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The London Correctional Institution Therapeutic Community: A Multi-disciplinary Treatment, Remotivation, and Education Project

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by

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PROGRAM FOR THE STUDY OF CRIME AND DELINQUENCY

COLLEGE OF ADMINISTRATIVE SCIENCE
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THE OHIO STATE UNIVERSITY

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Mr. Clyde Scott
Director of Social Services
Department of Rehabilitation
and Correction
1944 Morse Road
Columbus, Ohio 43229

Dear Mr. Scott:

The report transmitted herein represents the evaluation of The London Correctional Institution Therapeutic Community: "A Multi-Disciplinary Treatment, Remotivation and Education Project", and is submitted in compliance with our contract with the Ohio Department of Rehabilitation and Correction.

If you have any questions about the report, or would like an extended briefing, please call me at the address on this letterhead.

Thank you for the opportunity to render evaluative services to the Department, and for the opportunity to work together on this project. We look forward to being of assistance in the future.

Yours very truly,

Harry E. Allen

Harry E. Allen, Ph.D.
Director

HEA:mh

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THE LONDON CORRECTIONAL INSTITUTION THERAPEUTIC COMMUNITY: A MULTI-DISCIPLINARY TREATMENT, REMOTIVATION, AND EDUCATION PROJECT

Introduction

It has been amply demonstrated in recent years that traditional forms of correctional incarceration are often more conducive to recidivism than to rehabilitation. One result of this realization has been the development of a wide variety of community-based alternatives to incarceration for minimal risk offenders. Another result has been the establishment of therapeutic milieus or communities within institutions for the benefit of those offenders ineligible for community-based facilities and programs. The latter approach involves the creation of an interactional structure defined to operate within defineable limits or settings where there is a consensus among group members relative to goals and objectives of the group. More specifically, the essence of a therapeutic community is that: (1) the group knows why it exists, (2) the group has created an atmosphere in which its work can be done, (3) the group has developed guidelines for making decisions, (4) the group has established conditions under which each member can make his unique contributions, (5) the group has achieved communication among its members, (6) the group members have learned to give and receive help, and (7) the group members have learned to diagnose group processes and improve group functioning.[1]

The concept of the therapeutic community was first developed by Maxwell Jones at Belmont Hospital in England.[2] After World War II, Dr. Jones was charged with the responsibility of treating a group of psychologically disabled veterans described as chronic failures, trouble-makers, unemployable, and beyond treatment. The approach devised involved the careful management of relations within a closed institution where patients

were encouraged to accept responsibility and learn active cooperative participation. In light of the poor prognosis accorded Jones' patients upon entrance to the program, it is significant that 22% were rated as "fair" in regard to health, family life, work experience, and general adjustment six months after termination of treatment.

A therapeutic community approach with persistent offenders has been employed by Cormier and Angliker at the Diagnostic and Treatment Center at Dunnemora, New York, as a pre-release, pre-parole project within a maximum security setting.[3] Admitted to the program were 50 men who had been involved in delinquent and criminal activities throughout most of their lives. Forty-two completed the program and were released on parole from the Center. The remaining eight were returned to prisons at their own request or on the basis of poor participation in the program. The mean length of stay at the Center was just over 16 months. The men were followed up for 48 months after release and compared with a control group who served out their sentences in prison. The results of this study indicate that although recidivism rates were comparable for the two groups, there were qualitative differences both in personal adjustment and in violation types. The experimental group was violated more frequently on technical grounds, whereas the control group had a higher incidence of new arrests.

Variations of the therapeutic community approach have also been used with juvenile offenders and the most outstanding examples include The California Youth Authority's Community Treatment Project, The Highfields Project, The Provo Project, The Essexfields Project, and the San Francisco Project.[4]

The London Therapeutic Community

Philosophy and History

In line with the growing national recognition that correctional institutions have historically served primarily a custodial function, the Ohio Department of Rehabilitation and Correction in the early 1970's launched an effort to establish both community-based alternatives to incarceration and therapeutic community programs within institutions. Exemplary strides toward the latter goal had already been made at the Ohio Penitentiary where a therapeutic community program was being conducted for a small proportion of the population under the direction of Dr. H. J. Leuchter. The widely-heralded promise of this approach led the Department of Rehabilitation and Correction to apply for federal monies to expand and sophisticate the development of therapeutic communities within the Ohio correctional system. Such monies were granted in 1972, at which time plans were developed for the creation of a therapeutic community at the London Correctional Institution.

The London therapeutic community was designed to be a program in group living whose goal is to change attitudes, values, and behavior of offenders. The framers of the project have outlined specifically the changes sought through the program as follows:

> 1. A substantial reduction in the number of residents acting out in the institution that must be reviewed by the Disciplinary, Rules Infractions, and "Court" Committees. This should serve to de-emphasize the strong custody orientation and permit more time and attention on the part of staff toward rehabilitation efforts.
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> 2. The creation of a service delivery model to which all staff can ascribe. A major goal would be to have all staff committed to a treatment-education-remotivation philosophy, i.e., a therapeutic community.

3. A reduction of approximately 20% in recidivism of those resident parolees who go through the entire institutional program and adequate after-care service. This objective should include those who are released successfully from parole.

From the outset of the project in 1972, the Ohio State University Program for the Study of Crime and Delinquency was contracted with the Department of Rehabilitation and Correction to assist in the development of the London therapeutic community. More specifically, the Program for the Study of Crime and Delinquency agreed to develop a research design superimposed on the service delivery system which would measure effectiveness of services and correlate it with expenditure of monies and energy.

The efforts of both the Department of Rehabilitation and Correction and the Program for the Study of Crime and Delinquency were initially hampered in the early months of the project by a number of extraneous problems beyond their control. The therapeutic community was initially scheduled to be implemented at the old Ohio Penitentiary. With the opening of the Southern Ohio Correctional Facility and the closing of the Ohio Penitentiary, the site for the community had to be changed. After much deliberation, London Correctional Institution was chosen.

The change of location led to several other problems. Construction of offices and an area for a vocational program had to be completed in the dorm which would house the community. Due to the trucker's strike and time of construction, the implementation of the community was delayed several months. Before custody staff could be hired for the community, previously employed staff at other institutions which were cutting back had to be given an opportunity to apply for the positions. Even after a Coordinator was obtained late in 1973, he still faced delays involved in

ordering equipment, outlining a screening and selection procedure, and developing a treatment program.

Despite these problems, however, the London therapeutic community received its first members on May 21, 1974, and has been officially in operation since that date. The project is housed on the ground level Number 8 dorm of the London Correctional Institution. The dorm has been substantially modified to accomodate and enhance the goals of the program. A set of private offices have been partitioned off, another area has been converted into a classroom setting, and a group of chairs and couches have been purchased to create a lounge area.

Resident Admission Procedures

A very explicit procedure has been developed for processing applicants into the therapeutic community program. At the outset, a memo informing the residents of the existence of the program was posted throughout the institution. Application to the program is on a voluntary basis. A prospective member might apply through any institutional official, though residents are encouraged to contact Social or Psychological Services for the most complete and detailed information. If, after the official explains the program, both he and the resident feel that the latter can genuinely benefit from and contribute to the community, the official is to refer the resident to the reclassification committee.

The reclassification committee is composed of representatives from a wide gamut of institutional services, including psychologists, social workers, teachers, work supervisors, custody staff, and administrative staff (the Assistant Superintendent of Treatment). If the reclassification committee approves of the resident's application to the program, the case is then passed on to the staff of the therapeutic community. According

to original plans, one-half of the residents receiving final approval by the staff were to be placed in the therapeutic community and the other half were to be maintained in the general institutional population as a control group.

In outlining criteria for admission to the program, the staff emphasizes that the therapeutic community is not to be conceived of as a psychiatric unit. Instead, the community is described as a program for the average resident who feels some concern regarding his past and his future, who wants to improve himself and who is motivated to change his attitudes and behavior. Specific criteria for admission are: (1) genuine motivation, (2) basic literacy (for educational purposes), (3) residency in the main institution (as opposed to the honor farm), and (4) at least six months before eligibility for parole consideration.

The therapeutic community staff has suggested to other staff that three types of persons may profit most from the community, and has described these three as follows:

(1) The Inadequate:

> This behavior pattern is characterized by ineffectual responses to emotional, social, intellectual, and physical demands. While the person seems neither grossly physically nor mentally deficient, he does manifest inadaptability, ineptness, poor judgement, social instability and lack of physical and emotional stamina.
>
> This group looks very much like our successful basic skills candidate. Generally, he tends to be concrete and somewhat simplistic. As a group, for psychological purposes, the group falls in a below average range on mental ability and mechanical testing although they are certainly not retarded nor without academic and vocational potential.

(2) The Neurotic:

> Anxiety is the chief characteristic of the neuroses. It may be felt and expressed directly, or it may be displaced in the form of bodily complaints, depression, or free floating feelings of dread. There is no gross disruption of the personality but the person finds his symptoms troublesome and seeks relief.

(3) The Victim:

This group looks very much like group (1) and has in common with it the fact that its members are unable to effectively compete with stronger, more aggressive persons. It is distinguished from the first group in that its members can be quite bright and highly educated. Nevertheless, they present a picture of a likeable enough person who is always finding himself the target of some sort of trouble. Frequently they are physically smaller, younger, and passive, thus, both in civilian and institutional life they are easily "set-up" and often become the targets of more antisocial persons. Frequently this group retains strong civilian values.

Pointing out that all three types have great difficulty in successfully competing in civilian society, the staff of the therapeutic community believes that the intensive group nature of the community may be able to provide them with the social skills they require, or motivate them to seek opportunities to acquire these skills from other institutional programs. It is stressed that this typology is simply suggestive and not designed as rigid criteria or guidelines.

Staff and Program

The staff of the therapeutic community includes a project director (10% time), a project coordinator, a group leader, a secretary, and five correctional officer-counselors. Plans call for the addition of three more group leaders and a half-time teacher in the near future. The project director is the Director of Social Services for the Department of Rehabilitation and Correction. While he is based at the Department's administrative offices in Columbus, all others operate directly at the program site. The offices of the project coordinator and the group leader are within the dorm used by the therapeutic community. This represents an exception to the institution rule prohibiting treatment staff from functioning in living units.

Care was taken from the inception of the project to assure that the community would not be isolated from or foreign to the larger institution. Residents of the community have regular working assignments and are not barred from participating in regular institutional treatment and educational programs, although it is expected that most treatment services will be rendered by the community.

The spirit of the therapeutic community is perhaps best captured by the principles all members must agree to abide by:

(1) Sharing Mutual Experiences:

Community members adhere to the principle that everything anybody says, thinks or does which involves another member of the Community is subject to open discussion in the Community or its groups. In other words, the emotionally important experiences of any member are shared by all members. There are no secrets inside the Community or its groups.

(2) Ethical Confidence:

In contrast to Principle number 1, everything that goes on within the Community or its groups - everything! - must remain an absolute secret as far as any outsider (non-member) is concerned. Anyone participating in the Community and its groups automatically assumes the same professional ethics of absolute discretion which binds professional therapists.

(3) The Community's Goal:

The Community's goal is free communication on a non-defensive, personal, and emotional level. This goal can be reached only by a team effort involving officers, residents, and staff. Experience shows that the official therapists cannot "push" any group; the group has to progress by its own efforts. Each member will get out of the Community and its groups what he puts into it. If every member communicates to the group his feelings and perceptions and associations of the moment as openly as he can and as often as he can, the Community will become a therapeutically effective medium. The goal of free communication is freedom to be oneself most fully and comfortably.

(4) Rules:

The Project is an exercise in responsible community living on as nearly a civilian basis as possible. It is the belief of the staff that freedom can only be obtained by responsible living. This means that the member is responsible to himself, to others of

the Community, and to the Community as a whole. It is expected that all members will follow the rules of the institution; the day to day living rules will be worked out on a democratic basis. You are a member of a special project with great implications for the future of Corrections - do not place it in jeopardy.

(5) Leaving the Community:

Since participation in the Community is entirely voluntary, a member is free to leave at any time. Of course, if in the opinion of the team (officers, residents, staff) he has not benefitted fully, a certificate of completion cannot be issued. Community members will be expected to meet all requirements of the Community, including tests and assignments.

The project staff is clearly trying to alter the climate of an average dormitory to a group setting with a stress on individual responsibility. Specific treatment plans are developed for each resident, and professional staff, officers, and residents all work together as a team to accomplish the individual treatment plans. While it is emphasized that the community is part of the institution and is to follow the rules and regulations of the institution, in the day-to-day living program of the community, residents and staff work as a team in establishing the rules and regulations of the community. One of the major thrusts of the program is to simultaneously encourage residents to have some determination in the activities of the community and encourage custody staff to become vitally involved in treatment.

When the program first began operations in May of 1974, the project coordinator employed a lecture-discussion style of treatment approach. After experimenting with this and various other techniques, the staff and residents finally decided on transactional analysis as the most promising treatment modality. Transactional analysis is currently supplemented by the Synanon Game, and plans are being made to introduce psychodrama in the near future. Three small treatment groups have been developed, each based on a particular set of needs. These three groups are called the insight

group, the motivation group, and the interpersonal group. Every resident is a member of one of the three groups, and each group meets twice a week (sometimes during the day and sometimes during evening hours) for one-and-a-half hour sessions. In addition, all members of the community attend a large group meeting each Wednesday evening. Individual counseling is provided as needed. Efforts are currently underway to develop more activities-in-common for the community, especially under the aegis of what the staff calls "the creative use of boredom."

The Residents

Thirty-five residents are currently enrolled in the therapeutic community program. The first 16 men entered the program on May 21, 1974, and the last 10 on July 12, 1974. Only two men have been dropped from the program, and neither was a voluntary departure. Current plans call for a total of 50 residents, though the project coordinator emphasizes that 50 men cannot be properly managed within the program without the addition of three new social workers.

The Program for the Study of Crime and Delinquency has compiled a variety of demographic data on the 35 current residents, and these provide a profile of the average member of the community. Fifty-four percent of the residents are black (N=19) and 46% are white (N=16). The modal age category is 26-29 years (N=10), although another eight men are between 34 and 37 years of age. The 15 residents for whom information is available have a mean tested grade level of 8.52. The married men (including those involved in common-law relationships) comprise 40% (N=14) of the residents, the divorced another 20% (N=7), and the single another 23% (N=8). Marital status was unavailable for 17% (N=6) of the residents.

The 13 men for whom information is available claim a mean of 2.08 dependents, with the range running from one to five. While the mothers of 63% (N=22) of the residents are living, the fathers of only 31% (N=11) are living. The 35 men average 1.6 living brothers, ranging from six brothers down to the 16 men who have no living brothers. The men average 1.3 living sisters, ranging from five down to the 15 men who have no living sisters. With regard to employment record, 60% (N=15) of the 25 men for whom information is available have never held a job for longer than 18 months, and only 24% (N=6) have held a job in excess of 37 months.

The 35 men account for a grant total of 161 total offenses on their criminal records, with a mean of 4.6 and a range of one to ten. One-hundred-twelve adult felonies are attributed to the 35 residents, with a mean of 3.2 and a range again of one to ten. The 35 men have accumulated 116 felony incarcerations, with a mean of 3.3 and a range of one to 13. The typical offense has been of a personal nature for 31% (N=11) of the men, of a property nature for 46% (N=16), and of a victimless nature for 23% (N=8).

An examination of the length of their current incarceration to date finds 29% (N=10) in the 7-12 month block, 20% (N=7) in the 13-18 month block, 17% (N=6) in the 37+ month block, and 14% (N=5) each in the 0-6 and 25-30 month blocks. Sixty-nine percent (N=24) have at least 13 more months before eligibility for parole consideration. The 21 men for whom information is available have already averaged 1.43 continuances by the parole board. The total group of 35 residents averaged 2.33 court calls prior to June 1 of 1974. And finally, the 35 men are involved in an average of 1.71 institutional programs.

PSCD Evaluation Methodology

Research Design

Due to several administrative restrictions, the PSCD evaluation will be unable to utilize totally random assignment to the experimental and control groups as was originally planned. Therefore, to replace the true experimental design, a quasi-experimental design utilizing matched cohort groups will be implemented. As residents are assigned to the community, matched controls will also be selected from the general institution population. Control and experimental group members will be matched on the following factors:

1. Race
2. Age
3. Intelligence and grade level
4. Attitudinal classification
5. Offense record
6. Marital status
7. Time incarcerated
8. Time to parole board

The matched samples will be measured along several dimensions. Immediately upon selection to the community, the resident and his matched cohort will be given pre-experimental surveys. Throughout the experimental period, the cohorts will be monitored to identify differential treatment received and institutional behavior characteristics.

Following the resident's exit from the therapeutic community, both he and his matched cohort will continue to have their behavior monitored and will be issued post-experimental surveys. This will allow evaluators to document the length of the effect of the therapeutic community after the resident again joins the institutional population.

The cohort outcome will continue to be recorded for those who leave the institution by way of furlough, parole, or shock parole. Outcome

coding sheets will be provided to parole officers or furlough counselors supervising the cohort groups so that particular outcome criteria will be recorded.

The pre- and post-experimental surveys, treatment differentials, institutional behavior, and post-release behavior will be analyzed both individually and aggregately to provide indications of the effectiveness of the therapeutic community and identify areas of program operations as causal factors correlating to program successes and failures.

Measurement Instruments

The experimental surveys and follow-up study require measurement instruments covering several variables. The variables to be considered and the method of measurement are as follows:

Attitudinal Measurements. Both the MMPI and the Mellon-Illinois attitudinal surveys will be given intermediately to both the experimental and control groups. These scales will be given to both cohorts before the resident has entered the community, immediately following the resident's exit from the community and at three month intervals throughout the rest of his institutional stay. These scales will provide measures of shifting attitudes due to participation in the community, and will be utilized as a controlling factor in matching cohorts.

A scale will be developed to measure the effect of prisonization on the inmate cohorts. Since the community emphasizes breaking down individual pathology and constructing group responsibility, the scale will be given at the same time as the other attitude scales to test the causal effect of participation in the community. Not only will pre-post administration identify direct effects of the community, but continued administration of the survey will allow evaluation of the carry-over effect of the community

after the resident returns to the general population. The survey will include attitudes toward the constructiveness of the institutional stay as well as standard concepts of prisonization.

Institutional Behavior. Both the control and experimental groups will be monitored during and after participation in the community to determine the effect of the program on institutional behavior. Several factors will be considered in this analysis. The number of court calls within the institution will serve as an indication of conduct. Surveys completed by work supervisors will also allow comparison of attitudes and behavior on the job. Finally, participation in other institutional activities will be analyzed for both the control and experimental groups.

Relative Adjustment. Post institutional behavior measurement will go beyond traditional recidivism indicators. Although relative adjustment does include a recidivism index, it is a continuous rather than dichotomous model which emphasizes the seriousness of the offense committed rather than the disposition following the offense. This continuous scale increases the sensitivity of the outcome analysis and allows for adjustment in relative terms.

Just as important as the recidivism scale is a documentation of positive or acceptable behavior patterns developed by the ex-offender. By keeping records on such variables as vocational and employment performance, financial responsibility, involvement in self-improvement programs, and adjustment on parole, the ex-offender is assigned a score which indicates his positive behavior.

A prediction model will also be utilized as a back-up to the matched cohort sample. The model provides a prediction outcome score based on demographic and offense data for the groups being analyzed. Comparison

of actual and predicted scores leads to the "relative" adjustment of the individual. The emphasis is therefore on measuring improvement from the expected outcome of the ex-offender rather than a mere recidivism score.

Comparison of both the experimental and control groups' relative adjustment scores while controlling for demographic and offense data with the prediction model will provide a sensitive measure of the effect of the therapeutic community on changing post-release behavior. Although the therapeutic community is directed toward inmates with more than six months to the parole board, and several participants will have returned to the general institution population for several months before release, the hypothesis is that the program can have a positive effect on post-release behavior.

Summary

While the implementation of the London therapeutic community suffered from more than the usual combination of extraneous, administrative, and operational problems, the program is now underway. Thirty-five residents are currently enrolled in the community and engaging in a variety of treatment programs. The PSCD has developed and refined its evaluative methodology, and is working in conjunction with the project staff to maximize the value of the research contribution.

Although it would be extremely premature for the PSCD to offer recommendations at this time, it would perhaps be of service to identify a few areas that seem most problematic in these early stages of program operation. The community does appear to be in serious need of the additional staff planned on in order to expand and sophisticate treatment programming.

There also seems to be a continuing need to gain the cooperation and support of other personnel within the larger institution. These kinds of difficulties are, of course, rather typical in the development of any innovative program.

The PSCD looks forward to the ensuing year's efforts at the London Correctional Institution to further assist in advancing the development of innovative programs in Ohio's Correctional System.

NOTES

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2. Maxwell Jones, The Therapeutic Community: A New Treatment Method in Psychiatry (New York: Basic Books, 1953).

3. Bruno M. Cormier and Colin C. J. Angliker, "A Therapeutic Community for Persistent Offenders," in Corrections: Problems of Punishment and Rehabilitation, ed. by Edward Sagarin and Donal E. J. MacNamara (New York: Praeger Publishers, 1973).

4. U. S. President's Commission on Law Enforcement and Administration of Justice, The Challenge of Crime in a Free Society (Washington, D.C.: The Commission, 1967).

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