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Evaluation of the Department of Corrections' Substance Abuse Treatment Programs: Prison-Based Therapeutic Communities

Criminal Justice Research Center

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EXECUTIVE SUMMARY

In 1988, DOC began receiving state and federal Anti-Drug Abuse Act (ADAA) funds from DCJS to establish substance abuse education and treatment programs for prison inmates statewide. DOC was granted $1,600,000 over a period of five years, from FY 1989 through FY 1993. As a result of this funding, several types of substance abuse programs are in place in Virginia's correctional institutions. These programs include Alcoholics Anonymous/ Narcotics Anonymous (AA/NA) support groups, psycho-educational programs, outpatient model group counseling programs, and therapeutic community programs.

The literature indicates that the most promising approach to prison-based substance abuse treatment is the therapeutic community (TC). TCs are designed to provide substance abuse treatment services in a highly structured residential program format. The goal of prison-based TCs is to introduce substance abusing inmates to a drug-free, prosocial lifestyle and prepare them to continue this lifestyle when they are released back into the community. Although there have not been many outcome evaluations conducted on prison-based TCs, initial studies indicate that these programs can be effective in reducing recidivism.

As of July 1, 1994, TCs had been established in three of Virginia's correctional institutions: Botetourt Field Unit, Staunton Correctional Center, and the Virginia Correctional Center for Women. The combined capacity of the three programs is 169. TC staff consists primarily of Correctional Substance Abuse (CSA) Therapists, most of whom are certified substance abuse counselors. Inmates are generally referred to these programs by correctional treatment staff, although participation is voluntary. Participants receive individual and group therapy within a cognitive/behavioral treatment environment. Group sessions address a myriad of topics, including the 12-Step process, drug education, anger management, and relapse prevention.

In Calendar Year 1993, a total of 163 participants exited the three Virginia TC programs. Of these participants, 46 (28%) completed the programs and 117 (72%) did not complete the programs. Additional findings are as follows:

- Of the 46 TC graduates, 21 (46%) were returned to the general prison population, 3 (6%) were sent to work release, and 22 (48%) were released on parole.
- Of the 117 participants who did not complete the TC program, 77 (66%) either quit or were dismissed from the program, and 40 (34%) were released on parole or work release before they could finish the program.
- The amount of time spent in treatment by the program graduates varied substantially, both within and among the programs, ranging from three months to three years.

Our analyses indicate three issues in particular are in need of further examination. First, the low treatment retention rate suggests that the process by which inmates are assigned to TC programs is less than satisfactory. Second, almost one-half of the program graduates are being returned to the general prison population, which likely compromises progress made in treatment. Third, there is a distinct lack of aftercare services provided for TC graduates, a serious problem considering that previous evaluations of prison-based TCs emphasize the critical role aftercare plays in the long-time success of TC graduates.

The Department of Corrections is to be commended for its work over the last five to six years in expanding the treatment opportunities available to substance-abusing inmates. Based on the findings presented in this report, we offer the following preliminary recommendations designed to improve upon the services provided by the TC programs.

Recommendation #1: **DOC should consider delineating what it believes to be the minimum and maximum amounts of time that inmates should be allowed to stay in TC programs, and what determines successful program completion.**

Recommendation #2: **Where it is not possible to completely separate the TC program from the general prison population, TC staff should promote support for the treatment process by providing TC training for correctional staff who will be in contact with TC participants.**

Recommendation #3: **DOC should implement an objective screening tool for potential participants, and should collect data to determine the significant predictors of inmates' success in the TCs, with special emphasis on the nature of the inmate's current offense.**

Recommendation #4: **DOC should examine its screening criteria to minimize the occurences of inmates being paroled or otherwise released prior to completion of the TC program and program graduates being returned to the general prison population.**

Recommendation #5: **DOC should place a high priority on the issue of follow-up/aftercare services for TC graduates.**

Recommendation #6: **DOC should track program graduates in order to determine the impact of the program on offenders' drug involvement and criminal activity.**

STUDY PURPOSE

Background

Over the last 10 years, there has been a dramatic increase in the number of drug offenders committed to Virginia's prisons. As reported in Drugs in Virginia: A Criminal Justice Perspective (Criminal Justice Research Center, 1991), in 1983, about 1 out of every 10 offenders newly committed to Virginia's prisons was a drug offender; by 1990, this proportion had increased to nearly 1 out of every 3 offenders. This increasing number of incarcerated drug offenders brought with it a rise in the number of drug abusers serving time in prison. According to the Center's report, 55% of drug offenders displayed evidence of drug abuse. When added to the 29% of property offenders and the 27% of violent offenders who also showed signs of drug abuse, it becomes clear that a significant number of prison inmates have substance abuse problems.

In response to the growing number of drug offenders, the Virginia Department of Corrections (DOC) has developed a variety of prison-based substance abuse treatment programs. In 1988, DOC began receiving state and federal Anti-Drug Abuse Act (ADAA) funds from DCJS to establish substance abuse education and treatment programs for prison inmates statewide. DOC was granted $1,600,000 over a period of five years, from FY 1989 through FY 1993. As a result of this funding, several types of substance abuse programs are in place in Virginia's correctional institutions. These programs include Alcoholics Anonymous/ Narcotics Anonymous (AA/NA) support groups, psycho-educational programs, outpatient model group counseling programs, and therapeutic community programs. Specifically, grant funds were used to accomplish the following:

- Therapeutic Community (TC) programs were implemented in three correctional institutions: Botetourt Field Unit, Staunton Correctional Center, and Virginia Correctional Center for Women.
- Substance Abuse Education/Group Counseling (SAE/GC) programs were implemented in three correctional institutions: Nottoway Correctional Center, Powhatan Correctional Center, and St. Brides Correctional Center.
- A Substance Abuse Program Coordinator position and clerical support were established at DOC's headquarters.
- A Substance Abuse Program Trainer position was established at DOC's Academy for Staff Development to provide substance abuse training for institutional treatment staff and correctional officers.
- Program materials and references were given to program sites to support treatment activities.
- The Drug Offender Program Action Committee (DOPAC) was formed to provide field staff with a vehicle for input into statewide substance abuse policy and to recommend training.

In FY 1994, the State assumed the total personnel costs of the previously grant-funded programs. DOC also received state funding for four Regional Clinical

Supervisors to replace grant-funded contractual clinical supervision services, and a research position to focus on outcome evaluations of substance abuse programs. In FY 1994, DCJS awarded DOC $480,000 to expand the substance abuse programs in the prisons. In addition to expanding capacity in the existing programs, DOC is currently using these federal funds to:

- implement a TC program at Pulaski Field Unit;
- finance support costs (drug testing equipment, program materials, training, and travel) of previously established programs;
- support the activities of the Regional Clinical Supervisors in providing clinical supervision to substance abuse treatment staff;
- develop a data collection instrument that will allow DOC to track offenders' progress during and after treatment;
- provide additional training for substance abuse treatment staff; and
- support the activities of DOPAC.

The 1994 Appropriations Act instructed DOC to turn Indian Creek Correctional Center into a single-purpose substance abuse treatment facility for incarcerated male felons, using the TC treatment model. DCJS awarded DOC a grant, effective July 1, 1994, to establish this program. As currently conceived, the 800-bed Indian Creek facility will dedicate 660 beds for drug treatment services, including long-term TC treatment and other treatment modalities.

Research Center Evaluation

In 1993, DCJS' Criminal Justice Research Center (CJRC) initiated an evaluation of the TC programs established with federal funds. Midway through the study, the decision was made to change the focus of the evaluation from the three TC programs to the Indian Creek facility. This decision was based on two factors: (1) DOC initiated its own efforts to develop data collection procedures in the TC programs, providing evaluative information similar to that which would have been generated by the CJRC evaluation; and (2) the Indian Creek program presented the opportunity to build in data collection and evaluation procedures at the outset of the program, and to examine a program where the TC concept would presumedly be implemented more completely.

The present report is therefore limited in scope and is based on the following preliminary research activities and analyses:

- interviews with DOC's Substance Abuse Program Coordinator, Academy training staff, and DOC research staff;
- site visits to each of the three existing TCs and interviews with staff and program participants;

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- collection, automation, and preliminary analysis of program Exit Forms for Calendar Year 1993;
- examination of institutional and program records documenting inmate participation in the TCs; and
- review of the literature regarding prison TCs and related treatment issues.

While preliminary in nature, the findings presented here provide useful information for program assessment and management. This information can be used by DOC to guide its own assessment of the TC programs.

LITERATURE REVIEW

There is extensive literature regarding drug abuse treatment both in correctional facilities and in the community. The purpose of the literature review in this report is to establish a framework from which to better understand and assess the operation of prison-based TCs in Virginia. Therefore, the scope of this review has been narrowed to focus primarily on the experience and operation of prison-based TCs and the issues involved in the evaluation of these programs.

Substance Abuse Programs in Correctional Facilities

The use of TCs for substance abusers in correctional institutions is not a new idea. The National Institute on Drug Abuse (NIDA) conducted a nationwide survey of prison-based drug treatment programs in 1979. At that time, 160 prison treatment programs existed, 49 of which were based on the TC model. However, many of these TCs were shut down after only a few years of operation and their accomplishments and failures were never documented (Lipton, Falkin, and Wexler, 1992). Many of these programs reportedly died from a lack of institutional support. Unfortunately, the lack of documentation makes it impossible to assess these claims or learn anything meaningful from their experiences.

The programs currently available to substance abusers in correctional facilities can be divided into three basic types: (1) Alcoholics Anonymous (AA) and/or Narcotics Anonymous (NA) groups; (2) substance abuse education and/or group substance abuse counseling; and (3) residential treatment units modeled after TCs. Generally, AA/NA groups meet weekly or biweekly and are run by non-professional institutional staff or by the inmates themselves. Education and counseling programs are the most common type of prison-based substance abuse treatment (Brown, 1992). These programs vary in content and intensity and are usually run by institutional treatment staff. Currently, the TC is the most well-regarded form of prison-based drug treatment.

Therapeutic Community Concept

Most of today's therapeutic communities, both community- and prison-based, are the result of the convergence of two somewhat different treatment movements: (1) the self-help TC for substance abusers, originating with the Synanon program in the 1950's and (2) therapeutic communities developed in the field of mental health. For this reason, 'TC' has become a generic term that is used to refer to a variety of drug-free residential treatment programs (De Leon, 1991). Thus, the TC is not a well-defined program with specific elements, but rather a concept which encompasses a range of treatment approaches. Although certain elements are common among TCs, each program is unique in the mix of services it provides within the framework of a drug-free residential program. The Changing Tides Therapeutic Community at Ventress Correctional Facility in Alabama offers the clearest explanation of the TC concept as it is commonly understood:

> A Therapeutic Community is a long term, non-medical approach which employs recovering role models as well as other degreed counselors. Therapeutic Communities operate from the assumption that substance abuse and criminal behavior are manifestations of severe alienation of self and society, that through living in a community with a variety of intense interventions, an individual can learn to internalize pro-social behavior which will lead to a drug free positive life-style (Ventress Correctional Facility, n.d., p. 3).

A review of the literature on prison-based TCs revealed the following common elements among prison-based TCs:

- Holistic treatment philosophy - The treatment approach of prison-based TCs is generally based on the philosophy that drug abuse is a disorder of the whole person; thus, the goal of treatment is to change the negative behavior, thinking, and emotional patterns that make the individual susceptible to drug abuse (De Leon, 1984; Hooper, Lockwood, and Inciardi, 1993).
- Residential facility separated from general prison population - TC participants are usually segregated from the general prison population to the greatest extent possible.
- Highly structured program format - TC programs are highly structured. Each participant is responsible for certain chores, ranging from such "low status" chores as scrubbing floors to chores with more responsibility required, such as enforcing rules and various leadership roles. This hierarchy of chores and responsibilities provides a behavioral treatment framework of rewards and punishments for positive and negative behavior.
- Mutual self-help - Much of the treatment in a TC involves mutual self-help, meaning that in addition to learning how to help themselves, participants are responsible for confronting one another's negative behavior. This peer interaction provides a context for positive social learning experiences, one that differs dramatically from the general prison population as well as the environment many inmates come from.
- A variety of therapeutic techniques - The therapeutic techniques involved in TC treatment generally include group and individual counseling. TC groups frequently involve encounter sessions, where negative attitudes and behaviors are confronted. The specific issues addressed in group sessions vary among TCs and may include one or more of the following: criminal thinking, anger management, codependency, child abuse issues, and dysfunctional families.

Prior research has identified six characteristics commonly found among the more successful prison treatment programs. These successful programs are those

which: (1) are based on social learning theory; (2) are highly structured with clear rules and sanctions, anti-criminal modeling, and reinforcement of prosocial behavior; (3) provide training in personal and social problem-solving techniques; (4) utilize community resources for program support and aftercare; (5) emphasize empathic relationships between staff and participants, characterized by open communication and trust; and (6) employ ex-addicts/offenders who serve as credible role models (Trotman and Senigaur, 1994; Wexler et al, 1992).

Model Programs

In recent years, a number of TCs have been implemented in correctional facilities across the country: Alabama, Texas, Wisconsin, California, and Florida have all recently implemented such programs. However, two programs remain widely regarded as model prison-based TC programs: the Stay'n Out program in the state of New York and the Cornerstone program in Oregon. As model programs that have been in existence for over 10 years, these two have been more thoroughly evaluated than any other prison-based TCs. The programs represent two different approaches in the design and operation of prison-based TCs and serve as good illustrations of these approaches. The Stay'n Out program represents the original prison self-help TC model, staffed primarily by ex-offenders/addicts who serve as credible role models. The Cornerstone program represents more of a clinical treatment approach, staffed primarily by professional counselors. Most of the TCs in other states, including Virginia, fall somewhere in between these two different approaches.

Stay'n Out

The Stay'n Out program in New York is funded by the New York State Department of Correctional Services and operated by New York Therapeutic Communities (NYTC), a private agency. The program operates in two institutions: (1) the Arthur Kill Correctional Facility, a TC for male offenders established in 1977 and (2) the Bayview Correctional Facility, a TC for female offenders established in 1978. As of 1992, the TC at Arthur Kill contained three treatment units with 35 beds each and the TC at Bayview had one 40-bed treatment unit. Most of the TC staff members are ex-addicts who graduated from community-based TCs and are ex-offenders as well. Staff members are employed by NYTC and are contracted out to the Stay'n Out programs. While the treatment units are isolated from the general prison facilities, Stay'n Out participants eat meals and participate in some activities with other prisoners.

Upon entering Stay'n Out, the participant's needs and problem areas are identified through observation and assessment. Participants are initially assigned jobs with little status or responsibility. As they progress through treatment, participants can

earn higher level positions. Treatment consists of individual counseling, encounter sessions, and seminars. Counseling and group sessions deal with such issues as self-discipline, self-worth, self-awareness, respect for authority, and the acceptance of outside assistance. Program graduates are encouraged to continue treatment in a community-based TC. According to studies of the program, about half of the graduates continue in residential treatment upon release from prison (Wexler et al., 1992). This is considered to be crucial to the success of the program.

Cornerstone

Cornerstone is a residential treatment program for prison inmates located on the grounds of Oregon State Hospital in Salem, Oregon. The program is jointly administered by Oregon's Mental Health and Corrections Divisions. In 1985, the program operated a 32-bed residential program with a six-month aftercare program. At this capacity, the staff consisted of 18 full-time employees. A recreational therapist and psychiatrist also provided services on a part-time basis. The program has grown to a capacity of over 100 beds (Trotman & Senigaur, 1994).

Upon entering the program, each participant is required to commit to at least six months of aftercare services arranged for by Cornerstone. There are four phases of treatment in the Cornerstone program. The following is a brief summary of each of these phases:

- Orientation phase - This phase is designed to teach skills and concepts needed for effective treatment. Residents attend classes on assertiveness training, self-talk, group membership skills, values clarification, and wellness. During this phase, residents begin AA/NA 12-step work and attend unit meetings. The orientation phase lasts 30 days.
- Intensive phase - At the beginning of this phase, residents write their own treatment contract. Treatment emphasizes cognitive and behavioral interventions. Classes in criminal thinking and criminal patterns attempt to show residents how their criminality and substance abuse are interdependent. Additional classes deal with such issues as anger management, human sexuality, parenting, life skills, and relapse prevention. Towards the end of this phase, residents begin attending two community 12-step meetings each week. The intensive phase lasts 4 to 8 months.
- Transition phase - During this phase, residents begin community employment while continuing groups, classes, and 12-step meetings. Transition staff assists with job searches, family adjustment issues, and the establishment of post-release living arrangements. Group work focuses on stress management,

relationship building, and recovery planning. In addition, each resident completes 40 to 80 hours of community volunteer work.

- Aftercare phase - Transition staff members meet with a local treatment provider, parole officer, family members, and new AA/NA sponsor to establish a recovery plan. Residents who are paroled locally continue to receive treatment from Cornerstone.

Evaluations of Prison-Based TCs

There have not been many outcome evaluations conducted on prison-based drug treatment programs. The few studies that have been done indicate prison-based TCs are effective in reducing recidivism (Wexler et al., 1992; Field, 1989). An evaluation of the Stay'n Out TC in New York compared three groups of inmates: (1) those who participated in the TC program, (2) those who volunteered for the TC program but never participated, and (3) those who participated in other types of prison-based drug treatment (short-term counseling and milieu therapy). The groups were compared in terms of prior record, demographics, time-in-treatment, post-treatment arrests, time-until-arrest, and parole outcome. The study resulted in two major findings: (1) treatment in Stay'n Out was more effective than both no treatment and other treatment modalities in reducing recidivism; and (2) the longer inmates remained in the TC program, the more successful they were upon release, although the positive effects of time-in-treatment tapered off after 12 months (Wexler et al., 1992).

An evaluation of the Cornerstone program examined recidivism rates of four groups of program participants: (1) graduates, (2) non-graduates who completed at least six months, (3) non-graduates who completed two through five months, and (4) non-graduates who spent less than two months in the program. All four groups had similar arrest rates prior to treatment. After treatment, program graduates had lower rates of rearrests, reconvictions, and reincarceration than any of the other groups. The two partial treatment groups did better than the group that spent less than two months in the program. The results of this study indicate that treatment does reduce recidivism (Field, 1989).

Prior Studies of Substance Abuse Programs in Virginia's Prisons

As a result of a 1991 study of Virginia's parole system, the Joint Legislative Audit and Review Commission (JLARC) was asked to assess DOC's delivery of treatment services to substance abusers and sex offenders and the impact of treatment on discretionary parole grants (JLARC, 1992). The study found that in a sample of inmates with substance abuse problems who had their first parole hearing in 1990, 25% had not received any type of treatment. Of those who had received services, 55% participated in AA/NA support groups only, 17% received substance abuse education, 2% received substance abuse therapy, and 1% participated in a TC.

The JLARC report noted that no systematic assessments were in place to match inmates with the appropriate type of treatment. The arrest records of inmates appeared to play a large role in treatment placements. Among their recommendations, JLARC suggested that DOC develop a more comprehensive service delivery system, including standardized assessments and a multi-tiered system of treatment that is more responsive to the different levels of treatment needs among inmates with substance abuse problems. JLARC also recommended that DOC and the Parole Board develop an interagency agreement regarding conditions for release of inmates who successfully complete some treatment programs.

A 1992 report generated by the Governor's Institute on Alcohol and Other Drugs (GIAOD) entitled Substance Abuse Services in Virginia's Adult Correctional System: A Blueprint for the Future addressed many of the same issues as the JLARC report (Keve & Perkins, 1992). This report echoed the need for more standardized assessments, pointing out that better assessment would allow for more efficient use of limited correctional resources and increase the impact of the programs.

The GIAOD report maintained that the TCs in Virginia's prisons existed in name only - further program development was needed before the programs could accurately be considered TCs. The report also identified a number of impediments to the development of effective substance abuse treatment, including: demand for bed space for general population; competing activities; insufficient staff; insufficient training of staff; uncertain priorities; no linkages between components of the system which leads to interruptions of the treatment process; dilution of treatment impact through over-inclusion; and inappropriate physical facilities for treatment programs.

Summary

Therapeutic community treatment has become an increasingly popular approach to treating inmates with substance abuse problems. Correctional facilities nationwide are implementing TC programs. While these programs generally contain certain common elements, they often vary substantially in the range of services provided. Given the variability of prison-based TCs, it is difficult to generalize evaluation results from one or two specific programs to TC programs as a whole. In the absence of further evaluation research, the literature indicates that TC programs resembling one of the two model programs have the greatest chance of being successful.

PROGRAM DESCRIPTIONS

Current Status of Virginia's Prison-Based TCs

As of July 1994, three TCs were operating in Virginia's correctional institutions. The TCs are located at the Botetourt Field Unit, the Staunton Correctional Center, and the Virginia Correctional Center for Women (VCCW). All of the programs are voluntary. While the inmate may be encouraged by institutional staff to enter the program, participation in the TC is not required.

TC staff consists primarily of Correctional Substance Abuse (CSA) Therapists, most of whom are certified substance abuse counselors. DOC has required non-certified CSA Therapists in the TCs to begin working towards substance abuse certification. In an effort to obtain the most qualified staff, DOC pays for the clinical supervision necessary for certification and attempts to attract more qualified personnel by offering salaries commensurate with those offered in the public sector for masters-level certified or licensed clinical social workers.

Pulsar Therapeutic Community: Botetourt Field Unit

The Pulsar TC was established in August of 1989. The current capacity of the program is 50. The staff consists of one supervisor/CSA therapist, two CSA therapists, and one secretary. The supervisor and one of the CSA therapists are certified substance abuse counselors. The second CSA therapist is a licensed counselor from another state who is currently working to obtain certification in Virginia. The supervisor is in the process of hiring a third CSA therapist. A combination of state and federal funds are used to pay staff at this program.

Inmates usually learn about the program at intake from their correctional counselor. If the inmate decides upon treatment, the counselor gives the inmate a request form, which the inmate completes and submits to the TC staff. The TC staff reviews the inmate's file and conducts an interview with the inmate before making any decisions. Admission criteria for individuals entering the program include no institutional infractions within the past six months, no history of sex offenses, and at least one year remaining prior to parole eligibility/release. Violent offenders are carefully screened before being admitted into the program to ensure they do not pose a current risk to other program participants. No substance abuse assessment instruments are administered during this process.

The TC is located in a small unit on the grounds of Botetourt Field Unit, almost completely separated from the general prison population. Although the building houses only TC residents, a barber shop is located at the entrance to the TC, which causes some disruption to the functioning of the TC. The building is divided into two sections: the evaluation unit, with 20 beds, and the treatment unit, with 30 beds. Participants in each unit sleep in dormitories. Each participant has his own cot, trunk, and locker, which he is required to maintain in an orderly fashion. TC participants work, eat, attend classes, and spend recreation time with the general prison population.

This program is divided into two phases: (1) the evaluation/orientation phase and (2) the treatment phase. The evaluation/orientation phase lasts approximately three months and is considered a trial period for both the inmate and treatment staff. This gives the inmate a chance to decide if he is ready to make the necessary commitment to treatment. The inmate is free to withdraw at any time during this phase. The trial period also gives TC staff an opportunity to see how the inmate responds to the treatment process and determine his ability to benefit from the TC.

When the inmate enters the treatment phase, a formal two-page assessment is completed, documenting such things as custody status, mental health, treatment issues, etc. The treatment phase lasts one to two years. According to the TC supervisor, this program incorporates a variety of treatment modalities including behavior modification and the 12-Steps. In addition to drug education sessions and group therapy, each participant is seen individually by his counselor at least once a week. Each participant must complete a workbook dealing with many of the issues and concepts covered during the treatment process. The workbook takes about six months to complete. Throughout the treatment process, participants are instructed to confront and provide consequences for one another's negative behavior.

Uniquest Therapeutic Community: Staunton Correctional Center

Staunton Correctional Center has operated some form of TC since the late 1970s. Prior to receiving the ADAA grant funds in 1989, Staunton operated a 41-bed TC with 2 staff members. The grant funds permitted the program to expand to its present capacity of 61 beds and 4 staff members. The program staff consists of three certified counselors and one counselor who is near certification. The CSA therapists were funded with federal funds during the first grant cycle. The state has since assumed financial responsibility for these positions.

The Staunton TC accepts inmates from other institutions; in fact, most of the participants are from other institutions. Inmates learn about the program through correctional counselors and pamphlets available in the prisons. Generally, the inmate initiates the referral process by requesting an application from his correctional counselor. The correctional counselor and the inmate must complete the application and submit it to Staunton's treatment unit staff. Admission criteria for individuals entering the program include: a documented history of substance abuse; inmate motivation to abstain from drug use; the ability to understand insight therapy; 14 to 24 months from parole eligibility/release; A or B custody status; no history of violent or assaultive behavior; and no institutional infractions within the past six months. No substance abuse assessment instruments are administered during the admissions process.

The TC is located on one floor of a general population building at Staunton Correctional Center. Most of the participants sleep in one of two large dorms at each end of the building. Some double rooms are available for more senior participants. Meetings and group sessions are held on the TC floor. TC participants work, go to school, and eat with the general prison population.

There are two phases of treatment in this program: (1) the evaluation phase and (2) the model treatment phase. The evaluation phase lasts 10 to 12 weeks and provides the inmate with an orientation to the TC concept and basic educational information on drug use and abuse. The model treatment phase is more psychotherapeutic in content and lasts 9 to 21 months. According to treatment staff, this program utilizes a cognitive/behavioral treatment approach in dealing with substance abuse. The 12-Step program is included in the treatment process. Treatment involves both individual and group therapy, the ratio being about 50/50. Participants attend three group sessions per week in the evaluation phase and two per week in the model treatment phase. For those graduates who must be returned to the general prison population, the TC staff tries to allow them to remain on the TC floor or be placed in a nearby unit with easy access to 12-Step meetings.

The Right Choice Therapeutic Community: Virginia Correctional Center for Women

The Right Choice TC became fully operational in October of 1989. The current capacity of the program is 58 inmates. The program staff consists of three full-time CSA therapists and all three are working towards certification. The program staff was funded with federal funds during the first grant cycle. The state has since assumed financial responsibility for program staff.

Unlike the other two facilities with TCs, all inmates at VCCW are administered the COMPASS drug abuse assessment instrument at intake. The intake treatment team uses this score as a guide in recommending treatment for the inmate. If the inmate agrees to treatment, the inmate completes an application and submits it to the TC program. TC staff conduct interviews with eligible applicants before making a decision regarding program suitability. Admission criteria for individuals entering the program include A or B custody status, 10 to 24 months from parole eligibility, and the ability to understand treatment concepts.

The TC at VCCW fills one floor of a general population building on the grounds of VCCW. Participants share a room with one other person. Several private rooms are available for senior members of the group. The participants attend group sessions and eat on the TC unit but must work, go to school, and attend other programs with the general prison population.

This program consists of four levels of treatment - Orientation and Levels 1, 2, and 3 - through which TC participants progress at their own pace. Although the program was designed to be a 10-month program, CSA therapists estimate the average length of stay is 12 to 16 months, with some participants staying as long as two years. The following is a brief outline of what each of the four levels of treatment entails:

- Orientation - In this phase, participants are introduced to the basic concepts of the TC. They learn the rules of the program and what is expected of them as they progress through treatment.
- Level 1 - This is when treatment actually begins. The 12-Step process is begun, with Steps 1, 2, and 3 completed during this phase. The disease concept of substance abuse is explained, using the progression chart to illustrate the various stages of the disease. Each participant writes an autobiography which helps to identify individual treatment issues.
- Level 2 - Steps 4, 5, and 6 are covered during this phase. The disease concept is explored further and participants are encouraged to fully accept that they have a disease and learn what situations and feelings 'trigger' the desire to use drugs/alcohol. Participants also deal with other issues such as sexual abuse and anger management.
- Level 3 - Steps 7 through 12 are completed during this phase. Relapse prevention is addressed and participants develop aftercare plans. Each participant is required to present a seminar, to the TC group, on some personally relevant treatment issue.

Participants must complete all four levels, including the seminar, in order to graduate from the program. Graduates returned to the general prison population may attend a weekly 'aftercare' group and weekly NA meetings at the TC. These services are ongoing until the inmate is released from prison.

Summary

While the three programs vary in structure and content, there are two basic similarities. First, all three programs are modified therapeutic communities. Although the TC participants live together in a unit or floor separated from the general prison population, participants in all three of the programs continue to have daily contact with the general population through work and other activities. Second, none of the programs has an aftercare component of treatment, although two have made limited provisions for continued services. At best, TC graduates are immediately released on parole, with a recommendation to receive aftercare services in the community. However, TC staff report that it is difficult to place inmates in the program such that completion of the program coincides with parole release. For this reason, two of the TCs have made limited provisions for continued services for graduates returning to the general prison population.

STUDY FINDINGS

Data Sources

This evaluation incorporates both quantitative and qualitative data. A list of individual TC participants was obtained from the substance abuse program exit forms. This form is completed once for each participant as he/she exits the program and includes the following information: program, facility, name, inmate number, program entry and exit dates, progress, exit reason, placement upon exit, and completion status. The exit forms have been in use since October 1992 and are submitted monthly to the central office of DOC. For this study, the TC exit forms for calendar year 1993 (CY93) were automated and analyzed, thus establishing our sample group.

Additional quantitative data was obtained from two automated DOC databases - the Pre/Post-Sentence Investigation (PSI) database and the Offender Based State Correctional Information System (OBSCIS) database. Qualitative information regarding program implementation and operation was obtained through interviews with DOC's Substance Abuse Program Coordinator and Academy training staff and site visits to each of the three existing TCs, including interviews with TC staff and program participants.

Results

A total of 163 exit forms were included in the analysis: 48 from Botetourt, 51 from Staunton, and 64 from VCCW. Table 1 shows the graduation rates and time in treatment for the three programs. Of the participants exiting the programs, 28% completed the program (graduates) and 72% did not complete the program (non-graduates). The graduation rate was similar in Botetourt and Staunton, and somewhat lower at VCCW. The amount of time spent in treatment by the program graduates varied substantially, both within and among each of the programs, ranging from three months to three years.

Table 1

Facility	CY93 Exits	Graduation Rate	Weeks in Treatment (range for graduates)
Botetourt	48	31% (n=15)	32 - 165
Staunton	51	33% (n=17)	14 - 91
VCCW	64	22% (n=14)	30 - 84
TOTAL	163	28% (n=46)	14 - 165

Demographic and offense information on the TC participants was obtained from the PSI database (see Table 2). The demographic characteristics of TC participants were basically consistent with those of prison inmates in general. Overall, there was nothing unusual about the group of inmates who have participated in the TC programs. Interestingly, 18% were not classified as drug or alcohol abusers on the PSI. This inconsistency is most likely due to the lack of

Table 2

Offender Descriptors		
Demographics	**Number**	**Percentage**
Age (n=163)		
18 - 25	37	22.7%
26 - 30	51	31.3%
31 - 40	65	39.9%
41 +	10	6.1%
Gender (n=163)		
Female	58	35.6%
Male	105	64.4%
Race (n=163)		
White	50	30.7%
Non-white	113	69.3%
Education (n=137)		
1 - 8	24	17.5%
9 - 11	53	38.7%
12	42	30.7%
13 +	18	13.1%
Employment at time of offense (n=135)		
Full-Time	38	27.4%
Unemployed	88	62.2%
Other	15	10.4%
Drug/Alcohol Abuse (n=142)		
Yes	116	81.7%
No	26	18.3%
Criminal History	**Number**	**Percentage**
Most serious current offense (n=142)		
Person	27	19.0%
Property	44	31.0%
Drug	52	36.6%
Other	19	13.4%
Current sentence length (n=142)		
Less than 2 years	7	4.9%
2 - 5 years	39	27.5%
6 - 10 years	64	45.1%
More than 10 years	32	22.5%
Current or prior drug offense (n=142)		
Yes	76	53.5%
No	66	46.5%
Prior adult record (n=142)		
Yes	130	91.5%
No	12	8.5%

information available to the probation officer completing the PSI, rather than to a problem with the assignment of inmates to the TC programs.

Placement of TC graduates

The literature indicates that, ideally, TC graduates would immediately be released on parole and provided aftercare treatment. Regarding the placement of the 46 TC graduates in this study, it was found that 21 (46%) were returned to the general prison population, 3 (6%) were sent to work release, and 22 (48%) were released on parole. Staunton returned 82% of their TC graduates back to the general prison population, compared to 20% at Botetourt and 29% at VCCW. Unfortunately, there is no documentation of further treatment services received by TC graduates. While over half of the graduates were referred to continued treatment, either in the community or in the prison where available, there is no way to confirm that these services were actually received.

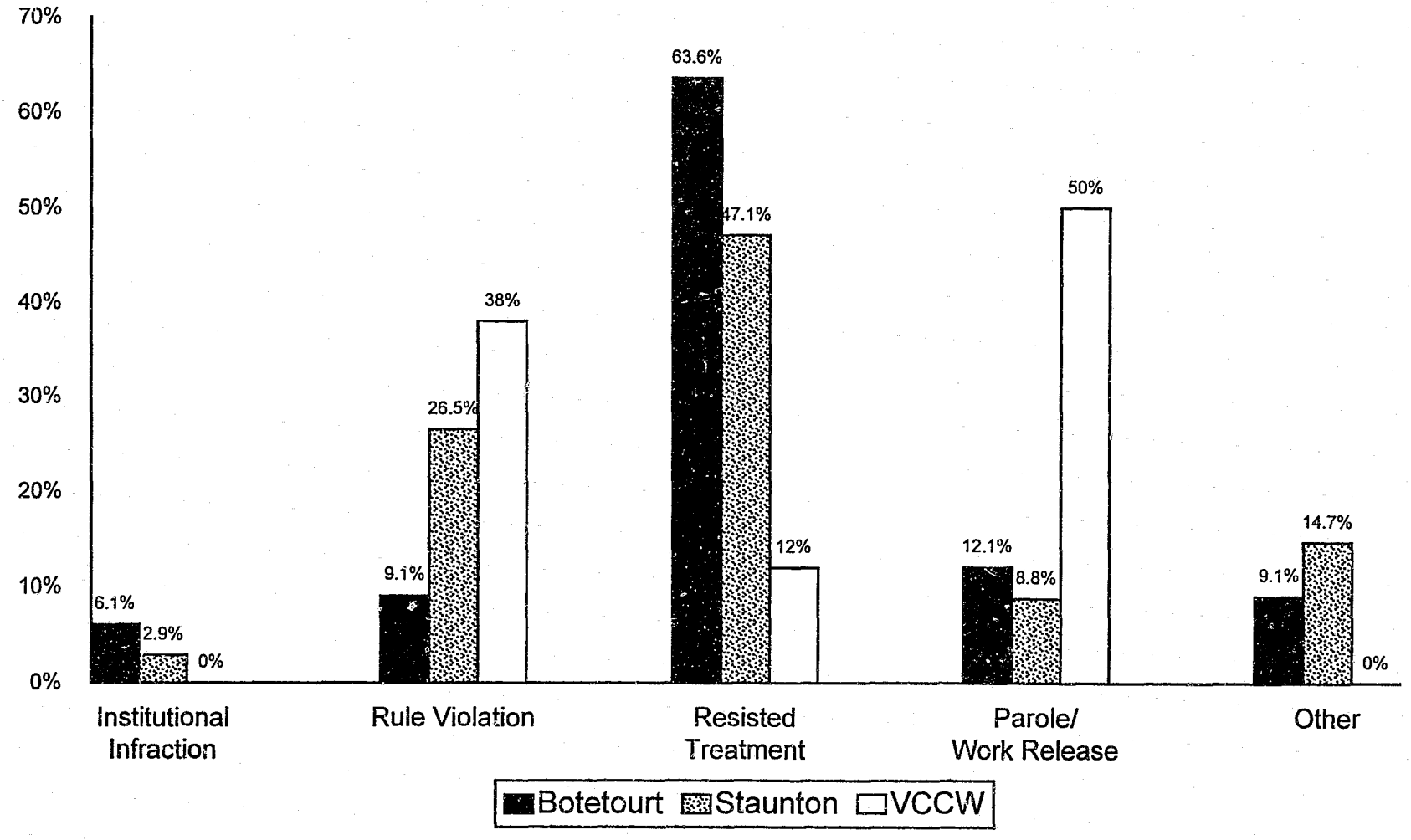
TC Non-Graduates

As stated earlier, 72% of the TC participants did not complete the program. Of the 117 participants who did not complete the TC program, 43 (37%) either quit the program or were dismissed for lack of cooperation with treatment, 32 (27%) were either released on parole or sent to work release before they could finish the program, 31 (27%) were dismissed for a program rule violation, 3 (3%) were dismissed for an institutional infraction, and 8 (7%) were dismissed for other reasons. There was a great deal of variation among the three programs in regard to the reasons participants did not complete the program (Figure 1). At Botetourt and Staunton, the primary reason was participant rejection of treatment, 63% and 47% respectively. Explanations provided on the exit forms indicated several ways in which participants rejected treatment: lack of cooperation with the treatment process; the inability to withstand the intensity of treatment; and voluntary withdrawal from the program without a specific reason. At VCCW, 50% of the non-graduates were either released on parole or sent to work release before they could finish the program.

The CSA therapists interviewed for this study stated that low treatment retention rates are to be expected due to the difficult nature of the inmates' problems. They further reported that any exposure to substance abuse treatment is good, regardless of the length of time spent in the program. The rationale is that treatment is a continuing process and each treatment experience builds on the previous one. Thus, even if some participants resist treatment, they may learn something that could make them less resistant to treatment in the future. CSA

Figure 1

Reasons For Not Completing Treatment By Facility



therapists also contend that dropouts occurring during the evaluation phase of treatment (generally the first three months) are a natural part of the assessment process and should not be viewed negatively.

Although it is impossible to determine the validity of the claims regarding the benefits of partial treatment without any type of relapse and recidivism data, we were able to compare the amount of time spent in treatment by program graduates and non-graduates. For this analysis, non-graduates were divided into two groups: (1) those who quit or were dismissed from the program due to an institutional infraction, program rule violation, or lack of cooperation (dropped out) and (2) those who were released on parole or work release before they could finish the program or did not complete the program for other reasons (paroled/other). The results of this analysis are shown below:

Table 3

Time Spent in TC Program	Graduated (n=46)	Paroled/Other (n=40)	Dropped Out (n=77)
under 6 months	2%	20%	70%
6 to 12 months	28%	65%	29%
over 12 months	70%	15%	1%

As Table 3 shows, the majority of graduates (70%) spent over 12 months in treatment; 28% were able to complete the program in 6 to 12 months. Of the non-graduates who were paroled before they could complete the program, 80% spent a comparable amount of time in treatment (over six months) as graduates. Assuming that this group was cooperating with treatment and probably would have graduated if they had more time, it seems reasonable to speculate that they derived some benefit from treatment.

Of the non-graduates who dropped out of treatment, 70% did so within the first six months of treatment. Since some fallout is inevitable during the initial assessment process, further analysis examined how many dropouts occurred during the evaluation phase of treatment. Although the three TC programs vary in terms of the content and formality of the evaluation phase, the first three months of treatment is generally considered somewhat of a trial period. Of the 77 participants who dropped out of treatment, only 26 (33%) dropped out within three months. These results indicate the evaluation phase is not working very effectively.

The graduation rates of various types of offenders were examined to determine if TC treatment may be more appropriate for certain offenders. The results are shown in Table 4. Of particular interest is the small percentage of violent (crimes

Table 4

Offender Descriptors		
Demographics	**% Graduated**	**% Dropped Out**
Age (n=123)		
18 - 25	25.8%	74.2%
26 - 30	27.8%	72.2%
31 - 40	50.0%	50.0%
41 +	50.0%	50.0%
Gender (n=123)		
Female	35.1%	64.9%
Male	38.4%	61.6%
Race (n=123)		
White	38.9%	61.1%
Non-white	36.8%	63.2%
Education (n=102)		
1 - 8	31.3%	68.8%
9 - 11	38.3%	61.7%
12	42.9%	57.1%
13 +	54.5%	45.5%
Employment at time of offense (n=106)		
Full-Time	41.9%	58.1%
Unemployed	38.1%	61.9%
Other	33.3%	66.7%
Drug/Alcohol Abuse (n=107)		
Yes	37.5%	62.5%
No	42.1%	57.9%
Criminal History	**% Graduated**	**% Dropped Out**
Most serious current offense (n=107)		
Person	20.8%	79.2%
Property	51.4%	48.6%
Drug	47.1%	52.9%
Other	14.3%	85.7%
Current sentence length (n=107)		
Less than 2 years	33.3%	66.7%
2 - 5 years	48.4%	51.6%
6 - 10 years	33.3%	66.7%
More than 10 years	35.7%	64.3%
Current or prior drug offense (n=107)		
Yes	44.4%	55.6%
No	32.1%	67.9%
Prior adult record (n=107)		
Yes	37.6%	62.4%
No	50.0%	50.0%

against persons) offenders (21%) who graduated from the programs. Unfortunately, the small sample size precludes any further analysis of this finding, making it impossible to account for the effects of dropout reasons and differences in individual programs. However, compared to the 51% graduation rate for property offenders and the 47% graduation rate for drug offenders, the results raise questions about the appropriateness of placing violent offenders in these particular TC programs. Additional findings show that older inmates have a higher graduation rate than younger inmates and that graduation rates increase with higher levels of education.

Results of Interviews

There appears to be a great deal of commitment and enthusiasm for prison-based TC programs among DOC's institutional treatment administrators and TC staff. Their support for TCs is based on three potential benefits of this type of treatment: (1) it provides more intensive substance abuse treatment than is ordinarily available in prisons, (2) it creates a prison environment which is more orderly and manageable than that of the general prison population, and (3) it reduces recidivism.

DISCUSSION OF FINDINGS

The analyses presented here suggest several potential concerns regarding DOC's therapeutic community programs that bear further examination:

- the three existing TCs had an average program completion rate of only 28%;
- of those inmates who completed the program successfully, about 50% were returned to the general prison population;
- there is a lack of availability of follow-up or aftercare services for those who complete the program

Program Completion Rate

The results of our analyses showed that fully 72% of the TC participants did not complete the program. The vast majority of these quit or were dismissed from the program, although about one-fourth were paroled or released to work release prior to completing the program. Almost all of those who did not complete the program spent less than one year in the program, and the majority spent less than six months in the program. Only about one-third of the dropouts occurred during the first three months of the program.

These results do not support the idea that most dropouts occur during the programs' assessment phase; that is, the first three months. It is not possible with these data to support or refute the notion that any time spent in the program is of benefit to the inmate (although the previously cited evaluation of the Cornerstone program suggests that this may in fact be the case). What is clear is that those who successfully complete the program spend substantially more time in the program than non-completers.

Of those who did not complete the program, about one-third were paroled or released for some other reason. Of these, 65% were released after having been in the program between 6 and 12 months. Since DOC knows the inmate's mandatory and discretionary parole dates, and since those denied discretionary parole are heard every year, it would appear to be a simple matter to alter the acceptance criteria of the programs to ensure that inmates who might be released prior to completion of the program are not accepted. If this option is not a desirable one, than the program itself could be altered so that inmates would be more likely to complete the program in 6-12 months.

The low treatment retention rate suggests that the process by which inmates are assigned to TC programs is less than satisfactory. The lack of rigorous treatment/offender matching was noted by two prior studies of Virginia's prison-based substance abuse treatment (JLARC, 1992; Keve & Perkins, 1992). While even brief exposure to the TC program may be helpful to some inmates, it seems clear that improved prediction of program success would result in more effective use of this resource.

DISCUSSION OF FINDINGS

Treatment retention is a complex issue. The frequent rejection of treatment by substance abusers is a phenomenon that is widely acknowledged and accepted in the treatment field. It is attributed to the tendency of substance abusers to deny they have a problem and their reluctance to make the difficult internal changes required during the treatment process. As a rule, treatment dropout is blamed on the client, not on the treatment. However, this fails to account for the fact that treatment programs are not all the same, neither in quality nor in content. Thus, when a substance abuser rejects treatment, it may be due to denial or an unwillingness to change or it may be due to the fact that the treatment approach is not right for that person.

Further complicating the situation is that substance abusers vary in terms of their treatment needs. There seems to be a growing acknowledgment that when it comes to substance abuse treatment, one size does *not* fit all (Murray, 1992; Winett, Mullen, Lowe, & Missakian, 1992). A variety of factors determine what type of treatment an offender needs, including the level of substance abuse or addiction, psychological functioning, and the degree to which the inmate is motivated to change. Research has shown that client motivation for treatment can be a significant predictor of short- and long-term treatment retention (De Leon, 1991). Florida's Department of Corrections incorporates a Readiness for Treatment Scale in the assessment process to help weed out those who are unlikely to benefit from treatment (Bell, Mitchell, Bevino, Darabi, & Nimer, 1992).

As mentioned earlier, research has yet to determine which elements of treatment interact with which client characteristics to produce positive changes. The literature identifies the following deficiencies of drug abuse treatment programs in general: clients are not clinically matched with treatment programs; treatment retention rates are too low; relapse rates are unacceptably high; and treatment programs are not adopting useful research findings into clinical practice (Pickens & Fletcher, 1991). More comprehensive documentation of the treatment process would allow for closer examination of the interaction between treatment and participants.

At the present time, the only standardized information regarding inmate treatment needs is that found in the PSI, which was not designed to be an assessment instrument. Without standardized documentation of inmate treatment needs, including severity of substance abuse problems, psychological functioning, and motivation for treatment, there is no way to assess the appropriateness of TC placements. This is an issue which our findings indicate needs further exploration.

DOC acknowledges the need for formal assessments, but reports that resources are not available for the purchase of standardized test instruments. While the use of such an instrument is desireable, there are resources at DOC's disposal for the development of a screening tool which would provide some information to program staff. Resources for the development of an assessment instrument include not only the expertise of DOC's Research Unit and Classification Unit staffs, but also DCJS' Research Center, local universities, and any number of federal agencies, such as the Center for Substance Abuse Treatment. The researcher hired under the current grant is developing an intake instrument to be used as an assessment tool.

Finally, our findings suggest that DOC consider a policy of excluding violent offenders from the TC programs. In our analysis, these offenders were much less likely to complete the program than property or drug offenders. Some experts recommend that violent offenders, sex offenders, and mentally ill offenders be placed in separate TC programs that can address their special needs as well as their substance abuse problems. Further study should attempt to clarify this relationship, and to determine whether the nature of the instant offense is an important predictor of program success.

Disposition Following Program Completion

Previous studies of TC programs suggest that once inmates complete the prison-based program, they should ideally be released from prison, with follow-up, so as not to negate the benefits of the program. In Virginia, about one-half of the inmates who complete the program are returned to the general prison population. While this is clearly a difficult factor to control, the programs should seek to avoid this situation whenever possible, and to provide a means of "extending" the program to inmate graduates returned to the general prison population (some of the programs already attempt to do this). More careful study of this group of offenders is needed to determine whether returning them to the general population does in fact compromise progress made while in the program.

Follow-up/Aftercare Treatment

The issue of disposition following program completion is directly related to the issue of the availability of appropriate follow-up treatment for those inmates who successfully complete the program. As noted previously, there is no current method available to determine the amount and nature of follow-up treatment received by TC graduates. Previous evaluations of prison-based TCs, however, confirm the critical role that such aftercare treatment plays in the long-term success of TC graduates.

The overarching goal of prison-based TCs is to introduce drug-addicted offenders to a drug-free, prosocial lifestyle and prepare them to continue this lifestyle when

they are released back into the community. Aftercare can be viewed as the bridge that enables substance abusers to transfer the knowledge and skills learned in the 'artificial' environment of a TC to the real world from which they came. As evidenced by the Cornerstone program, aftercare involves not only continued treatment, but also assistance in dealing with everyday life problems such as finding employment and making family adjustments. What, then, is the effect of placing graduates back into the 'antisocial' environment of the general prison population, as occurs for almost 50% of Virginia's TC graduates? How easily do the coping skills and principles learned in the TC transfer to the prison environment or the community to which an inmate may return? How often do graduates released on parole actually receive aftercare services?

Unfortunately, TCs have typically dealt with aftercare issues during the course of treatment, and have not provided any extended services beyond program completion (De Leon, 1990). Inmates have been expected to continue the treatment process by participating in community treatment programs. This practice is problematic for two reasons. First, community treatment services may not be available or accessible in the community to which the inmate is paroled. Second, community treatment programs usually treat substance abuse from the traditional mental health perspective which is quite different from the TC self-help approach (De Leon, 1990; Trotman & Senigaur, 1994). This discontinuity in treatment makes it difficult for TC graduates to receive the support services they need as they attempt to enter, or reenter, mainstream society.

Thus, aftercare has been a frequently neglected aspect of TC treatment programs, and the ramifications of this have not yet been empirically determined. However, in theory and practice, aftercare is important for the transfer of skills learned in the TC to the 'real world' to which inmates return. An additional benefit of aftercare is that it provides a potential feedback mechanism through which TCs can receive follow-up information on program participants. Aftercare service providers can document relapse and recidivism information, both of which are important for future evaluations of TC programs.

DOC staff maintain that the issue of aftercare treatment for TC graduates is largely a systems issue, and one over which they have little control. While this may be true, if aftercare is, as we have suggested, such a critical determinant of TC program success, then the ultimate responsibility for ensuring that all system components work together to provide aftercare treatment for TC graduates belongs to DOC. The Department has already had some limited success with this: the Botetourt TC, for example, has developed a link with a local community treatment center which gives preference to Botetourt TC graduates who are paroled locally. In addition, DOC already has Memorandums of Agreement (MOA) with Community Service Boards in probation and parole districts with

Intensive Supervised Probation. In these localities, these MOAs could be used to ensure followup services for TC graduates. It would appear that what is needed is a greater degree of cooperation and coordination between DOC's Division of Institutions, Division of Community Corrections, the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS), and the private sector, in order to foster a variety of agreements similar to the one noted above.

In addition, the programs need to more carefully and systematically document the nature and extent of follow-up services received by program graduates. At a minimum, the programs should work with DOC's Research Unit to establish a procedure for determining when TC graduates have returned to the criminal justice system. Through the use of existing automated databases, DOC can determine if program graduates are convicted of new offenses or violate their conditions of parole, and if they are returned to prison on a new conviction. This information should prove useful to the program staff in determining how to go about improving the programs.

RECOMMENDATIONS

The Department of Corrections is to be commended for its work over the last five to six years in expanding the treatment opportunities available to substance-abusing inmates. Given the scope of the substance abuse problem among inmates, a continued focus on treatment in the prisons is one of the most effective means at DOC's disposal to help to promote positive behavior change and reduce recidivism rates among inmates leaving its institutions.

Since the analyses presented here are preliminary and did not seek to address outcomes, any recommendations offered must also be considered preliminary. The following represent considerations for program changes, or raise issues for further study by DOC:

Recommendation #1: DOC should consider delineating what it believes to be the minimum and maximum amounts of time that inmates should be allowed to stay in TC programs, and what determines successful program completion.

Right now, there is a great deal of variability in how long inmates are allowed to stay in TC programs. The literature on prison-based TCs suggests that 6-12 months is the most fruitful length of stay for inmates in such programs.

Recommendation #2: Where it is not possible to completely separate the TC program from the general prison population, TC staff should promote support for the treatment process by providing TC training for correctional staff (security, teachers, work supervisors) who will be in contact with TC participants.

The literature on prison-based TCs is unclear about the implications of the failure to completely separate TC participants from the general prison population. Given that security demands make it difficult to isolate prison-based TC programs, it is important to expand support for the therapeutic process wherever possible within the confines of the prison. Thus, TC staff need to educate correctional staff regarding the TC process and encourage cooperative working relationships among those who will be in contact with TC participants.

Recommendation #3: DOC should implement an objective screening tool for potential participants, and should collect data to determine the significant predictors of inmates' success in the TCs, with special emphasis on the nature of the inmate's current offense.

The dropout rate for TC participants is very high. More careful screening of potential candidates should result in fewer dropouts, and therefore more effective use of this limited program resource. Our preliminary analysis suggests that

violent offenders may not in general be good candidates for the TC programs; further analysis is necessary to confirm or refute this preliminary result.

Recommendation #4: DOC should examine its screening criteria to minimize the occurences of inmates being paroled or otherwise released prior to completion of the TC program, and program graduates being returned to the general prison population.

Our study showed that a fair number of inmates do not complete the program because of release from prison. This should be easily avoidable once clear criteria for program completion and appropriate time frames have been established. In cases where an inmate completes the program prior to release on parole, the inmate should remain in a TC environment until release, rather than being placed back into the general prison population. The goal should be to maximize the number of program graduates being directly released on parole.

Recommendation #5: DOC should place a high priority on the issue of follow-up/aftercare services for TC graduates.

This element appears to be critical for program success. DOC should establish cooperative agreements with community treatment providers, and use already established agreements, to ensure that appropriate follow-up services are received for all graduates released from prison. Those graduates who are returned to the general prison population should, at minimum, have continuing access to the TC program. The programs themselves, in conjunction with DOC central office staff, should be responsible for ensuring that such aftercare services are available, and for documenting the delivery of such services to program graduates.

Recommendation #6: DOC should track program graduates in order to determine the impact of the program on offenders' subsequent drug involvement and criminal activity.

The ultimate test of the success of the TC programs is to be found in measures of the program's impact on its graduates. Factors such as subsequent involvement with drugs, along with rearrests and recommitments to prison, should be tracked. The programs should work with DOC's Research Unit in the central office to establish procedures by which the programs can receive followup information on TC graduates.

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