137631

CONNECTICUT DEPARTMENT OF CORRECTION
ADDICTION SERVICES UNIT

MODEL
ALCOHOL AND DRUG TREATMENT PROGRAM

NOVEMBER 22, 1991

137631

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I Introduction

A. Task Force Assignment

A Task Force was established by the Director of the Division to develop a Model Alcohol and Drug Treatment Program which would be utilized as a base-line for implementing and assessing institutional and community-based programs throughout the Department. The Task Force was asked to incorporate a Continuity of Care Model, and was charged with developing standards which included staff workload requirements. The Model Program and standards were to provide the basis for a consistent alcohol and drug treatment program and a field performance review mechanism for the Department. The Task Force met monthly with subcommittees meeting more frequently to address various program components. The group was established with a five (5) month termination date at which time the final report was to be submitted to the Director of Programs and Treatment for review.

To ensure the appropriate level of commitment and ownership, the Task Force was comprised of the following individuals:

Lawrence Mayer, Chairperson, Director of Addiction Services

Eileen Buck, Correctional Counselor Supervisor, New Haven Community Addiction Services

Edward Davies, Deputy Warden, CCC-Bridgeport

Todd Fisk, Community Service Administrator

Hans Fjellman, Regional Director, New Haven Regional Community Services Office

Cathy Levey, Deputy Warden, CRCI-Enfield

David May, Deputy Warden, Western Substance Abuse Treatment Unit

Charlene Perkins, Deputy Warden, CCI-Niantic

Marion Rawlinson, Regional Director, Bridgeport Regional Community Services Office

Robert Ronne, Deputy Warden, CCI-Manson Youth Institution-Cheshire

Steven Tozier, Deputy Warden, CCI-Somers

The Task Force looked to improve the system for successful implementation of substance abuse treatment including:

- formalized policies and procedures to address continuity of care, recovery, staffing and operations,
- interventions designed to break down denial or resistance to treatment of non-motivated inmates,
- adequate service capacities, program components, and program space for inmates with treatment needs.

The Task Force also recognized the diverse resources and physical disparities among the many correctional facilities. The Model Program would incorporate a vigorous evaluation.

II Statement of the Problem

Drug and alcohol abuse is a substantial problem in our society, and one that directly affects corrections. According to the U.S. Department of Justice, Bureau of Justice Assistance, FY 1988 Report on Drug Control,

> "The link between drug use and crime has been firmly established, making it difficult to discuss one to the exclusion of the other." (1988:5).

Estimates by social science researchers and correctional authorities indicate that as much as 70 to 80% of the nation's prisoners used drugs prior to incarceration; however, only about 10 percent are in prison-based treatment programs (Chaiken, 1989; Innes, 1988) Not only do drug-dependent offenders commit a substantial amount of crime, but as the frequency of abuse increases, so does the frequency of crime (Ball, 1986; Chaiken and Chaiken, 1983; Johnson et al., 1985). Research studies from the National Institute on Drug Abuse, the National Institute on Alcoholism and Alcohol Abuse and Therapeutic Communities of America substantiate that

> "Treatment interventions in the criminal justice system can reduce both the frequency and severity of the offender's drug and alcohol abuse."

Connecticut's drug and alcohol abuse problem mirrors the nation's.

- Over 80% of all serious crimes are drug related.
- Criminal arrests have increased by 79% since 1980.
- Drug arrests alone increased by 25% from 1980 to 1989 (Bidorini, ed., 1991).

The Connecticut Department of Correction labors under the burden posed by these above statistics. As of March 16, 1991, of the 9,016 inmates incarcerated, and 6,090 inmates in supervised home release, according to DOC's Objective Classification, 79.2% have "T scores" identifying a significant need for substance abuse treatment.

III Addiction Services History and Philosophy

The Addiction Services Unit of the DOC was legislatively created in 1969, one year after the inception of the Department, to serve substance-abusing offenders. In 1972, Project FIRE, which is now called Community Addiction Services, was created as it became evident that a re-entry community-based component was needed in addition to institutional programming. Since 1973, the "continuity of care" concept, a continuum of drug/alcohol treatment services from the prison to the community, has been the cornerstone of the Unit's treatment philosophy.

In the latter 1970's, program expansion and staff training to include "alcohol" as a drug was emphasized. The Behavioral Studies Program was implemented. Client treatment planning and staff clinical training were emphasized.

In the 1980's, various infusions of federal and state funds have allowed for expansion of programming to nearly all correctional facilities and community locations, implementation of additional program components, and clinical emphasis on the various counselor functions in line with alcohol and drug counselor certification (CADACCB).

In the past four years, Hartell DWI Unit, Eddy DWI Unit and Western Substance Abuse Treatment Unit were opened. Addiction Services was recognized by several national organizations as a model program devoted to continuity of care. Federal grants were received to insure that comprehensive training programs were designed and delivered to all Addiction Services staff. An Automated Management Information Client Tracking System was developed to track clients through the continuity of care model and have the potential of generating statistical information for research purposes. The Office of Treatment Improvement (OTI), of the Department of Health and Human Services provided funding for intensive substance abuse treatment at Manson Youth Institution, CCI-Niantic, CCI-Enfield and CCC-Litchfield.

The Winner's Circle, a support group comprised of successful program graduates, was created. The Community Addiction Services (Project FIRE) Program was redesigned to respond to the volume and needs of the service population and to utilize current strategies in the substance abuse field. Formal program audits were instituted to better assess and improve substance abuse programming.

The Unit currently operates an array of treatment programming directed to the varied needs of the offender population. These services include a number of group treatment modalities aimed at introducing the client to the issues surrounding his/her addiction, accepting ownership of their present situation, providing skill building and changing their behavior patterns. Basic to this approach is the encouragement of involvement of self-help and mutual-help fellowships as found in 12 Steps and 12 Traditions of Alcoholics Anonymous (AA) and Narcotics Anonymous (NA). In conjunction with the 12 Steps Program, specialized group treatment is directed to the unique needs of the inmate such as language barriers, family problems, and issues of denial. In addition to various types of group therapy, individual counseling is provided as possible.

The Addiction Services Unit has recognized the following components for the successful treatment within institutional and community programming:

- a shared philosophy of addiction and recovery,
- offering a variety of treatment options to meet individual offender's needs,
- incorporation of innovative resources to treatment programming,
- utilization of learning theory practices, group dynamics, and recovery process theory, and
- maintaining a level of highly qualified and motivated staff through a comprehensive in-house training program.

IV Literature Review

A. Discussion

The Committee directed a literature review on effective programs in drug and alcohol treatment within the corrections system. This section discusses elements of an effective drug and alcohol treatment program within corrections. It also argues that a better integration of what has been learned about prison-based drug and alcohol treatment with principles of recovery utilized by non-criminal justice community-based programs, might provide a stronger foundation for any model program.

The 1980's saw a tremendous increase in prison populations across the country; among the booming population were drug offenders. The widespread popularity and use of crack cocaine caused serious public concern which lead to tougher drug laws nationwide, increased federal funding to drug education programs, law enforcement, and substance abuse treatment. "In particular, the Anti-Drug Abuse Act of 1986 called for substantial new resources for correctional drug treatment efforts." (Lipton et al., 1990:2).

A national program, known as Project REFORM was conceived by the Federal Bureau of Justice Assistance under the Anti-Drug Abuse Act in July, 1987 to assist state departments of correction develop comprehensive drug treatment plans. The Narcotic and Drug Research, Inc. (NDRI), was chosen to administer Project REFORM. NDRI is a private, non-profit organization devoted to substance abuse research, training, and technical assistance. Dr. Douglas Lipton and Dr. Harry Wexler, two leaders in the research of offender drug programs, were asked to serve as the Project's Co-National Program Coordinators. The Project has been renamed Project RECOVERY. Ten (10) states including Connecticut continue to be involved with the Project. Much of the research presented in this section was derived from the work of Lipton, Wexler, and NDRI.

B. Treatment Approaches

Wexler, Lipton and Johnson (1988) state that broadly defined, there are two (2) sets of forces that impede successful drug and alcohol treatment outcomes (reduction of recidivism). One is institutional resistance; the other is primarily related to intervention techniques.

These authors found that institutional resistance, and a lack of support from correctional administrators and officers, can easily hamper successful outcomes. In addition, these individuals concluded that the insidious antisocial inmate code can undermine the best of therapeutic approaches.

Lipton, Blackmore and Wexler (1990) state that certain structural characteristics of treatment intervention are prone to failure. These characteristics are primarily related to a theoretical basis of treatment and its approach toward offenders.

Gendreau and Ross, in works completed between 1983-1984, and 1987, support Wexler and Liptons' position that interventions based on punishment as deterrence models (such as "Scared Straight" programs, which attempt to instill fear) have shown very limited treatment effects, and in some instances have been associated with increased offending. Programs that are permissive and over-identify with offender attitudes (styles, gestures, speech) are not successful. Non-directive therapy and under-structured peer group interaction have also been found ineffective. Programs that rely on interpersonal domination and abusive authority do not work. Finally, there is no evidence to support the contention that programs based on traditional psychotherapy or a disease model work. Following a review of several studies, Gendreau and Ross concluded, "whether the disease is some form of psychopathology or biological deficit, we have not found one well controlled positive report." (1983-1984: 34). Ross contends that offenders have a deficit in cognitive skills and that training in such skills is an essential component of effective correctional programs (Ross and Fabiano, 1985).

Lipton and Wexler (Reform, 1989) conclude that the lack of success of certain treatment models stems from their failure to strike a balance between recognizing the antisocial behavior of clients and emphasizing the development of pro-social conduct. Behavioral programs that are imposed without involving inmates in their own development, do not work as well as those that do involve inmates. Such programs are often targeted at antisocial behavior rather than focusing on pro-social behaviors. This approach gives undue attention to the reinforcement of negative behavior.

These authors contend that programs which either fail to neutralize the inmate code or utilize inmate peer pressure in a positive way, tend to be unsuccessful. Other factors that tend to inhibit success are a lack of well-trained, dedicated staff, insufficient resources, and lack of aftercare services. Recidivism rates are higher when there is no continuity of care, that is, when the treatment begun in prison is not sustained after inmates return to the community. These authors conclude that drug treatment programs that do not overcome resistance from external forces, and do not tailor treatment to the characteristics peculiar to prison inmates, tend to be unsuccessful (Reform, September, 1989).

In contrast to what are perceived as ineffective treatment models, Lipton and Wexler assert that promising and effective programs have been derived from a social learning theory of criminal behavior. This theory suggests that criminal behavior and attitude is learned through a process of social interaction; these behaviors can be altered by reinforcing pro-social behavior. Gendreau and Ross (1983-1984, 1987) have found that effective interventions include self-help approaches (such as therapeutic community), interpersonal cognitive problem-solving skills training, peer oriented behavioral programs, family therapy, contingency contracting, role playing and modeling, and vocational social skills training. Evidence exists to support the contention that techniques based on theories of relapse prevention work (Annis and Davis, 1987; Bandura, 1977; Brownwell, et al., 1986). These theories are especially relevant to correctional-based drug and alcohol treatment because these interventions focus on reasons why inmates relapse and justify the need for continuity of care.

Wexler, Lipton and Johnson (1988) state that inmates with chronic polydrug abuse and extensive involvement in crime need comprehensive, intensive treatment. Programs that have been successful in treating serious offenders include a variety of components, such as encounter groups, individual counseling, drug education, and specialty groups (which focus on special topics such as anger management, problems of adult children of alcoholics, and stress reduction techniques). These programs tend to emphasize the development of problem-solving capabilities; are intensive; provide inmates access to staff when needed; and are designed to keep inmates in treatment for an adequate duration (usually more than six months). Successful programs not only require an effective approach, but capable management and staff. The success of treatment programs in correctional settings also depends on the degree of integrity. Program integrity requires a staff commitment to the goals of the program, effective leadership, and competent staff (Quay, 1977; Selchrest 1979). Successful programs have capable directors who provide adequate supervision to well-trained staff.

Drug treatment programs for offenders developed through Project REFORM and RECOVERY are based on the following guidelines:

- Programs should emphasize a self-help approach;
- A sequence of intervention should be planned which gives a variety of treatment options appropriate to the needs of the offender;
- Resources should be targeted to the minority offenders that are chronic polydrug abusers;
- Residential correctional-based treatment programs should be allocated as a separate unit;
- Programs should establish and enforce a clearly articulated set of rules and rewards;
- The staff should include ex-offenders/ex-addicts;
- Correctional-based treatment should be followed by treatment in the community;
- Coordination between correctional authorities and aftercare providers is essential; and
- Evaluation of treatment programs should be integrated into the design of the program.

Lipton and Wexler, have developed extensive literature which highlights which drug and alcohol treatment efforts have been successful in correctional systems. These authors have utilized the research initially developed by Dr. George DeLeon (Phoenix House and Daytop Village) to replicate drug treatment therapeutic community concepts for effective use within corrections.

Wexler and Lipton have generally ignored the treatment potential, clinical experience, and theory of most community alcohol and drug treatment programs, except those using the therapeutic community modality of treatment. Their view appears to be that programs based on a disease model have not been found to be effective and/or these programs are not intensive enough to impact the antisocial behavior patterns of the correctional client.

These authors stress that there are certain personal characteristics, e.g. inadequacy, immaturity, dependence, cognitive deficiency, antisocial attitudes, and habitual impulsivity, that impede an offenders' ability to function at a generally acceptable level, i.e. substance abuse-free, in one or more basic social areas. Dr. Lipton (1990) states that

> "the difficulty in performing at a generally acceptable level of behavior by offenders significantly contributes to the return of criminal conduct. Treatment should be directed at overcoming a persons' antisocial thinking and behavior".

Lipton, Wexler, and others emphasize that altering antisocial behavior will return inmates to the society substance-free, thereby, reducing recidivism and lowering the crime rate. There is little concern for the disease concept of substance abuse in their work.

C. The Disease of Addiction

Most drug and alcohol programs, however, are based on the disease concept of substance abuse. The Committee thought it was important to explore these concepts in order to determine what, if any, role this approach should have in the formulation of a Model Alcohol and Drug Program.

The alcohol treatment field has spent many years recognizing alcoholism as a physical disease. One proponent of this theory, Dr. James Milan (1981), has strongly asserted that psychological and social factors play no stronger role in alcoholism than any other chronic disease. He has challenged the notion that alcoholism is caused by psychological susceptibility and presents the view that the body of a person who becomes addicted to alcohol does not react to alcohol the same way as a person who does not become addicted. Gorski and Miller (1986) define the disease of addiction as a condition in which a person develops a biological, psychological, and social dependence on any mood-altering substance.

Addiction progresses through three identifiable stages: an early stage, a middle stage and a chronic stage. In the early stage, it is very difficult to distinguish addictive from non-addictive use because there are few outward symptoms. The major symptom of early stage addiction is an increasing tolerance. The middle stage of addiction is characterized by a progressive loss of control as the person is no longer able to use the same quantities without becoming intoxicated or creating problems. The chronic stage of addiction is marked by deteriorations - physical, psychological, behavioral, social, and spiritual. All body systems can be affected at this stage. Getting ready to use, using, and recovering from using, become the life activities of addicted people. Chronic abusers break promises, forget commitments, lie - all to be able to use drugs. Drug seeking behavior becomes a life style.

Gorski and Miller (1986) view the addiction cycle as a deadly trap which is made up of the following elements: 1) Short-Term Gratification, 2) Long-Term Pain and Dysfunction, 3) Addictive Thinking, 4) Increased Tolerance, 5) Loss of Control, and 6) Biological, Psychological-Social Damage.

1) Short-Term Gratification: The addicted individual feels good now, and assumes the drug or behavior is good for him or her.

2) Long-Term Pain and Dysfunction: The short-term gratification is eventually followed by long-term pain. This pain comes partly from physical withdrawal and partly from the inability to cope psycho-socially without drugs.

3) Addictive Thinking: The long-term pain and dysfunction trigger addictive thinking. Addictive thinking begins with obsession and compulsion. Obsession is a continuous thinking about the positive effect of using alcohol and drugs. Compulsion is an irrational urge to use the drug to get the positive effect. This leads to denial and rationalization in order to allow continued use. Denial is the inability to recognize there is a problem. Rationalization is blaming other situations and people for problems rather than drug use.

4) Increased Tolerance: More and more of the drug is required to produce the same effect.

5) Loss of Control: The obsession and compulsion become so strong that the addicted individual can no longer think about anything else.

6) Biological, Psychological-Social Damage: Eventually, the addicted individual does damage to the health of the body (physical health), mind (psychological health), and relationships with other people (social health). This damage increases the addicted persons pain which increases the need for addictive use.

The disease model of addiction puts forth that total abstinence is necessary to recover from an addiction, but abstinence alone, is not recovery. Bold statements are made regarding the effectiveness of Alcoholics Anonymous and other self-help groups. In fact, Gorski and Miller (1986:52) state the following:

"Alcoholics Anonymous is the single most effective treatment for alcoholism. More people have recovered from alcoholism using the program of AA than have recovered using any other form of treatment. It is for this reason that AA needs to be a vital part of any recovering alcoholics sobriety plan. There are similar self-help groups for other addictions".

Gorski and Miller state that many times in the course of recovery, the recovering person will confront specialized problems.. These problems may be marital, emotional, psychological disorders, financial difficulties, or behavioral problems that are the direct result of addiction. They further state that while these problems

> **"will usually improve with a self-help program alone, it has been demonstrated that professional counseling and therapy can provide assistance in resolving these issues more rapidly and effectively. The most successful form of treatment combines a self-help group with professional treatment" (1986:53).**

Milton Maxwell (1984) stresses that it is difficult to recover from an addiction without what is referred to in AA and Narcotics Anonymous (NA) as a "Spiritual Program". The principles of AA teach that alcoholics are powerless over their condition and cannot manage their lives until they accept the help of a greater power. A life that includes wholesome living, uplifting relationships, commitment to values outside of oneself, and spiritual growth supports long-term health and sobriety. Reorienting life around values that are non-drug centered is an essential part of recovery. A life style which supports substance use is not conducive to sobriety.

The addictive disease model (Gorski, 1985) claims that it is helpful to think about the recovery process as having six (6) developmental periods. In the **pretreatment** stage, the addicted person learns by consequence that the individual cannot safely use addictive chemicals. In **stabilization**, the individual regains control of thought processes, emotional processes, memory, judgment and behavior. **Early recovery** is categorized by the individual accepting the disease of addiction and learning to function without drugs and alcohol. **Middle recovery** involves developing a normal, balanced life style **Late recovery** includes the development of a healthy self-esteem, spiritual growth, healthy intimacy, and meaningful living. The **maintenance period** involves staying sober and living productively.

The disease concept of addiction states that recovery from addiction must be an active process. Recovering persons must work at a daily program of recovery. They must remind themselves daily that they are suffering from an addiction. They must have an active recovery program that provides guidelines for effective and productive living. Proponents of this model further state that once an addicted individual abandons a recovery process, it is only a matter of time until the symptoms of post-acute withdrawal appear. If nothing is done to manage these symptoms, the addicted individual experiences a period of out-of-control behavior that is called relapse syndrome. Relapse is a progressive process that is marked by definite, predictable, progressive warning signs. The addictive disease model stresses that addicted individuals need to create a relapse prevention plan that will allow them to successfully manage warning signs of relapse. Most alcohol and drug programs stress that the key to recovery is a combination of professional treatment, self-help group involvement based upon the twelve steps of AA and NA, and a program of relapse prevention planning and action.

D. Other State Department of Correction Treatment Programs

A number of other states, recognized as leaders of Correctional Substance Abuse Treatment have designed models that integrate what has been learned about prison-based drug and alcohol treatment with principles of recovery utilized by non-criminal justice community-based programs. Of particular note are the following:

The **Florida Department of Correction** (September, 1988) has a sequenced four-tier treatment approach: Tier 1 provides substance abuse education (35-40 hours); Tier 2 offers a four to six week intensive drug treatment with four major learning themes; Addiction, Life Management/ Skill-Building, Self-Help Fellowships and Relapse Prevention; Tier 3 is an in-house intensive Therapeutic Community, and Tier 4 is assignment to community treatment after release.

The Florida program emphasizes substance abuse as a problem of the whole person, affecting some or all areas of functioning. The program utilizes a developmental model of recovery in conjunction with a formalized, multifaceted, integrated and balanced program of life-skill training. The objectives of the program include abstinence and personality and behavioral growth.

New York's Alcohol and Substance Abuse Treatment (ASAT) Program (June, 1989) includes 1) residential settings (at least 15 hours of programming a week), 2) scheduled modular settings (one program module per day, 4 or 5 days a week/at least 8 hours a week), 3) outpatient settings (5 hours of programming each week). The basis of the treatment approach is education and counseling to assist an inmate change behavior and accept individual responsibility. The 12 Step approach is the guiding set of principles for substance abuse treatment.

The New York State Department of Correction also funds the Stay 'n Out program at Arthur Kill Correctional Facility on Staten Island, and the Bayview Correctional Facility in Manhattan. These programs, recognized as national models, utilize the therapeutic community approach. They are intensive residential programs which utilize confrontational approaches first developed by Daytop Village and Phoenix House, community drug treatment programs located in New York City. The therapeutic groups of these programs focus on areas of self-discipline, self-worth, self-awareness, respect for authority, and acceptance of guidance. At the onset, clients are given low level jobs and granted little status in the community. During the latter phases, "residents" are given opportunities to earn high level positions and increased status through sincere involvement in the program and hard work.

The **Delaware** model (December, 1987) developed a Social Learning Center (Therapeutic Community) as the hub of a comprehensive treatment model. Three components are present: 1) peer counselors who share drug information with inmates not involved in the Center, 2) the Center which is a separate housing unit and the 3) community corrections phase.

The goal of treatment is to stimulate pro social conduct as much as possible. The program utilizes intensive interventions across a wide range of social, behavioral, and functional areas. The program "is based on Kurt Lewin's need for a major restructuring of life space as it relates to the persons psychological representations of self and the world. Fundamental changes in the cognitive patterns that underlie social actions can emerge from interventions"(Delaware:1).

A literature review of other state programs offers particular treatment insights:

Alabama: 28 day residential programs combining group sessions of 12 Step structure with training in stress and impulse control (1987).

Oregon: The development of a Self-Exploration Workbook for Inmates entitled "Understanding My Choices" for pretreatment intervention. Development of the highly respected Cornerstone pre-release treatment program for alcohol and drug-dependent offenders which is modeled on the therapeutic community concept (1988).

Oregon/New Jersey (1988,1989): A Curriculum for Family Education and Training to teach family members more effective ways of coping with substance abuse as the client progresses through the recovery process.

Florida, New York, Delaware, New Mexico (1987): Utilization of "peer inmate counselors" as role models who assist with program activities.

Oregon (1988): Utilization of incentives to enhance alcohol and drug knowledge of offenders.

E. Summary and Conclusions

Based on a complete review of the literature, the Task Force concluded that treatment elements contained in both Lipton/Wexler and Ross, et al., and Gorski and Miller, et al., have merit. Based on the evaluative research of Lipton and Wexler (1990) and Gorski and Miller (1986), and clinical practice, the elements of the most successful drug and alcohol correctional treatment programs in the United States today have the following components:

1. A self-help approach. Offenders should receive a thorough understanding of the Addiction Cycle. Clients should be encouraged to join Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) and the 12-Step Groups of these fellowships.

2. A variety of treatment options appropriate to the needs of offenders. Programs should provide intake procedures based on level of need, case reviews and reassignment based on client progress. Treatment plans should be developed through consultation between clients and their counselors which clarify goals and expectations, overcome and resolve client obstacles, and structure the recovery process.

3. Clear and unambiguous rules of program conduct.

4. Utilization of program staff with the following abilities and personal characteristics (Ross, et al., 1986):

   - Above average verbal skills
   - Ability to relate positively and homeopathically to offenders without compromising the regulations of the correctional agency
   - Sensitivity to group dynamics and ability to stimulate groups
   - Ability to confront offenders without demeaning them

- Capacity for empathy, effective problem-solving, well-developed values, rational and logical reasoning, openness to new ideas
- Successful experience in managing groups of poorly motivated individuals who are passively or aggressively hostile
- Willingness to consider other points of view
- Enthusiasm

5. Utilization of the ex-offender/ex-addict as role models, as staff, and volunteers (Winner's Circle, Connecticut).

6. An emphasis on strengthening and integrating pro-social behaviors, thoughts, attitudes through structured programs.

7. Provision for peer role models and utilization of peer pressure. Imitation, practice, and group identification have been found to be efficient methods of response acquisition. There needs to be peer support, group reinforcement, family support, and self-validation.

8. A climate of recognition which emotionally involves the substance abusing offender through individual treatment in a safe atmosphere which promotes an understanding of "where the offender is coming from" and has optimistic expectations about "where the offender is going". Residential resources must be employed for the common good of treating the substance abusing offender.

9. Education of clients on relapse and encouragement of client relapse prevention plans.

10. Establishment of continuity of care from onset of custody to termination of custody. Successful programs involve community linkages with self-help programming such as AA, NA, and Cocaine Anonymous (CA).

11. Maintenance of treatment program **integrity** (stay committed to goals and vision), **autonomy** (avoid undermining by "prison code" and resistant staff), **flexibility** (adapt to changing fiscal (program) and physical conditions), and **openness** (encourage access by all interested parties).

12. Integration of treatment evaluations into the design of the programs. Evaluations should focus on implementation, issues, process considerations, and outcome variables.

13. Presentation of a clear and consistent treatment theory and philosophy. The program services should be based on this theory and philosophy.

In developing the Model Alcohol and Drug Treatment Program, we have attempted to incorporate these above elements to ensure successful treatment intervention.

V Overview of Treatment Intervention

The operational premise of the Alcohol and Drug Model Treatment Program is that recovery is a developmental process (Gorski and Miller 1982, Gorski, 1988), during which the substance abusing offender learns new values, attitudes, reasoning and social skills (Lipton, Wexler, 1990, Ross, Fabiano, Ross 1985, Flores 1988). The Recovery Model links stages of recovery with specific tasks, issues, and skills to be accomplished. Page 17 provides a graphic presentation of the Model. Pages 18-23 offers a detailed description of the implementation process for the Model at each correctional facility, and each community program.

The Model begins at the Transition Stage in which the offender is introduced to the beginning of the process of change. A rapport is established through the exchange of information which is intended to move the offender into recovery. Tasks include:

- Identifying symptoms of chemical dependency and the cycle of addiction
- Breaking down denial and other defense mechanisms
- Identifying consequences of using alcohol and/or drugs
- Beginning to connect life problems with chemicals
- Beginning to accept the need for abstinence, assistance, and direction through programming (Flores, 1988)

Program components include initial and extended orientations. (see orientation curriculum).

The tasks of Early Recovery include:

- Admitting problem and perception of powerlessness
- Developing understanding and recognition of addiction
- Identifying self-defeating patterns of behavior
- Learning non-chemical coping and stress management skills
- Developing a sobriety centered value system
- Learning to identify and manage feelings
- Learning to change life style
- Developing recovery identification

Program components include (see B. Treatment Intervention Procedures for definitions):

- Recovery Education Series Curriculum Topics, Substance Abuse Education Modules (see Appendix A)
- 12 Step Format (Hazelden Step Pamphlets, Keep it Simple Series, "A Way Out" (see Appendix B),
- A Handbook for Teaching Cognitive Skills, Participant's Workbook, Supplements, by Robert R. Ross, Elizabeth A. Fabiano, Roslynn D. Ross, (see Appendix C),
- Life Skills (see Appendix D), and
- Fellowship/Meetings/Beginners speaker discussions.
- Individual Counseling and Family Intervention.

The tasks of Later Recovery include:

- Establishing commitment to recovery
- Altering self-defeating patterns of behavior
- Acknowledging interpersonal responsibilities
- Building a balanced chemical free life style
- Developing self-maintenance relapse prevention program

Program components include Relapse Prevention (see Appendix E), Family Systems Theory, Special Focus Group, Change Program, and Advanced Fellowship Meetings. The Model seeks to encourage the client to continue in a program which fosters and supports personal growth during and after release from the Department of Correction. This can in part be accomplished through encouraging clients to become Peer Counselors and/or members of the Winner's Circle.

Additional learning theory premises are incorporated throughout the stages of recovery and utilized in the component of this program. These include:

- Repetition - significant concepts and skills need to be repeated throughout the program stages,
- Role Modeling - successful participants will be utilized as role models (i.e. peer counselors in beginning stages, Winner's Circle for later stages of recovery, community volunteer sponsors),
- Practice - components should encourage practicing and personalizing acquired skills and
- Group Identification - components should foster "recovery identity" for cohesiveness, support, sharing and qualities emulation.

The goal of the Model is to provide substance abusers with a continuum of intervention for each level of confinement and during community supervision. The Program Components will address the specific stages of recovery, assign appropriate timeframes for completion, and be consistent at each facility and community program.

There will be a standard Addiction Services hard copy file at each correctional facility and community program which will accompany or follow the Master File. The Client Tracking System (CTS) will provide an electronically based system to track each client from site to site and provide an assessment of the offender's motivation and participation level, outcome of involvement at each program site, and an Assessment which will assess the client's improvement and/or stage of recovery at each program site.

MODEL ALCOHOL AND DRUG TREATMENT PROGRAM

ORIENTATION	CONTINUOUS	OPTIONS	TRANSITION STAGE Tasks
A. Initial 1. Program Description 2. Expectations 3. Request for Treatment Form			Identify symptoms of chemical dependency and the cycle of addiction
	I		Break down denial and other defense mechanisms
B. Extended 1. Chemical Dependency/Denial 2. Alcohol/Drugs & You, Understanding my Choices 3. Utilization of Peer Counselors 4. Program Guidelines Form	N D I V I D		Identify consequences of using alcohol and/or drugs Begin to connect life problems with chemicals Begin to accept the need for abstinence, assistance, and direction through programming
FOUNDATION PROGRAM	U A L		
		F	EARLY RECOVERY STAGE Tasks
	C	E	
A. Recovery Education Series Curriculum Basic Instruction in All Aspects of Chemical Dependency to Assist in Understanding Addiction Recovery Process	O U N S E L	L L O W S H	Admit problem and perception of powerlessness Develop understanding and recognition of addiction Identify self-defeating patterns of behavior
B. Reasoning and Rehabilitation Series Cognitive Skills Enhancement	I N G	I P	Learn non-chemical coping and stress management skills
C. 12 Step Series Hazelden Step Booklets	/	M E	Develop a sobriety centered value system
		E	Learn to identify and manage feelings
D. Life Skills Curriculum Behavioral Recovery Skills	F A M I L	T I N G S	Learn to change life style Develop recovery identification
MAINTENANCE PROGRAM	Y		
			LATER RECOVERY STAGE Tasks
A. Relapse Prevention Program Relapse Process and Management	I N		
	T		Establish commitment to recovery
B. Family Systems Theory Dynamics, Co-dependence, etc.	E R		Alter self-defeating patterns of behavior
	V		
C. Special Focus Groups Parenting, Cultural Issues, etc.	E N		Acknowledge interpersonal responsibilities
	T		Build a balanced chemical free life style
D. Change Program Behavioral Alternatives	I O N		Develop self-maintenance relapse prevention program
E. Peer Counselors Role Models			
F. Winner's Circle Graduate Fellowship Group			

B. Treatment Intervention Procedures

Programming is to be offered at each location to ensure continuity and encourage the substance abuser to continue what was begun at each facility and community program. A similar modality of intervention should prevail throughout all confinement locations. The treatment outline for the inmate should be clear to both inmate and staff.

Change is the essential ingredient in the recovery process from addiction. The following core components of counseling provides a sequence of activities to promote change within the Model Alcohol and Drug Treatment Program. (See Chart, page 17, for program menu and sequence.) **See Appendix G for all forms referenced below for the Model Alcohol and Drug Treatment Program.**

Orientation. The initial inmate contact, conducted in a group or individual setting, informing the inmate of the nature and guidelines of the program.

All inmates shall attend within one week of admission to a correctional setting or if stipulated or referred to a community site , 1) an Initial Orientation to Addiction Services treatment, which will include a) a presentation and written description of services and program guidelines including staff names and contact procedure, b) the program's expectation of the participant and the client's rights, c) distribution of a Request for Treatment Form and 2) an Extended Orientation (60 minute group), which will include a) a presentation on "symptoms of chemical dependency/denial" utilizing a video tape and discussion, b) distribution of the Program Guidelines Form. Peer Counselors, inmates identified as good role models in recovery, may be utilized for "testimony" and assistance in group facilitation.

The Initial Orientation Group shall be held at least once a week. The Extended Orientation (see Appendix I) can be held when appropriate.

Screening. The process by which an inmate is identified as having a need for substance abuse treatment and is referred to the Addiction Services Unit.

Upon admission to a correctional facility, each inmate shall receive an evaluation as to substance abuse treatment needs in accordance with the Department's Objective Classification System. T2 through T5 classifications can be referred to the Addiction Services Unit. A written list of referrals may be utilized and/or a Request for Treatment Form may be submitted by facility staff or the inmate. Addiction Services counselors may recommend a revision of the inmate's T score through classification.

Referrals may receive an indepth group curriculum entitled "Alcohol/Drugs and You- Understanding My Choices" (see Orientation Curriculum). Peer Counselors may be utilized for "testimony" and assistance in group facilitation. Each inmate that attends shall sign a Program Guidelines Form indicating: 1) understanding of the program's rules and philosophy and 2) respective selection of program component(s). A Refusal For Substance Abuse Treatment Form shall be available for individuals not electing to participate in substance abuse programming.

Those inmates not currently interested, may request and receive treatment at a later date.

Program Admission. The administrative and initial assessment procedures for admission to a program:

Intake. The program shall collect at least the following personal and drug history information on a standardized Program Admission/Intake Form from each person at Program Admission: a) name, b) date of birth, c) home address and telephone number, d) criminal justice status and inmate number, e) sex, f) race/ethnicity, g) social security number, if available, h) referral source, i) signature and title of intake worker and j) classification T score.

The client's history shall include the following: a) treatment history, b) substance abuse history and problems, c) family and personal history, d) education and employment history, e) medical history, and f) history of arrests and convictions.

Information of the client's current patterns of abuse will be collected through a questionnaire. A self-diagnostic tool will also be utilized.

Each inmate requesting or requiring treatment involvement shall be seen at an individual intake session within one week following Program Orientation by an Addiction Services counselor. Inmates will be admitted into the program, or placed on a waiting list, who have T2 through T5 scores and/or 1) have a drug and/or alcohol problem, 2) are capable of functioning within the structure of the program, 3) are willing to accept and understand the program guidelines, and 4) comply with the treatment plan.

Exception: Inmates participating solely in the Component-Fellowship Meetings, or whose program selection indicates less than 4 sessions of programming, shall not require a formal Program Admission/Intake. Only an Attendance Log Sheet will be utilized for this status.

Assessment/Treatment Plan/Plan Review: 1) The **Addiction Severity Index Form** will be utilized as the comprehensive assessment tool. This Assessment shall include a statement of the inmate's current phase in recovery and accompanying task(s)/goal(s). The identified task(s)/goal(s) are utilized to formulate the Treatment Plan. 2) Treatment Plan. The process whereby the inmate and counselor determine a plan of treatment. A Treatment Plan shall be developed with the inmate indicating a) treatment goal(s)/task(s) generated by both staff and inmate, b) assignment of a primary counselor, c) description of the type, frequency, and number of scheduled hours of treatment intervention. 3) Plan Review. The process whereby the inmate's status, treatment plan and schedule, motivation and progress toward goal(s)/task(s) are to be periodically reviewed. The date of such review with relevant staff signatures will be documented. The Assessment/Treatment Plan/Treatment Review developed at Program Intake shall be reviewed by the Addiction Services Program Coordinator, in conjunction with other case team members, 30 days after the initial treatment session, every 60 days thereafter for the first year, at least every 120 calendar days after the initial year, and 30 days prior to Program Discharge to insure appropriate case planning and referrals for continuity of care. The Assessment/Treatment Plan may be modified as necessary depending on the inmate's specific needs. The Plan Review shall be utilized as the method to 1) encourage continued treatment participation through planned intervention strategies and 2) insure appropriate referrals for continuity of treatment and support services.

Treatment Methods. The utilization of special skills to assist individuals in achieving objectives through exploration of a problem, examination of attitudes and feelings, consideration of alternative solutions, and decision-making.

Substance abuse treatment program sites shall be available at each correctional facility and at each of the regional community facilities. A variety of program components shall be used to provide services responding to individual needs based on respective recovery stages and tasks to be accomplished.

1. Group Counseling: A safe and supportive environment shall be developed between a counselor and inmates to facilitate peer sharing and confrontation, shared identity, and learning and recovering skills.

Group Component Curriculums are to be viewed as "dynamic" packages of materials which can be added to or changed following an Addiction Services Unit review. Group Components are to address the tasks/goals and identify the specific concepts or skills targeted and having diverse modules and accompanying "prompts" available. Appendices suggest possible curriculum presentations targeting the desired concept/skill.

Foundation/Program Components

A. Recovery Education Series: This component shall present a general framework for defining and considering "substance abuse" with its key physical (concepts and commonly used terms are compared and discussed), psychological (concentrates on personal issues involved with substance abuse), and social concepts (addresses relationships and family systems). Groups are directed to the learning process which encourages participant personalization (Appendix A).

B. Reasoning and Rehabilitation Series -Cognitive Skills: This component promotes the development of reasoning and thinking strategies. This series targets specific cognitive skills deficits in such areas as problem solving, communications, negotiation skills, managing emotions, creative thinking and values enhancement (Appendix B).

C. 12 Step Series Format: This component introduces the foundation steps for recovery based on the AA/NA philosophy. Specific curriculum is utilized to concretely understand major concepts (Appendix C).

D. Life Skills: This component promotes learning non-chemical coping skills. This phase targets specific life skills deficits in such areas as stress management, employment choices, nutrition and exercise, leisure time, relationships, and goals (Appendix D).

Maintenance/Program Components

A. Relapse Prevention: This component deals with understanding the relapse process, identifying high-risk factors, extinguishing conditioned cues, developing a drug-free socialization network, managing feelings and reducing stress.

B. Change: This component emphasizes that recovery is a continuing change and growth process.

C. Family Systems: The chemically-dependent family system is presented to learn about family of origin issues. Major conflict areas such as communication patterns, co-dependency, parenting and decision-making are emphasized. This component can be built into the Foundation/Program modules in Cognitive Skills.

D. Special Focus Groups: This component is designed to meet the special needs of particular inmate groups with substance abuse problems, e.g. mens and womens issues, cultural differences, nutrition, acquired immune deficiency (Aids), sexuality, and use of leisure time.

E. Peer Counselors: Inmates identified as good role models in recovery may be utilized to promote recovery identification. Peer counselors may give "testimony" to model personalization which is the essential aspect of recovery. The Peers' function is to assist and support the treatment effort. Peers do not have authority over other inmates. Peer counselors may be heavily utilized in the Orientation component. A formal identification, training, and group component needs to be developed for peer counselors.

F. Winner's Circle: Former inmates and clients will be encouraged to participate in this fellowship group. The Winner's Circle objective is to support continued growth among its membership through sharing experiences and providing strength and hope with the inmate or community client in treatment.

Group Format: The ideal group format has the following elements:

Confidentiality.
. Confidentiality is emphasized with regard to what is discussed in each session.

A Consistent Format.
. The opening of each session has a consistent format to create both familiarity and motivation.

Concise Material.
. Material is presented concisely and concretely to convey the concept or skill to be addressed. There is utilization of "prompts" (exercises, materials that trigger thinking and discussion).

A Personalized Message.
. Participants personalize the concept or skills to individual life experiences for relevancy. Statements are in the first person "I" showing ownership. Attention is on the "here and now".

Group Participation.

- Group participation and interaction is promoted. Participants practice good listening and communication skills providing support and/or confrontation appropriately.

All members are treated with respect and validation.

- The facilitator acts as role model and makes interventions to expand Content knowledge, and more significantly, focus on Process (how content is received, valued and responded to).

- The closing of each session is to be consistent and elicit feedback and input from the participants on the session. This will create interest for the next one.

2. Individual Counseling: A safe and supportive environment shall be developed between a counselor and inmate. An inmate can examine problems, patterns of coping with stress, the need for mood altering substances and new behaviors which permit the inmate to remain drug and alcohol-free.

   Family Intervention: Family support and involvement are a significant part of the recovery process. Alanon and Naranon participation shall be encouraged, with such groups being held inside correctional facilities, as appropriate. Groups involving "significant others" fostering recovery skills such as parenting, and other family issues, should be part of the program menu.

3. Fellowship Meetings/Beginners and Advanced: The intent of these self-help groups is to assist recovering substance abusers with helping each other overcome addiction by following AA/NA Steps, and Traditions, and developing a recovery identification. Volunteers are heavily utilized for speakers and sponsorship. All volunteers in these programs shall be approved as required in the Department's Administrative Directive.

Program Participation shall be maintained in a log to indicate treatment interventions rendered and progress made toward goal(s) in accordance with the Treatment Plan.

Pre-Release. All program participants, when possible, are to attend a pre-release component which shall include critical re-entry issues for the substance abuser. Peer pressure, support systems, and referrals should be addressed.

Program Discharge A Successful program completion is determined by an inmate's performance in compliance with program guidelines. A Program Discharge Form shall indicate: 1) a recovery assessment, 2) motivation level, 3) program involvement (components, treatment hours, program outcome) and 4) recommendations/referrals to insure continuity of care. Addiction Services counselors shall encourage those inmates who have requested treatment services to be involved in community treatment programs upon discharge or release to the community. The Addiction Services counselor will contact the specific program in coordination with the respective Regional Coordinator when appropriate.
Treatment Records Each program site shall maintain a standardized case record to document and monitor inmate care in compliance with the Connecticut Alcohol and Drug Abuse Commission Standards and Requirements. Records shall be forwarded in a sealed envelope to accompany or follow the

Master File to insure continuity of intervention. Confidentiality procedures are to be consistent with the handling of DOC medical/mental health records. This record should be continued rather than re-initiated on each new admission to a facility or community program.

A. Forms (Appendix G)

1. Request for Treatment Form
2. Program Guidelines
3. Intake
4. Assessment/Treatment Plan/Plan Review
5. Program Participation
6. Motivation Scale
7. Program Discharge
8. Confidentiality

B. Confidentiality The confidentiality of the treatment file, and any record of an inmate's participation in treatment, shall be maintained in accordance with the existing federal and state statutes and regulations. Inmate treatment records shall be maintained in secure locked cabinets to insure such confidentiality and accessibility to Addiction Services staff.

Disclosure intra-departmentally shall be on a case-to-case basis to authorized personnel with a need to know. Disclosure of treatment information outside the DOC shall only be made with informed consent of the inmate utilizing an Authorization of Disclosure or by Court Order.

C. Client Tracking System An automated tracking of inmates receiving Addiction Services programming. This tracking continues through substance abuse treatment among correctional institutions and from correctional institutions to Community Addiction Services, to insure continuity of care. All inmates who have received a Program Admission shall be entered on the automated client tracking system to provide individual client data.

Treatment Environment In order to insure program integrity and a safe environment, each program site shall have, whenever possible, adequate space to provide treatment. Individual rooms, with privacy, shall be available for each respective Addiction Services counselor to insure confidentiality. In addition, rooms to accommodate small groups (8-12) and larger groups (25 plus), conducive to treatment, shall be available at each program site.

The ideal seating arrangement promotes peer interaction and cohesiveness. A circle arrangement is recommended, with the facilitator being part of the group. No desks or other barriers are present. The traditional classroom arrangement with the authority figure speaking "down" to the members is to be avoided. The atmosphere is to be informal, personal, and optimistic.

Incentives and Sanctions Offenders with substance abuse problems are unlikely to seek treatment on a voluntary basis, and have a poor record of participating in voluntary treatment. A progressive system of incentives and sanctions should be developed to increase offenders' motivation and accountability for treatment. For example, positive urine/urines for any type of substance abuse might result in a performance failure citation and may require the need for a higher intervention program as an alternative to a negative discharge for non-compliance and potential re-incarceration.

C. Administration

The Addiction Services Unit shall provide substance abuse services during institutional custody, community release, parole, and supervised home release, to those individuals identified as in need of such services.

Addiction Services staff in all Units are subject to the line authority and supervision of the Unit Administrator or the Community Regional Administrator. On matters of Addiction Services program implementation and operation of treatment modalities, Addiction Services staff shall be provided with the clinical expertise and technical assistance of the Director of Addiction Services.

The Unit Administrator or the Community Regional Administrator shall be responsible for adhering to the approved Alcohol and Drug Model Treatment Program. Under the supervision and approval of the Unit Administrator or the Community Regional Administrator or designee, the Addiction Services Program Coordinator shall set semi-annual service goals to include the program menu selection and capacity levels at each program site (see Appendix G for form). The Director of Addiction Services will approve Semi-Annual Treatment Unit Goals and be responsible for conducting semi-annual audits on each program site.

The Unit Administrator or the Community Regional Administrator or designee, shall establish counselor functions to reflect optimum scheduled treatment hours and professional development. Effective counselor utilization shall reflect: 1) an average work week with 20 hours of inmate face-to-face substance abuse service, 2) documentation of client records, 3) clinical supervision and 4) professional development.

Standard criteria for Program Audits will be utilized by the Addiction Services Unit to insure program effectiveness and treatment program procedures consistent with the Department and CADAC regulations and guidelines (see VII Program Evaluation). Under the direction of the Director of Addiction Services, Program Managers shall conduct semi-annual on-site audit visits to monitor significant program areas, provide consultation where needed, and cite program recommendations and corrective action. A written audit shall be submitted to the Unit Administrator or the Community Regional Administrator. The Unit Administrator or the Community Regional Administrator or designee shall review this report with the respective Program Coordinator. Respective Program Coordinators shall submit a Program Development and Improvement Plan approved by the Unit Administrator or the Community Regional Administrator to comply with those program recommendations.

Addiction Services Program Managers shall visit program sites to review selected inmate cases, provide technical assistance to the staff, exchange ideas and provide clinical expertise. Each program site shall submit designated, monthly, quarterly and annual activity and training reports to the Unit Administrator or the Community Regional Administrator. These reports shall be collated and submitted to the Director of Addiction Services.

Continuity of care shall be insured by all institutional and community program sites utilizing a consistent treatment methodology. Program sites shall have the same operations protocol for case management, inmate records, treatment and process, and training. Regular Addiction Services staff coordination meetings shall be conducted by the Director of Addiction Services with the Regional Director and Unit Administrators or designee to facilitate unit training and exchanging and updating programmatic information and ideas. The Client Tracking System (see VII Program Evaluation) shall be maintained and reviewed.

VI Staff Development

A. Staff Training Plan

Implementation of a Model Alcohol and Drug Treatment Program requires drug and alcohol treatment staff exposure to a rigorous training program that will teach new skills, improve and enhance existing skills, and challenge staff in areas specific to job function, professional development and personal growth. Training will provide an opportunity to remain current on all new developments in the substance abuse field. Training will be goal directed, such as, for the purpose of Alcohol and Drug Certification.

The training will provide an opportunity for staff to consider other alternatives/options/points of view. Training will facilitate the completion of a process by which information/techniques are first presented, then a learning phase occurs, and then what is learned is appropriately applied in the correctional facility and/or in the Community Addiction Services program.

The trained Addiction Services counselor will be a person who, by virtue of special knowledge, training and experience, will be uniquely able to inform, motivate, guide and assist alcohol/drug abusers and those persons affected by problems related to the abuse of alcohol and other drugs. This individual will possess the professional skills necessary to perform the following tasks in providing alcohol and drug abuse treatment to correctional clients: screening, intake, orientation, assessment, treatment planning, counseling, case management, crisis intervention, client education, referral, reports and record-keeping, and consultation.

All Addiction Services counselors shall receive specialized Basic First Year In-Service Training that meets Category I criteria of the Connecticut Alcoholism and Drug Abuse Counselor Certification Board, Inc. (CADACCB). Training (see Appendix F) may include, but not be limited to:

An Overview of Substance Abuse (12 hours)
Short-Term Client Systems (24 hours)
Group Counseling Process (24 hours)
Recovery Model (12 hours)
Denial (4 hours)
Confidentiality (4 hours)
Chemically Dependent Family Systems (12 hours)
Relapse Prevention (12 hours)
Professional Ethics (4 hours)
Cognitive Skills Therapy (21 hours)
Behavioral Studies Program (21 hours)
12 Core Functions of a Substance Abuse Counselor (40 hours).

Post First Year Training shall be provided on a regular, continuing basis to enhance professional development and growth so that Certification and Recertification standards may be fulfilled. Appendix F, entitled Staff Training Curriculum for Substance Abuse Counselors provides an outline and objectives for further staff training. All Addiction Services counselors shall receive a minimum of 40 hours of Post First Year Training per year. Post First Year Training will be provided by the Addiction Services Unit,

the CADAC Institute of Addictions, the Connecticut Alcohol and Drug Abuse Commission, and other training programs certified by the Connecticut Alcoholism and Drug Abuse Counselor Certification Board. A computerized annual training record system shall be maintained by the Director of Addiction Services on all Unit staff.

B. Clinical Supervision

One of the essential components of a Model Treatment Program is clinical supervision. It is recommended, when possible, that Addiction Services counselors receive direct clinical supervision including on-site clinical supervision of individual and group practice by a Counselor Supervisor or a CRSO II. This will meet the required hours of training and counseling experience for CADACCB Approved Clinical Supervisor Status (1990). All active individual client files will be reviewed and signed off every sixty days by the respective clinical supervisor. This clinical supervisor will have the following knowledge and skills:

1. Advanced knowledge on how alcohol/drug abuse relates to other physical, behavioral, cognitive, emotional, socio-cultural, and economic aspects of mental and emotional disorders and adjustment reactions.
2. Demonstrated familiarity of a variety of therapeutic modalities.
3. Operational experience with a variety of treatment approaches.
4. The ability to deal effectively with supervisee's psycho-dynamics as they relate to work with clients.
5. Knowledge of various roles and techniques employed in the clinical supervisory process.

Regularly scheduled in-house Addiction Services staff meetings shall be utilized to discuss programming, conduct case presentations, exchange clinical ideas, and insure progress toward program service goals.

C. Counselor Certification

All Addiction Services counseling staff shall be encouraged to seek Certification as an Alcohol and Drug Counselor in accordance with the requirements established by the Connecticut Alcoholism and Drug Abuse Counselor Certification Board (CADACCB), and as approved by the Connecticut Alcohol and Drug Abuse Commission (CADAC). Certified Alcohol and Drug Counselors shall be encouraged to meet the standards of Recertification established by the CADACCB and CADAC. All Counselor Supervisors shall be encouraged, within two (2) years of employment at this level, to become Approved Clinical Supervisors through CADACCB and CADAC. It is recommended that the State compensate the counselor for certification costs.

The capacity to be Certified and receive Approved Clinical Supervisory status from CADACCB and CADAC shall be a important factor in the selection of Addiction Services counselors and supervisors. The Director of Addiction Services shall be consulted regarding all potential job applicants for capacity to meet counselor and supervisory standards established by the CADACCB and CADAC.

VII Program Evaluation

A. Client Tracking System

Components of the Alcohol and Drug Model Treatment Program include the A. Client Tracking System, B. Addiction Services Monitoring Audit and Third Party Evaluations of Addiction Services Programs.

Addiction Services has designed and implemented a computerized Management Information System known as the Client Tracking System. This will strengthen the continuity of care system and enhance program evaluation capabilities. The primary objective is to enhance communications between all program locations involved with the inmate/client and provide accountability for the treatment services that are provided. This system will produce automated statistical reports, and is designed to assist the Addiction Services counseling staff in properly evaluating the offender's treatment needs. The CTS will provide a record of Addiction Services interventions in each facility and community program. The record will be built upon rather than reinitiated on each new admission. The tracking system will follow the individual into the community so that Addiction Services intervention can continue without undue repetition. If the individual is reincarcerated, the record of program involvement should follow them back into the facility.

The major components of the Addiction Service Client Tracking System include:

- Objective classification system code for substance abuse treatment need.
- Prior drug/alcohol treatment by type and date of discharge. This includes self-reported information of treatment received from the DOC or other agencies not captured on the new system.
- Primary and secondary drug use as to the type, age at first use, age at last use, age at peak use and level of use at peak.
- An Assessment charting the client's improvement over a time in each program site. This assessment contains three (3) levels of improvement from Transition to Later Recovery.
- Program information concerning the offender's motivational and participation level, outcome of involvement at each program site and referral status.

The case-tracking will have the capacity to evaluate Addiction Services continuity of care objectives and provide a basis for evaluation of facility and community treatment programs.

B. Addiction Services Monitoring Audit

Twice each year, a program audit will be conducted on each Addiction Services program by Addiction Services Central Office Staff. The audit will evaluate each correctional facility and community program according to the standards developed and approved for the Alcohol and Drug Model Treatment Program. The audit (see Appendix H) will include, but not be limited to, the following audit subjects:

1. Number of Certified Counselors
2. Programming Environment: (e.g. office and programming space allocation, physical conditions, resources)
3. Programming Utilization/Activities: (e.g. program menu, schedule, capacity and participation, compliance to standards and quality assurance)
4. Counselor Utilization: (e.g. staff functions and percentage of time, scheduled and actual treatment hours, clinical supervision)
5. Case Management: (e.g. coordination of services, referrals, team consultation, systems support)
6. Documentation: (e.g. recordkeeping, program activity reports)
7. Client Tracking System: (e.g. implementation status, maintenance, staff training)
8. Professional Development: (e.g. staff training/number of hours, clinical supervision, certification)
9. Comments

The audit will include Commendations and a Corrective Action Plan with appropriate timeframes. The findings will be submitted to the Unit Administrator or Community Regional Administrator, and the Director of Programs and Treatment. Unit Administrators and Community Regional Administrators are responsible for ensuring the implementation of the Corrective Action Plans. The Corrective Action Plan will be monitored by the Addiction Services Central Office staff consistent with the timeframes presented.

C. Third Party Evaluation of Addiction Services Programs

1. Connecticut Alcohol and Drug Abuse Commission

The Connecticut Alcohol and Drug Abuse Commission (CADAC) provides third party evaluations of Addiction Services programs. As the state pass-through agency, CADAC provides approximately two (2) million federal dollars from the Department of Health and Human Services to the DOC. Fiscal and programmatic audits are completed by CADAC on the eleven (11) DOC correctional facility programs and five (5) community programs funded. Each fiscal year, program measures are defined by the DOC in its grant application and approved by CADAC. These program measures are monitored each quarter by CADAC through written reports submitted by the DOC. CADAC also provides on-site program audits. These reports are submitted to the DOC. If needed, the DOC provides a Program Improvement Plan which is monitored for compliance by CADAC.

2a. In addition to CADAC audits, there should be other third party evaluations of Addiction Services programs such as the American Correctional Association, Narcotic and Drug Research, Inc., New York City, Office of Treatment Improvement of the Federal Department of Health and Human Resources.

b. A program evaluation should also be conducted by DOC every two years utilizing a designated team independent from the program. The evaluation should consist of base-line and outcome measures gauging the efficacy of the model program, which could include the following:

1. Implementation (i.e., whether the correctional facility or community program has developed as proposed);

2. Process (i.e., whether the correctional facility or community program has developed as proposed);

3. Cost-Effectiveness (i.e., expenses measured by unit of service);

4. Valid Data Available (i.e., accurate information about clients served, numbers and types of programs, and characteristics of the clients);

5. Outcome Measures (i.e., what changes to the participants occurred as a result of the program - see below);

A. Criminality
   1. Percent Arrested and Charged
   2. Percent Readmitted to Correctional System
   3. Percent Convicted on New Offenses

B. Drug Use
   1. Percent Opiate-Free
   2. Percent Using Marijuana
   3. Percent Cocaine/Crack-Free
   4. Percent Abusing Alcohol
   5. Percent All Drug-Free

C. Employment
   1. Percent Employed Full Time
   2. Percent Employed Part Time
   3. Percent Unemployed

D. Terminations from Program
   1. Percent Terminating for All Reasons
   2. Percent Terminating by Reason for Leaving
   3. Successful Completions as a Percentage of All Terminations

E. Social Stability
   1. Length of Time in Community
   2. Percent Living with Spouse
   3. Percent Living Alone
   4. Percent Changing Place of Residence
   5. Percent Changing Jobs
   6. Percent Involved in Outpatient Substance Abuse Treatment
   7. Percent Involved in Self-Help Groups (AA/NA)

VIII Recommendations

1. The Director of Programs and Treatment should establish a Curriculum Committee composed of two (2) facility and two (2) community Addiction Services counselors, two (2) Task Force members, and a representative from the DOC's Training and Staff Development Division to collate program component curriculums utilizing key elements from each of the foundation program components of the Model Program in 4-24 unit packages targeting recovery tasks.

2. The Addiction Services Unit should have operational the Client Tracking System (CTS) in all program locations by April 1, 1992.

3a. The Western Substance Abuse Treatment Unit (WSATU) should have a large scale quantitative analysis relating measures of treatment outcome (e.g. rearrest, reincarceration) to both client characteristics and program attributes (time in program and termination status). The study should include both treatment and non-treatment comparison groups.

b. All program sites should undergo evaluations with base-line and outcome measures. These evaluations should be conducted by a DOC evaluation team, consisting of personnel independent from the respective program.

4. Offenders with substance abuse problems are unlikely to seek treatment on a voluntary basis, and have a poor record of participating in voluntary treatment. A progressive system of incentives and sanctions should be developed to increase offenders' motivation and accountability for treatment.

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