/judicial circuits are targeted for the first STOP adult facilities and services.

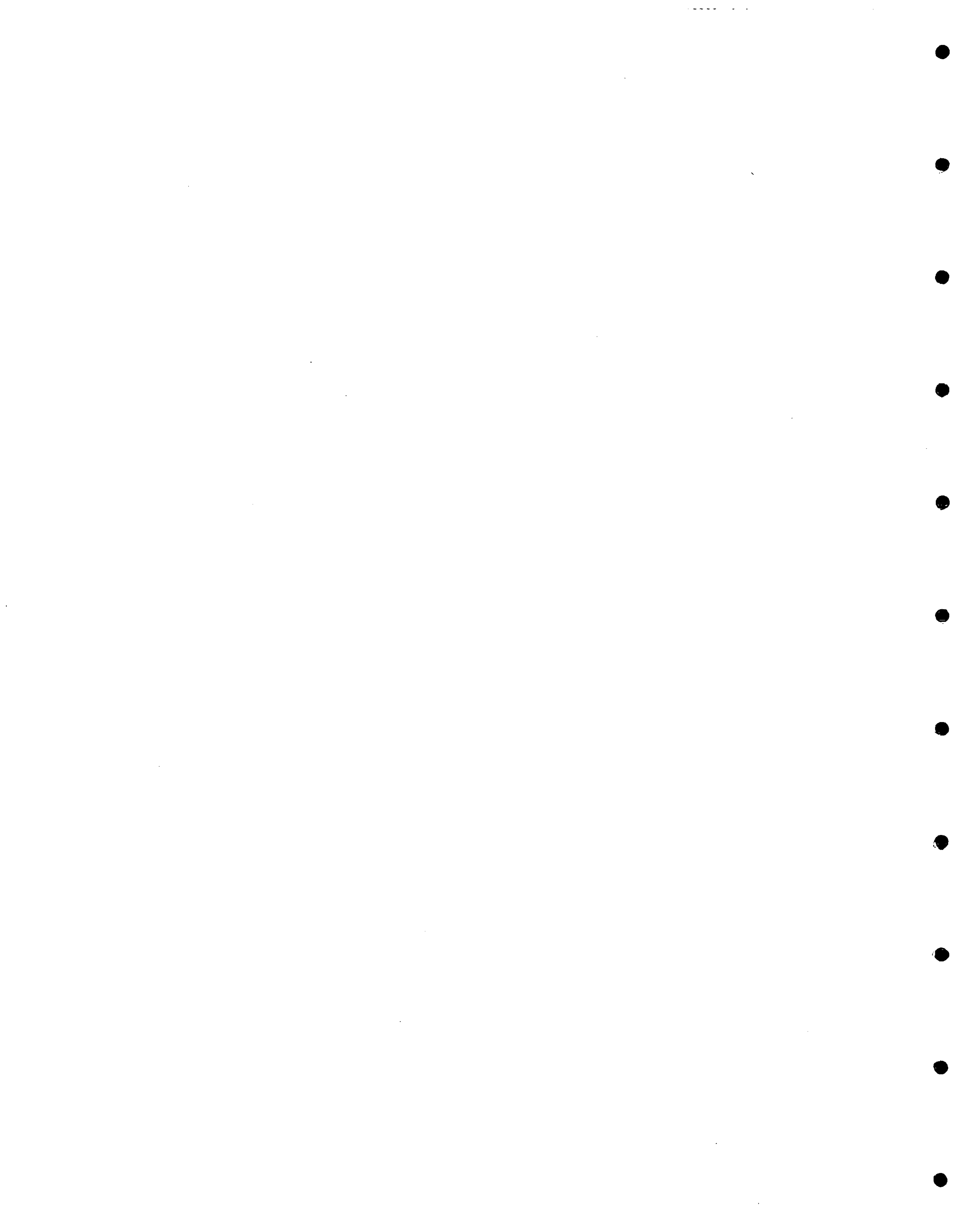
As FMHI will play an initial role in pre-qualifying vendor proposals, training, monitoring and evaluating STOP adult programs, Hillsborough County, the 13th Judicial Circuit is recommended for the first STOP adult program. This siting will simplify the logistics of implementation. Two additional facilities - one each for Broward and Dade Counties (the 17th and 11th judicial circuits) are recommended to be implemented in the second year. The needs assessment conducted by the Department of Corrections working with FMHI will determine the overall number of STOP facilities needed for statewide operation and the number of facilities needed to meet the diversionary service demand. It is recommended that each Judicial circuit be assigned a minimum of one STOP facility



(maximum of 140 beds for each Phase I facility). Note: While a Phase I STOP facility should not exceed 120 participants (+ 20 intake beds), a single treatment unit is not to exceed 40. Depending upon circuit need a STOP facility can be as small as forty treatment beds (+ 5 intake) or 80 treatment beds (+ 12 intake beds).

Each STOP facility should be located with reasonable accessibility to the committing circuit so that the significant others of each STOP offender can be included in treatment as appropriate to the offender's treatment plan and the program can access the necessary treatment professionals, drug treatment vendors, vocational and training opportunities etc. to support effective and quality treatment services. For example, the Broward County STOP community should be served by a Phase I facility which is accessible to the STOP offender's family, to community resources who will assist in the integration to the community, to employers who will hire the STOP client, to the probation officers who should be systematically linked to treatment progress, community needs, and to follow-up community treatment providers. Continuity of care and good casemanagement for effective programs should not be frustrated by the isolation of program components one from another or from the community to which the STOP offender will return.

If the Phase I facilities are located within access of each committing circuit then the reentry component can be co-located with the Phase I component. The only necessary qualification of such co-location is that the reentry component be capable of programmatical and physical segregation from the secure Phase I facility and be amenable to a graduated release function allowing increasingly open access to community activities for the graduating reentry STOP participant. These reentry activities should follow and be consistent with each participant's treatment program. The STOP advisory board will advise DOC on the development and implementation of the STOP program. Major responsibilities of the board are to assure that assessment, treatment, and evaluation programs are conducted in an effective and timely manner, and in accordance with the STOP program design. The advisory board may review difficulties that arise in any area of the STOP program and recommend to the Department of Corrections or to the Florida Mental Health Institute program procedures to remediate these difficulties.



The STOP advisory board will consist of at least one staff from the Department of Corrections, the Department of Health and Rehabilitative Services, the Florida Mental Health Institute, the Florida Alcohol and Drug Abuse Association, and a member of the judiciary[1]. The advisory board will meet at least quarterly during the first two years of the STOP program, and twice yearly after this period. This board is strictly advisory and will report to the Department of Corrections, Assistant Secretary of Programs of the Department (or his/her designee). The Florida Mental Health Institute will staff this board.

STOP Activities

Year One

In order to implement the STOP adult programs the following activities are required:

Department of Corrections

1) Enter into contract to fund FMHI for STOP Quality Assurance and Program Evaluation Activities.
2) Appointment of Advisory Board.
3) Design of STOP facilities for Phase I and II.
4) Site location and acquisition for Phase I and Phase II facilities.
5) Development of requests for applications for STOP Phase I and Phase II program providers. There requests for applications will be developed in collaboration with FMHI and reviewed by the Advisory Board.
6) Development of requests for applications for STOP assessment services. These requests will be developed in collaboration with FMHI and reviewed by the Advisory Board.

[1] A member of the Florida Consortium may also be designated as a member of the STOP Advisory Board.

7) Contract for construction of STOP Phase I or Phase II facilities.

8) Enter into contracts for STOP Phase I and Phase II program providers.

9) Develop requests for applications for STOP vendor training programs. These requests will be developed in collaboration with FMHI and the STOP advisory board.

10) Enter into contracts for training vendors to train Phase I, Phase II, Phase III, and Assessment providers.

11) Design and conduct STOP needs assessment to allocate STOP programs statewide.

12) Hire STOP probation staff.

13) Monitor STOP vendors.

14) Train vendors and probation staff.

FMHI

1) Sign contract to fund STOP activities.

2) Designate member of Advisory Board.

3) Hire STOP staff.

4) Assist Department of Corrections develop requests for applications for Assessment, Phase I, Phase II, and Phase III vendor competition.

5) Review and pre-qualify vendor proposals based on vendor qualifications and quality of STOP proposals.

6) Develop quality assurance client care monitoring and evaluation procedures to implement STOP.

7) Assist DOC in facility design to implement Phase I and Phase II programs.

8) Assist DOC in site selection.

9) Assist DOC in development of training request for applications.

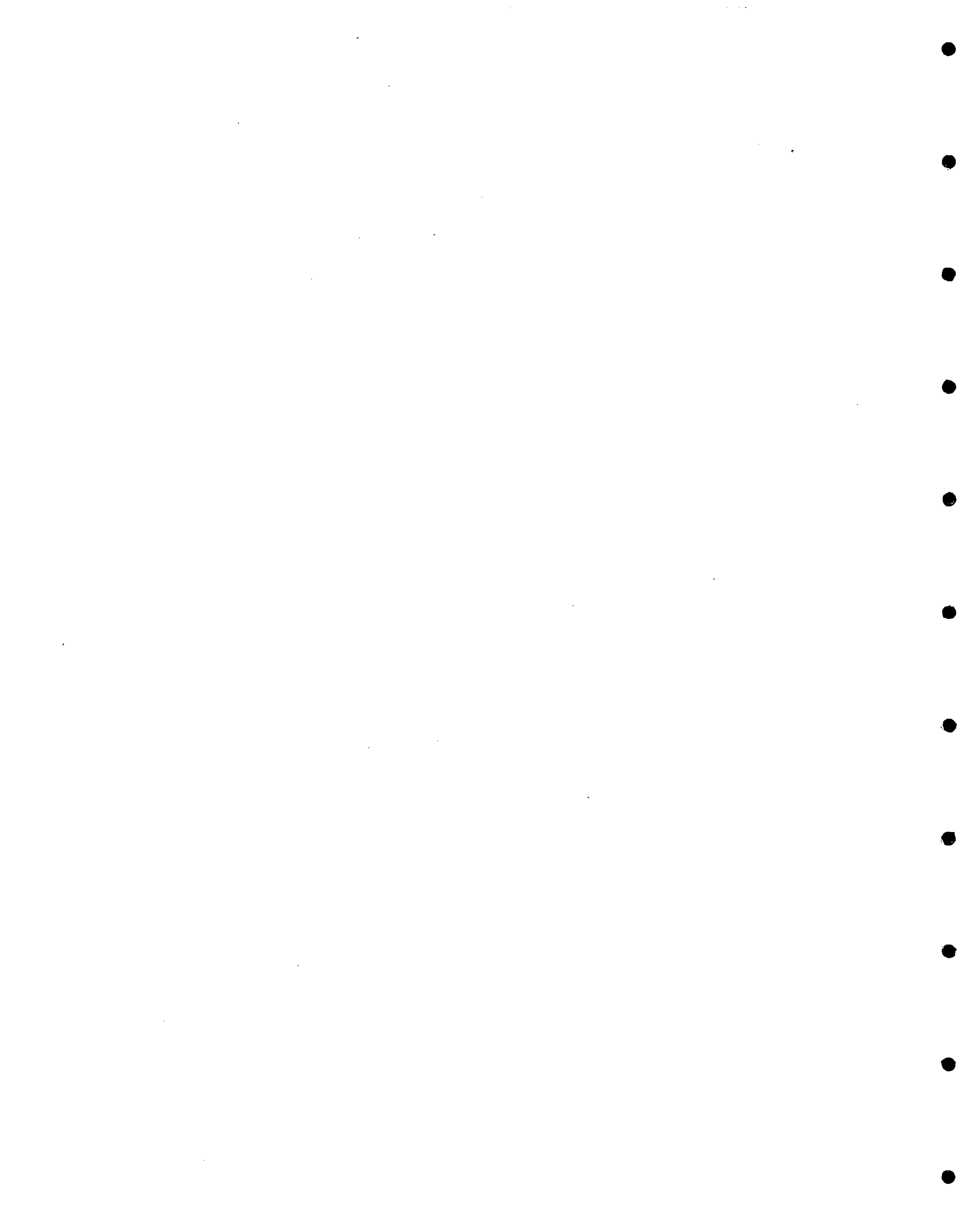
10) Pre-qualification of training proposals for Assessment, Probation, Phase I - III staff.

11) Review curriculum and training manuals.

12) Monitoring of STOP training.

13) Consultation and technical consultation of implementation of STOP programs.

14) Implementation of Quality Assurance and Evaluation Programs.



15) Assist vendors in development of treatment manuals.

16) Prepare STOP report on first year for legislature.

Advisory Board

1) Review of vendor request for applications.

2) Review of pre-qualified proposals for recommendation to DOC.

3) Review of site acquisition.

4) Review of architectural prototypes of Phase I and Phase II facilities.

5) Review training curriculum.

6) Overall review of coordination of vendors, DOC, FMHI and communities.

Vendors

1) Vendors respond to RFA's for Phases I - III activities.

2) Vendors selected by DOC enter into service provider contracts.

3) Development of Policy, Procedures and Implementation plan to submit to Advisory Board.

4) Hire STOP staff.

5) Enter into STOP training.

6) Assess Probation Referrals.

7) Accept STOP clients.

The timetable for this phased implementation is seen in Figures 3, 4, 5, and 6.

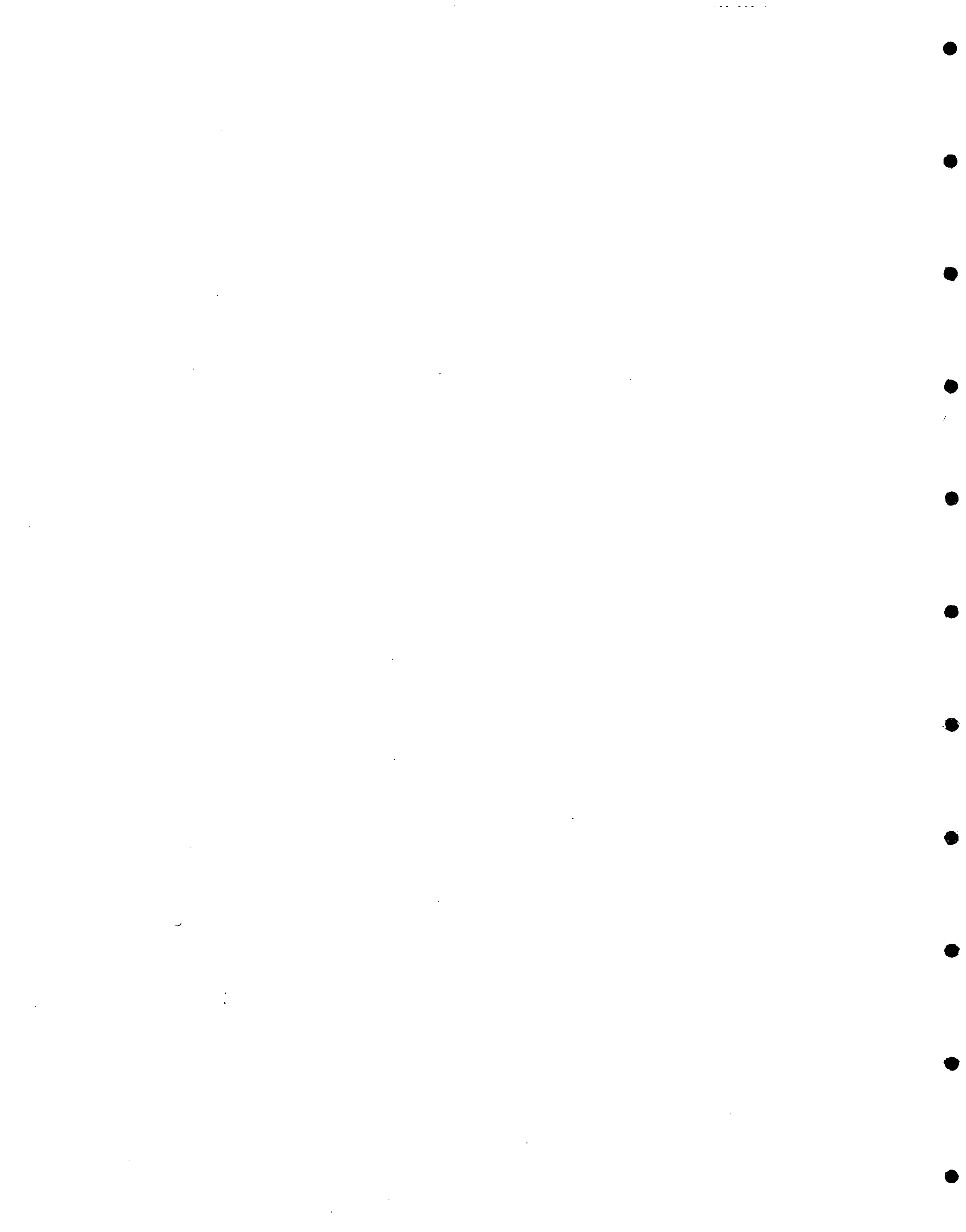


Figure 3:
STOP Program Timetable
Year One
Department of Corrections

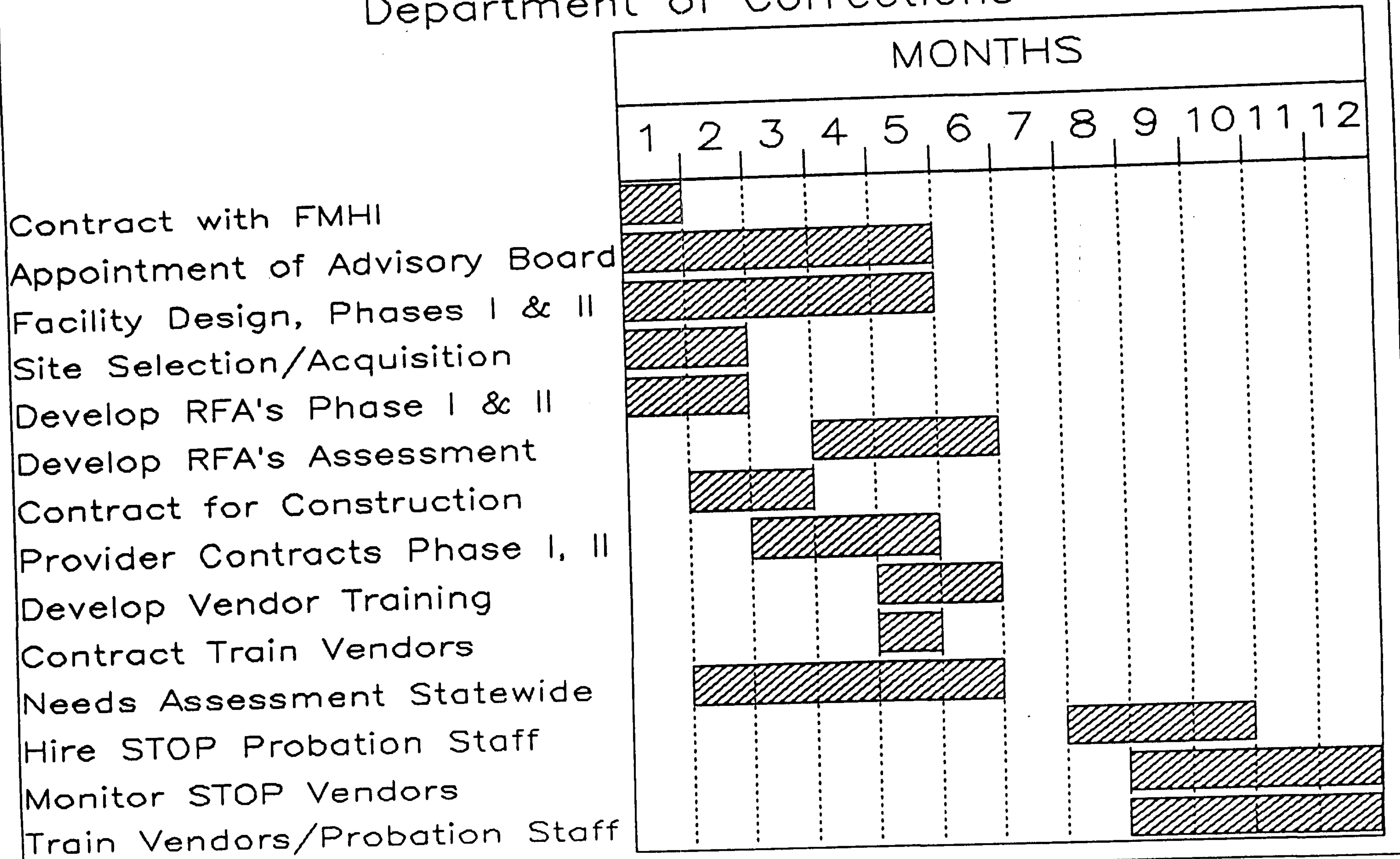
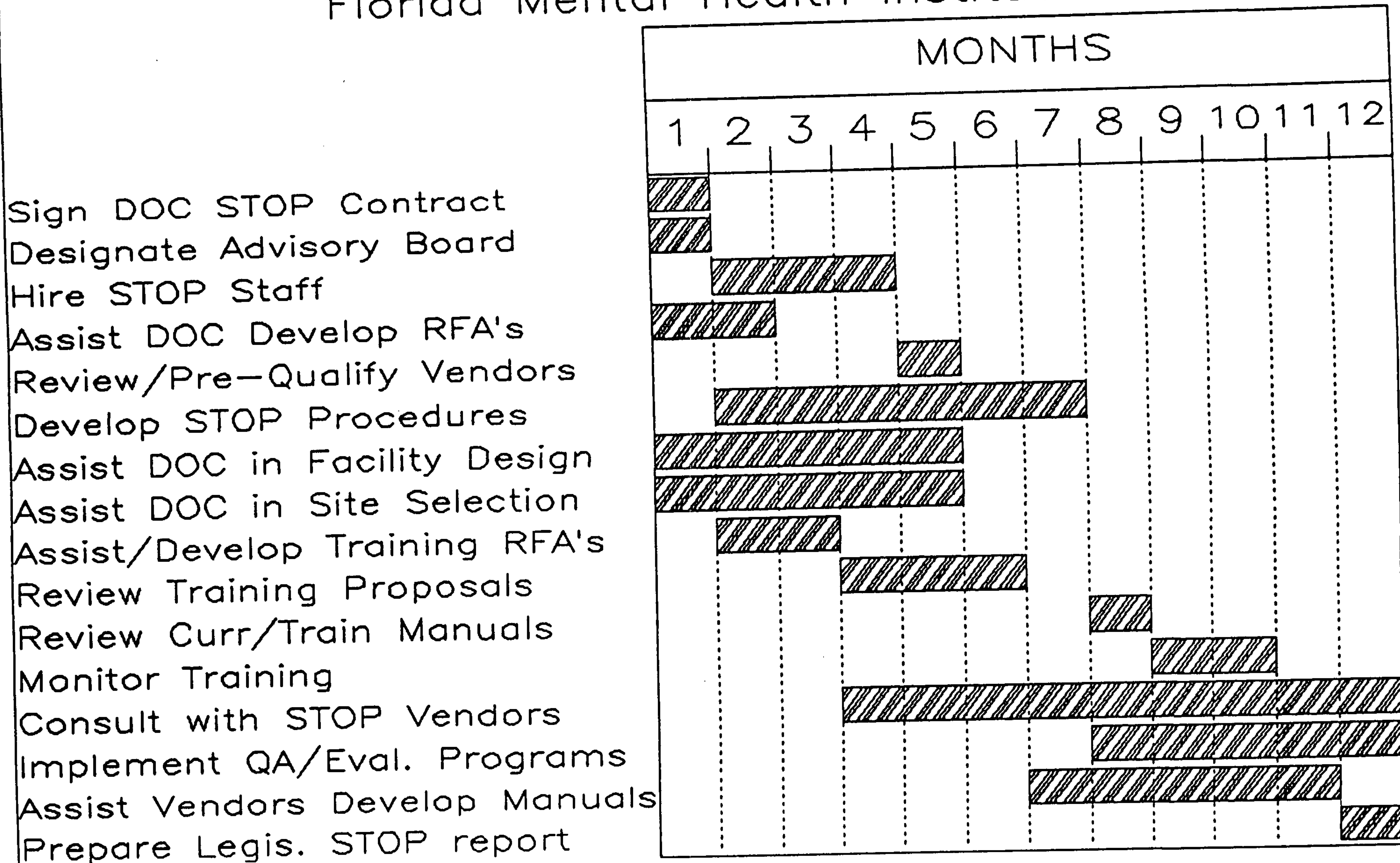


Figure 4:
STOP Program Timetable
Year One
Florida Mental Health Institute



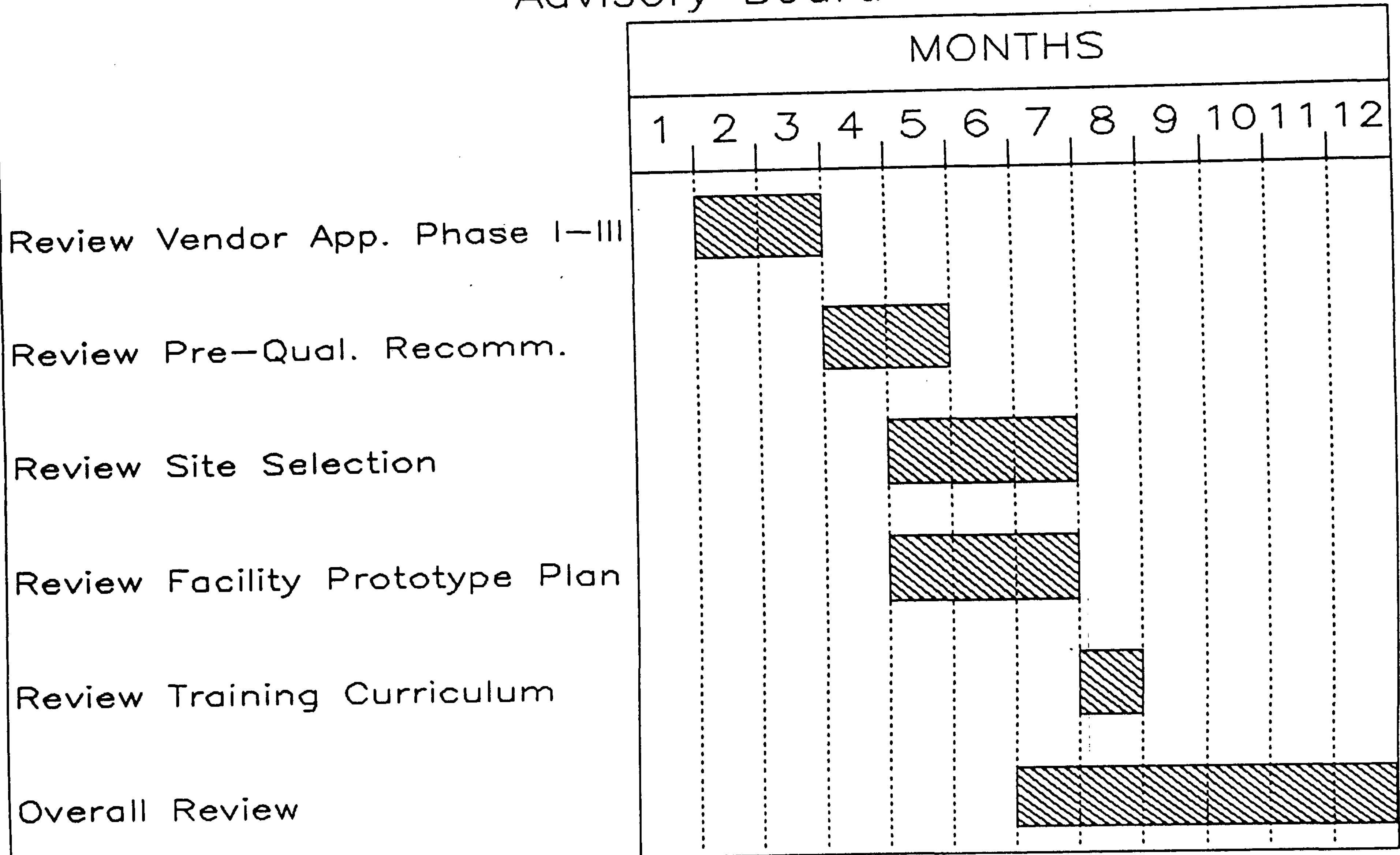
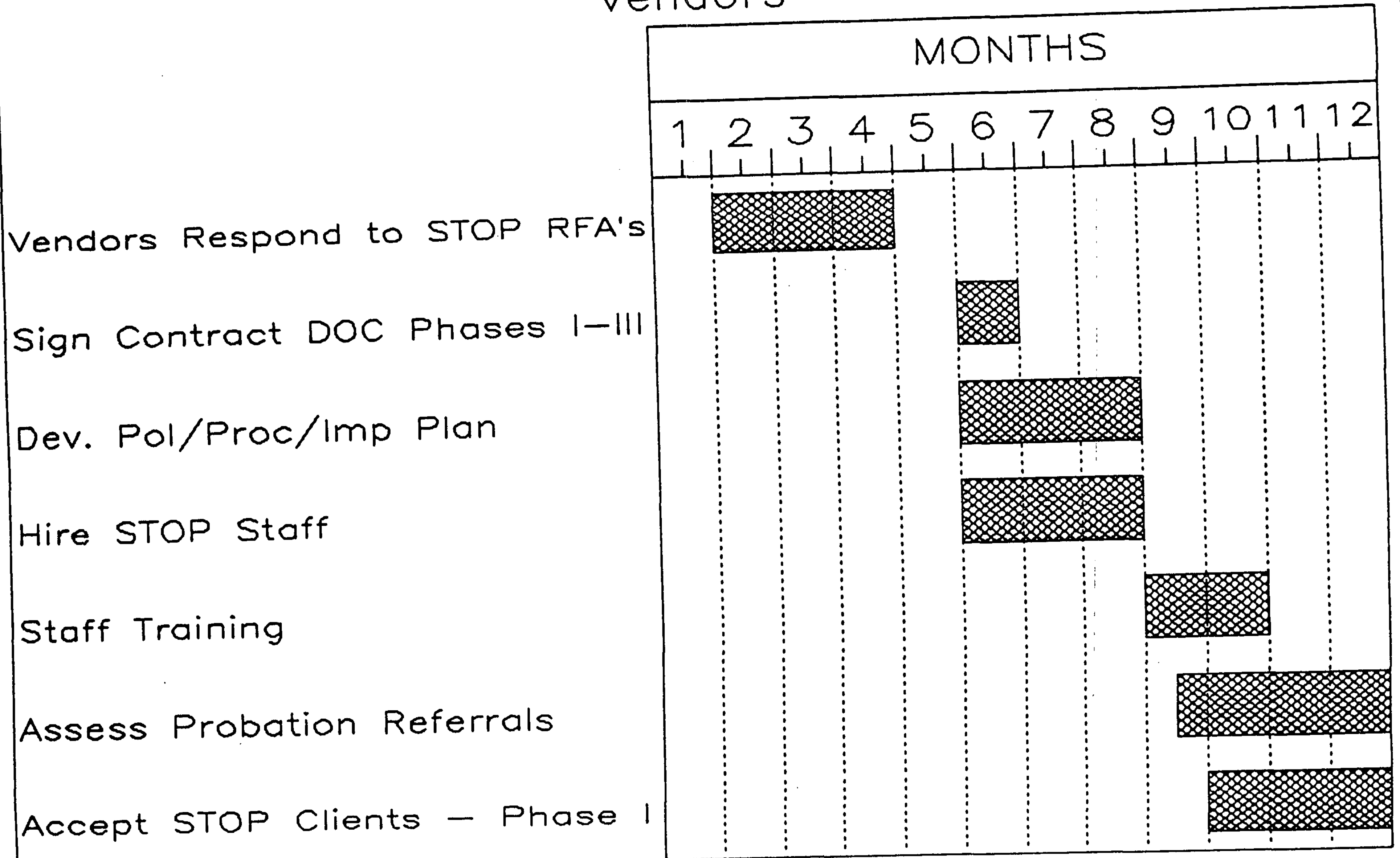


Figure 5:
STOP Program Timetable
Year One
Advisory Board
MONTHS
1 2 3 4 5 6 7 8 9 10 11 12
Review Vendor App. Phase I–III
Review Pre–Qual. Recomm.
Review Site Selection
Review Facility Prototype Plan
Review Training Curriculum
Overall Review

Figure 6:
STOP Program Timetable
Year One
Vendors



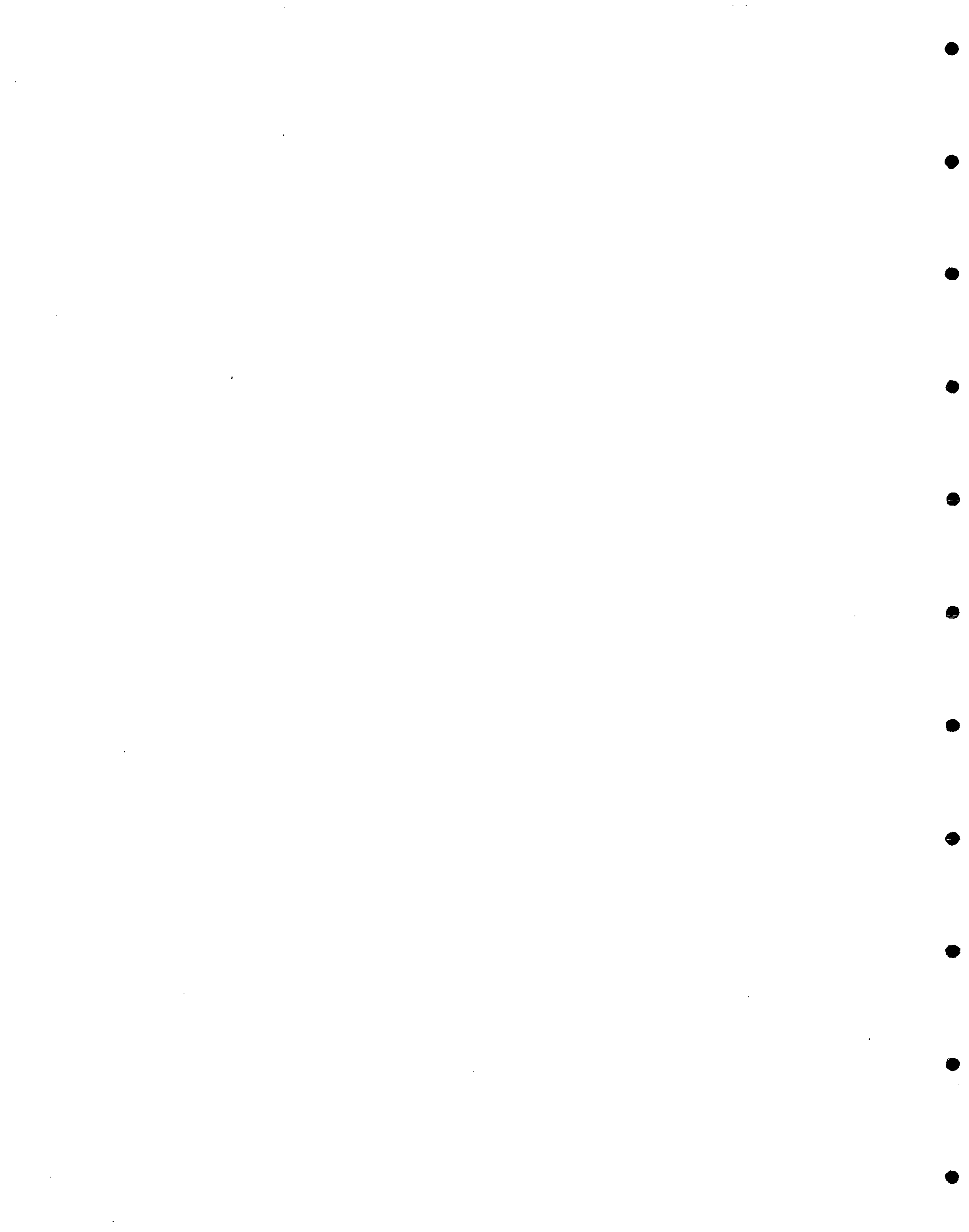
Year Two

The second year of the STOP implementation will involve full development and operation of the STOP program in the first judicial circuit of the STOP program (recommended to be the 13th Judicial Circuit). This circuit will be scheduled for a full year operation budget for DOC to fund the contract assessment, treatment, quality assurance and program evaluation vendors as well as the funds for the specialized STOP probation staff.

The second year will also include bringing the next two circuits into operation following the same schedule of implementation as for the first implementing circuit the first year. These two recommended circuits are the 11th Judicial Circuit and the 17th Judicial Circuit.

Representatives for the quality assurance, program evaluation assessment vendors, and probation services will serve as technical assistants to implement services in these two circuits. The implementation plan will be reviewed by the STOP advisory board to be approved by the Department of Corrections.

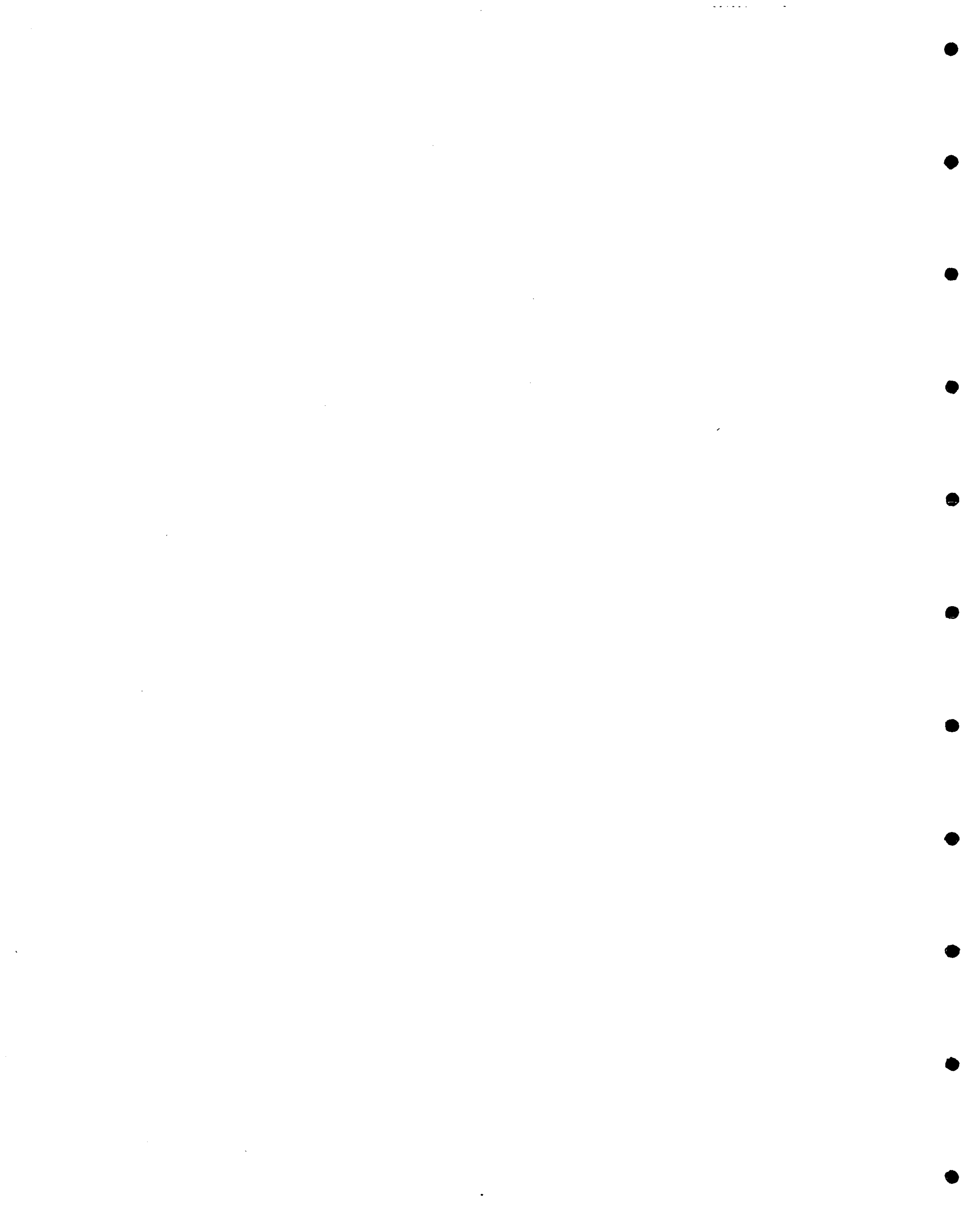
An implementation plan for statewide adoption of STOP will be based on the STOP needs assessment and will be coordinated by the STOP advisory board and implemented by the Department of Corrections in collaboration with the Florida Mental Health Institute which provide annual reports to the Florida House of Representatives, Florida Senate, Governor and Department of Corrections as to quality assurance and cost/benefit program evaluation.



Years Three - Five

Based on the implementation plan, needs assessment and program evaluation information provided the legislature will approve the complete implementation of STOP for the State of Florida. This plan will be approved by the Department of Corrections and submitted to the Florida legislature for funding the second year of the STOP program. By year five it is recommended each Judicial Circuit of Florida have a STOP program based on needs and effectiveness data provided by the Florida Mental Health Institute and the Department of Corrections.

Ongoing recommendations for program modification will be provided annually based on the quality assurance and program evaluation data made available to the Florida legislature and Governor as reviewed by the STOP legislation.



Chapter 7

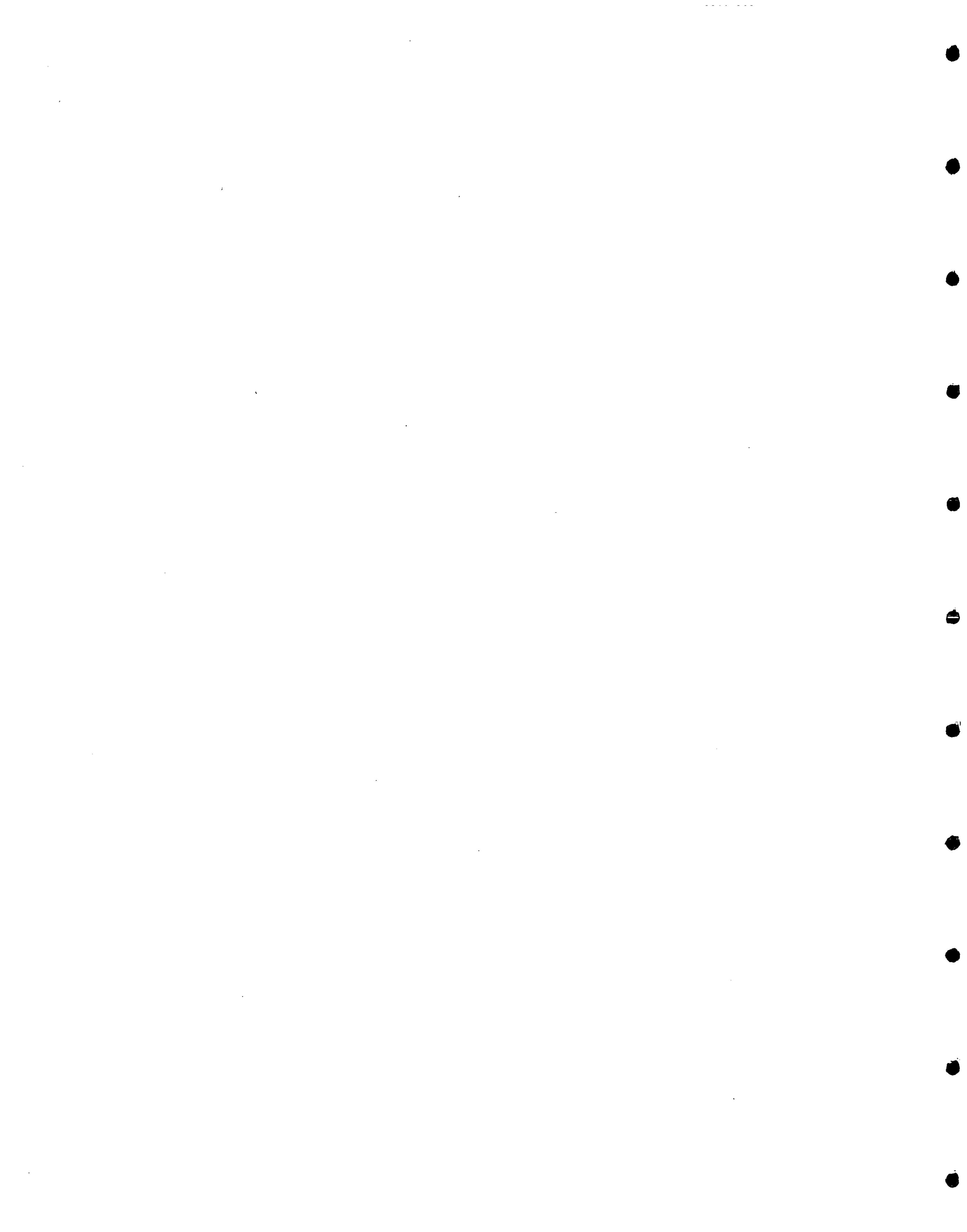
QUALITY ASSURANCE

To ensure quality and appropriateness of service delivery within the STOP program, FMHI staff will conduct four major monitoring activities: Utilization review (UR), Client Care Monitoring (CCM), Quality Appropriateness Monitoring and Evaluation (QUAME) and Staff Development. The guidelines for these activities are in accordance with those that are required by the Joint Commission for the Accreditation of Health Organizations (JCAHO), and are widely accepted as mechanisms through which the highest standards of care may be achieved (see Appendix B for a description of the JCAHO consolidated standards and procedures).

Utilization Review

The purpose of the UR is: (1) to ensure the appropriate use and efficient scheduling of STOP program resources, specifically those of STOP Program facilities and community treatment sites, (2) to assist in the maintenance of high quality care at all STOP facilities and other sites where vendor services are provided. UR requires that admission and discharge criteria and length of stay norms for the STOP program are established and an objective review of the following is undertaken:

1. Admission Decisions.
2. Transitional Care Planning.
3. Discharge Planning.
4. Continued Stay Decisions.
5. Use of Adjunct Referral Services.



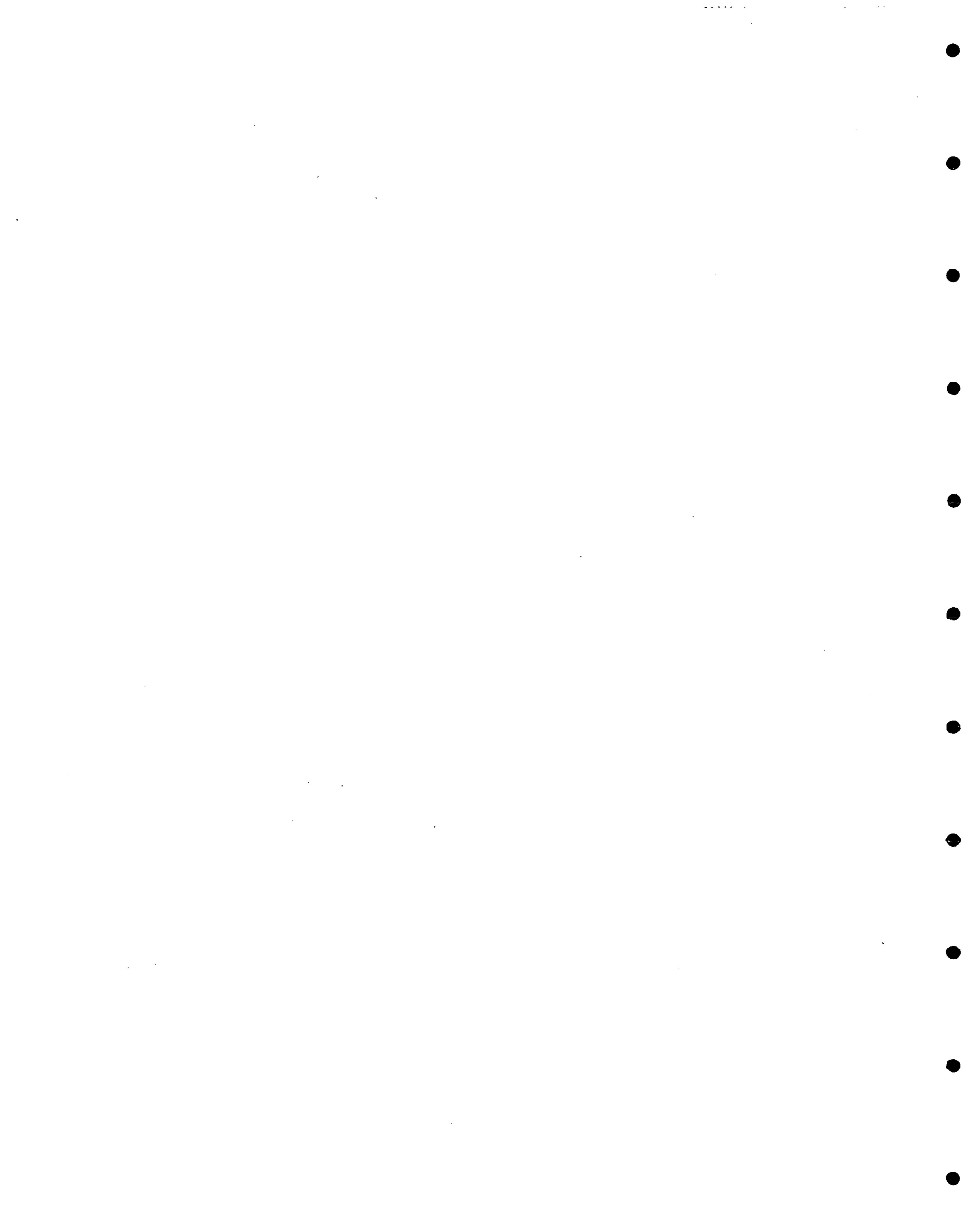
The UR will be conducted at least monthly during the first year, and quarterly thereafter by FMHI Quality Assurance Review Teams. This will consist of a review of a sample of not less than 10% of randomly selected files for those probationers admitted and/or discharged during the given quarter, random sampling of extended stay decisions made and discharge plans effected during the given quarter.

FMHI Review Teams will obtain the information needed for the UR from data found in the probationer's clinical record. This information should be found by reviewing the eligibility assessment instrument (see Appendix G), treatment plans, social histories and discharge summaries, and in some cases, progress notes for each probationer. This review will be conducted no later than one week after the last day of the quarter. The data will be compiled and made available to the unit supervisors in the form of a Quarterly Report. Unit supervisors will be informed as soon as possible of those areas that call for immediate action. Staff involved in UR activities must maintain confidential records of their activities. These records include any worksheets, reports, notes, or any other findings and recommendations pertaining to the scope and responsibilities of the UR. No identifying probationer information will be reported.

Admission Criteria

The focus of this review will be to determine whether the eligibility criteria established for the STOP program are met for each new admission. The criteria are as follows:

1. Meets statutory criteria for admission (see Appendix E).
2. Charged with or convicted of a violation of probation related to drug abuse.
3. Has at least 18 months left to serve on sentence if revoked from probation.
4. Experienced difficulty in a community drug treatment program, or community drug treatment is unavailable.
5. History of drug use and dependency.
6. History of crime related to drug use.



7. Absence of overt psychopathology, or evidence of recent violent or aggressive behavior that would disrupt treatment activities.

Probationers may be denied admission for clinical reasons (e.g., severe psychopathology) as determined by the unit supervisor.

Transitional Care Planning

The utilization review team will determine whether aftercare plans developed prior to transition to Phase II and III of the program appropriately document the offender's service needs. The aftercare plan must carefully describe the transfer of casemanagement and treatment responsibilities as the offender moves to each different Phase of the STOP program.

Discharge Criteria

The utilization review team will examine discharge procedures implemented in all STOP facilities. Probationers may be terminated (discharged) for a number of reasons ranging from violent behavior to refusal to participate in treatment activities. Additionally, probationers are discharged from the formal treatment program upon completion of six months of Phase I institutional treatment, three months of Phase II community residential treatment (reentry), and nine months of Phase III community supervision. At least six months prior to discharge, discharge planning must take place. Documentation of this planning should be in the probationer's clinical record. Within ten days after discharge, a discharge summary should be written for the clinical record. This should minimally address the probationer's progress toward treatment goals, reason for discharge, and an individualized summary of an aftercare plan.

Continued Stay Decisions

Length of stay norms for all STOP probationers have been established in accordance with the legislative protocol. The average length of stay in each treatment component has been described above and will be at least a total of 18 months. Decisions to detain probationers beyond the specified times in any given component will need to be documented in the clinical record and revisited at least quarterly. These decisions will be based on the behavioral criteria established in the treatment plan as discussed in Chapter 4.

Adjunct Services

Adjunct services (e.g., for medical, religious, neurological, etc.) when needed will be provided by the Department of Corrections or STOP vendors. The need for such services must be well documented by STOP staff and timely referrals must be made.

Conflict of Interest

Admission decisions are based on the criteria set forth by the STOP program protocol. The final responsibility for all admission and termination decisions lies with the Unit Supervisor. The UR will be conducted by FMHI reviewers who have no direct client care responsibilities and do not participate in admission decisions.

Client Care Monitoring

The purpose of CCM is to ensure that quality clinical services are delivered through regular reviews of treatment plans, appropriate reviews of difficult cases, and timely and appropriate crisis management. CCM meetings should be held regularly and attended minimally by the unit supervisor and staff most familiar with the probationers case. If a CCM issue arises affecting the security of STOP program staff, of STOP participants, or the STOP facility, DOC custody staff at that facility shall be involved in all related CCM meetings. The agenda for the CCM meetings will be set by the unit supervisor in consultation with project staff and will vary, but will be prioritized according to the following probationer screens. Management of difficult probationer issues includes but is not limited to situations where:

1. The probationer is judged to be a danger to himself or others.
2. The probationer is at high risk for drug relapse (e.g., positive urines, possession of drug paraphernalia).
3. The probationer has difficulties carrying out treatment plans.
4. The probationer is an escape risk (e.g., off grounds without permission, verbalizes escape fantasies, etc.)

In addition to the above, other issues to be addressed are:

1. Routine treatment plan reviews.
2. Review of termination decisions.
3. Review of new admissions.

Depending on the nature of the cases and problems presented, in-service needs will be identified by staff. All decisions will be appropriately documented. <u>All documentation related to the CCM is</u>

confidential and should be handled accordingly. Decisions affecting probationers should be recorded in the progress note section of the probationer's clinical record. A report summarizing the activities of the probationer care monitoring meetings will be prepared quarterly by the STOP director and submitted for review by the FMHI QA team.

Quality Appropriateness Monitoring and Evaluation

The purpose of QUAME is to evaluate the appropriateness of essential aspects of care provided to STOP probationers. The essential question to be answered is "has the right service been provided to the right client at the right time?". The focus of the review is on staff performance as service deliverers, not on client problems (see CCM). Methods of review will include monitoring of QUAME records, as well as random (at least monthly) site visits during which services will be observed directly.

Scope of Service

The STOP program is designed to provide a graduated program of assessment and substance abuse treatment services to adult drug-dependent offenders in need of long-term intensive care. The ultimate goal of the program is to prevent relapse of drug use and thereby reduce the associated criminal activity. The program will provide multi-modal treatment including structured treatment groups based on a variety of cognitive-behavioral therapies, individual casemanagement and crisis intervention, educational/vocational counseling, peer support/milieu activities, and NA/CA groups. All treatment will be provided according to individualized treatment plans which are reviewed on a regular basis.

Responsibility

The STOP program has several clinical interfaces with probationers including assessment, individual and group therapy, casemanagement, and other psycho-educational interventions. It is the responsibility of the unit supervisor to monitor the clinical activities of all other staff. It is the ultimate responsibility of the unit supervisor to carry out the functions of Q&A monitoring including identifying indicators, supervising data collection, evaluating care, and following through on recommended actions. A summary of all monitoring activities will be made available quarterly to the FMHI Quality Assurance Team.

Important Aspects of Care

Below are a list of the aspects of care that are currently identified for monitoring. This list is not exhaustive and is expected to be modified as opportunities for improvement are identified by STOP program staff.

1. Assessment
2. Intake interview/Social history
3. Crisis intervention
4. Group therapy
5. Casemanagement/Transitional Care
6. Treatment planning
7. Discharge planning
8. Disciplinary Actions

Thresholds for Evaluation

For each major aspect of care, indicators of what constitutes quality care and thresholds for evaluation (i.e., how much error can be tolerated) will be specified.

Data Collection and Organization

Guidelines for the frequency with which each monitoring activity is to be carried out and the data sources from which evidence of the activity may be obtained will be outlined in a joint meeting of FMHI's QA team and STOP providers. However, it is expected that the majority of the data will be obtained through review of progress notes, client care monitoring records, random audiotapes of sessions, and random site visits to groups by members of the FMHI QA team. Collected data will be organized monthly and reported quarterly by the FMHI's QA team.

Evaluation of Care

When a threshold is reached (i.e., a standard has not been met by a given staff member), a meeting of the unit supervisor, FMHI's QA review team and the staff member of concern will be called to determine the next course of action. Through an objective review of the aspect of care, this team may determine that client care was acceptable, in which case no further action will be taken. If however, the team decides that inadequate judgement or lack of skill has resulted in deficient client care, a problem will be identified and monitored by the immediate supervisor. A "problem" will be defined as a deficiency in care that is serious, repeated or widespread. An "opportunity for improvement" is present when a level of quality is acceptable but could be improved.

Corrective Action

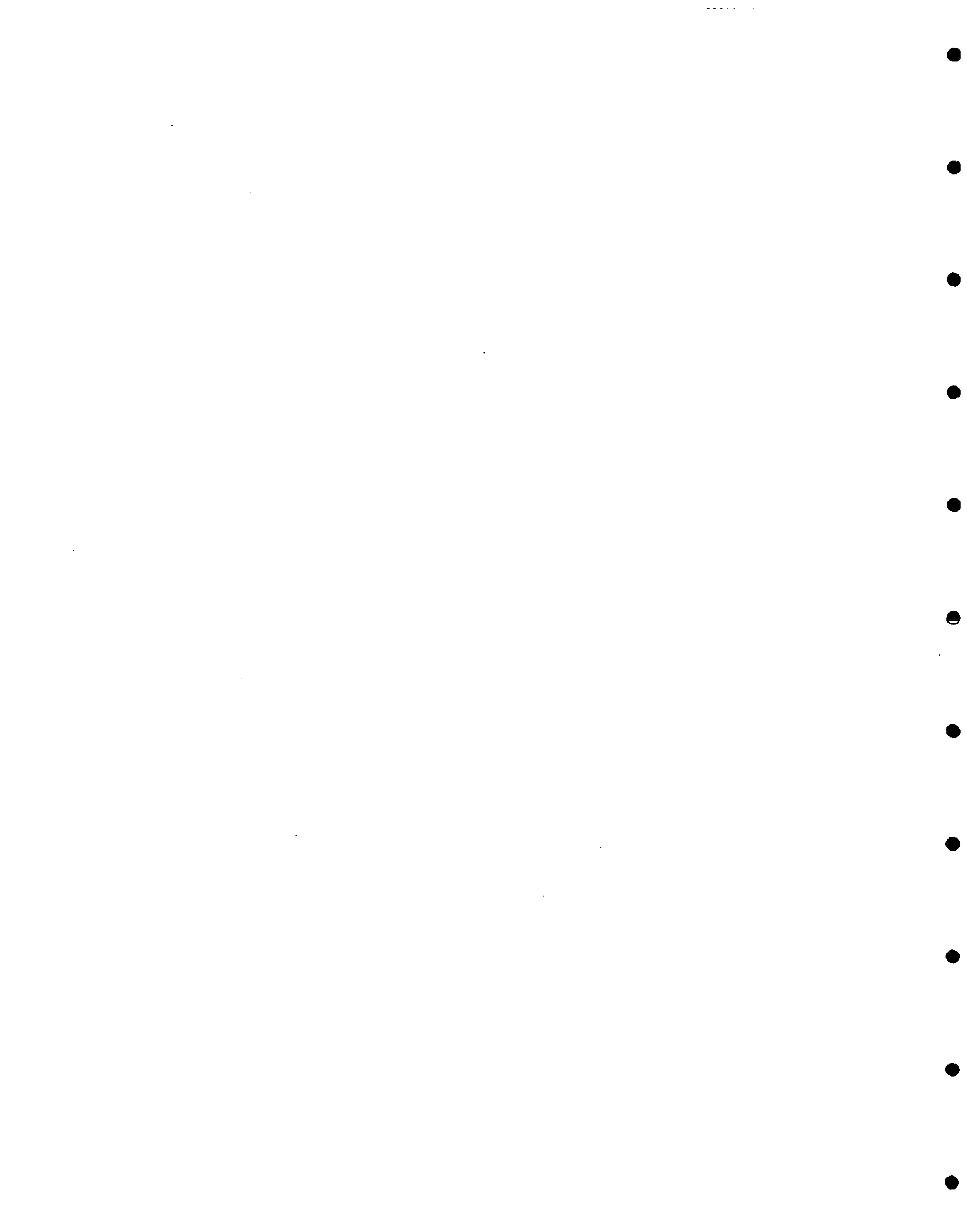
When a problem or opportunity for improvement is identified, a plan will be formulated by the team of reviewers. Progress will be monitored weekly in individual supervision until such time the problem is resolved. Records of these supervision meetings will be kept and made available to the QA review committee.

Followup Assessment

The followup assessment will focus on the identified problem, not the action taken. Thus, continued routine monitoring of the major aspects of care will serve to flag any continued problems. If the same or different problems are identified, new action will be taken immediately.

Staff Development

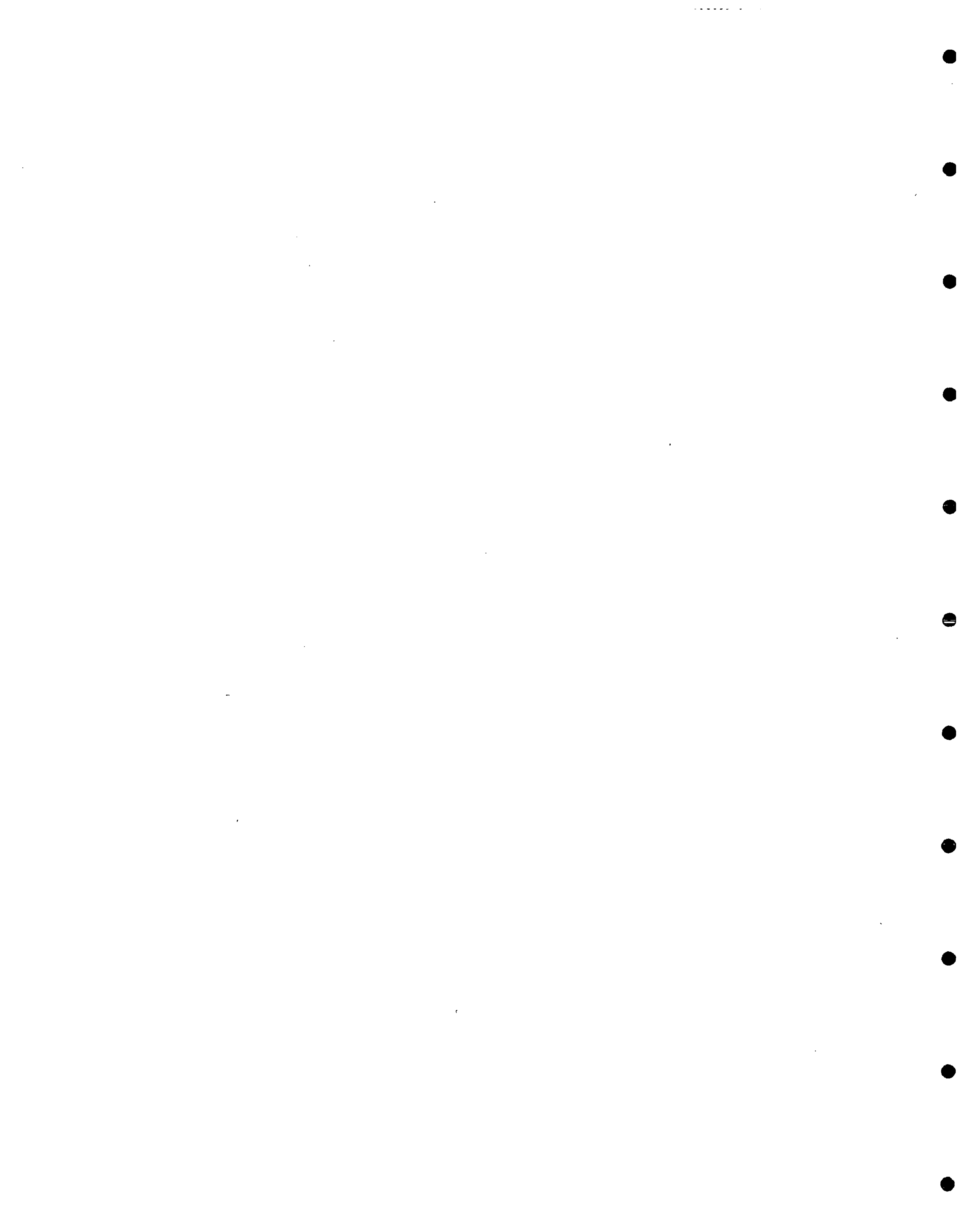
STOP assessment and treatment staff will be independent vendors, contracting with the Department of Corrections and after pre-qualification of proposals by FMHI. Such vendors must be licensed by HRS but will be reviewed by FMHI for compliance to the STOP design. However, initial training and orientation will be provided through FMHI or another qualified vendor. These training activities will be attended by all STOP program staff. The STOP program advisory board will review and recommend a program of training for treatment provider staff during the first year of program implementation that is consistent with the STOP treatment approaches and interventions. The advisory board will identify and contract with training consultants who have expertise in assessment and in each area of treatment. By the end of the first year of program implementation, consultants will develop a training curriculum in the designated area of assessment or treatment and will provide intensive



preservice training for STOP program staff and train-the-trainer sessions to develop skills in use of the training curricula. Records should be kept of any additional training received in prevention/treatment of substance abuse and related areas. The name and date of the event, the name of the presenter, and the name of the person in attendance should be recorded. All records should be made available to the FMHI team by the end of each quarter. More importantly, in-service training needs are to be monitored through issues raised in UR, CCM, or QUAME activities. Every effort to identify and remedy important areas of deficits should be made conjointly by FMHI and DOC staff as those needs are identified.

Staffing Pattern

The following staffing pattern is recommended for quality assurance activities. An associate professor at FMHI will serve as the STOP program director for both quality assurance and evaluation activities. The program director will be a licensed psychologist or psychiatrist or license eligible, and will coordinate quality assurance activities, will develop regular quality assurance and evaluation reports, and will maintain liaison with facility and unit supervisors. The program director will be assisted by an administrative secretary and a part-time records administrator. An assistant professor with a terminal degree in social or behavioral sciences and experience in quality assurance activities will serve as quality assurance coordinator and will supervise on-site records review and clinical services monitoring within each STOP facility. An Assistant in Research with at least a Masters degree in social or behavioral sciences will coordinate quality assurance data management and will supervise a research assistant in data analysis. To account for growth in the quality assurance program over the course of phased implementation of the STOP program, the following additional quality assurance/evaluation staff



positions will be provided per each STOP facility: an on-site quality assurance/research liaison (.25 FTE), a records administrator (.08 FTE), a secretary specialist (.08 FTE), and a research assistant (.125 FTE). State employee classification codes, pay grades, and yearly salaries for quality assurance staff are described in Appendix H.

Chapter 8

EVALUATION PROGRAM

Program evaluation is an ongoing component of the STOP program and serves a vital function in examining the effectiveness of STOP drug treatment interventions. Effectiveness is examined through data collected at all Phases of STOP: 1) screening, 2) assessment, 3) treatment intake, 4) treatment services 5) reentry, 6) community followup and 7) after termination from STOP. Program effectiveness is assessed by measurable outcomes that include criminal behavior, relapse to drug use, employment, and payment of victim restitution. Information from offender interviews is supplemented with comprehensive clinical assessment of drug and alcohol dependence, and psychological, social and physical impairment. Treatment outcomes are compared for offenders entering treatment with varied patterns of drug abuse and levels of psychosocial impairment. STOP clients who have received varied types and durations of treatment will also be compared. The STOP program evaluation utilizes a range of methods, procedures, and instruments developed in federally-funded longitudinal studies of drug treatment outcome, including the Drug Abuse Reporting Program (DARP, Simpson and Marsh, 1986), the Treatment Outcome Prospective Study (Craddock, Bray, and Hubbard, 1985), and the recently designed Drug Abuse Treatment Outcome Study (Research Triangle Institute, 1989). Instruments used in these studies have been extensively field-tested and have been found to be both accurate and reliable. Adoption of standard data collection strategies and formats enhances the potential for comparison between STOP offenders and large samples examined in other settings, including several criminal justice populations to be examined in the national multi-site DATOS project.

Primary goals of the STOP evaluation program are as follows:

1. To determine the effectiveness of the STOP program in reducing criminal behavior, arrest and commitments to the Florida prison system.
2. To examine the cost effectiveness of the program relative to the costs of institutional commitment and community supervision.
3. To evaluate the community adjustment of STOP offenders in areas of employment, involvement in treatment, and use of other community services.
4. To assess improvement made by offenders over the course of treatment in areas of skills development, emotional functioning, and motivation.
5. To identify offender characteristics that are predictive of positive outcomes during and following STOP treatment.
6. To determine whether STOP assessments and treatment interventions are provided as intended, according to curriculum treatment manuals, and other treatment provider guidelines.
7. To examine changes in the treatment program that occur over time.

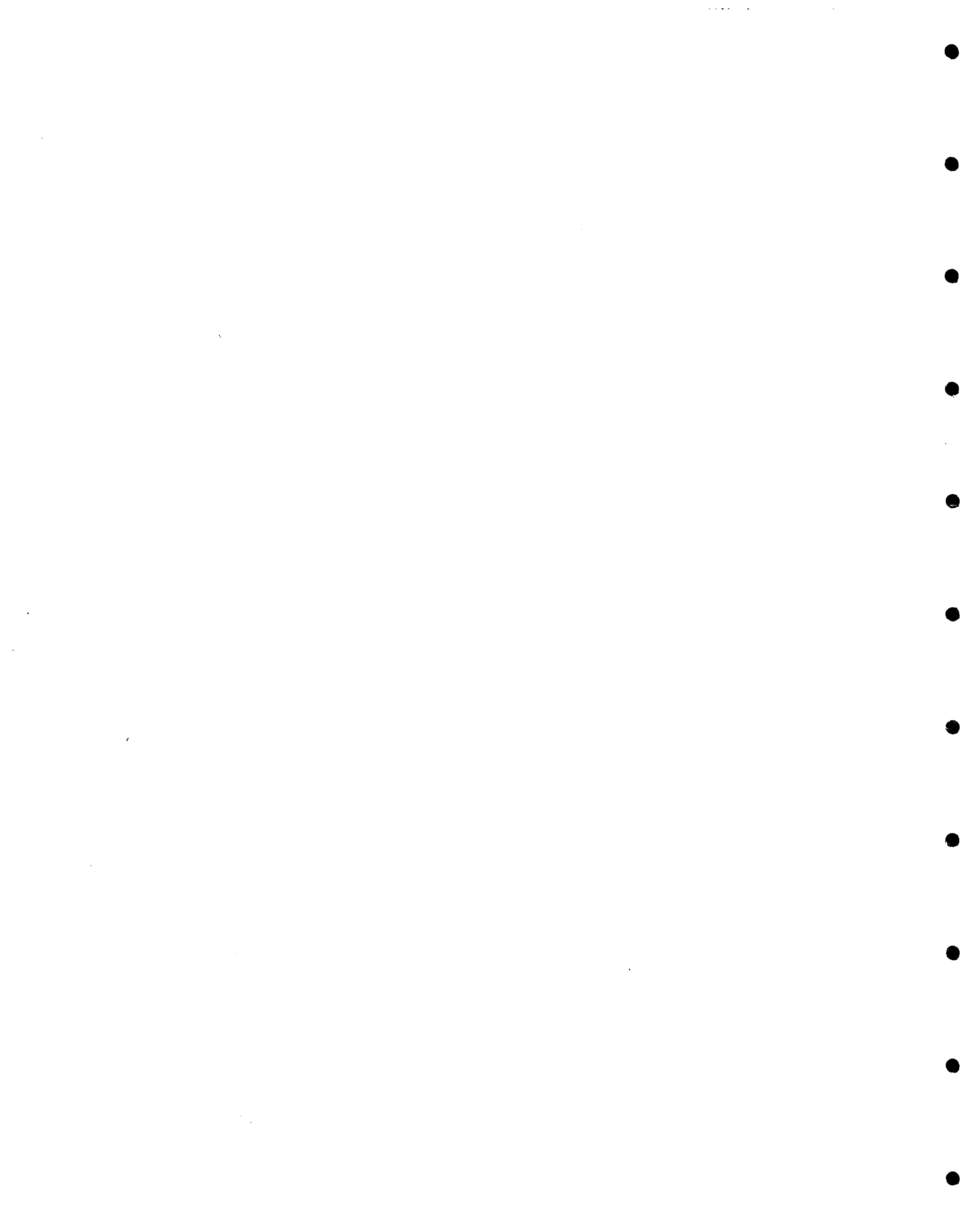
These goals are accomplished through three types of evaluation activities: (1) initial assessment of offenders entering the STOP program, (2) assessment at various predetermined "markers" during Phases I - III of treatment, and (3) examination of treatment outcomes following completion of the program.

Intake Assessment of Offender Characteristics and Behaviors

A major area of focus within the STOP evaluation examines the nature of the offender population served, based on intake data. Evaluation activities in this area are designed to identify important characteristics and pre-treatment behaviors, including history of drug use, criminal behavior, employment, current mental health status, and impairment in other areas. These variables are useful in examining offender characteristics that influence treatment outcome. Intake data will provide important baseline measures of psychological functioning, status of family relationships, employment, medical status and drug use that will assist in evaluating program impact and effectiveness.

Instruments

A range of standard evaluation instruments are employed to measure a variety characteristics, behaviors, and treatment outcomes for all probationers admitted to the STOP program. Intake evaluation instruments include the use of a modified version of the Addiction Severity Index (ASI), the Treatment Outcome Prospective Study (TOPS) Intake Form (see Appendix S), or the intake and assessment battery currently being developed for the DATOS project. The intake interview instrument is used to obtain baseline data regarding sociodemographic characteristics, education, vocational training, employment history, and previous living arrangements, AIDS knowledge and behavior, patterns of substance use, problems related to substance abuse, treatment history, and previous criminal justice involvement. A locator form is completed that enables efficient tracking of offenders during Phase III of treatment and after completion of the STOP program (Appendix T). A comprehensive clinical assessment battery will also be administered that includes examination of alcohol and drug dependence, psychiatric impairment or disorders, health status, social and cognitive functioning, and of coping skills to manage high risk situations for drug relapse. Instruments employed for this purpose include the



Hopkins Symptom Checklist/SCL-90, the Shipley Institute of Living Scale, the Cocaine Abuse Assessment Profile, and a situational competence test, such as the Problem Situation Inventory (PSI; Appendix U).

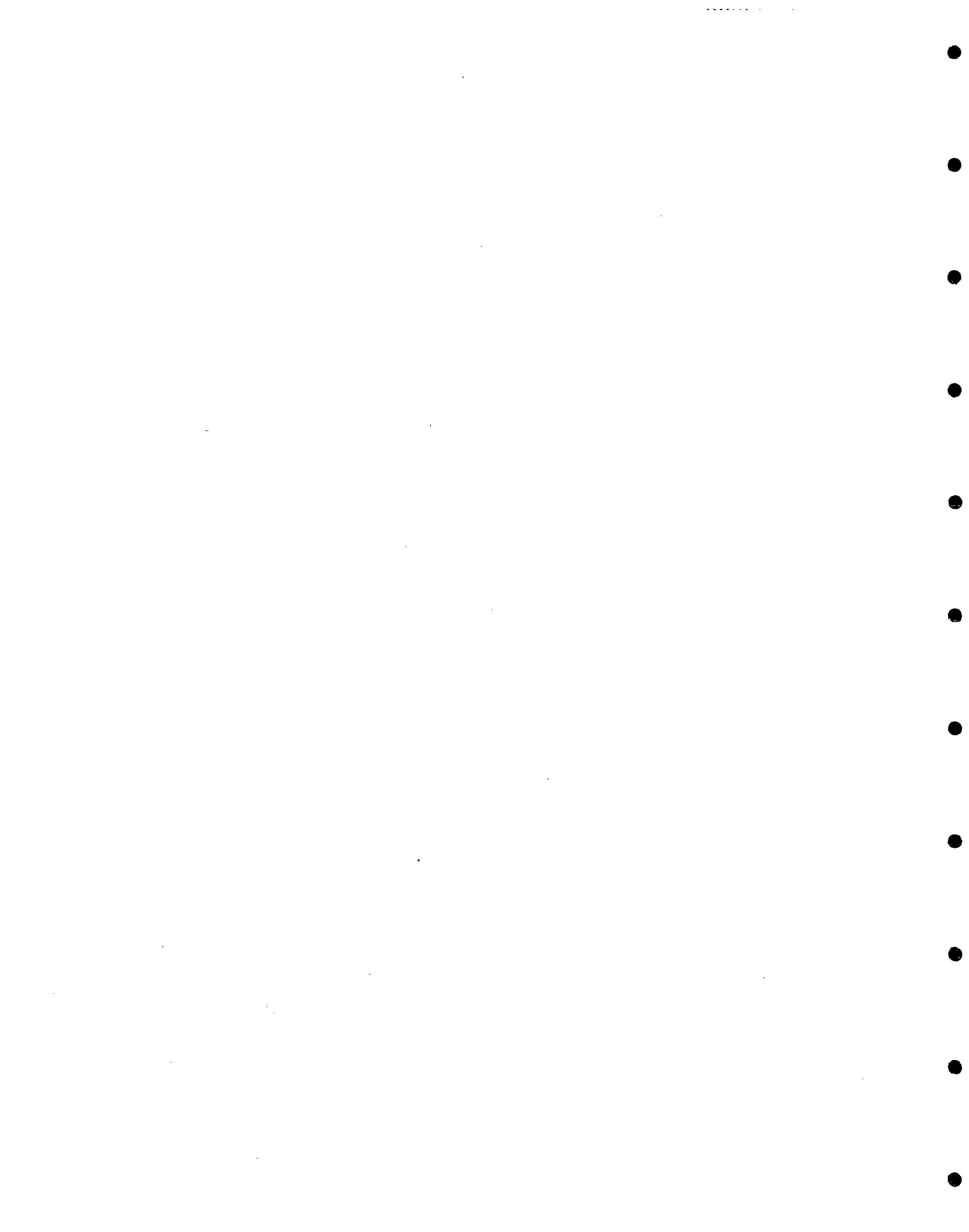
The intake evaluation assessment battery will require from two to three hours to complete, and may be administered by an entry-level counselor with pre-service training in use of the assessment instruments. The intake evaluation assessment battery is seen as fully compatible with the needs of Phase I treatment providers for initial clinical assessment pursuant to treatment planning. Evaluation staff will provide training and consultation to treatment providers to ensure that information obtained from evaluation assessment during the course of treatment is available to provider staff in a format that will contribute to treatment planning and clinical management. As self-report measures taken in criminal justice related settings are sometimes questioned, several collateral sources of information will be obtained to validate information obtained in the clinical assessment. Collateral sources include criminal justice system "RAP" sheets and followup clinical assessments.

Procedures and Analysis

The FMHI Evaluation Team provides on-site training and supervision in use of instruments and data collection procedures. An intensive training workshop will be provided for all intake counselors in the administration of evaluation instruments, prior to admission of probationers to the STOP facility. A random sample of 50 probationers selected from a comparison group (see subsequent section on "Evaluation of Post-Treatment Outcome") will also be administered the battery of intake evaluation assessment measures. This will provide important information regarding the similarity and comparability of STOP probationers to untreated probationers in other areas of the state. The evaluation coordinator will provide training for a correctional probation officer who is designated to administer intake evaluation measures to probationers in the comparison sample. A STOP program research liaison staff will be appointed by the evaluation provider within each Phase I and II facility, who will coordinate data

collection on the treatment site. This arrangement will enable careful monitoring of STOP offender admissions and effective implementation of data collection procedures. The primary responsibilities of the research liaison staff are to ensure that evaluation data is collected in an efficient and timely manner through on-site monitoring of intake staff, to coordinate pre-service and in-service staff training in data collection procedures, and to monitor on-site data entry. The research liaison staff is skilled in monitoring clinical intake activities and should be paid a comparable salary to the clinical staff. The research liaison staff will also supervise data entry of intake and other in-treatment evaluation protocols by a full time clerk-typist. Evaluation of data entered in each STOP facility will be sent to the evaluation coordinator at FMHI and will be merged in a single data file for purposes of analysis.

A FMHI evaluation coordinator is assigned responsibility for data collection, data management, and supervision of fieldwork activities. The coordinator is assisted by an on-site evaluation coordinator for each STOP facility during the first two years of operation. After the first two years of operation, an on-site coordinator will be assigned for every two STOP facilities. The on-site coordinator will have responsibility for training and supervision of the research liaison staff. This staffing pattern allows one evaluation team member to remain at FMHI to receive phone reports, while other staff visit program sites. Data management for the STOP program will include a variety of procedures to ensure accurate and efficient coordination of data. Intake data is added to the database as collected with linkage of a single data file for each offender at the conclusion of intake. Use of intake data for outcome evaluation will be accomplished by development of a longitudinal file that includes selected intake, treatment, and followup measures. This file will include information selected from probation records. Analysis of intake evaluation data will examine the impact of drug history, past criminal behavior, psychiatric impairment, and other characteristics on expected treatment progress and outcome.

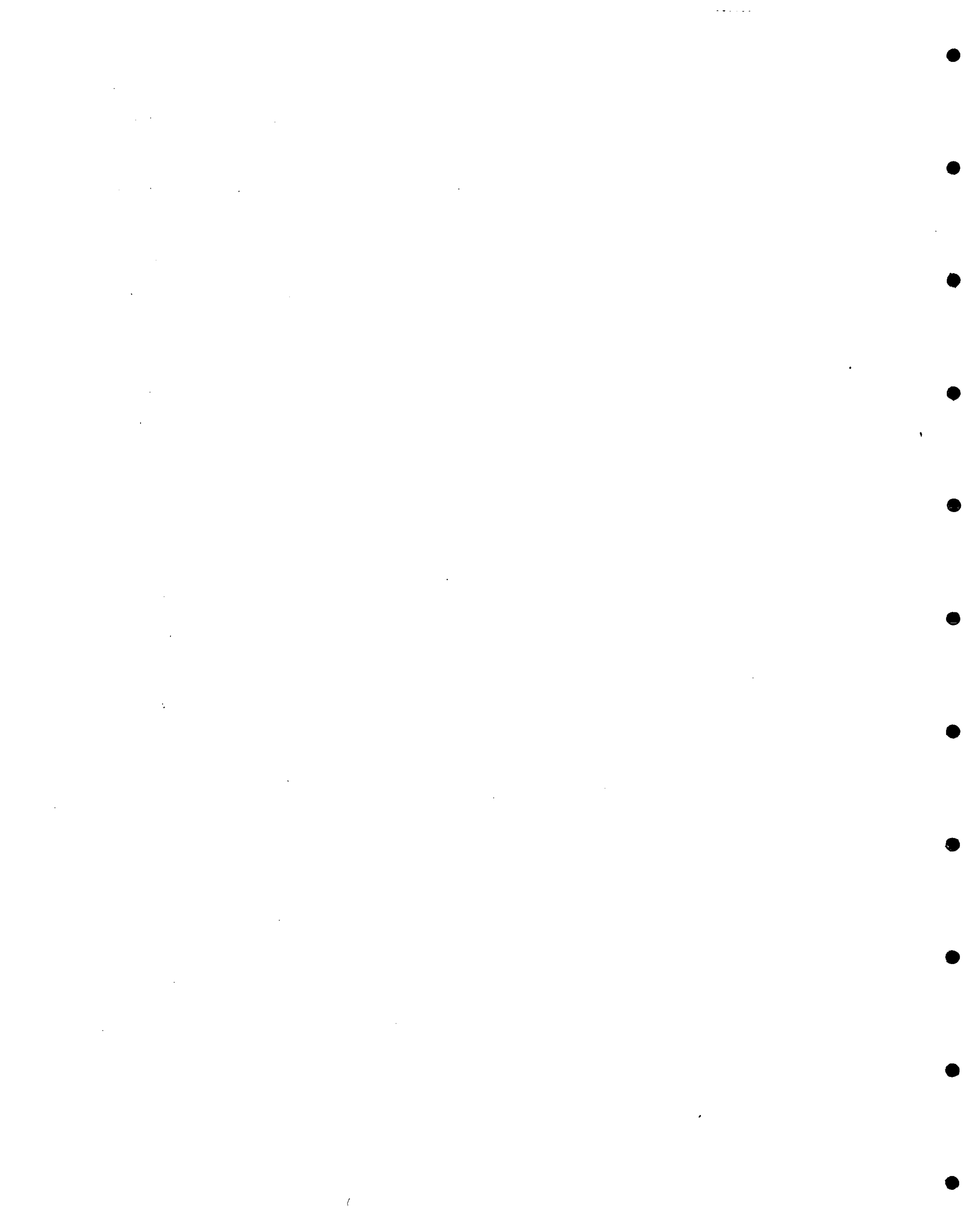


Evaluation of Progress in Treatment and Treatment Integrity

Another component of evaluation involves examination of progress made by STOP offenders during the course of treatment to ensure that high quality interventions are provided. Process variables are examined within each component of treatment, and during each phase of treatment through the use of quality assurance data. This information will help determine whether STOP treatment interventions are provided as intended and are of sufficient intensity and quality to meet the intended program goals. This element of evaluation also ensures that progress made in drug treatment may be attributable to a specific and definable treatment intervention. In-treatment evaluation will provide information critical to the assessment of expected levels of improvement in areas of self-esteem and emotional adjustment, cognitive and behavioral skill development (e.g. development of drug refusal, and urge coping skills), knowledge of key concepts provided in drug/AIDS education and relapse prevention curricula, and motivation and commitment to maintain abstinence. Progress in treatment will be monitored for all STOP offenders.

Instruments

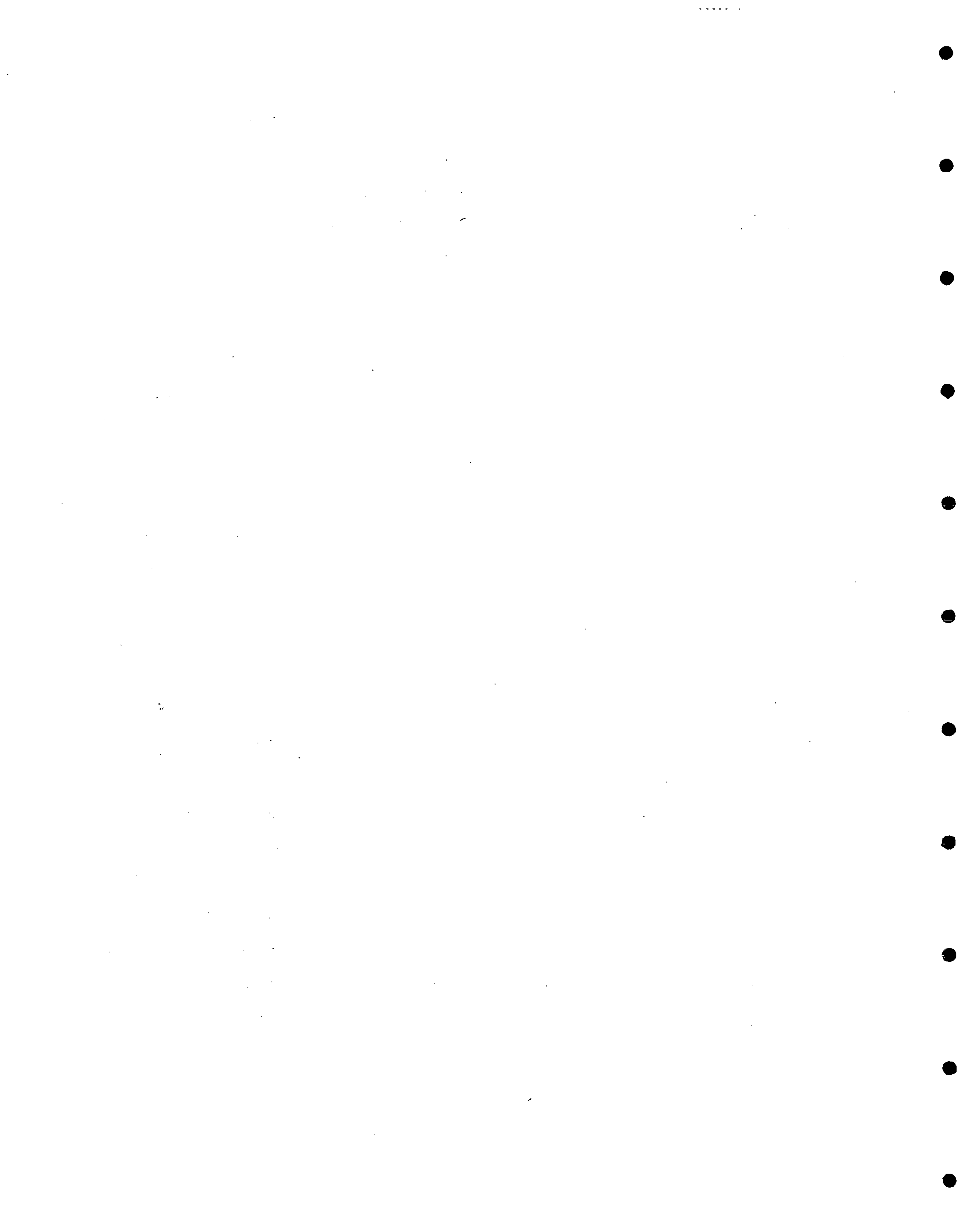
Several instruments are used to evaluate qualitative aspects of treatment and others will examine progress of program participants over the course of the STOP program. Instruments will be administered at regular intervals during involvement in the STOP program: At one month in treatment, at three months in treatment, at the conclusion of Phase I of treatment (six months), at the conclusion of Phase II of treatment (nine months), at twelve months in treatment, and at the conclusion of Phase III of treatment (18 months). This strategy allows for careful calibration of initial treatment effects with the quality of initial program interventions provided. Program intervention evaluative data is reviewed



with STOP unit supervisors and will serve to encourage corrective action and to assure appropriate levels of program treatment services in the critical first few months of the program.

Qualitative program-level data are collected through use of survey instruments administered to STOP facility directors and unit supervisors (Appendix V). A description of basic treatment services is obtained through a self-administered questionnaire completed by STOP treatment counselors, casemanagement counselors, and other service providers (e.g. vocational staff, and adjunct psychological or psychiatric staff). Evaluation of each program participant's experiences in the STOP program are assessed through repeated measures of questionnaires focusing on types of treatment received (modality, duration, orientation), specific treatment services received (vocational, psychological, group interventions) and participant satisfaction with treatment services. Evaluation staff will serve as independent raters of treatment sessions at each STOP facility and will be assisted as needed by other licensed psychologists or psychiatrists from the community in conducting periodic checks on the reliability of treatment integrity ratings. Following observation of treatment sessions, evaluation staff will complete a Treatment Integrity Rating Scale (Appendix W). This strategy ensures that within-session treatment services conform to activities prescribed in treatment curriculum manuals.

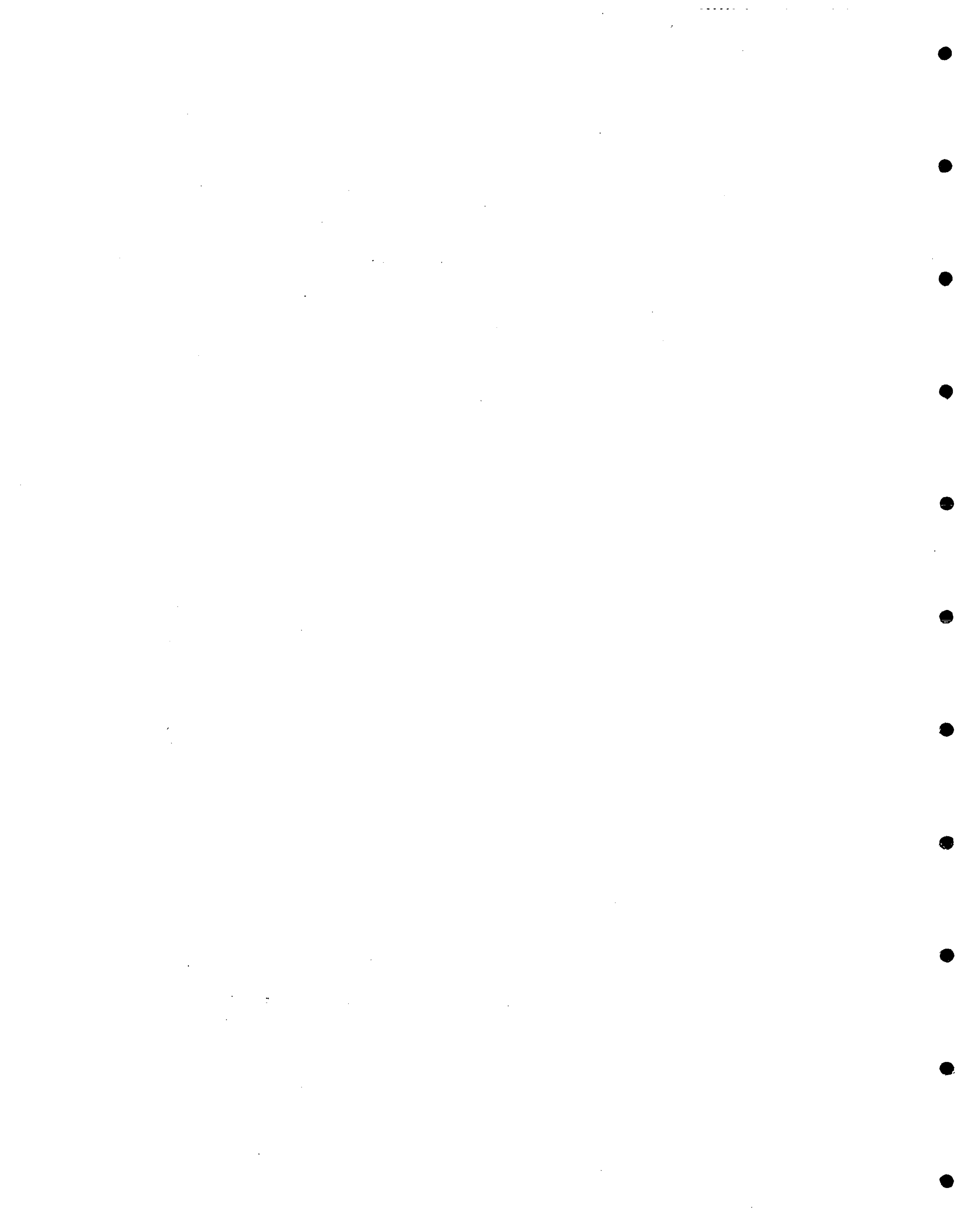
Additional evaluation instruments are administered to assess progress of STOP offenders during treatment. Program participants are assessed at regular intervals (described above) to examine changes in motivation and attitude towards treatment, in knowledge of key concepts related to drug education and treatment, and in cognitive and behavioral skills in managing high risk situations for relapse to drug use (Appendix X). The SCL- 90 (Appendix F) is administered as a repeated measure to identify changes in emotional and psychiatric status during treatment. The Tennessee Self-Concept Scale provides a similar means to gauge changes in self-esteem and social adjustment. The Addiction Severity Index (Appendix F) is administered at intake to the STOP program. An abbreviated version of the ASI, examining drug use and psychological and vocational functioning, is administered following completion of Phase I and II of the STOP program. The full ASI will be readministered at the completion of Phase III of treatment. The ASI will assess changes in key areas of functioning (e.g. psychological,legal,



medical, family/social, employment/financial) affected by drug abuse and dependence. Other in-treatment evaluation measures used to examine progress during treatment will include urinalysis results, and participant and counselor rating scales (see Appendix K).

Procedures and Analysis

STOP program research liaison staff will monitor collection of treatment data by intake and treatment counselors. In-treatment measures will ordinarily be administered during group treatment activities (e.g. during sessions of general group counseling or relapse prevention groups) to minimize staff time required for assessment. Interpretation and discussion of in-treatment measures will be integrated within treatment activities whenever possible. All program staff involved in assessment are provided extensive training in data collection procedures during a pre-service training workshop. A random sample of 50 probationers selected from a comparison group (see subsequent section on "Evaluation of Post-Treatment Outcome") will also be administered the battery of in-treatment evaluation measures at similar intervals to STOP offenders. This will provide important information regarding changes over time in measures of in-treatment progress (e.g. improvement in self-esteem and in psychological functioning) that may be expected among untreated probationers and that are not attributable to involvement in the STOP program. The evaluation coordinator will supervise the administration of in-treatment evaluation measures to probationers in the comparison group in close collaboration with staff from the Department of Corrections. The evaluation coordinator will also provide training for a correctional probation officer who is designated to administer in-treatment evaluation measures to offenders in the comparison sample. The program research liaison staff will conduct treatment surveys and interviews and will monitor collection of in-treatment assessment data collected by program counselors using equivalent training and quality control procedures implemented in the intake assessment. The evaluation coordinator will provide a check on the validity of

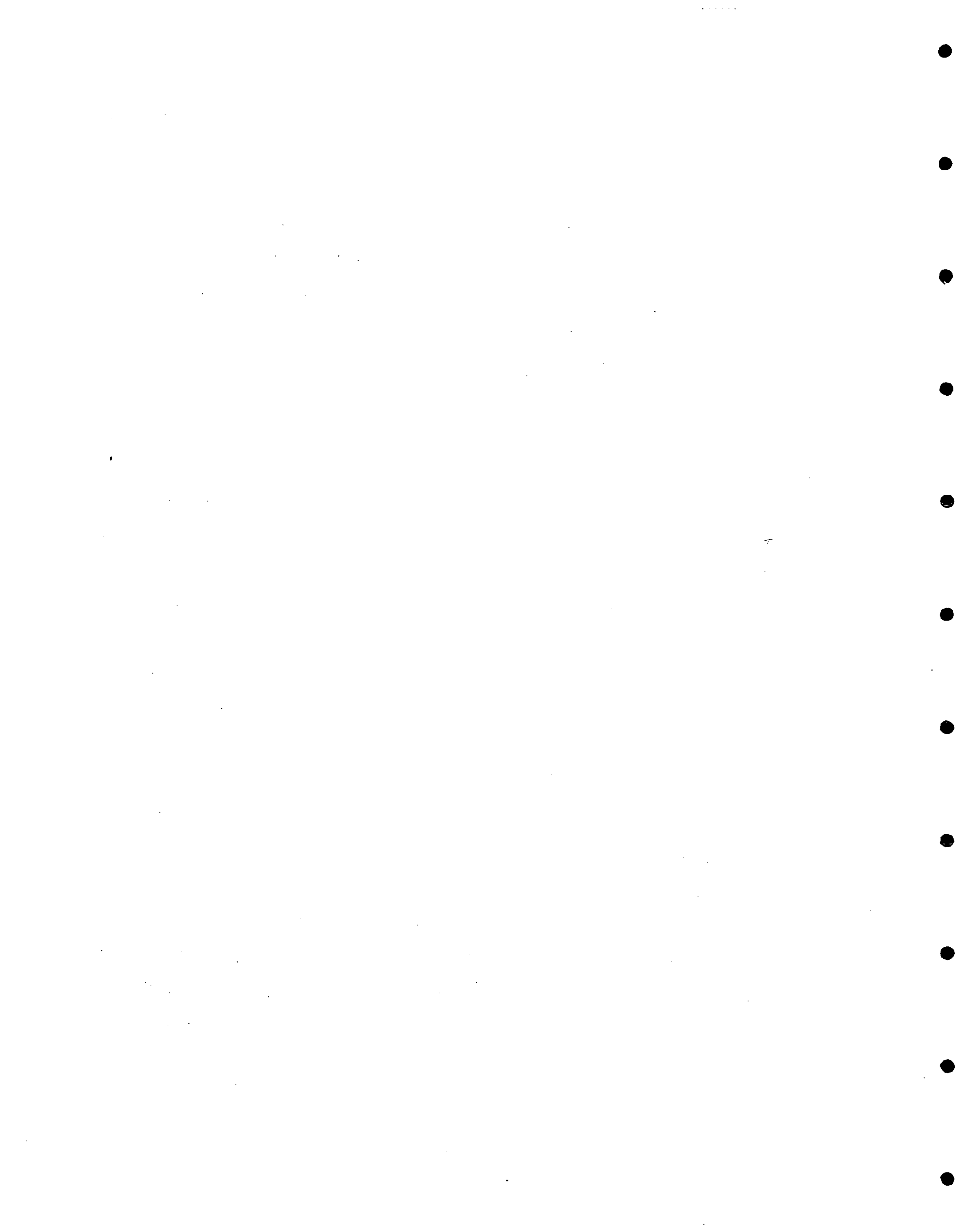


questionnaire responses by conducting periodic interviews with program participants. FMHI evaluation staff are charged with review and entry of all data collected from in-treatment assessment.

Treatment integrity ratings are obtained monthly during Phases I, II, and III for each major treatment activity, during the first three months of program operation, and every four months after this period. Raters will be doctoral level clinicians with prior drug treatment experience, and who are familiar with the STOP treatment modalities. Measures are taken to assure that this process is minimally obtrusive. Treatment integrity ratings reflecting substantial disparities between the treatment presented and treatment prescribed in curriculum manuals (or in other guidelines) will provide cause for immediate review by the quality assurance coordinator and the on-site evaluation coordinator. Should a treatment integrity score fall below an average of three (on a scale of five), the counselor receives an immediate evaluation of his/her performance deficits by the unit supervisor, and appropriate retraining prior to resuming treatment responsibilities. Quantitative methods for this component of evaluation will include multivariate analysis of changes over time in relevant skills and levels of psychosocial functioning. Qualitative evaluation methods are used to ensure that current STOP treatment interventions are consistent with the program design, and that problems in the implementation of treatment program activities are addressed and remedied by provider staff.

Evaluation of Post-Treatment Outcome

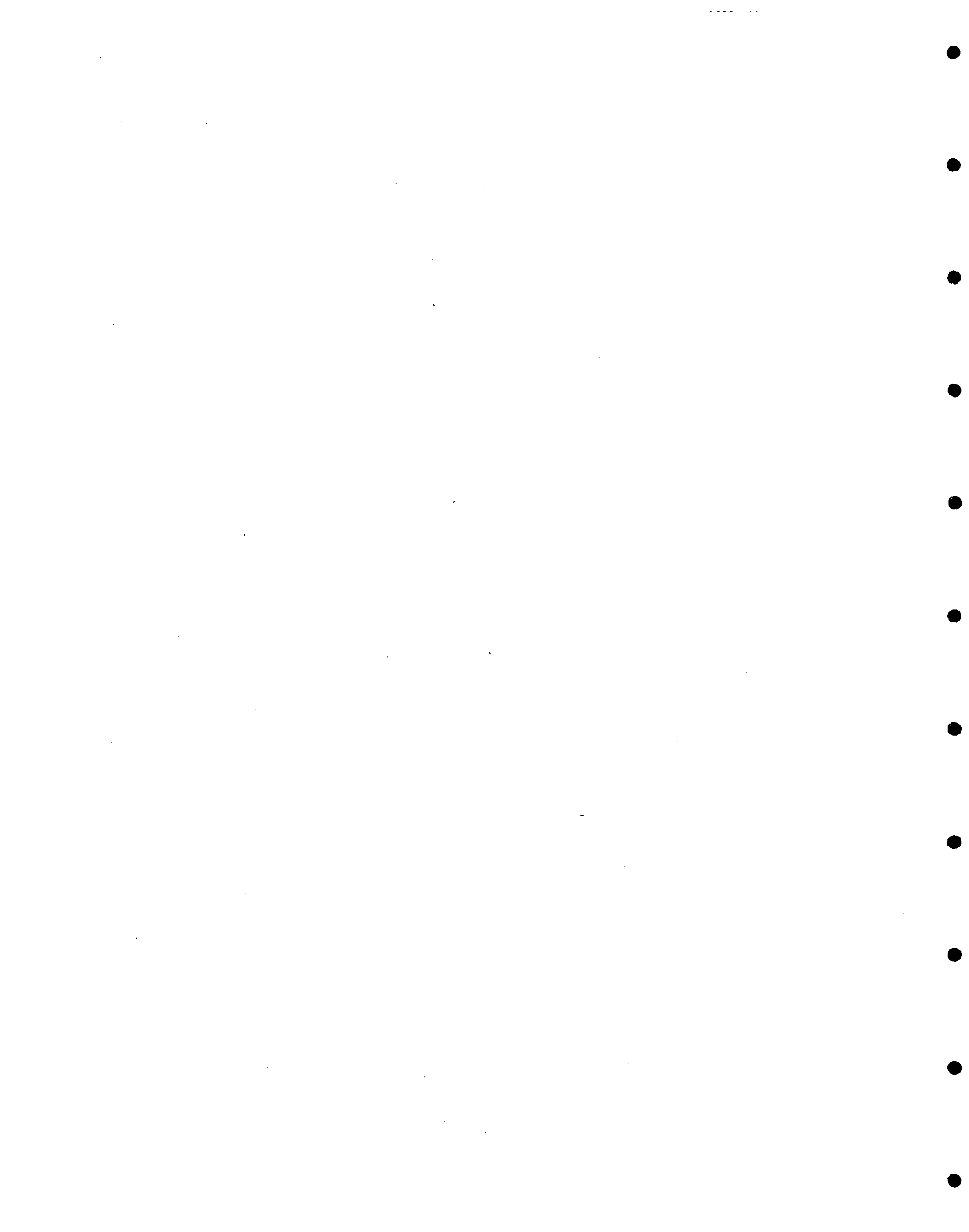
A primary evaluation task involves examination of the effects of drug treatment on offender outcomes following completion of the STOP program. Major areas of outcome evaluation will examine the impact of treatment on post-treatment variables of drug use, employment, criminal behavior, and social functioning. The outcome evaluation is also designed to assess the magnitude of change in baseline measures of psychosocial functioning at program intake to similar measures obtained at post-



treatment followup. The evaluation provides additional information regarding the impact of factors such as duration in treatment and progress achieved in treatment on treatment outcome.

A central evaluation issue is the extent of criminal recidivism observed among offenders completing the STOP program. Tracking of STOP offenders and of a comparison group of untreated offenders will enable evaluation of reductions in recidivism and cost effectiveness as a result of the STOP program. In order to determine the impact of the STOP program on criminal recidivism, a large sample of offenders will be tracked for a period of four years following admission to the STOP program. A comparison group of untreated probationers also will be identified and tracked for a similar period. Analysis of cost effectiveness will be based on: (1) marginal reductions observed in arrests, convictions and incarceration that are attributable to the treátment intervention as determined by evaluation of differences in baseline levels of criminal activity and in post-treatment criminal activity, and by contrasting these differences with those obtained from a comparison (untreated) sample, and based on (2) costs of crimes, court proceedings and incarceration that are prevented as a result of these marginal reductions in criminal activity. Cost effectiveness formulations will be guided by analysis conducted by the RAND corporation (Gendreau, 1989) that involves: (1) evaluation of pre-treatment arrest rates, (2) estimated crimes per arrest, (3) probability of incarceration following arrest, (4) expected length of incarceration, (5) expected length of criminal career, (6) estimated total crimes committed (without treatment), and (7) estimated crime and corrections costs.

The STOP treatment program is expected to evolve and change considerably during the first year of implementation. As a result, outcome data obtained from tracking STOP offenders admitted during this period may not reflect the full impact of the intended treatment program. A common evaluation strategy employed in these circumstances, and one that is proposed here, is to reserve major tracking efforts until the second year of program implementation. At this later stage of implementation the program interventions will have matured due to staff training and quality assurance activities, and to greater consistency in application of program policies and procedures. This will enhance validity and generalizability of post-treatment evaluation results.



The recommended post-treatment evaluation design includes several components:

1. An initial stage of outcome evaluation will assess criminal recidivism of at least 100 first-year STOP admissions (selected randomly from an estimated sample of 240 admissions) and an equivalently sized sample of untreated probationers. This latter comparison sample will include probationers who are supervised in a judicial circuit not served by a STOP facility, but who are assessed (through use of the eligibility assessment instrument) as eligible for STOP admission. Treatment and comparison samples will be tracked for two years to determine rates of rearrest and reincarceration. Additional indices of drug use will be assessed whenever available (e.g. through probation records). This initial evaluation will provide useful information regarding outcomes (e.g. probation violations, revocations, arrests, incarceration, employment status) that can be expected for STOP-eligible probationers who are placed on probation supervision rather than in intensive drug treatment.

2. A second, more intensive stage of outcome evaluation will track STOP offenders who are admitted to the treatment program during the second full year of operation. All offenders admitted to the designated STOP facility in the second year of operation (including probationers who are terminated prior to completion of the program) will be tracked for a period of at least four years following intake to the program. This tracking period will enable monitoring during the full 18 months of treatment and over two years beyond discharge from the program. It is estimated that this sample will include approximately 250 STOP offenders. A comparison sample consisting of a similar number of untreated probationers will be selected prior to the second year of the STOP program operation. This sample will consist of probationers from a judicial circuit that is not served by a STOP facility. The comparison sample will include only those offenders who are determined (through use of the eligibility assessment instrument) to be eligible for the STOP program. Offenders from this sample will be evaluated to assess comparability to the treated STOP offender sample on dimensions of relevant demographic variables, criminal history, drug use history, and treatment history.

   Tracking efforts will examine patterns of recidivism among STOP offenders and the comparison group. Cumulative recidivism data will be compiled at the end of each year during the outcome evaluation (year one, two, three, four). From the larger comparison sample it will be possible to examine several sub-groups for additional analysis, including probationers receiving either: (a) no treatment, or (b) community inpatient/outpatient treatment, and either (a) community control or (b) regular probation. Analysis of these sub-groups will enable evaluation of STOP program effectiveness in comparison to alternative models of community-based drug treatment and of probation supervision. When completed, this phase of evaluation will provide the most extensive controlled outcome study (to date) of state correctional drug treatment in the United States.

3. A third and final stage of the post-treatment outcome evaluation involves followup interview of a random sample of 20% (approximately 55) of the larger sample of STOP offenders who are tracked in stage two of the post-treatment evaluation (offenders admitted to the STOP program during the second year of program implementation). Followup interview and assessment will be conducted four years after admission to the

STOP program, providing additional information regarding changes that have occurred over time in drug use, psychosocial functioning, employment, financial status, family marital relationships, self-esteem, and utilization of drug treatment and other social services. This evaluation activity provides an opportunity to examine qualitative aspects of the offenders adjustment to the community that are difficult to ascertain from criminal recidivism data, and will assist in calibrating the long-term impact of involvement in the STOP treatment program.

Instruments

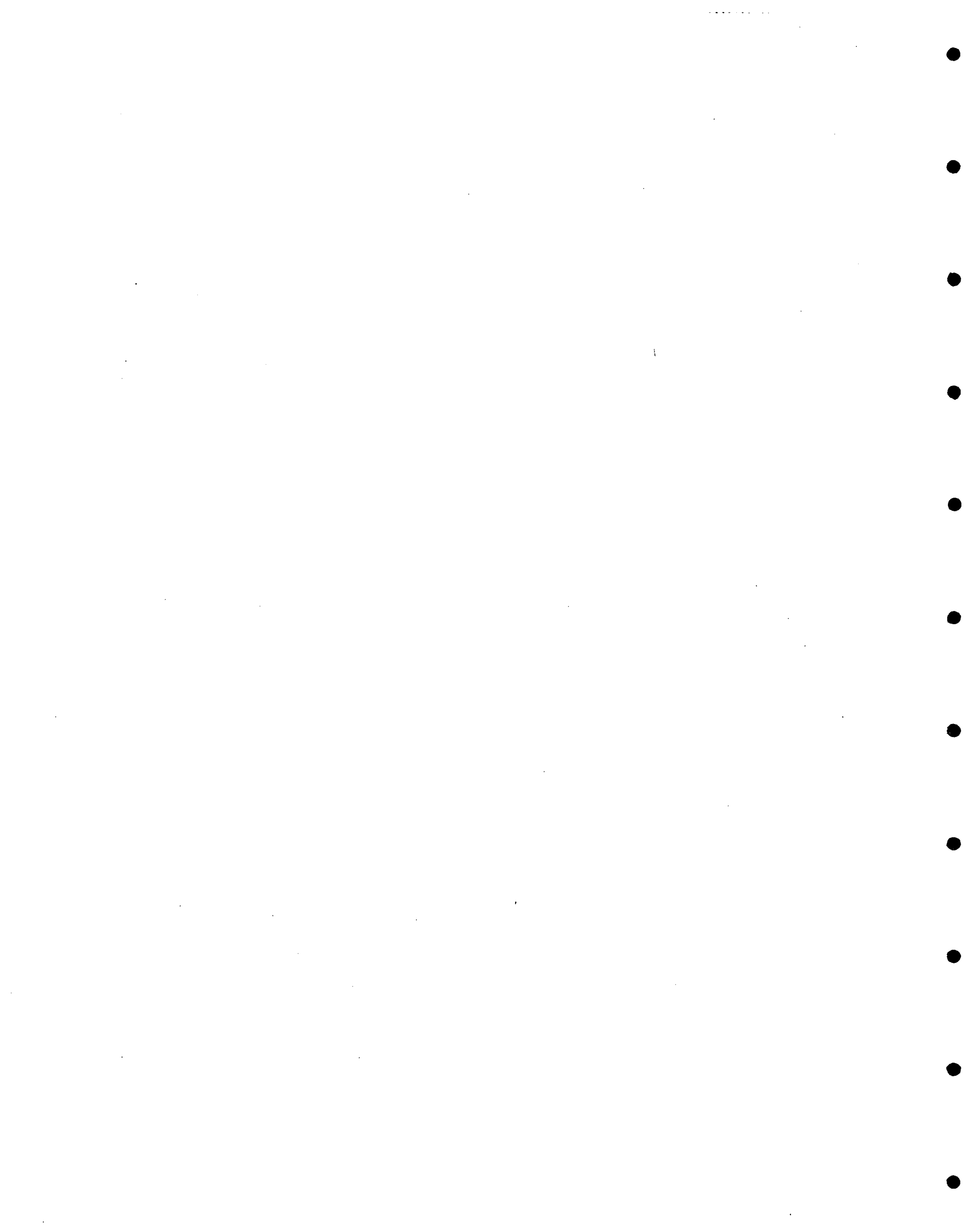
Post-treatment evaluation of recidivism will utilize criminal justice databases (FCIC, NCIC), and information from probation records (where available), including urinalysis results, probation violations and revocations, and other evidence of drug abuse. A complete 'RAP' sheet will be obtained for all STOP offenders who are released and tracked in the community. These sources provide information regarding arrest, conviction and recommitment, and offer a valuable source of data to assess reliability of self-report data. During stage two of intensive followup of STOP offenders (beginning in the second year of program operation), U.S. Department of Social Security Administration records will be reviewed to assess employment income during the post-release period.

Outcome evaluation involves followup assessment by personal interview conducted four years after admission to the STOP program. The Twelve Month Followup Interview (Appendix Y) instrument used in the Treatment Outcome Prospective Study will be modified for use in the STOP evaluation. The structured interview format includes coverage of most areas included in the intake interview and clinical assessment. Areas examined include drug and alcohol use, criminal activity, employment, psychiatric status, health status, social functioning, social support, use of community resources, retention of treatment experience, and drug relapse. Other instruments administered during the post-treatment followup will include the SCL-90, and a modified version of the Addiction Severity Index addressing drug use and psychosocial functioning.

Procedures and Analysis

The evaluation coordinator will supervise all tracking and followup interviews. The evaluation coordinator will meet with staff of the Department of Corrections during the first year of STOP program implementation to identify an appropriate judicial circuit from which to select the comparison sample for stages one and two of the post-treatment evaluation. The coordinator will subsequently meet with the DOC circuit administrator for Probation and Parole Services to establish procedures for administration of the STOP eligibility assessment instrument to a sample of probationers in order to select the comparison sample. It is estimated that the eligibility assessment instrument will have to be administered 300 times to provide a suitable (e.g. eligible for STOP admission) comparison group of 100 probationers for stage one of the post-treatment evaluation. Similar procedures will be used to select the comparison sample of 200 probationers for stage two of the post-treatment evaluation. Evaluation staff will conduct field training with probation officers prior to selecting the comparison sample to review the scope of, and rationale for the evaluation program, and to provide instruction in methods of administering and scoring the eligibility assessment instrument. The evaluation coordinator will consult with the Department of Corrections and the Florida Department of Law Enforcement to obtain "RAP sheets" for STOP offenders during stage one and two of the post-treatment outcome evaluation. The coordinator will also contact the U.S. Department of Social Security Administration to obtain release of information waivers regarding SSI taxes paid by STOP offenders during post-treatment followup. Each STOP offender will be asked during intake to the program to sign a voluntary release of SSI information.

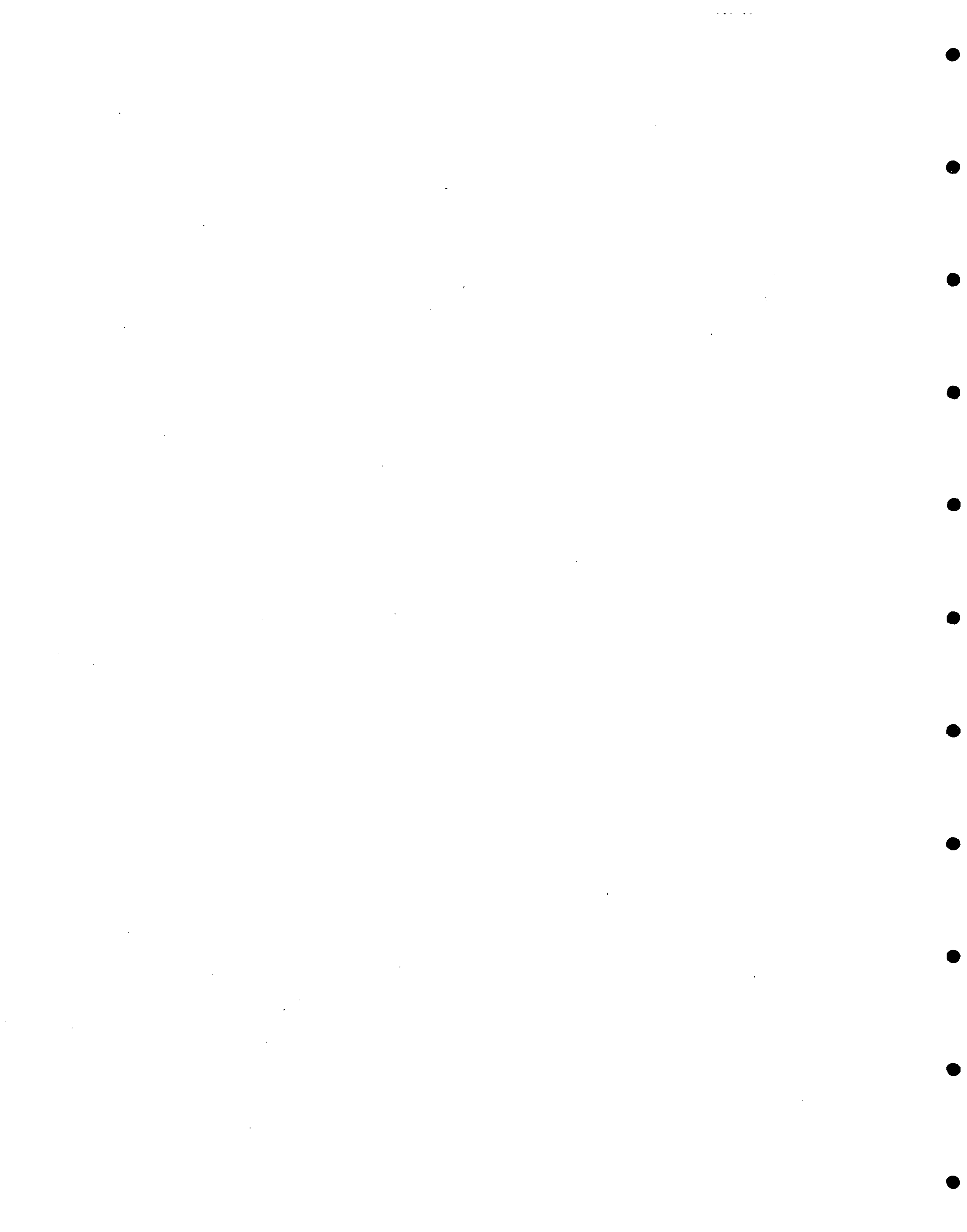
Evaluation staff will compile and analyze recidivism data at the conclusion of both the first and second year of stage one of the post-treatment evaluation. Staff will also compile and analyze similar data from the more intensive stage two of post-treatment evaluation. An annual report will be developed and disseminated to the Florida Legislature, to the Department of Corrections, and to the Department of Health and Rehabilitative Services, providing a summary of important evaluation findings



from the STOP program. In addition to describing critical program statistics (e.g. number of offenders treated, number unsuccessfully and successfully discharged, length of stay, cost of treatment per day), the annual report will describe in a comprehensive manner the outcomes of probationers treated in the STOP program, and of probationers in the comparison sample, and will address preliminary evidence regarding cost effectiveness of the STOP program in comparison to community supervision. Evaluation reports will also provide updated information from the STOP program intake assessment evaluation and the in-treatment evaluation. This portion of the report will describe characteristics (e.g. drug use history, criminal justice history, demographic characteristics) of probationers in the STOP program and in the comparison sample, and will describe changes over time in measures of psychological functioning and in other in-treatment measures.

Followup interviews for stage three of the post-treatment evaluation are conducted in the community by trained evaluation staff who will receive two days of pre-service training in data collection procedures and use of survey instruments. An interviewer manual will be developed prior to the followup evaluation that describes methods of locating STOP offenders, of maintaining confidentiality, and specific interview techniques. Information obtained from STOP offenders at the time of program intake is used to locate potential respondents during followup. Probation officers and outreach workers from the National Institute on Drug Abuse (NIDA) or from other federally-funded programs may also be contacted to assist in obtaining this information. The followup interview includes an informed consent and, if possible, is conducted at the respondent's place of residence. The interview will require approximately one hour to complete.

Similar procedures for supervision and quality control (during intake and in-treatment evaluation) are used in the post-treatment outcome evaluation. Quality of interview data is examined monthly, and forms are reviewed for consistency of responses and coding errors. At least 10% of offenders interviewed during the first six months of stage three of post-treatment evaluation are verified through use of a telephone survey. Evaluation staff will readminister several key assessment items, and check for inconsistencies in responses. Multivariate analysis is used to determine the relative effects of



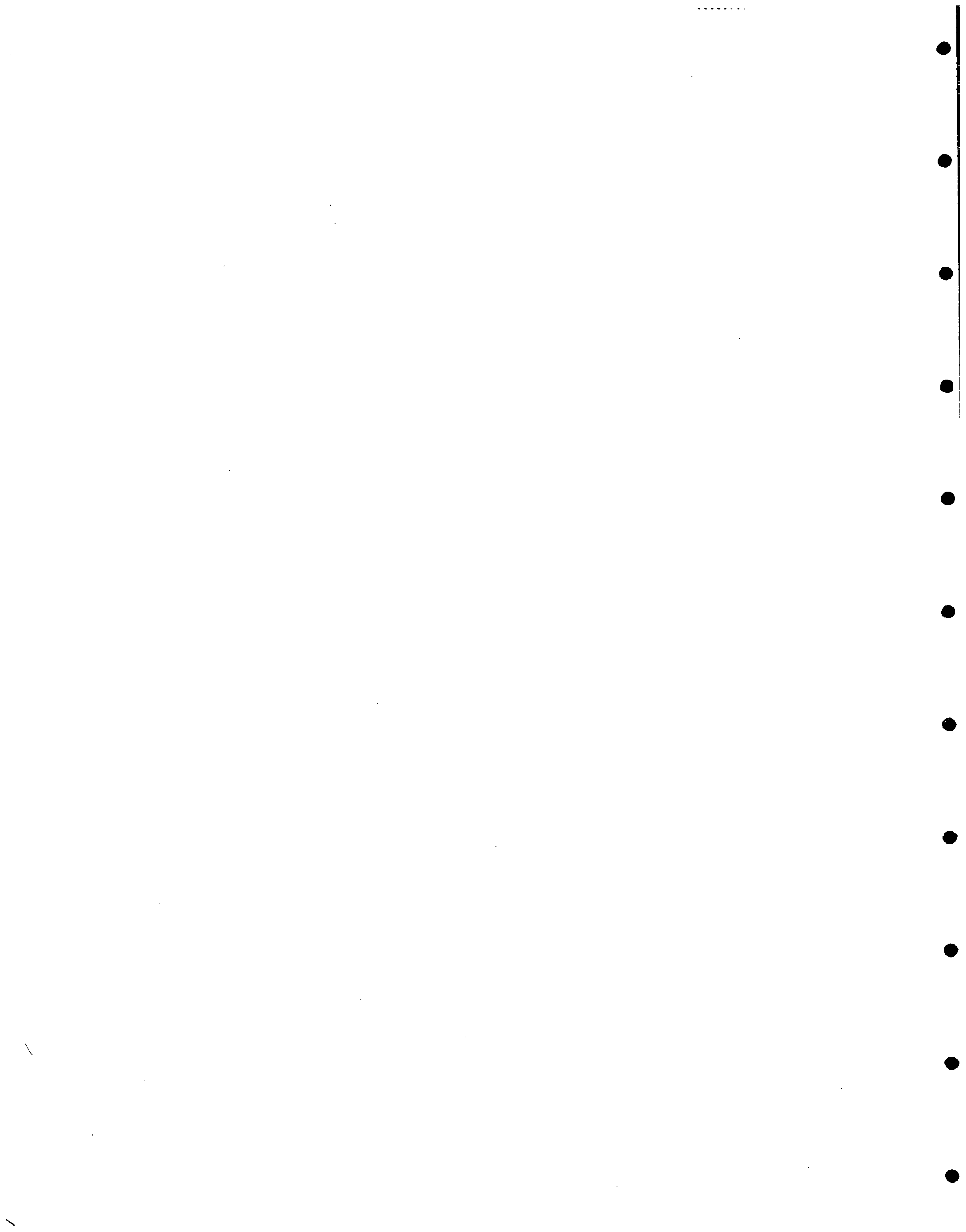
treatment or of no treatment on measures of recidivism, drug use, employment, and other indicators. Also to be examined are the effects of retention and successful completion of STOP treatment, improvement in skills, psychological functioning, and of pre-treatment variables on treatment outcome. Measures of recidivism and community adjustment among STOP offenders provides an opportunity to evaluate the cost effectiveness of intensive community-based drug treatment in comparison to traditional incarceration.

Quality Control

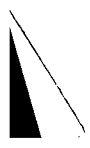
The STOP research liaison staff from each STOP facility is required to maintain weekly contact with the FMHI evaluation team during the first three months of program operation, and every two months thereafter. Two randomly completed intake and in-treatment evaluation protocols are to be selected by the research liaison staff each month for inspection and review. Evaluation staff will conduct a quarterly site visit to each STOP program during the first three months of operation, and every two months thereafter to monitor data collection and to review any difficulties. Quality control procedures are implemented at each stage of data collection, scoring, entry, document control, and data management.

Staffing Pattern

An associate professor at FMHI will serve as the STOP program director for both quality assurance and evaluation activities as discussed in Chapter 7. The program director is assisted by a secretary specialist. An Assistant Professor with a terminal degree in social or behavioral sciences and experience in evaluation of drug treatment programs will serve as research coordinator. The research coordinator will provide on-site training to STOP program staff in data collection techniques and will



supervise administration of qualitative measures and treatment integrity ratings. An Assistant in Research with at least a Master's degree in social or behavioral sciences and expertise in statistical analysis and design will coordinate data collection, input, and analysis. A research assistant with at least a Bachelor's degree and field interview experience will conduct individual tracking and followup. To account for growth in the evaluation program over the course of phased implementation of the STOP program the following additional quality assurance/evaluation staff are recommended per each Phase I facility: an on-site quality assurance/research liaison (.25 FTE), a records administrator (.08 FTE), a secretary specialist (.08 FTE), and a research assistant (.125 FTE). State employee classification codes, pay grades, and yearly salaries for evaluation staff are described in Appendix H.



REFERENCES

American Psychological Association. (1990, January). Message for Hill Staff: Drug treatment works. APA Monitor, p. 21.

Andrews, D. and Kiesling, J. (1980). Program structure and effective correctional practices: A summary of CaVIC research. In R. Ross and P. Gendreau (Eds.) Effective correctional treatment. Toronto: Butterworth.

Anglin, D. (1988). The efficacy of civil commitment in treating narcotic addiction. In C. Leukefeld and F. Tims (eds). Compulsory treatment of drug abuse: Research and clinical practice. Research Monograph Series #86. Rockville, MD: National Institute on Drug Abuse.

Bandura, A. (1979). The social learning perspective: Mechanisms of aggression. In H. Toch (ed.) Psychology of crime and justice. New York: Holt, Rinehart, and Winston.

Barton, W. (1982). Drug histories and criminality of inmates of local jails in the United States (1978): Implications for treatment and rehabilitation of the drug abuser in the jail setting. The International Journal of the Addictions, 17(3), 417-444.

Becker, M. and Joseph, J. (1988). AIDS and behavioral change to reduce risk: A review. American Journal of Public Health, 78, 394-410.

Brownell, K., Marlatt, A., Lichtenstein, E., and Wilson, G. (1986). Understanding and preventing relapse. American Psychologist, 41(7), 765-782.

Bureau of Justice Assistance Supports the War on Drugs. (1988, June). REFORM Newsletter, 1 (1).

Bureau of Justice Statistics. (1986). Drug Use and Crime, State Prison Inmate Survey, 1986. (Special Report). Washington, D.C. U.S. Government Printing.

Craddock, S., Bray, R., and Hubbard, R. (1985). Drug use before and during drug abuse treatment: 1979-1981 TOPS Admission Cohorts (NIDA Treatment Research Monograph Series). Rockville, MD: National Institute on Drug Abuse.

Craig, R. (1988). Diagnostic interviewing with drug abusers. Professional Psychology, 19 (1), 14-20.

Davidson, W., Gottschalk, L., Gensheimer, L. and Mayer, J. (1984). Intervention with Juvenile Delinquents: A Meta-analysis of treatment efficacy. Washington, D.C.: National Institute of Justice and Delinquency Prevention.

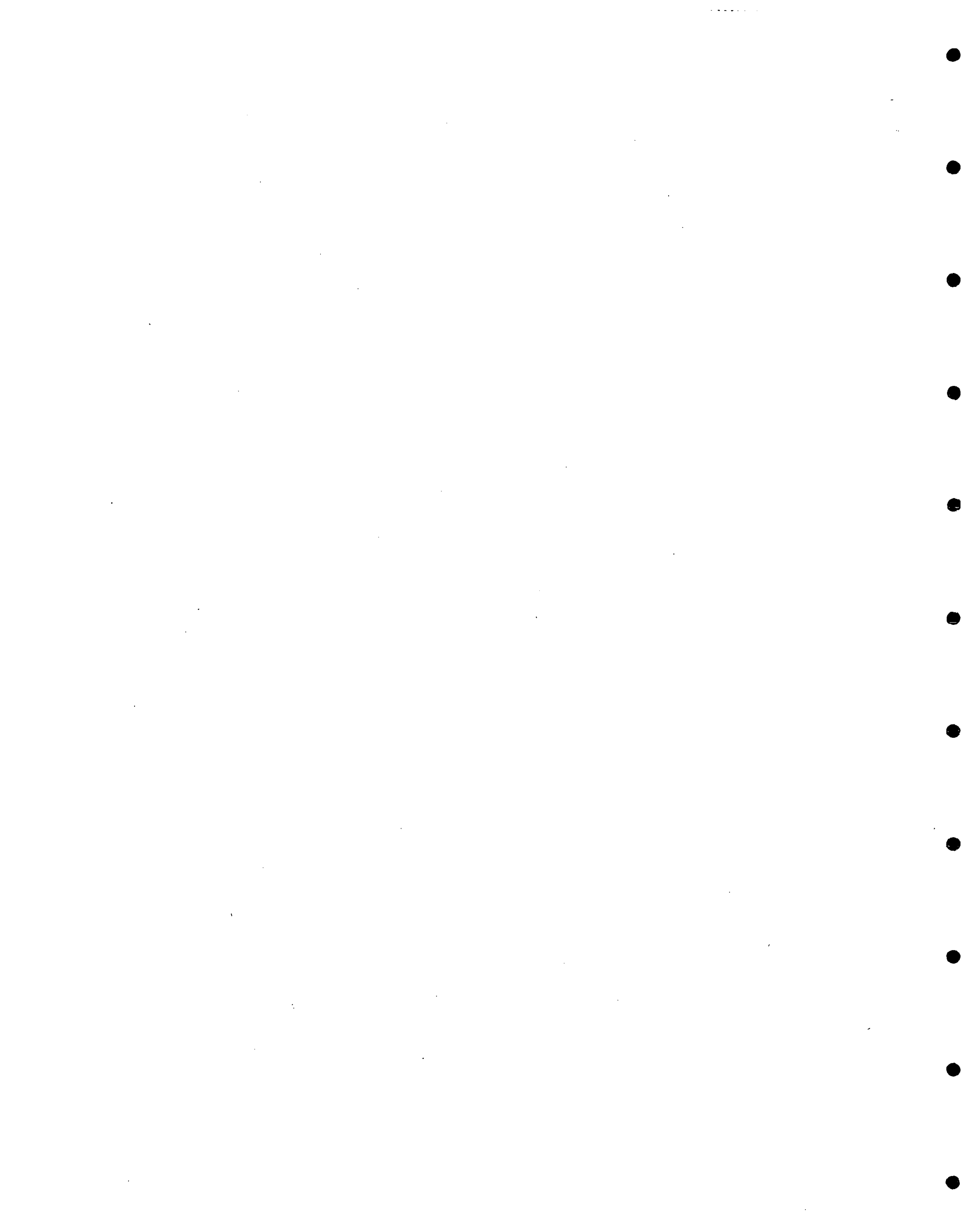
DeLeon, G., Wexler, H. and Jainchill, J. (1982). The therapeutic community: Success and improvement rates 5 years after treatment. International Journal of the Addictions, 17(4), 703-47.

Des Jarlais, D. and Friedman, S. (1988). The psychology of preventing AIDS among intravenous drug users: A social learning conceptualization. American Psychologist, 43, 865-870.

Diskind, M. (1960). New horizons in the treatment of narcotic addiction. Federal Probation, 24, 56-63.

Diskind, M., and Klonsky, G. (1964a). A second look at the New York State parole experiment. Federal Probation, 28, 34-41.

Diskind, M., and Klonsky, G. (1964b). Recent developments in the treatment of paroled offenders addicted to narcotic drugs. Albany, NY: New York State Division of Parole.



Field, G. (1985). The Cornerstone program: A client outcome study. Federal Probation, 49(2), 50-55.

Field, G. (1986). The psychological deficits and treatment needs of chronic criminality. Federal Probation, 50(4), 60-66.

Field, G. (1989). A study on the effects of intensive treatment on reducing the criminal recidivism of addicted offenders. Unpublished monograph, Oregon Correctional Treatment Programs.

Florida Department of Corrections. (1988). Annual Report: 1987-1988. Tallahassee, FL: Author.

Garrett, C. (1985). Effects of residential treatment of adjudicated delinquents: A meta-analysis. Journal of Research in Crime and Delinquency, 22, 287-308.

Gendreau, P., and Ross, R. (1984). Correctional treatment: Some recommendations for successful intervention. Juvenile and Family Court Journal, 34, 31-40.

Gendreau, P. (1989). Principles of effective intervention. (Available from Paul Gendreau, Centracare Saint John Inc., P.O. Box 3220, Postal Station B, Saint John, New Brunswick, E2M 4H7).

Inciardi, J. (1988). Some considerations on the clinical efficacy of compulsory treatment: Reviewing the New York experience. In Leukefeld, C. and Tims, F. (Eds.) Compulsory treatment of drug abuse: Research and clinical practice. Rockville MD: Research Monograph Series #86: National Institute on Drug Abuse.

Izzo, R. and Ross, R. (in press). Meta-analysis of rehabilitation programs for juvenile delinquents. Criminal Justice and Behavior.

Kadden, R., Cooney, N., Getter, H. and Litt, M. (in press). Matching alcoholics to coping skills or interactional therapies: Posttreatment results. Journal of Consulting and Clinical Psychology.

Kramer, J. (1971). Statement in Narcotic Research, Rehabilitation, and Treatment. Hearings before the Select Committee on Crime, House of Representatives, 92nd Congress, 1st Session, April 26-28 and June 2-4. Washington, D.C.: Supt. of Documents, U.S. Government Printing Office, p 668.

Maddux, J. (1988). Clinical experience with civil commitment. In C. Leukefeld and Tims, F. (Eds.) Compulsory treatment of drug abuse: Research and clinical practice. Rockville MD: Research Monograph Series #86: National Institute on Drug Abuse.

McGlothlin, W., Anglin, M. and Wilson, B. (1977). A follow-up of admissions to the California Civil Addict Program. American Journal of Drug and Alcohol Abuse, 4, 179-199.

Millon, T. (1981). Disorders of personality DSM III: Axis II. New York: Wiley and Sons, 1981.

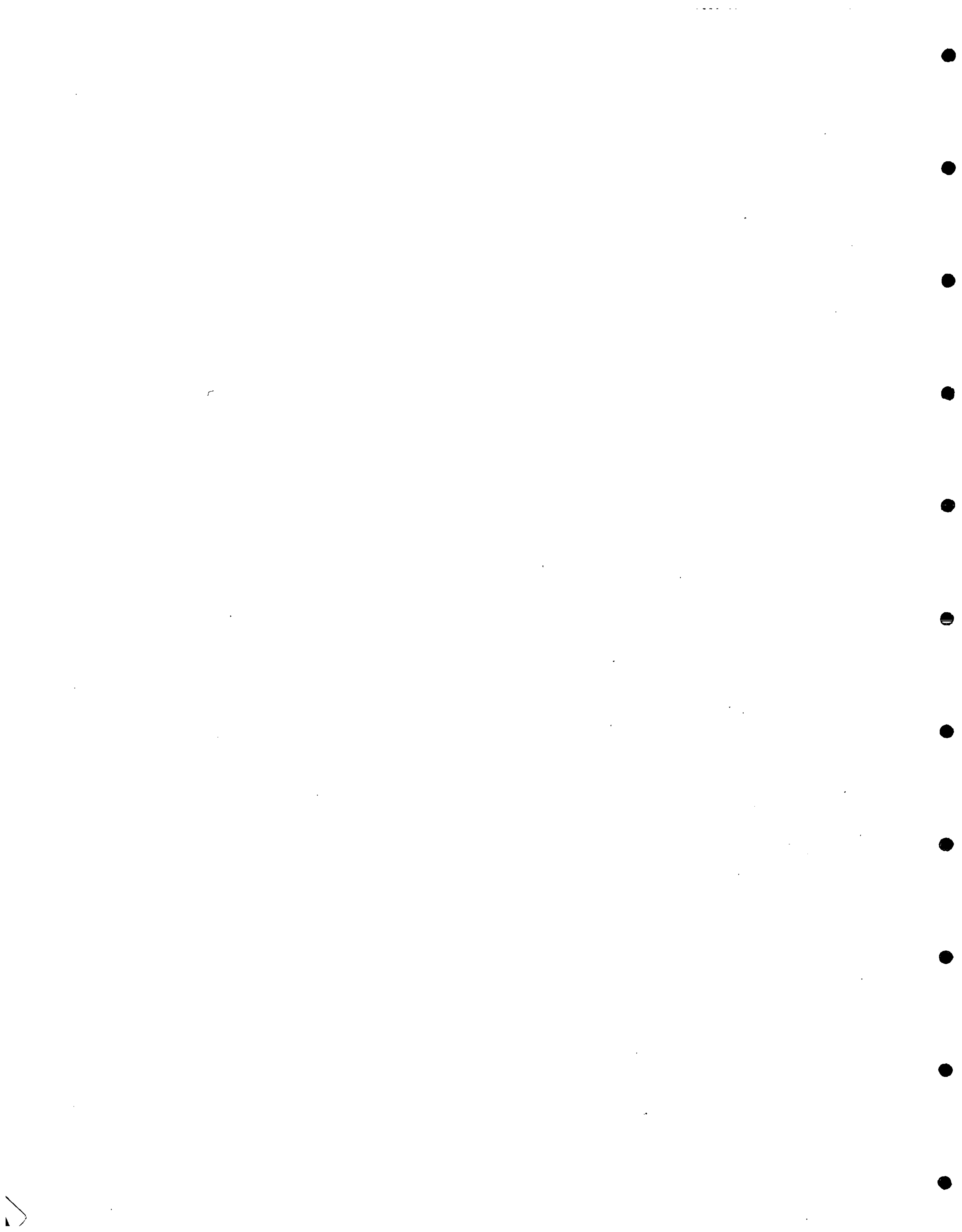
Monti, P., Abrams, D., Kadden, R., and Cooney, N. (1989). Treating alcohol dependence. New York: The Guilford Press.

National Conference of State Legislatures. (1989). Promising Approaches to Drug Treatment in Correctional Settings (Criminal Justice Paper #7). Washington, D.C.: Author.

National Criminal Justice Association. (1988, March-April). Justice Research.

Research Triangle Institute. (1989, November 21). Proposed research plan: Drug abuse treatment outcome study (DATOS). Research Triangle Park, NC: author.

Sells, S., DeMarre, R., Simpson, D., Joe, G., and Goruch, R. (1977). Issues in the evaluation of drug abuse treatment. Professional Psychology, 8, 609-640.



Simpson, D., Joe, G., and Bracy, S. (1982). Six-year follow-up of opioid addicts after admission to treatment. Archives of General Psychiatry, 39, 1318-1323.

Simpson, D. (1984). National treatment system evaluation based on the drug abuse reporting program (DARP) followup research. In F. Tims and J. Ludford (eds.) Drug abuse treatment evaluation: Strategies, progress and prospects. Research Monograph Series #51: National Institute on Drug Abuse. Rockville, MD.

Simpson, D. and Marsh, K. (1986). Relapse and recovery among opioid addicts 12 years after treatment. In Tims, F. and Leukefeld, C. (eds.) Relapse and recovery in drug abuse. Research Monograph Series 72, Rockville MD: National Institute on Drug Abuse.

Simpson, D., Savage, L., Lloyd, M. and Sells, S. (1978). Evaluation of drug abuse treatments based on first year follow-up. (NIDA Services Research Monograph Series). Rockville MD: National Institute on Drug Abuse.

Swanson, R. (Ed.). (1990). Critical Drug Abuse Challenge: Toward A Unified Systems Approach, Conference Proceedings. Tampa, FL: University of South Florida, Florida Mental Health Institute, Department of Law and Mental Health.

Tims, F. (1981). Drug abuse treatment in prisons. Rockville, MD: National Institute on Drug Abuse, Division of Prevention and Treatment.

Vaillant, G. (1966). A twelve year follow-up of New York narcotic addicts: I. The relation of treatment to outcome. American Journal of Psychiatry, 122, 727-737.

Vigdal, J. (in press). Wisconsin's Drug Abuse Treatment Unit. Washington, DC: Bureau of Justice Assistance Monograph.

Washington State Department of Corrections. (1988). Substance abuse treatment programs: Evaluations of outcome and management report. Report to Division of Management and Budget, Planning and Research Section.

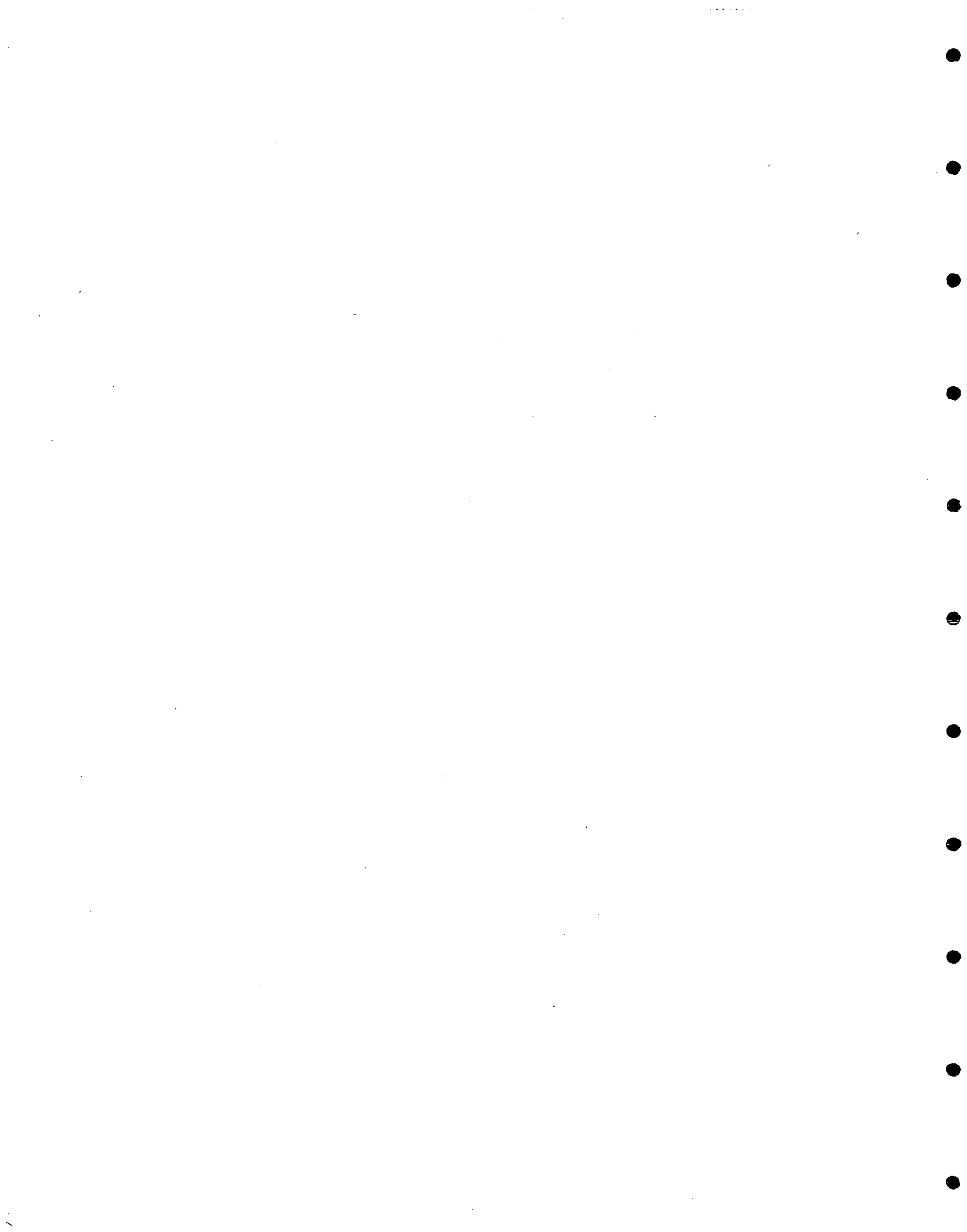
Washton, A. (1987). Outpatient treatment techniques. In A. Washton and M. Gold, (eds.) Cocaine: A clinician's handbook. New York: The Guilford Press.

Wexler, H., Falkin, G., and Lipton, D. (1990). Outcome evaluation of a prison therapeutic community for substance abuse treatment. Criminal Justice and Behavior, 17(1), 71-92.

Wexler, H., Lipton, D., and Johnson, B. (1988). A criminal justice system strategy for treating cocaine-heroin abusing offenders in custody. Washington, DC: National Institute of Justice (US GPO 1988-202-045: 80082).

Wexler, H. and Williams, R. (1986). The Stay-N-Out therapeutic community: Prison treatment for substance abusers. Journal of Psychoactive Drugs, 18(3), 221-230.

Yochelson, S. and Samenow, S. (1976). The criminal personality, New York: Jason Aronson.



14-Mar-90

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* FLORIDA ADULT S.T.O.P. PROGRAM *
* 1 TREATMENT FACILITY-YEARS 1 & 2 *
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SUMMARY:	90/91 YEAR ONE	91/92 YEAR TWO
ASSESSMENT	34,125	117,000
PHASE I (140 BEDS)		
SALARIES AND BENEFITS	443,409	1,773,636
EXPENSES	259,668	628,559
OCO	36,800	0
PROBATION/PAROLE	94,124	405,196
TOTAL DIRECT COSTS	834,001	2,807,391
INDIRECT COSTS @ 20% *	166,800	561,478
PHASE II (40 BEDS)		
SALARIES AND BENEFITS		445,563
EXPENSES		249,468
OCO		20,700
INDIRECT COSTS @ 20% *		143,146
PHASE III - OUTPATIENT SERVICES		414,720
FMHI **	291,390	431,256
GRAND TOTAL	$1,326,316	$5,190,722

* INDIRECT COSTS INCLUDE PERSONNEL MANAGEMENT, FINANCE & ACCOUNTING, PLANNING/EVALUATION, QA, PAYROLL, LEGAL, & LICENSING

** OVERHEAD COSTS INCLUDED IN FMHI EXPENSES INCLUDES GRANT ADMIN., PERSONNEL SERVICES, FINANCE AND ACCOUNTING, UTILITIES, & SUPPORT STAFF