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The Texas Treatment Initiative

Overview and Recommendations from the Criminal Justice Policy Council Program Evaluations

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Criminal Justice Policy Council

State of Texas

Tony Fabelo, Ph. D.
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Criminal Justice Policy Council

State of Texas

Tony Fabelo, Ph.D.
Executive Director

Note from the Director

This report summarizes the Criminal Justice Policy Council's initial evaluation of the Texas treatment initiative for substance abusing offenders. Evaluation findings indicate that offenders completing treatment have reduced recidivism rates. However, offenders who enter treatment but drop-out have recidivism rates at or higher than comparison inmates. Significant numbers of offenders drop-out of treatment, thus negatively impacting the success of these programs. This report details issues associated with program implementation and operation that present challenges to the success and cost-effectiveness of these programs. These issues are particularly important now that the Legislature is considering the expansion of these programs for the next biennium.

In September 1994, the Governor's Office requested that the Criminal Justice Policy Council project the potential demand for Substance Abuse Felony Punishment (SAFP) treatment beds. The CJPC report, *Projected Demand for SAFP Beds*, projected a maximum need of 7,200 beds with programs for the next biennium. This capacity will serve close to 10,000 offenders. Projecting the number of beds required for SAFP presents significant challenges since there has been limited experience in determining the need for intensive residential treatment for this population. There is also little analysis of the number of offenders who will benefit from this specific approach to addressing problems of criminality and chemical dependency. As a matter of fact, the original estimate of the need for 12,000 SAFP beds has no scientific or empirical basis.

The CJPC projection of 7,200 program beds was based on the limited sentencing experience at that time, including information from major CSCDs on the number of offenders screened for substance abuse treatment, estimates of the intensity of intervention necessary for offenders screened as needing substance abuse treatment, and estimates of the demand necessary to meet planned capacity for the next biennium. While it is not possible to project suppressed demand due to inadequate capacity, our projections indicate that a significant increase in SAFP demand from present levels will be necessary in a very short time to be able to fully utilize the 7,200 beds.

With the expansion of SAFP beds from the present level of 3,205 to 5,200 in the next four months and expansion to 7,200 beds by FY 96, the SAFP program will have a treatment capacity of approximately 10,000 offenders per year. In FY 1994, 2,971 offenders were admitted to SAFP treatment, while 895 offenders remained on a SAFP waiting list (as of February 1995). This backlog will be absorbed in 1995 as the SAFP facilities planned for completion this year become operational. Moreover, demand for SAFP beds will have to increase from the present level of approximately 350 offenders sentenced to SAFP per month to approximately 750 offenders sentenced per month to fill capacity, if 7,200 beds become operational.

The true unrestricted capacity needed for the SAFP program remains to be seen. However, several other concerns with a program of this size warrant caution at this time when considering the pace and size of program expansion. These concerns are:

- *The availability of trained, experienced counseling staff to operate a program of this size*

    √ The number of staff required for this program has made quality staffing an issue at the current size, which will be exacerbated as the program expands.

- *The lack of a standardized screening, assessment, and selection process for placing offenders in the SAFP program*

    √ This program is an expensive intervention lasting almost two years. Selecting those offenders who are most in need of this kind of treatment and are ready and motivated to benefit from this treatment is a more complex process than current selection procedures require. Improper allocation of treatment resources to offenders not needing this type and level of treatment is an inefficient use of these resources. Simple screening can not properly select appropriate clients for this program. TCADA is in the process of reviewing methods to enhance the screening, assessment, and selection process, however, new processes will take months to institutionalize.

- *The development of a post-release treatment program consistent with the quality and effort of the in-prison treatment*

    √ SAFP clients are released to residential transitional treatment centers and outpatient counseling programs. This phase of the program is still in a developmental stage and inconsistency in programming from the SAFP to the post-release program has been detrimental to treatment outcomes.

The state should be cautious about having capacity drive demand in a program so new and evolving. In the first years of this program, demand driving capacity will better reflect true program need rather than a need to fill the program because capacity is available. Coupled with the implementation, organizational, and infrastructure challenges presented by a program that has expanded and evolved so rapidly, slower growth is more likely to result in long-term successful outcomes. Close examination of the current program suggests that a period of development, maturation, and institutionalization of policies and procedures is necessary before the country's largest treatment initiative for offenders grows larger. Therefore, the key questions for the Legislature to consider are:

- Should program capacity be stabilized at the present level of 5,200 beds in SAFP facilities and 2,000 beds in IPTC facilities?

- If not, can the present operational infrastructure of the SAFP program effectively handle the expansion of this initiative to 7,200 program beds during the next biennium?

- If SAFP program beds are not to be expanded from the present biennial level, what policies are needed for the state to be more selective in the placement of offenders so that local officials do not "screen in" more offenders than program capacity and efficient operation allow?

To conclude, I recommend the Governor and the Legislature to carefully consider the distinction between the popularity of this program among sentencing officials and the ability of the state to deliver an effective program at the scale being considered. These programs can be critical in our attempts to reduce recidivism, but should be carefully implemented with the proper infrastructures in place to be able to achieve this goal. Otherwise, we might end up with a very popular but ineffective and costly intervention.

Tony Fabelo, Ph.D.
Executive Director

THE TEXAS TREATMENT INITIATIVE

OVERVIEW AND RECOMMENDATIONS FROM THE CRIMINAL JUSTICE POLICY COUNCIL PROGRAM EVALUATIONS

The 72nd Texas Legislature created, through the passage of House Bill 93 and Senate Bill 828, the nation's largest offender correctional substance abuse treatment initiative. Three programs comprise the Texas treatment initiative: the Treatment Alternative to Incarceration Program (TAIP), the Substance Abuse Felony Punishment Program (SAFP), and the In-Prison Therapeutic Community (IPTC) program.

Treatment Alternatives to Incarceration Program (TAIP)

TAIP provides screening, assessment and referral to community-based treatment and counseling services for substance using pre-trial offenders and probationers. The goal of TAIP is to intervene early in the drug/crime cycle by linking the criminal justice system to treatment. TAIP is currently established in Bexar, Dallas, El Paso, Harris, Tarrant, and Travis counties. Potential clients are referred by the court or a probation officer to a Screening, Assessment, and Referral agency (SAR), where need for treatment and level of intervention required is assessed. If treatment is indicated, clients are referred to a treatment program funded through the Texas Commission on Alcohol and Drug Abuse (TCADA).

Substance Abuse Felony Punishment (SAFP)

SAFP is a six to twelve month therapeutic community program for probationers that is based in nine institutional facilities throughout the state. The goal of SAFP is to provide intervention when substance use is a hindrance to successful probation. After being screened as needing substance abuse treatment, placement in a SAFP facility can be used as a condition or modification of probation. Upon completion of SAFP, probationers continue treatment within the community.

In-Prison Therapeutic Community (IPTC)

IPTC is a nine month prison program for inmates screened as needing substance abuse treatment. The goal of IPTC is to reduce drug use, and thereby reduce recidivism, for inmates with serious drug problems who are about to parole. Upon completion of the IPTC, inmates continue treatment within the community. There are four sites for the IPTC program: the Wackenhut facility in Kyle, the Interventions facility at the Hackberry unit in Gatesville, the Lone Star Stay 'n Out at the Clements unit in Amarillo, and the Amity facility at the Stiles unit in Beaumont.

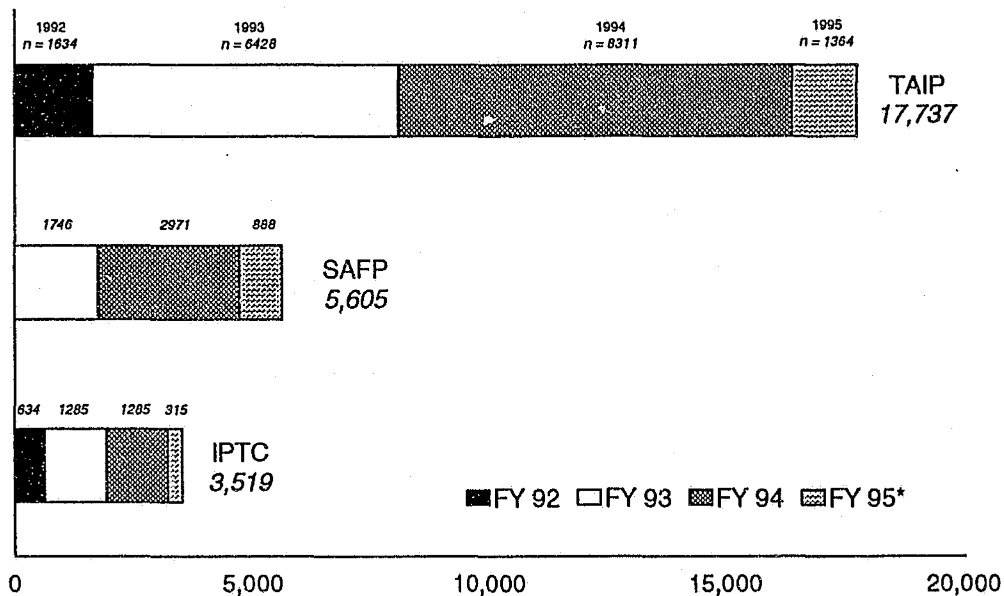
Continuum of Care

Both SAFP and IPTC have an aftercare component where treatment is continued in a community residential Transitional Treatment Center (TTC) for 1 to 3 months after release. There are TTCs located in most major Texas cities. After completion of residential treatment, offenders receive outpatient treatment for up to 12 months.

Implementation and operation of the treatment initiative programs require cooperation between criminal justice agencies and treatment providers. The Texas Department of Criminal Justice (TDCJ), [which includes the Community Justice Assistance, Institutional, and Pardons and Paroles Divisions (CJAD, ID, PPD)], local Community Supervision and Corrections Departments (CSCDs), the Texas Commission on Alcohol and Drug Abuse (TCADA), and contract treatment providers have worked together to place and supervise offenders in treatment. Although new procedures have been developed within each agency to integrate the programs into existing missions and responsibilities, several pressing implementation and infrastructure issues remain which, if not addressed, could threaten the success of the programs.

PROGRAM IMPLEMENTATION

Since becoming operational in 1992, the TAIP, SAFP, and IPTC programs have been successful in admitting offenders to treatment. The successful "take-off" of the treatment initiative is counterbalanced by problems the programs have had retaining offenders in treatment.



FY 95* contains data for the first two months, September & October 1994 only

- A total of 17,737 offenders have been admitted into TAIP funded treatment since it began in May of 1992, with almost one-half (8,311) admitted in FY 94 (the last full year for which admission data is available).

  ✓ In a CJPC study of 497 offenders admitted to TAIP treatment, 34% remained in treatment for three months or longer.

  ✓ Of the TAIP offenders studied who remained in treatment three months or longer, 7% had recidivated after 18 months, compared with a 28% recidivism rate for TAIP offenders who did not enter treatment or did not complete three months.

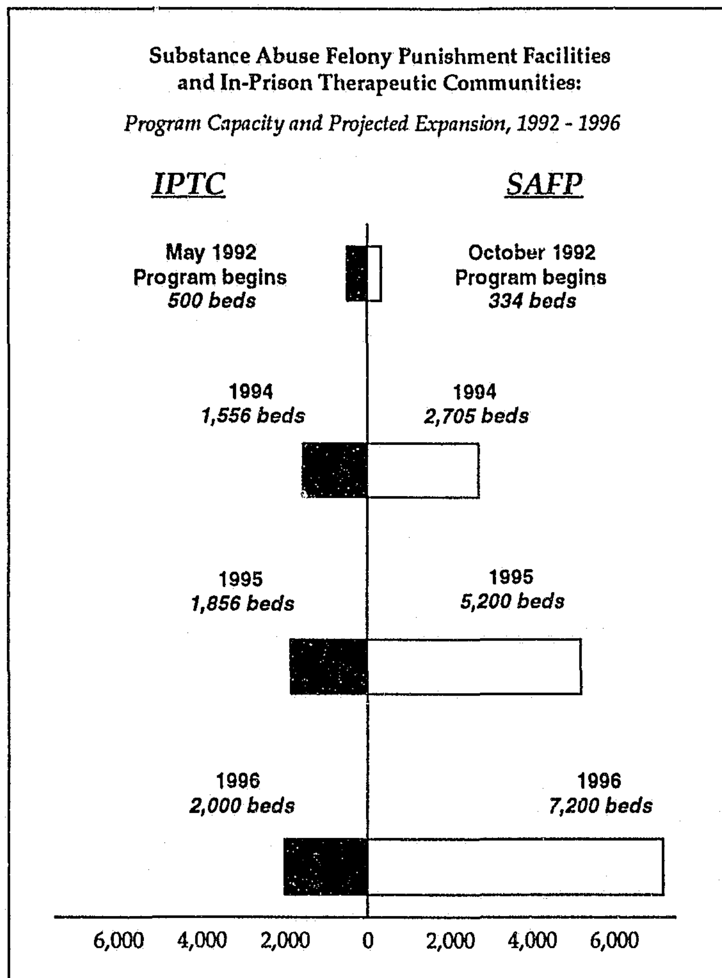
- A total of 5,605 offenders have been admitted to SAFP treatment since it began in October of 1992 , with over half (2,971) admitted in FY 94.

- A total of 3,519 offenders have been admitted to IPTC since it began in May of 1992, with steady admissions in FY 93 and FY 94 (1,285 each year).

  ✓ In a CJPC study of 672 offenders who began the IPTC program, 42% completed the nine month in-prison component and the minimum community treatment component (a total of four months in a transitional treatment center and/or out-patient counseling).

  ✓ Of the offenders studied who successfully completed the minimum required community treatment component, 7.2% had returned to prison one year after release, compared to 19.1% of IPTC offenders who did not complete the minimum community treatment and 18.5% of comparison group offenders.

PROJECTED PROGRAM EXPANSION



The legislature has funded the construction of 10,598 SAFP and 2,000 IPTC beds. The original plan submitted by TCADA for the 1996-1997 biennium called for the expansion of program capacity to all 10,598 SAFP beds (maintaining the 2,000 IPTC beds). TCADA estimated program costs at $379 million for the 96-97 biennium.

However, in 1994 the Criminal Justice Policy Council projected a treatment need of 7,200 SAFP beds for the 1996-1997 biennium. This projection was based on the present screening criteria used by the five largest counties to identify SAFP eligible offenders with substance abuse problems. (At present, the information has not been collected and analyzed to determine if the screening procedures used at the local level are effectively identifying the offenders who can best benefit from this program).

TCADA's projected modified program cost for 7,200 SAFP beds and 2,000 IPTC beds is approximately $191 million for the 1996-1997 biennium ($188 million less than the projected cost for the original plan). At this time TDCJ plans to utilize the additional SAFP beds not used for substance abuse treatment programming (approximately 4,000 beds) to house other types of offenders. Even at this modified level, this will be the largest correctional substance abuse treatment initiative in the nation.

The pace and size of the expansion of the drug treatment initiative is a policy question dependent on the judgment of the legislature as to whether the numbers of offenders needing treatment merit rapid expansion and whether the infrastructure can support expansion. Issues pertaining to the program infrastructure are presented to address this policy question.

THE TEXAS TREATMENT INITIATIVE: IMPLEMENTATION ISSUES AND RECOMMENDATIONS

Since the beginning of the TAIP, SAFP, and IPTC programs, several issues have been identified as obstacles to the successful implementation of the programs. These obstacles can be classified into two main categories: retention in treatment and program cohesion.

Common to all three programs is the need for screening and assessment procedures to ensure placement of inmates/offenders who are most likely to remain in and benefit from the treatment. Program success is also dependent upon effective communication, coordination, and interaction among criminal justice officials and treatment providers. Additionally, the ability to track offenders as they progress through each phase of treatment is essential to documenting program success and determining areas requiring modification and improvement. Finally, all three programs need qualified staff, especially counselors, experienced with substance abusing offenders and the therapeutic community treatment modality. Detailed below are some specific issues presenting obstacles to effective program implementation and recommended actions.

Implementation Issues

Retention in Treatment	Program Cohesion
Screening, Assessment and Placement Procedures ✓ *Standardized procedures* ✓ *Appropriateness of the treatment decision maker* ✓ *Client readiness* ✓ *Intensity of treatment required* **Case Management**	**Program Continuity** **Program Staffing** ✓ *Training* ✓ *Turnover* ✓ *Number of staff required* **Clash of Institutional Cultures** ✓ *Communication* ✓ *Priorities* ✓ *Relapse issues* ✓ *Triangulation*

Retention in Treatment

Placement of offenders who will benefit from treatment is key to treatment retention, as is monitoring an offender's progress and providing support throughout the often lengthy treatment process. This can be accomplished through screening, assessment, and placement procedures and the case management function.

Screening is a brief procedure used to identify a potential problem. *Assessment* is the collection of detailed information concerning the client's alcohol or drug abuse problem and the extent of treatment needed. *Placement* in a treatment program occurs after offenders are screened as needing substance abuse treatment and, ideally, after clients' alcohol or drug abuse problems are assessed. Placing offenders into treatment involves both a treatment decision and a criminal justice decision. Ultimately, the goal of screening, assessment, and placement is to accurately identify and efficiently place offenders who will benefit from treatment into a treatment program. *Case management* consists of tracking offenders through the system and monitoring their progress, providing support when needed. Integral to the case management function is the coordination of the treatment needs and criminal justice responsibilities of the client.

Analysis of the data from the TAIP and IPTC programs indicates a number of issues associated with the screening, assessment, and placement process and the case management function, which are presented below.

- ***There is no standard screening and assessment process.***

  ✓ In TAIP, IPTC, and SAFP, participants are screened for substance abuse problems, however, the screening instruments vary among the agencies conducting the screening.

  ✓ TAIP uses a Screening, Assessment, and Referral (SAR) agency to develop an appropriate intervention plan based on a clinical screening and assessment process, which determines the level and intensity of treatment needed for TAIP referrals. As an indicator of the efficacy of assessment, one-quarter of the offenders screened for substance abuse treatment were assessed as not needing TAIP funded treatment.

  ✓ There is no clinical assessment required for placement in the SAFP or IPTC programs.

  ✓ A recent review by consultants from the Center for Substance Abuse Treatment (CSAT) showed that in two large urban Texas counties "many offenders are sentenced to SAFPs with little or no objective information about treatment need." The consultants go on to state "presently there is no system in place to ensure that offenders entering SAFPs have been properly matched" (Feb. 7, 1995; Memorandum to TCADA).

- ***There is no centralized decision-making process for placing an offender into treatment.***

  ✓ Placement into treatment in TAIP is done by the SAR after referral from the criminal justice system.

  ✓ Placements into SAFP are made as a condition of probation after screening for abuse problems. Offenders who violate probation may be placed in SAFP as punishment, not because they need or will benefit from intensive residential treatment.

  ✓ Placements into IPTC are made by the Board of Pardons and Paroles based on information obtained from screening. The primary responsibility of the BPP is to determine readiness and suitability for parole, therefore the process may not focus on selecting inmates who most need the treatment offered by the IPTC program.

- ***There is no determination of client readiness for treatment.***

  ✓ No state funded treatment initiative assesses potential clients' readiness for treatment or motivation for treatment, although both have been linked to successful treatment. For example:

    - In the first two months of the IPTC program all clients were program volunteers. These clients had a drop-out rate of 22%, compared to a 35% drop-out rate when non-volunteers were included.

    - In TAIP, 55% of clients who acknowledged a substance abuse problem entered treatment, while only 33% of clients denying a problem entered treatment.

  ✓ Involuntary placement may occur in TAIP, SAFP, and IPTC.

- ***There is no evaluation on the effectiveness of screening instruments in determining intensity of treatment required.***

  ✓ The inappropriate use of a screening instrument to determine intensity of treatment can result in an inefficient use of treatment resources. Treatment options for probationers include peer counseling (AA or NA), various outpatient treatment programs (TAIP), and residential treatment programs (SAFP). For inmates, treatment options include IPTC and a number of in-prison modalities, such as group counseling or peer programs.

- ***There is no case management in the TAIP program to coordinate treatment delivery and monitor offender progress.***

  ✓ Case management is a core component of SAFP and IPTC and is cited as critical to retaining clients in treatment by monitoring their progress and communicating problems between criminal justice and treatment providers.

Retention in Treatment
Summary and Recommendations

- ***There is no standard screening and assessment process.***
- ***There is no centralized decision-making process for placing an offender into treatment.***
- ***There is no determination of client readiness for treatment.***
- ***There is no evaluation on the effectiveness of screening instruments in determining intensity of treatment required.***
- ***There is no case management function in TAIP.***

The 72nd Legislature, in creating the treatment initiative programs, gave broad latitude to TDCJ and TCADA to develop criteria for selection and placement into treatment. Representatives from both agencies are currently reviewing selection and assessment criteria. The Criminal Justice Policy Council recommends continuing the work of this committee, with the goal of refining (and perhaps re-defining) selection criteria and procedures. To that end, the CJPC offers the following recommendations for action.

✪ ***Develop and implement a standardized screening and assessment process.***

The screening and assessment process should include:
- assessment of clinical need for and intensity of treatment;
- assessment of motivation and readiness for treatment; and
- assessment of likelihood for completion of treatment.

✪ ***Prioritize placement based on agreed upon assessment criteria.***

✪ ***Develop and use a case management system in TAIP.***

The case management system should include:
- a case management plan;
- monitoring the client's progress through the treatment system;
- reporting the clients status to the justice system; and
- coordinating the efforts of treatment providers and criminal justice system personnel.

Program Cohesion

Program cohesion refers to the overall completeness of the program. Program cohesion includes adherence to the goals set forth in the planning of the program, implementation that is amenable to changes necessary to meet those goals, and communication and cooperation of all entities involved in the service delivery. In order to achieve effective implementation and operation of these programs it is necessary to establish continuity in the TC treatment modality, hire enough experienced staff and provide their training, develop case management procedures, and maintain focus on the treatment goals.

- ***There is no consistent therapeutic community program structure in aftercare.***

Many of the aftercare programs (Transitional Treatment Centers) are not therapeutic communities. Some are support-group oriented (twelve step), while others use techniques such as acupuncture or behavior modification. Additionally, policies concerning relapse, attendance, or participation are not consistent among aftercare programs.

Research has documented that program consistency (or lack thereof) affects treatment outcomes. As stated in a Technical Assistance Review by the Center for Therapeutic Community Research,

> ...the aftercare or continuity of care settings and services, which are not explicitly committed to the same philosophy, practices, and values of the primary treatment facility, are inefficient in sustaining a continued recovery in the client. The discontinuity between inpatient and outpatient treatment results in inefficiency and often discouragement in the client (DeLeon, 1993, p 4).

Specific problems relating to the lack of a consistent TC structure in aftercare include:

- ✓ There are no commonly shared policies and procedures relating to the TC structure and the SAFP and IPTC programs between correctional and treatment staff. This contributes to inconsistent implementation of the aftercare programs.

- ✓ "Commingling" of TTC clients in aftercare treatment with other clients not in the same type of treatment can negatively affect SAFP and IPTC clients attempting to maintain recovery.

- ✓ Surveys of TAIP and IPTC clients indicate inconsistent sanctions for program violations and false expectations regarding program length and services. The inconsistent application of sanctions may result in drop-outs when offenders believe no sanctions will occur.

- ***There will not be adequate numbers of experienced, trained staff to effectively implement and operate the expanded programs of the Texas treatment initiative.***

SAFP and IPTC require staff trained to serve offenders in the TC modality. Expansion of the initiative will further stretch the number of trained personnel available.

✓ At the end of Fiscal Year 1994 there were a total of 309 professional treatment staff for the IPTC and SAFP programs (including TTCs). By FY 95, there will be a need for 570 professional treatment staff, and by the end of FY 96, 1,240 professional treatment staff will be needed to operate the IPTC and SAFP programs.

✓ In addition to substance abuse counselors, case managers are needed to ensure continuity of treatment, and parole and probation officers are required to give additional time to offenders undergoing treatment in a TTC.

  ♦ Surveys of IPTC staff indicate that the average caseload for a parole officer serving IPTC clients was 70. The average caseload for case managers serving IPTC clients was 58. The average caseload for a treatment counselor was 32. Parole officers and case managers have reported that these caseloads are too high given the additional work responsibilities associated with the treatment initiative programs.

✓ Although no turnover data is available, surveys indicate that keeping experienced staff in counselor and case manager positions is problematic. Surveys of IPTC respondents at programs that had been operational for at least 24 months indicated the average time in current position:

In-Prison counselor :	13.4 months
TTC Counselor:	10.1 months
Case Manager :	8.4 months
Parole Officer :	10.4 months

- ***There is a clash of goals and priorities between the correctional and treatment cultures.***

Open communication, adhering to the treatment goals, and maintaining focus on the client are key to the success of the treatment initiative. However, each of the different agencies involved in the initiative have (necessarily) different missions and priorities. Some examples are addressed below.

✓ The first priority of TDCJ and prison management is public safety and prison security. The IPTC program focuses on developing a client's acceptance of personal responsibility for their actions, with increased authority and privilege accorded to that achievement. These needs are not always consistent with the security needs of prison management.

- ✓ Relapse (using drugs or alcohol) is viewed as part of the recovery process by treatment providers, who recognize substance abuse as a chronically relapsing disorder. Criminal justice officers view relapse as a violation of conditions of probation or parole. There is an ongoing debate about how relapse should be handled: as a treatment problem or as a violation of supervision.

- ✓ The number of staff, clients, and agencies involved in the initiative make communication of policies and procedures problematic. This is compounded by the interplay of communication between two parties to the exclusion of a third party. Administrators have termed this problem "triangulation." For example, clients have access to TCADA administrators to communicate problems occurring in treatment. This selective communication, which excludes the treatment counselor, may then result in conflict between clients, treatment providers, and administrators. Similar situations occur between clients, treatment providers, security staff, parole officers, and case managers.

Program Cohesion
Summary and Recommendations

- ***There is no consistent therapeutic community program structure in aftercare.***

- ***There will not be adequate numbers of experienced, trained staff to effectively implement and operate the expanded programs of the Texas treatment initiative.***

- ***There is a clash of goals and priorities between the correctional and treatment cultures.***

To address these issues, the Criminal Justice Policy Council offers the following recommendations.

Program Continuity

✪ ***Develop, implement, and evaluate an integrated IPTC, TTC, and Outpatient treatment demonstration program that contains all elements of a therapeutic community.***

- The demonstration program can serve as the foundation for modifying the aftercare component and provide adequate experience to assist in the development of contract requirements for future TTCs and Outpatient programs for the treatment initiative.

Program Staffing

✪ ***Enhance on-going training and education programs relating to the goals, policies, and procedures of the treatment initiative, as well as the therapeutic community model, for criminal justice and treatment personnel working in the treatment initiative programs.***

- Training must address the problems associated with (and resulting in) high turnover rates among criminal justice and treatment personnel.

Clash of Cultures

✪ ***Development of a policy and procedures manual that allows for flexibility yet still represents a consensus among participants regarding a system of sanctions, relapse policies, and program movement.***

- By FY 96 adequate prison, jail, and SAFP space will allow the use of criminal justice coercion to promote treatment retention. However, these resources must be used in a consistent, judicious, and cost-effective manner. Use of beds for relapse, sanctioning, and other purposes must be coordinated in a way that reinforces program goals.

Information Issues
Overarching Recommendations

The recommendations below address the need for ongoing evaluation to ensure that implementation and operation remains on track and to prevent the issues uncovered in this report from derailing program success.

- ***Ongoing evaluation aimed at improving program success and determining cost-effectiveness of the treatment initiative programs is needed as part of an interactive planning and implementation process. This includes:***

  - An evaluation of the SAFP program, the largest component of the treatment initiative.
  - Evaluation of the screening, assessment, and selection process of the treatment initiative programs to determine if an enhanced selection process can improve retention rates.
  - Continuation of the outcome evaluation of IPTC, adding sites (the Clements unit or the Stiles unit) to determine if the success of the Kyle program can be replicated by other programs. A three year outcome study is necessary to determine if the reduction in recidivism persists over time.
  - Evaluation of the demonstration TC, TTC, and Outpatient program to determine if this part of the system is effective.
  - Continual monitoring of retention rates, staff turnover, and other factors that may impact retention in treatment for all initiative programs.

- ***Rapid access to accurate operational, management, and evaluation information contained in the Substance Abuse Management Information System is crucial to achieving program consistency, maintaining offenders in treatment, and providing ongoing evaluative information. This requires:***

  - Improvement of the substance abuse MIS and development of an audit system to determine the accuracy, utility, and efficacy of the system.

CONCLUSION: OPTIMAL SIZE OF THE TEXAS TREATMENT INITIATIVES

In summary, Texas has implemented the largest treatment initiative for offenders in the United States in a short period of time. The next two years should be dedicated to assess and stabilize the programs, examine areas requiring program development and modification, and plan for the future. The issues discussed in this report have raised questions regarding the effectiveness of the screening, assessment, and selection process, the anticipated demand for professional staff and the need to develop a state-wide continuum of care. Each of these issues presents a long-term challenge to program expansion at the level of quality now realized. The overarching issues facing policy makers and treatment planners is determination of the optimal size of the initiative and the pace of planned expansion. Several parameters are critical in determining these two issues, including:

- ***The number of offenders in need of treatment***
- ***The number of offenders ready for and able to benefit from treatment***
- ***A process to select offenders ready for and able to benefit from treatment***
- ***Staff trained to meet the needs of offenders in a therapeutic community setting***
- ***Adequate funds to implement the program as designed***

To this end:

✪ ***The legislature should carefully examine whether enough progress has been made in these critical areas for the infrastructure to effectively support an expansion of the SAFP program to 7,200 beds from the present end of Fiscal Year 1995 level of 5,200 beds.***

Key Questions for the Legislature to Consider:

- Should program capacity be stabilized at the present level of 5,200 beds in SAFP facilities and 2,000 beds in IPTC facilities?
- If not, can the present operational infrastructure of the SAFP program effectively handle the expansion of this initiative to 7,200 program beds during the next biennium?
- If SAFP program beds are not expanded, what policies are needed for the state to be more selective in the placement of offenders so that local officials do not "screen in" more offenders than program capacity and efficient operation allow?

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