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A COLLABORATIVE EVALUATION OF  
PENNSYLVANIA'S PROGRAM FOR  
DRUG-INVOLVED PAROLE VIOLATORS

Report prepared for the National Institute of Justice,  
grant #98-RT-VX-K002

Douglas Young  
Rachel Porter

Vera Institute of Justice  
May 1999

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# Executive Summary

## Introduction and Program Overview

In 1998 Pennsylvania established two new 60-bed drug treatment programs in state prisons under the federal Residential Substance Abuse Treatment (RSAT) initiative. Of the more than thirty RSAT programs across the country, Pennsylvania's programs are unique in targeting technical parole violators (TPVs). Mirroring a national pattern, TPVs account for a growing proportion of prison admissions in Pennsylvania, contributing to a state prison population that remains above capacity. Pennsylvania's RSAT programs are also unique in their focus on cost-savings. Instead of the 12 to 36-month prison recommitment that typically results from a parole revocation, RSAT participants are committed to twelve months of treatment, half of which are spent in relatively low-cost residential halfway houses.

The RSAT programs are maintained through the joint management of the state Department of Corrections (DOC), Board of Probation and Parole, Pennsylvania Commission on Crime and Delinquency, and two private service providers that operate the programs. An interagency working group was formed to oversee RSAT implementation and program development, and works to identify, monitor, and resolve implementation issues as they arise.

Entry into RSAT begins when male TPVs are brought into custody and screened by Parole and Corrections staff for eligibility. Men selected for RSAT from the state's eastern region are then transferred to the State Correctional Institution at Graterford, about 30 miles northwest of Philadelphia; men from western Pennsylvania are sent to SCI-Huntingdon, in the central part of the state. Participants spend the first six months of the RSAT sentence in a therapeutic community (TC) at these facilities, where they are segregated from the rest of the inmate population. Graduates from this phase are then transferred to DOC-operated or sponsored Community Corrections Centers (CCC), where they reside, obtain employment in the area, and attend outpatient aftercare. Private treatment providers operate and staff the TCs, and are responsible for maintaining treatment for the six-month aftercare period. A parole officer is assigned to each RSAT site to assist in transition to independent living. Participants who complete both stages of the program are released on parole, while those who terminate early from either stage of RSAT are returned to custody.

The Vera Institute of Justice is conducting evaluations of RSAT implementation and impact in Pennsylvania. This report presents findings from our process evaluation of the first year of RSAT implementation. Key findings in three areas are presented below.

## Program Admissions and Participants

- The programs filled to capacity within the first months of opening in February 1998. In May, each site expanded from 50 to 60 beds to meet demand and have remained at or near capacity. Through December 31, 1998, 237 TPVs had entered the two RSAT programs.

- RSAT participants have high levels of self-reported drug use and need for treatment, indicating that these men are appropriate referrals for the program. Substantial minorities (25 to 30 percent) also have medical and psychological problems and most have poor vocational and educational histories. The RSAT programs do not directly address these service needs, but focus on substance abuse and the “criminogenic thinking” that underlies the various life problems experienced by parole violators. In interviews done upon exit from the prison phase, RSAT participants judged the programs as helpful in addressing substance abuse problems, as well as vocational and educational areas, suggesting they are receptive to this indirect approach. Still, in the impact research, it will be important to examine whether prior problems in these areas contribute to failure in the community after RSAT. Future research should also explore differences in participants at the two sites, once the samples are larger. At this point, differences are apparent on a few background factors, but there is no pattern to suggest either group is more disposed to succeed or fail in treatment.

## Program Retention and Completion

- There is very little dropout in the first, six-month phase of prison treatment, as less than 10 percent of those entering RSAT failed during this period. So far there is no pattern of differences between the programs in terms of participant characteristics or dropout during the prison phase.
- By the end of 1998, 38 percent of the Graterford graduates, who attend a CCC in Philadelphia, had failed; 22 percent of Huntingdon graduates, who attend CCCs in the western region, had failed. These figures are based on small samples (of about 50 each), and they may change as we track larger, more stable samples of parolees. Nearly half the failures are drug-related; a significant portion (40 percent) stem from such infractions at the CCC as curfew violations and fighting with another resident. While certainly in the range of expectations for parole violators, failure rates in this phase of RSAT were high enough in the first year to be of concern to the interagency working group. Outlined below, several initiatives have been undertaken with the intent of increasing RSAT retention in the CCC.

## Program Implementation

- Both treatment providers, CiviGenics at Graterford and Gateway at Huntingdon, have implemented sophisticated, highly structured curriculums during the prison phase. They mix traditional 12-Step principles with a cognitive-behavioral approach; much of the programming focuses on changing thoughts, emotions, and behaviors associated with drug use and criminal acts. Structured, compulsory treatment, delivered in group sessions, is scheduled from about 8am to 4pm Monday through Thursday. Some of the inmates’

other, unscheduled time is spent in therapeutic activities in the form of low-level labor and community work duties, homework assignments, elective 12-Step and individual counseling sessions, and recreational activities. Observations and interviews at the sites suggested that inmates were not taking full advantage of elective therapeutic opportunities, and needed to be further encouraged to attend them. Overall, participants rated the RSAT services as moderately to very useful, and gave their highest ratings (just under '4' on a 1-to-5 scale) to measures of counselor competence and rapport. These ratings confirm previous research findings on the importance of participant confidence in treatment counselors, and counselor integrity.

- Both research and clinical experience suggests that treatment is more effective if it is tailored to individual needs. These programs conduct extensive individual assessments and create detailed treatment plans; however, they do little to act on them. The highly structured core curriculum employed by both programs is administered to all participants and leaves little room for individualized treatment. To utilize the assessments and address individual treatment plans, programs must be sufficiently flexible and staff adequately trained to incorporate individual counseling into the curricula; more individual sessions are also needed. Greater focus on personal histories and needs would further engage participants and would enhance their preparation for independent living.
- Issues surrounding the conflicting priorities of treatment and correctional security surfaced in both programs, but especially at Graterford. In addition to tensions between staff, this led some inmates to disengage from active participation at times, and to express anger and frustration over a perceived lack of support. Assertive leadership by state administrators, program directors and central treatment offices have helped to identify and address these problems, easing tensions, and establishing stronger, cooperative relationships between treatment and corrections staff.
- Counselors in both programs labored to balance DOC requirements while carrying a full caseload and running meetings and sessions. Staff stability and experience in the correctional setting assists in anticipating DOC demands, and lessening the negative impact such demands place on treatment delivery.
- Transition to the community is a vulnerable period for inmates. Prompted by the failure rates in the CCC phase, new initiatives include additional discharge planning in the final weeks of the RSAT prison phase, with the intent of preparing participants for responsibilities they will assume when they return to the community setting. These are coordinated between treatment staff at both sites, and CCC and DOC facility officials. It is also evident that corrections staff should have a clear understanding about treatment expectations, and anticipate and resolve issues that relate to mixing RSAT participants with general population parolees in the CCC.
- Finally, states should establish an interagency monitoring and response system that identifies and resolves RSAT implementation issues. Anticipation and early identification

of problems facilitates their resolution. In Pennsylvania, the RSAT programs benefit from steady monitoring by a management group that includes all involved agencies, public and private.

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# Chapter One

## Residential Substance Abuse Treatment in Pennsylvania Prisons: Introduction and Overview

### Introduction

At the end of 1997, the number of inmates in state and federal prisons reached nearly 1.25 million – about two and one-half times the number incarcerated in 1985 (Gilliard & Beck, 1998). This increase is largely attributable to the skyrocketing number of offenders committed for drug offenses or other drug-related crimes since the crack epidemic of the mid-1980s (Belenko, 1998). As a result, interest in combining drug treatment with traditional sanctions, and using the powers of the criminal justice system to compel offenders to attend and remain in treatment has increased in recent years (e.g., Lipton, 1996; Nielsen & Scarpitti, 1996; Lipton, 1994; Siegal, et al., 1993). Policymakers have come to recognize that significant savings can also be realized by shortening prison stays for non-violent drug offenders and reducing recidivism among repeat offenders by using their time in prison for intensive treatment programming.

The national pattern is mirrored in Pennsylvania, where the state prison population has grown to 149% of capacity, totaling 36,603 on April 30, 1999. As elsewhere, commitments of offenders charged with drug-related crimes have fueled this escalation. So has the growing number of individuals who have been recommitted to prison for drug-related parole violations. Between 1994 and 1996 the parole violator population in Pennsylvania prisons increased 41%; at present, about one in five inmates are in prison because they were returned on parole. Over half (52%) of these parole violators are recommitted for technical violations and face new sentences of nine to 36 months. While precise data are not currently available, corrections and parole officials report that the great majority of these parole violations are related to relapse into substance abuse and drug-related crime.

An August 1998 front-page story in the New York Times underscored the growing, “built in” burden that recommitted parole violators represent to prison populations that continue to increase and remain above capacity in many states despite significant declines in reported crime. Citing a new federal report (Gilliard and Beck, 1998) and statements from Pennsylvania Department of Corrections (DOC) Secretary Martin Horn, the story noted that states are recommitting parole violators at increasing rates and that this practice is partially responsible for the steady increase in prison populations.

Pennsylvania has responded to the growing volume of parole violators by establishing several community-based programs and, most recently, two new in-prison programs that are the subject of this research. Both the programs and the research were funded through the federal Residential Substance Abuse Treatment (RSAT) program administered by the U.S. Department of Justice. RSAT-funded prison treatment programs now exist in 33 states, and 22 of them are, like the Pennsylvania programs, the subject of local evaluations. Research interest in these programs follows on the heels of several studies that have shown that graduates of prison

treatment have lower criminal recidivism rates than comparable offenders who are not exposed to treatment (e.g., Simpson et al., 1999). The National Institute of Justice (NIJ) seeks to expand empirical knowledge about the implementation and impacts of prison-based drug treatment through RSAT research.

## Interim Performance Measures and Long-Term Goals

The first product of a two-phase research effort, this report presents findings from the Vera Institute of Justice's process evaluation of Pennsylvania's RSAT programs. Process research focuses on the implementation of programs, assessing the development of program operations, such as staffing and service delivery, and operational performance indicators, such as participant admissions and completion rates. The report is both descriptive and analytic – descriptive of the program and its implementation, and analytic about the problems of implementation and their solutions. It documents the growing diversity of clinical approaches in treating offenders, particularly the move from traditional 12-Step (AA and NA) programs to a focus on changing the thinking and the behaviors associated with drug use and criminal acts. It also documents the challenges inherent in establishing therapeutic interventions in prison settings. The conflicting priorities of treatment and security – and at a deeper level, of support and punishment – inevitably surface in prison programs. As a result, our case study of the ways these and other implementation issues took shape and were addressed in Pennsylvania will be useful to others who are planning or operating similar programs. Also, as this and other process evaluations of RSAT are completed, researchers and policymakers can identify the implementation issues that reflect local circumstances and those that are inherent in the program and occur across settings and states.

Like most prison-based programs for substance abusers, the RSAT programs in Pennsylvania are predicated on the notion that intensive treatment services will help participants break the cycle of drugs and crime. The programs' logic model posits that substance-abusing parole violators who participate in intensive treatment in prison, followed by residential aftercare, will be less likely to return to drug use and to reoffending than if they had been returned to the general prison population. Both Pennsylvania programs take a cognitive-behavioral approach to drug treatment. Their logic model presumes that RSAT participants will learn to make socially responsible decisions and develop new responses to social and environmental cues that previously led them to use drugs and commit crimes. To this end, the programs provide a highly structured curriculum that reflects this behavioral treatment orientation mixed, to some extent, with more traditional self-help techniques. To facilitate acquiring and internalizing new ways of thinking and behaving, the programs seek to establish a supportive, therapeutic community in the prison setting.

This research provides an interim assessment of the implementation of this logic model. It examines the extent to which components of RSAT treatment are in place and the integrity of program operations. It is important to note that the report covers the first year of RSAT

operations in Pennsylvania and many of the implementation issues that arose and are described here have been resolved, in some cases since this report was first drafted in the spring of 1999. We chose to leave in the report our discussion of these issues, while noting when changes were made, to provide the general reader with an understanding of implementation developments that can occur with prison-based programs.

This process research has also informed plans for an impact study of the programs that we have just begun, and will be essential in interpreting outcomes from that research. The impact evaluation will test whether participation in RSAT treatment leads to improved outcomes in the long run, and also explore whether certain participant characteristics or program components are associated with success after release.

We structured the current study around a set of research questions about RSAT implementation. This research focuses on the first six months of the RSAT program, the intensive, prison-based treatment that forms the core of the sentence. Future research should also examine the content and impact of the aftercare phase. The questions are presented near the end of this chapter, following a summary description of Pennsylvania's system of treatment for inmates and parole violators, and of the two RSAT sites.

## RSAT in Pennsylvania

### **Treatment for Inmates and Parolees in Pennsylvania.**

Apart from the two RSAT programs, Pennsylvania has built intensive residential treatment programs in five state institutions and recently opened an 1100-bed correctional facility devoted solely to substance-abusing offenders with less than a year of remaining prison time. Programs for parole violators or parolees threatened with a violation have also been developed in community-based settings in several areas of the state. Instead of being recommitted to prison, technical parole violators (TPVs) in the eastern region who are judged as "low risk" may be ordered to one year of community-based treatment (including three months in a residential program followed by six months of full-day outpatient and three months of weekly outpatient treatment).<sup>1</sup> Another statewide alternative for parole violators is a "halfway back" program, where the parolees are placed in a state corrections-supervised halfway house, until residence staff recommend that they are ready for release (or their maximum sentence on the original offense has been completed). Both of these programs are for parolees who, while failing to fulfill the mandates of their prison release, appear to pose a minimal risk to the public; by sending these individuals to community-based programs, the state avoids the high costs of reincarceration and addresses their underlying treatment needs.

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<sup>1</sup> Eligibility for these different programs is judged by parole agents, using procedures established by their agency, the Pennsylvania Board of Probation and Parole (PBPP). Low-risk TPVs are those with relatively short criminal histories, less severe, non violent prior convictions, and no history of prison infractions, previous parole violations, absconsions, or escape attempts.

Nonetheless, numbering about 400, the low-risk parolees afforded these treatment opportunities account for a small proportion of the total parolee population. The great majority of TPVs are returned to a state correctional institution. This is the context in which Pennsylvania developed two RSAT programs targeted at TPVs. Opened in early 1998 in two correctional facilities for men, each of these programs now serves 60 male TPVs with a history of substance abuse. With additional federal support, the state plans to expand RSAT programming in late 1999 to serve women and general population inmates.

In addition to the traditional goal of reducing participants' rates of relapse and criminal recidivism, the two programs for TPVs are intended to relieve overcrowding and reduce system costs by shortening the time TPVs spend in prison. Instead of nine to 36-month terms typical for parolees recommitted for violations, RSAT participants serve six months in prison-based intensive therapeutic communities, followed by six months of aftercare in a DOC-sponsored Community Corrections Center (CCC), similar to a halfway house.

RSAT programs currently serve TPVs from ten counties in the eastern and western parts of the state. Parolees from Philadelphia and other eastern counties attend the program at SCI (State Correctional Institution)-Graterford, while those from Pittsburgh and the west attend RSAT at SCI-Huntingdon.<sup>3</sup> SCI-Graterford is located about 30 miles northwest of Philadelphia and SCI-Huntingdon is in the center of the state, about 40 miles southeast of State College. DOC elected to contract with private, for-profit companies to provide the treatment in each facility. The program at Graterford is operated by CiviGenics, a Massachusetts-based company that operates correctional facilities and programs nationally. Gateway Rehabilitation Services, a Pennsylvania-based drug treatment provider that runs programs throughout western Pennsylvania, operates the RSAT program at Huntingdon. Graterford graduates attend one of two CCCs located in the Philadelphia area, while Huntingdon graduates attend CCCs in Pittsburgh and in Erie County in the northwest corner of the state.

**Figure 1: Agencies Involved in RSAT Components**

RSAT Component	Department of Corrections			PBPP	Private Treatment Providers	PCCD
	Central	SCI	CCC			
RSAT Coordination	•	•	•	•	•	•
Parole Revocation				•		
Screening	•		•	•		
Prison Treatment		•		•	•	
CCC Aftercare			•	•	•	
Return to Parole				•		

<sup>3</sup> Referrals from Bucks, Chester, Delaware, Montgomery, and Philadelphia counties attend RSAT Graterford, while Huntingdon accepts TPVs from Allegheny, Beaver, Butler, Erie, and Westmoreland counties.

Statewide coordination of the RSAT alternative for TPVs has been a joint effort of the Department of Corrections and the Pennsylvania Board of Probation and Parole (PBPP). The state administrative and planning agency, the Pennsylvania Commission on Crime and Delinquency (PCCD), is also involved in RSAT planning and monitoring. Figure 1 depicts the RSAT screening and treatment process, and the numerous agencies and their internal departments that coordinate responsibility for the programs.

### **Overview of RSAT Selection and Treatment**

Parolees suspected of violating Parole Board-mandated conditions are taken into custody by their supervising field parole officers after consultation with a unit supervisor. Typical violations include missing scheduled meetings with the parole agent or turning in positive results in drug or alcohol urinalyses. The TPV appears before a hearing examiner who determines the merit of the revocation. If the charges are upheld and the parole agent believes the TPV is appropriate for RSAT, the agent administers a Program Suitability Screening Form designed by the PBPP for violators with histories of substance abuse. To be eligible for RSAT, TPVs must have at least 18 months remaining on their (maximum) sentence, a demonstrated need for drug abuse treatment, and no history of escape, arson, or significant difficulties in the community corrections centers. If the TPV is approved for RSAT, and he elects to enter the program, he is transferred to the SCI which houses the RSAT program. There, he must complete standard inmate intake procedures prior to entering the treatment program – a process that can take several days at Graterford and several weeks at Huntingdon, where the program is located in minimum-security trailers outside the prison's main walls.<sup>3</sup>

All RSAT recommitments carry a mandatory time limit of 12 months. Regardless of the length of time between coming into custody for the technical violation and entering RSAT treatment, all participants must complete six months of the prison-based program component. During the programs' first year of implementation, the remainder of the 12-month RSAT sentence was spent in the CCCs – that is, any “up front” processing time was subtracted from the six months allotted to CCC residence, resulting in varying lengths of stay in CCC aftercare. In the spring of 1999, the RSAT working group agreed to restructure the “12-month clock” to start it upon admission to RSAT treatment, and not when the individual was initially selected for RSAT at the local parole office. All participants will now attend the two phases for six months each.<sup>4</sup>

Participants who do not complete the six-month prison phase of RSAT are returned to the general population, where their release eligibility is periodically reviewed by the State Parole

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<sup>3</sup> The screening process was modified in early 1999 to include an additional assessment of readiness for treatment by drug treatment specialists from CiviGenics and Gateway.

<sup>4</sup> One advantage of the original policy to start the 12-month period when the TPV was selected for RSAT was cost-savings, since the costs of holding the RSAT candidate for processing (the period between selection at the local jurisdiction and placement in the RSAT unit) were at least partially made up by reducing his CCC stay for an equivalent period. State officials who oversee RSAT recognize that processing time must be monitored and kept at a minimum to ensure that costs do not escalate under the new plan.

Board. Those who complete the prison treatment phase graduate into the supervised community living component. The DOC operates some CCCs while others, including those in the Philadelphia area, are operated by private agencies under DOC contract. A parole officer, assigned to each RSAT prison site, prepares participants to return to community living and continues to meet with participants in the CCCs. While living in the CCCs, participants must attend outpatient treatment twice weekly and attend 12-Step groups three times a week. DOC's contracts with CiviGenics and Gateway require that, in addition to the prison component, they are responsible for CCC outpatient care. Gateway provides this treatment to Huntingdon graduates, while CiviGenics has elected to contract with another provider for delivering this service in the Philadelphia CCC. Residents are required to obtain employment within a week and, eventually, to secure stable housing. They abide by a curfew that can be relaxed based on compliance. RSAT participants live and eat together with other parolees in the facility.

At the end of the twelve-month period, the TPV is released to standard parole supervision and returns to living independently in the community. Federal strictures on RSAT funds do not permit them to be used for aftercare in the community. Pennsylvania, however, has elected to fund this treatment under a "continuing care" initiative launched with a mix of other federal and state monies. Once this program starts in the fall of 1999, RSAT graduates of the CCC will have the opportunity to attend treatment with community-based providers contracted by the PBPP.

## Research Questions

Implicit in the RSAT logic model were a set of operational performance indicators that anchored this process research, for example do the programs achieve full capacity, and do they retain participants. From meetings and discussions with state officials involved in RSAT, we devised a set of research questions that integrated the operational measures with what they wished to know about the programs. In framing the questions, we also considered the interests of NIJ and the larger field of offender treatment. In answering these questions here, we describe the programs, discuss the successes and challenges evident in their implementation, and identify lessons that can be applied beyond Pennsylvania. The following questions guided this process evaluation:

- What is the underlying treatment philosophy of the RSAT program? What therapeutic methods are used and how is the program structured?
- What is the program setting? How does the correctional setting affect treatment delivery?
- How are new RSAT participants processed upon entry? What are the program's rules and how are they enforced? Were there any particular successes or problems in implementing this aspect of the program?
- What treatment and other services are delivered in the program? How does the program's phase structure work? What is the program environment? Were there any particular successes or problems in implementing these aspects of the program?
- How is the program staffed? Were there any particular successes or problems in establishing and maintaining program management and staffing?

- What are the characteristics of program participants? What are participant perceptions of the programs?
- What kinds of aftercare are provided after RSAT participants complete the in-prison treatment phase? Were there any particular successes or problems in implementing the program's aftercare components?
- Did the program reach full capacity and remain there? What are the early program outcomes regarding participant retention and completion rates? What do findings on those who fail say about the program?
- What are the lessons of this evaluation for other prison treatment programs nationally?

## Research Methods

### Sample

The process evaluation was conducted during a 13-month period between December 1997 and February 1999. Our findings are based on intake interviews of RSAT participants administered by program staff; participant interviews conducted upon exit by Vera onsite researchers; review of program file data; structured interviews of staff; and observation and informal participant interviews. Of the 237 individuals who entered the programs through December 31, 1998, 160 (67.5%) completed intake interviews. Seventy-seven of 110 program graduates completed exit interviews by this date.<sup>5</sup> In addition to onsite researchers' weekly observations and discussions with program staff, senior project researchers interviewed two to four staff members from each treatment program, visited each program at least six times, and maintained regular telephone contact with program directors and staff. Senior staff also attended a number of statewide interagency meetings on RSAT, and had ongoing discussions with DOC, PBPP, and PCCD officials about the programs.

### Interviews and Instruments

The intake interview included a supplemented form of the Addiction Severity Index (ASI) (McLellan et al., 1989). Probably the most widely used and studied assessment measure for substance abusers, the ASI measures history and current status information in the following areas: demographics, education, employment, family and social factors, legal problems, medical and mental health, criminal record, and substance abuse. It was supplemented with additional questions, developed at Vera, about criminal behavior and employment history. The exit interview included the Community Oriented Programs Environment Scale (Moos, 1988), program rating and satisfaction measures developed by researchers at Texas Christian University (Simpson, 1994), an adapted version of the Treatment Services Review (McLellan et al., 1992), as well as a

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<sup>5</sup> Most of those who were not interviewed at intake entered early in the research, when protocols for administering the intake interview were not fully in place. Additionally, 33 inmates refused to be interviewed at admission. Those who missed the exit interview included 4 who refused to participate in it; the remainder graduated during a period when no research staff were available at the study site. It will be important to assess possible differences between the interview sample and those who refused to be in the research in future analyses of program outcomes.

series of questions about experiences on parole. Structured staff interviews were developed by Vera researchers for this evaluation. Researchers recorded site observations using two additional instruments, again designed for that purpose, based on materials made available at RSAT cluster conferences organized by NIJ.

## Report Structure

This report is organized into five chapters. Chapters Two and Three describe and assess the implementation of each of the RSAT programs, and report process indicators of performance, such as program completion rates. The fourth chapter presents quantitative findings from intake and exit interviews with program participants. These middle chapters (two, three, and four) provide an extensive narrative account of RSAT implementation and specific details from the Pennsylvania experience. Some readers may wish to jump immediately to the fifth and final chapter, where we summarize the findings and identify the key treatment and administrative issues that emerged in our evaluation of RSAT program implementation in Pennsylvania.

## Chapter Two

### RSAT at SCI-Graterford: The CiviGenics Program

*1. What is the underlying treatment philosophy of the Graterford RSAT? What therapeutic methods are used and how is the program structured?*

#### **Program Philosophy**

The RSAT program at SCI-Graterford is operated by CiviGenics, a Massachusetts-based private, for-profit company that operates corrections programs in several states. CiviGenics calls their treatment model the Correctional Recovery Academy (CRA), which they describe in program documents as an adaptation of the traditional therapeutic community model that is effective in various correctional settings. The model is based on the notion that drug use and criminal acts are behaviors learned in the absence of healthy socialization. Program literature describes criminal behavior as a function of the individual's perception of the world, and contrasts CiviGenics' method of "providing a window to the world" with the "mirror to the self" approach used in traditional therapeutic communities (TCs). The program tries to focus participants on social learning, i.e., how they interact with and affect people around them, in contrast to psychodynamic approaches that emphasize identifying and fulfilling deep, emotional needs. While CiviGenics' programs do not use some TC approaches such as aggressive confrontation, they maintain what they view as the essential elements of the therapeutic community, namely structured cognitive and behavioral group therapy delivered in a community self-help environment.

In the CiviGenics' model, criminal acts and substance abuse are viewed as habitual, impulsive behaviors. According to program documents, the offender must "learn to learn" in order to change destructive behaviors and become socially integrated. The curriculum is designed to teach offenders "core skills," such as establishing priorities, which promote healthy social interaction and appropriate decision making. In an effort to assist participants in learning what the organization terms "pro-social skills," staff guide participants in continual practice of these skills with the expectation that they internalize them. Because this approach does not require staff to directly affect emotional change in participants, the agency does not utilize self-abasement, extreme confrontation, or similar approaches that it finds more harmful than beneficial, and that are seen in some traditional TCs.

#### **Method and Structure**

CiviGenics' Correctional Recovery Academy model combines cognitive behavioral treatment (learning skills) with social learning (understanding other people's reactions) using a highly structured curriculum. The CRA curriculum was developed by Fred Zackon in consultation with criminal justice and drug treatment researchers including Paul Gendreau and George DeLeon. The core curriculum includes a series of "Correctional Recovery Training Sessions" (CRTs),

which were developed with the Harvard School of Public Health and tested in controlled clinical trials.

The CRTs are arranged into five topic areas: core attitudes and values; drugs/addiction factors; social relations; work and productivity; social service utilization; and propensity to violence. CRT sessions are supplemented with a variety of specialized classes (for example, orientation to the program or reentry issues), weekly “process” meetings used to resolve interpersonal conflicts that develop as a result of participants living together in the program, and additional classes that are intended to reinforce skills introduced in the CRTs.

The extensive CRA curriculum is written out word for word, so that any staff member can literally read from the appropriate session manual to conduct a class. CiviGenics does not intend for staff to read the written curriculum, but to use it to avoid content distortions which result from ambiguity. In practice, however, during this first year of implementation, the RSAT staff uniformly indicated that they did read the curriculum when leading group sessions, and observations confirmed that they rarely engaged in improvisation. Perhaps with greater experience and training, staff will come to rely less on written materials.

The model is organized around a three-phase residential component and an aftercare component. The curriculum is intended to be cumulative; participants first develop basic skills, then use those skills to understand situations that can lead to substance use. Finally they apply that understanding to develop plans for an independent, socially productive life. Each curriculum component includes homework that can range from identifying “triggers” to relapse to contacting a twelve-step group. Inmates are expected to pass written tests about the lessons learned in each phase before advancing to a higher phase.<sup>1</sup>

Each phase includes a set number of classes; participants remain in the phase until they attend all classes, complete the homework, and pass the test for that phase. Should a participant fail the test, he would be required to study further and retake the test. The CRA curriculum is designed so that inmates may begin the next phase by entering a class at any point in the cycle. Participants thus do not always begin a phase with the same class, but everyone will pass through the cycle and attend all the same phase classes before moving on.

## *2. What is the program setting? How does the setting affect treatment delivery?*

### **The RSAT Unit**

The Graterford program is housed on a cellblock within the walls of a maximum security prison. This cellblock is relatively new, while the prison to which it is attached is one of the older prisons in the state. All personnel enter the cellblock into a large, open common area that has fixed tables and stools. A corrections officer’s desk is near the entryway. This room is light and noisy; the ceiling is two stories high, the walls are recently painted masonry. Cell windows do not open and

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<sup>1</sup> Participants who are illiterate are tested orally. Program literature notes that literacy is not required for successful participation in the program.

the block is not air conditioned in the summer, nor well heated in the winter. Large fans circulate air but also contribute to the level of background noise, as do program participants not in group sessions and interruptions from DOC staff.

Corridors off the central room and up a stairway lead to approximately 35 cells that house the RSAT inmates. Five empty cells off the central area serve as the program staff's offices. There is a small, relatively quiet classroom off the central area that can comfortably seat ten to 12 people. The program is restricted to the cellblock, so all group sessions take place in the central area, the classroom, or the corridors.<sup>2</sup> Program participants are segregated from the general population, except for recreation, meals and off-block visits, for example to the commissary and infirmary.

### **Program Environment**

Many participants have told us that the prison environment is not therapeutic, and program staff have repeatedly expressed frustration at the noise level and lack of space. Nonetheless, the program has succeeded in delivering services according to schedule and, according to participant interviews and site observations, group activity generally goes uninterrupted. Participant complaints about the environment have not led to high rates of attrition during the in-prison phase.

*3. How are new RSAT participants processed upon entry? What are the program's rules and how are they enforced? Were there any particular successes or problems in implementing participant intake?*

### **Participant Intake and Monitoring**

Upon arriving on the RSAT cellblock at Graterford, new participants are assigned one of two primary counselors. The counselor provides a brief overview of the program and program expectations. An Orientation Committee, composed entirely of program participants, provides a more comprehensive introduction to program structure and rules, and to daily functioning on the unit. Participants receive an Inmate Guidebook and Offender Handbook upon entry. These booklets, which are standard issue for all CiviGenics' programs, explain the program philosophy and list program goals, components, and rules. New participants start attending groups immediately, entering a continuous cycle of orientation classes.

Within two weeks of intake, the participant is administered an extensive intake interview by his primary counselor. The intake interview is designed to culminate in an individual treatment plan. While the individualized plan will have to conform to the general phase structure, the counselor may use individual goals to focus the participant, both in group classes and in

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<sup>2</sup> Discussions between the RSAT director and the Graterford Superintendent over space constraints led to the program being allotted an additional classroom in April 1999. Staff report that the additional space has substantially improved program environment and service delivery.

individual sessions. The intake interview includes sociodemographic items, substance abuse treatment history, and an extensive psychological assessment. Using a scale of one (minor) to three (major), staff assess the needs of new participants in the following areas: specific addiction factors, motivations and values, critical thinking and planning, anger and violence, work and discipline, social support and resources, social sensitivity. Together, these areas comprise the formal needs assessment.

Once the needs assessment is completed, the counselor and participant meet to develop a specific treatment plan. The treatment plan is the most individualized aspect of RSAT treatment, and may be revised as needed over the course of treatment. In accordance with the plan, inmates are assigned to a work committee – the therapeutic job that they fill during their stay at Graterford – and may be given individualized homework assignments. The main set of structured program activities, however, is not affected by the treatment plan; these group activities are standardized for all inmates.

Staff monitor participant progress using a review system developed by CiviGenics. Counselors rate participants once a month in several areas that are grouped under personal recovery and community participation. Personal recovery includes skills mastery, social support building, resource utilization, and regular practice. Community participation is measured according to task accomplishment, personal time management, pro-social deportment, peer support, and rule compliance.

### **Rules and Sanctions**

All participants are required to attend all sessions and complete homework assignments designed for each session. The daily schedule for inmates is intended to be strictly regimented and coordinated with prison requirements. Inmates are expected to conform to all house rules.

Program participants are subject to both DOC and CiviGenics regulations. Practically, this means that for serious infractions, such as fighting or drug possession, the DOC handles the sanction. For less serious infractions, such as leaving a group without permission or being disrespectful, the program sanctions the participant in ways that are intended to be therapeutic (e.g., by assigning a writing exercise). All acts of physical violence and possession of either weapons or drugs result in discharge from the program. When an RSAT participant is returned to the general population, DOC generally places the inmate into solitary confinement for a period of a few days to over a month and then returns him to the prison's general population to serve the rest of his original prison sentence.

For lesser infractions, staff and participants refer to CiviGenics' Guidelines for Program Sanctions to assess severity and the appropriate sanction. Program sanctions can include delaying graduation from a treatment phase, additional work duty, a ban on speaking with other program participants, lockdown for the weekend, or loss of privileges (such as commissary or telephone). Program sanctions are graduated and can eventually end in discharge from the program. Other than graduation from phases and public displays of recognition from staff and other participants, no reward structure exists in the Graterford program.

## **Implementation**

The program intake interview provides detailed and useful information on both the background and psychological profile of new participants. However, in this first year of operations, staff made limited use of these intake assessments. Given the program's emphasis on a highly structured and consistent curriculum and the tight six-month time frame of the prison phase of RSAT, all inmates attend the same set of structured group activities. In this model, counselors have limited opportunities to make use of individualized assessment and treatment planning. Participants can only benefit from these efforts if program staff is very skilled at incorporating individualized lessons within a structured group curriculum, or at least employing these lessons in individual counseling, work assignments, and the participant's elective activities.

*4. What treatment and other services are delivered in the Graterford RSAT program? How does the program's phase structure work? What is the program environment? Were there any particular successes or problems in implementing these aspects of the program?*

## **Program Structure**

As in the program at Huntingdon (and typical of most prison-based TCs), Graterford RSAT participants spend the approximate equivalent of a work day in structured treatment programming. Groups and other program activities comprise most of the hours between 8 a.m. and 4 p.m., Monday through Thursday. The rest of the time is spent in a mix of activities that include: community work duties, homework assignments, and elective 12-Step and individual counseling sessions; unstructured activities, such as playing cards and watching television; and DOC-mandated activities, such as meals, lockdown, and inmate count. Fridays are reserved primarily for elective and ancillary activities, which may include doing homework and other therapeutically-oriented tasks. Program staff are on site for administrative work and individual counseling, and are available as necessary, but there is no structured "phase" programming on Fridays other than the morning meeting (see below). Inmates follow a DOC schedule on the weekends.

The program at Graterford uses a modified version of the CiviGenics curriculum in order to adapt to the combined constraints of a six-month program limit and DOC inmate management regulations. All RSAT inmates attend the daily morning meetings which include a mix of therapeutic content (e.g., discussion of TC slogans and a "Reading of the Philosophy") and current program announcements or developments. AA/NA meetings comprise the largest single portion of programming, meeting three times weekly throughout the six-month period. All participants attend a weekly academy meeting, where they can discuss group concerns and voice complaints. Described in detail below, most of the rest of the programming is organized around phase groups that correspond with the participant's progression through the program.

Most group activity involves more than one phase group, so classes are fairly large, averaging 30 members. Morning meetings and 12-step groups involve the entire program population, approximately 60 people. Some phase groups, particularly in the later weeks of the program, are much smaller, typically around ten inmates. Classes are generally presented by staff directly from CiviGenics materials. This approach, coupled with the size of the groups, lends itself to staff lectures and the groups usually lack the spontaneity of group discussion. When observing the large groups, we rarely saw participants address each other; however classes often split into smaller work groups, where participants discuss the class material among themselves without a staff member present.

While the curriculum is geared toward group classes, participants at Graterford receive individual counseling at least once every two weeks and additionally as needed. Individual sessions last approximately 30 minutes on average, with drug treatment and participant performance accounting for most of the content. Staff specify that they avoid psychological counseling in individual sessions, in accordance with the CiviGenics model. Participants and staff report that participants can see counselors as often as they need to.

Although inmates at CiviGenics are excused from DOC labor, the program requires that everyone join one service committee established by the program. The names of these committees are Orientation, which facilitates new program intakes; Ways and Means, which monitors all supplies; Art, which decorates the cellblock; Environment, which maintains the area; and Academy, which serves as a liaison between the program director and the participants. The committees, which meet weekly, are intended to provide structure and assist the treatment process, as well as provide services for program functioning.

### **Program Phases and Content**

The program is divided into Orientation, Main, and Re-entry phases, with each phase lasting approximately two months. At intake, an inmate is expected to be skeptical about the usefulness of the program, so classes focus on defining program expectations. After sitting in on groups, the participant is expected to open up to program concepts and practice specific skills for specific situations. By the time the participant completes the second phase, the program guides him to think about how he will remain in recovery once he is released from prison. In the third phase the participant models productive behavior for newer members and continues to practice skills and develop strategies for dealing with situations that will occur upon his release. Table 2A details the content of each phase.

**Table 2A: Phase Content**

<b>Phase I Orientation</b>	<b>Phase II Main</b>	<b>Phase III Re-Entry</b>
Orientation Groups	Correctional Recovery Training (CRT)	CRT
Core Skill Groups	Conflict Resolution	Conflict Resolution
Principles of Recovery	Intro. to 12-Step Fellowship	Release Preparation
Intro. to 12-Step Fellowship	Learn to Work	Learn to Work
Conflict Resolution	AA/NA	AA/NA
AA/NA		

The first phase lasts approximately two months and provides the foundation on which the treatment is based. Participants must complete 13 Core Skills classes and 14 Principles of Recovery classes to move into the second phase. Together these classes are intended to introduce concepts and techniques for maintaining a socially acceptable and productive life. The Correctional Recovery Training Sessions are the centerpiece of phase two, and to a lesser extent, of phase three. CRTs are the foundation of CiviGenics' philosophy, and are designed to focus the participant on issues that must be addressed to overcome "criminal addictive thinking." Participants are asked to reconsider their perspectives on drug use, personal relationships, and individual responsibility. The Graterford program uses 40 CRTs that include such titles as "Say it Right," "Reaching Agreement," and "Using Help." Release preparation groups are held frequently in the final phase, to ease the transition to the community, and prepare the participant for life in the community.

Participants in the CiviGenics program – through CRT sessions in particular – are expected to develop practical skills with which to assess and respond to specific situations. Group sessions often revolve around potential situations in which a person might return to substance use, and are used to illustrate techniques to avoid drugs by choosing an alternative resolution to the situation. The group discusses the different options available in a given situation and considers the merits of various outcomes.

To better learn the material, participants are regularly given homework in phase groups and seminars. Participants are required to complete assignments and are expected to work on them during free time. Homework may be collected or checked, and is usually discussed in class. Each participant must also present at least one session in the curriculum.

### **Phase Advancement**

The CiviGenics CRA manual specifies that advancement in the program is performance-based and that participants must take and pass a written test to move to the program's second and third phases. RSAT staff reported, however, that almost no one is held back from advancing to a higher phase (or demoted to an earlier phase or within a phase). Very few inmates fail the phase tests, and those that do study further for the test, retake it quickly, and move on. In practice, all RSAT inmates participate in the same three-phase structure and take the same classes in each phase. This reflects the effort to combine flexibility (i.e., performance-based advancement and individualized planning), a highly structured, standardized curriculum, and a six-month time frame that is effectively pre-determined for all RSAT participants.

Federal mandates specify that RSAT participants attend six to twelve months of prison-based treatment, and states are encouraged to develop models like the one in Pennsylvania, where the prison phase is followed by a community-based treatment phase. To ensure that inmates attend some months in this second phase at the Community Corrections Center (particularly given delays in moving some new RSAT admissions to the prison treatment sites), the prison phase of Pennsylvania RSAT must be held to six months. Although the Graterford program stresses its adherence to the traditional TC phase structure, the combination of program requirements and CiviGenics' commitment to a highly structured curriculum means that RSAT staff can use only a diluted form of phase advancement as a motivational tool with participants.

### **The Treatment Approach: Tightly Focused or Overly Narrow?**

Drug abuse and criminal behavior dominate the sessions' content at Graterford RSAT. Staff and participant interviews confirm that little, if any, programming is devoted to health education or to such rehabilitation mainstays as educational and vocational development. While there are no classes or groups targeting illiteracy or job skills development, all activities are regarded as educational by program staff, because they involve teaching inmates judgment skills. Staff also cover these issues, as needed, in individual counseling sessions.

The formal curriculum at Graterford, as at Huntingdon, is not tailored in any specific way to parolees as a group distinct from general population inmates. CiviGenics staff point out, however, that the program focuses on criminal thinking and relapse into substance abuse – the same two issues that underlie all RSAT participants' failure on parole. Both problem behaviors, according to the agency, stem from poor socialization and decision-making skills; improving these skills is the goal of treatment at Graterford. In groups and individual counseling, staff may ask inmates to reflect on the thinking and decision-making that led to their return to prison on a parole violation.

The program does not focus on what it terms the emotional underpinnings of criminal activity, nor on participants' moral frameworks; it assumes that lasting changes in individual emotions and moral norms are beyond the scope of the program. Staff state that the CiviGenics approach does not incorporate "therapeutic counseling" – meaning psychological counseling – and that, in adhering to the model, they will not provide such counseling to inmates either in groups or in individual counseling sessions.

In our interviews with them, Graterford counselors appeared to have mixed feelings about this approach. Staff generally believed that the curriculum would be improved by the addition of a therapeutic component, particularly in individual sessions. Some staff indicated that the release preparation classes have been modified to include some therapeutic elements, and that individual counseling may also include limited therapy.

In support of the program's cognitive-behavioral focus, the counselors repeatedly said that participants benefit from sessions even before they "buy in" to the program philosophy. Staff maintain that by the time inmates complete the program, most understand that the skills they have learned in group sessions will help them stay sober, and that sobriety contributes to a better life. Our interview data indicated that program participants were not aware they were not receiving psychological counseling, and most reported receiving at least a moderate amount of assistance with educational and vocational issues in individual counseling sessions. The data suggest that participants did not view the CiviGenics model as distinctly different from traditional drug treatment.

### **Establishing a Therapeutic Environment**

A few issues emerged during this early implementation phase at Graterford that reflect the difficulties inherent in implementing specialized rehabilitation programs within a large, general population (GP) correctional setting where security concerns must be paramount. This theme has been struck in some previous commentaries on prison-based substance abuse treatment (e.g., Chaiken, 1989; Lipton, 1995), and, based on our observations at both RSAT programs, remains one that requires joint attention and preparation by program staff working closely with corrections administrators.

Attributing significance to tensions between security and therapeutic concerns is an uncertain process – inmates' commentaries on these issues may be legitimate or may reflect what is widely considered to be "standard inmate griping." In several of our interviews, for example, RSAT participants told us they could not exhibit behaviors that were encouraged in treatment sessions (self-disclosure, empathy, support) when they were with the general prison population for fear of being mocked or attacked. Some men in RSAT reported that DOC officers resented them as sheltered and more privileged than GP inmates and sometimes singled them out to "put them back in their place." However, there have been no recorded incidences between the RSAT and GP inmates. Similarly, while participants gave generally low ratings to the helpfulness of corrections staff at Graterford, corrections officers on the cellblock told us they make no distinction between their roles on the RSAT cellblock and in the rest of the facility. Further, corrections officers did not express particularly negative opinions about RSAT participants.

Inmate complaints about these issues gained legitimacy, however, from our process observations and interviews with RSAT staff at Graterford, who seemed to feel a sense of impotence in dealing with DOC regulations. In interviews, CiviGenics program staff emphasized a policy of strict observance of DOC strictures and guidance. They interpreted DOC regulations

against fraternizing as severely limiting expressions of support or empathy for an inmate. At least during the program's first year, they were reluctant to push for solutions to deal with protocols that made it difficult to bring in outside materials, and thus the program was bereft of such things as a blackboard, flip charts, a VCR, or television.

The program staff's reluctance to deal with DOC rulings regarding RSAT participants' movement appears to have had the greatest impacts on program morale and engagement. Both participants and staff complained in interviews that all RSAT programming had occasionally halted because of full day "lockdowns" ordered by DOC staff. Additionally, for the last several months of our data collection period, corrections officers made inmate cells off-limits during group sessions and other programming to discourage theft. Participants resented this rule, which they regarded as much more limiting than movement rules imposed on the general population. CiviGenics staff did not respond to these DOC actions, at least partially to avoid appearing to be allied with inmates against the DOC.

An occurrence observed at a site visit in December 1998 illustrates this issue. A DOC lieutenant came onto the cell block and interrupted programming to address all RSAT participants and staff about repeated requests for access to cells (apparently to get a homework assignment). The lieutenant proclaimed to the entire block that he would lock them all down if they continued to request exceptions to the rules. The participants were uniformly furious and, in later conversations, cited this as an example of DOC staff's resentment toward program participants. While participant anger was clearly evident to the researcher, program staff did nothing to address the incident during or after it took place. A group began shortly after the lieutenant left and group members sat in near silence while a counselor lectured on "Sources of Strength." After the group, participants told us they sometimes "just shut down" and don't bother to engage in groups in response to these kinds of events. Staff reported later that the issue of inmate access to cells had been ongoing, and that "participants like to complain about it." Again, staff emphasized that they would not contradict DOC protocol and intervene in this kind of situation.

These kinds of tensions can potentially snowball and impede the development of a therapeutic atmosphere, and positive, therapeutic relationships with program staff. Participants may see little distinction between program staff and corrections staff if they feel that program staff are unwilling to address or even acknowledge any grievance arising from corrections rulings or enforcement. If participants make this connection they are less likely to invest themselves in the treatment process. Instead, they may "shut down" or start "jailing" – just going through the motions of treatment without internalizing the concepts of recovery. In the close quarters of a prison cellblock, this disengagement can be contagious, affecting the behavior and morale of peers; participants can lose respect for staff, lose faith in the curriculum, and refuse to contribute to building a therapeutic environment.

This worst-case scenario never developed at Graterford, as stronger and more consistent leadership emerged to foster relations among agencies at the program site. During the first year of operations, turnover in the project director position and other staff lines, and staff's lack of

experience in providing treatment within the prison setting likely contributed to their sense that, if they addressed participant concerns, they might be acting unprofessionally or in violation of DOC standards. In interviews, program staff also indicated that their limited interactions with DOC staff reflected their parent organization's policy that CiviGenics central office staff manage all relations with the DOC.

CiviGenics' decision, in early 1999, to increase regional and central office involvement in the program has helped to enhance its relationships and stature within Graterford, and to improve the treatment environment, adding needed resources and space, as well as heightening communication between the treatment provider and corrections staff.

***5. How is the program staffed? Were there any particular successes or problems in establishing and maintaining program management and staffing?***

**Staff**

The Graterford program is staffed with a project director, two counselors and an additional counselor who works half-time, all of whom are CiviGenics employees. The project director oversees all service delivery, provides limited counseling, interacts with the central office, and represents the organization at RSAT meetings.

The two counselors lead all groups, provide assessments, case management, and counseling, and work with DOC staff as needed. Each counselor is assigned a caseload and is responsible for updating the program director on participant status. The half-time counselor completes all DOC classification paperwork, both upon intake into the program and in preparation for release to the community. The half-time counselor also leads some phase three groups; however, this is a temporary arrangement and will not continue after the spring of 1999. Staff hours are staggered so that at least one person is on site from 7:00 a.m. until 7:30 p.m. Based on our observations during the first year, it was not uncommon for a single counselor to be the only staff present on the cellblock.

CiviGenics' director of treatment monitors program management from the organization's headquarters through monthly reports and telephone contact. A regional supervisor is also in regular contact with on-site staff, and makes occasional visits to the program. In recent months CiviGenics has increased the involvement of the regional supervisor, who will now handle all DOC-related concerns, such as policy and protocol issues. Additionally, in January 1999, CiviGenics assigned an assistant director of programming, also working out of the Massachusetts office, to supervise all treatment delivery through regular contact with the Graterford project director.

A corrections officer has a desk on the block, in addition to the officer who controls the doors from another office at the cellblock entrance. A senior parole officer is also on site at least once a week. This individual passes on release papers to the CCC upon an inmate's departure from Graterford, and is available to respond to inmate questions about reporting requirements and other issues regarding parole supervision. The parole officer provides the inmate with the

only overt connection between the RSAT program and his status as a parolee. In the future, this function may be developed by increasing the role the senior parole officer has in preparing participants for the CCCs and for returning to parole.

According to program literature, staff receive 20 hours of initial training and an additional 40 hours of agency training annually. However, none of the staff at SCI-Graterford reported receiving any CiviGenics training. The program director told us that funding for training is available, but any training is at the initiative of the individual staff member, who would have to arrange for and request the time required. On-site training takes the form of teaching the curriculum to a group of new inmates and receiving feedback from administrators and fellow staff. Prior to coming to Graterford, none of the staff (working as of March 1999) had experience providing treatment in a correctional setting. Most of them, however, have extensive experience providing substance abuse treatment and three of the four staff members worked together for several years in a community treatment setting.

### **Staff Turnover**

The staff has undergone significant changes since the program opened in February 1998 with a director and two counselors. The first project director left the program less than two months after the opening. He was replaced by one of the counselors, leaving the program with a shortage of one counselor. This shortage was not filled until June 1998, just after the program capacity increased from 50 to 60 beds. Even after that position was filled, staff continued to request assistance, and a third counselor was hired part-time in July. In September she began to work full-time, when the program director elected to decrease his responsibilities and to work half-time. He anticipates leaving the program in the spring of 1999. A counselor who had been with the program from the start assumed the position of project director in September.

Impacts of staff turnover are that program staff felt somewhat overwhelmed by shifting responsibilities, and that DOC officials said they were not always clear about who at the program site was responsible for program leadership. Because only the first program director, and not the remaining program staff, was involved in the RSAT planning stages, the staff never established close, working relationships with DOC administrators. The program staff, including the two later directors, were not always aware of DOC concerns, such as participants' poor attitudes in the CCCs. The distant relationship between CiviGenics agency headquarters and the Graterford program resulted in a dearth of communication between the central agency and the DOC. The absence of a relationship between staff and DOC administrators led to program staff feeling cut off from state administrators. We observed, for example, that program staff were not promptly notified about upcoming meetings, and appeared reluctant to initiate meetings to address implementation problems as they arose. DOC administrators were not always aware of program concerns and frustrations. Again, these concerns were addressed by management changes made at the site in the early months of 1999.

**6. Where do RSAT participants go after completing the in-prison treatment phase at Graterford? Were there any particular successes or problems in implementing the program's aftercare components?**

**Two Phases of Aftercare**

CiviGenics oversees the first six-month aftercare phase that is completed in a supervised community residence at a Community Corrections Center. While participants are in Graterford, the program attempts to prepare them for this stage and the one that follows – independent living in the community upon release from the CCC. Linkage to formal aftercare in this final, community phase is not provided under the federal RSAT umbrella, however the state is using other fund pools to contract with community-based providers to ensure treatment for RSAT graduates of the CCC. This Continuing Care program is slated to begin in autumn, 1999.

Upon completion of the prison phase of RSAT, graduates are transferred to the CCC closest to their residence.<sup>3</sup> While at the CCC, participants are required to attend treatment in an outpatient program twice a week, as well as the in-house group and individual counseling provided by the CCC. Residents must eventually obtain employment and secure stable housing. CCC residents abide by a curfew that is modified according to their program compliance. Participants live and eat together, but are expected to spend increasingly more time independently. The CCC monitors outside activity, by approving and verifying residents' appointments. Most participants of the Graterford program are from Philadelphia, and are sent to the Beacon Center in central Philadelphia. Operated by a private agency under contract with the DOC, Beacon Center has a total capacity of 107 beds. RSAT graduates are housed on one floor of a six-story facility. The center is in an economically depressed area where some parole staff claim drug use and sales are common. Both parole staff and participants reported to us that the CCC is located across the street from a crack den.

**Aftercare Implementation**

CiviGenics is required, under its agreement with the DOC, to provide, or contract for, the outpatient treatment that RSAT graduates receive at the CCC. Shortly before the first graduates were released to the Beacon Center, the private provider that had been contracted for these

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<sup>3</sup> An unexpected responsibility came when CiviGenics staff were told they would be responsible for reclassifying inmates on security status. The DOC requires that all inmates are reclassified for any move. Participants of the RSAT program are reclassified for release from the prison into the Community Corrections Centers upon graduation. CiviGenics staff were not familiar with DOC records or standards for classification, and therefore had to learn that system while they maintained program activity. This additional task proved burdensome for the staff, who struggled to complete all the required file review without additional support. A significant amount of time was required to learn the reclassification process, to go through DOC files, and to complete the reclassification. Program staff reported falling behind in both program case files and in conducting intake interviews for the evaluation. Once the new director decided to assign the one part-time staff person to processing reclassification, staff were better able to devote themselves to programming.

services pulled out of its agreement with CiviGenics, which then had to scramble to find another provider, Riverside Care. Although the DOC contract specifies that participants must receive at least two days of outpatient programming a week, Riverside initially provided just one group counseling session weekly. This discrepancy was first noted at a meeting in September 1998 that was convened to address CCC failure rates. The shortfall in service most likely reflects a lack of communication; prior to this meeting, CiviGenics staff working at Graterford had no contact or involvement with Riverside Care or with CCC representatives, and the central CiviGenics office had only minimal contact – not enough to recognize that Riverside was not providing enough outpatient treatment. The lack of contact between the two providers may also have hampered CiviGenics ability to track graduates in the CCC phase, a problem that became clear when researchers asked for tracking data from the in-prison treatment staff.

Since this issue surfaced, however, the directors of the RSAT program and CCC staff have worked to expand and solidify their relationship and regular communication, partly to facilitate participant tracking. The program director receives updates on RSAT graduates from CCC staff. She also responds to all inmate-initiated contact, both from the CCCs and from former participants who were returned to the general population at Graterford. Concern for the participants failing in the CCC phase has also sparked some additions to the final, phase three programming at Graterford. Topics such as finding a job and filling up free time are routinely introduced as part of the CiviGenics curriculum in this phase, so that participants can anticipate obstacles they will face upon release. Once attention was focused on the performance of RSAT graduates in the CCC, DOC managers there convened meetings where RSAT program staff could work with parole staff, CCC staff, and the DOC to better anticipate and respond to the needs of program participants. At the same time, CCC staff adjusted their expectations of RSAT participants in an effort to relieve some of the pressure on them to find jobs in the early days of their recovery from drug addiction.

*7. Did the program reach and maintain full capacity? What are the early program outcomes regarding participant retention and completion rates? What do findings on those who fail say about the program?*

#### **Program Census**

Each RSAT program was originally intended to serve 50 inmates. In May 1998, that number was increased to 60 for both facilities and the Graterford program remained at or near capacity through the reporting period. On January 1, 1999, the program census was 60.

**TABLE 2B: Graterford Program Performance**  
(through December 31, 1998)

<b>Admitted to RSAT</b>	119
<b>Currently in Treatment</b>	60
<b>Terminated during Prison Phase</b>	7
Medical or Psychiatric Reasons	4
Program Infractions	3
<b>Graduated from Prison Phase/ Admitted to CCC</b>	52
Currently in CCCs	28
<b>Terminated during CCC Phase</b>	20
Curfew Violation	3
Positive Drug Test	6
Other Program Infractions	3
Absconded/Escaped	8
<b>Graduated from CCC Phase</b>	4

**Program Completion**

As of December 31, 1998, 119 technical parole violators had entered the program. Table 2A details the numbers of inmates who were terminated from Graterford RSAT, who graduated from the residential component and entered the Community Corrections Centers, and who were terminated from the CCCs. Only seven participants (6%) were terminated from the program during the in-prison phase. Four of these had physical or mental health needs which could not be addressed by program staff, and therefore reflect problems in screening rather than program failure.

Of the 52 men who had completed the prison phase and entered the CCC, four had graduated and returned to the community. Twenty participants – 38% of those entering the CCC – failed in this phase of the program.

Three men were returned for violating curfew stipulations, six for positive drug tests, and three for other program infractions, such as threatening a counselor or another resident. Additionally, eight of the RSAT participants escaped, that is, left the CCC and failed to return. We assume that at least half of the 20 failures are related to drug use, given the likelihood that several of those participants who failed to be on site by curfew and who absconded from the program did so knowing they would test positive for drug use.

Unfortunately, there are no data available on CCC failure rates for other populations in this eastern region (or elsewhere, for that matter) to provide a context for interpreting this 38% figure. While program staff and some state officials said they were neither surprised nor alarmed by this rate, other officials saw it as an early indication of program failure. Staff working in the CCC opined that, compared to general population inmates, RSAT graduates were arrogant and disregarded CCC rules, and several PBPP officials voiced related concerns about the appropriateness of RSAT for inmates with a history of failure. Most everyone, however, recognized that it is early in the game, and that the various strategies outlined above (e.g., new program management, improvements in aftercare linkages) deserve to be tried and monitored for their effectiveness.

Finally, it is important to note that these interim retention rates are inflated because they include participants who are still in the program – these men are counted as retained in these figures, even though they could still terminate from the CCC phase before completion. We are currently seeking data on the length of time the current sample have actually spent in the CCCs to adjust for this “time at risk” factor in the retention results. As the sample increases and a higher portion of participants either graduate or are terminated, the retention rate will decrease to reflect the program’s true rate.

## Chapter Three

### RSAT at SCI-Huntingdon: The Gateway Program

#### *1. What is the underlying treatment philosophy of the Huntingdon RSAT? What therapeutic methods are used and how is the program structured?*

##### **Program Philosophy**

The RSAT program at SCI-Huntingdon is operated by the Gateway Rehabilitation Center, a for-profit drug treatment provider operating various treatment facilities throughout western Pennsylvania. The program is run in accordance with treatment guidelines established by Gateway for all their residential programs. Gateway's RSAT program is modeled on a modified therapeutic community structure with an emphasis on 12-Step principles, as well as cognitive behavioral learning; as such, it is a more traditional drug treatment program than CiviGenics. Twelve-Step principles include recognizing one's addiction, understanding how lifestyle maintains the addiction, changing lifestyle to support sobriety, and learning by sharing experiences with other substance users. The program is based on learning in "community" groups and meetings, in addition to skills-based relapse prevention and independent living classes that target criminal thinking and substance use. Program administrators and materials emphasize the process of treatment and the "total immersion experience" that can lead participants to accept and benefit from treatment.

Program materials connect the concept of a treatment community with the development of productive social values. The Gateway model attributes substance abuse and criminal activity to poor skills and values, which grow out of deficient interpersonal relationships. Drug treatment shows participants the connection between drug use and legal and social problems by focusing on the importance of community response. According to the Gateway philosophy, when a participant considers the consequences of getting high or committing a crime against others, he will desist from illegal and otherwise harmful activity. The treatment program forces participants to be active members in the community of other inmates, and forces them to answer their peers' questions and criticism. Gateway acknowledges that this treatment community is artificial, but believes it is still powerful enough to encourage the development of habits that will continue when the inmate is released.

The program specifies four basic goals for participants:

- to accept their chemical dependency and begin to actively participate in a recovery program;
- to acquire the necessary skills to maintain long-term sobriety and live a life free of chemicals;
- to identify key life changes necessary for sobriety;

- to develop an aftercare plan and identify sources of ongoing support for relapse prevention and recovery.

### **Method and Structure**

Members of the community are expected to take part in group discussions, learn to express themselves honestly, and respond to the statements and concerns of fellow residents. The program rewards positive behavior and discourages negative behavior using the same group dynamic. Since groups are intended to provide the medium for interplay among participants, staff elicit participant response on scheduled themes, and stimulate near-constant discussion.

The extensive use of the group dynamic fosters challenges from the group, which are the mechanism for introspective criticism and eventual change. The sense of group norms is maintained through routines in interaction and schedules. Incorporating a standard 12-Step practice, participants learn early on that when they speak in a group they should identify themselves by name and as an addict, and that the group should respond immediately. For example when called on to express an opinion in the middle of a group, a participant will say, "My name is Walter." The group then responds in unison, "Hello Walter", and Walter will continue, "I'm an addict and I think..." Counselors call on participants to give their opinions in groups, but participants also offer comments on their own.

The treatment model uses three phases, the last of which focuses on release into the community or, in the case of RSAT participants, the Community Corrections Center. Program content makes extensive use of written exercises, films, and activities, all of which revolve around how the individual sees himself and how others see him. Homework is structured to elicit individual responses, in the form of short answers to focused questions, which are later discussed in groups. Participants are encouraged and expected to extend the self- and peer-monitoring they utilize in group work throughout their days in the RSAT community. Staff monitor participants through individual counseling that, according to participants, is typically scheduled at their initiation.

### **2. *What is the program setting? How does the setting affect treatment delivery?***

#### **The RSAT Unit**

The RSAT program at SCI-Huntingdon is located in a fenced-in modular unit outside the prison wall. The unit has the lowest security rating at SCI-Huntingdon and is connected with similar units housing other minimum security inmates. The facility has its own kitchen and recreational facilities, but inmates enter the main prison for medical and commissary needs. RSAT participants interact with other inmates in the unit during meals, work, recreation, and other non-program time.

The RSAT block is separated from the other blocks by a door and a short corridor. The unit itself is composed of two long corridors with open inmate cubicles on either side, and open areas at the front end of each corridor. The program director has a small office along one of the

corridors, near the group area. A staff office for all the counselors is at one end of the unit, as is a small conference room. The DOC security station occupies a third of the other end of the facility; the rest of the space at that end is divided into the two open areas where all groups take place, one on either side of the security area. A divider is used to separate the space during treatment group activity. The cubicles generally house four men, although some house two and others house six or eight (in a double-bunked four-man space). The cubicles are separated from each other by walls approximately three feet high. There are no doors or full walls on the cubicles except those separating cubicles from staff offices.

The corrections office is at one end of the unit, with full view of program activity. The office is locked, but not soundproof. Usually, only one officer is on site. Corrections officers are assigned to the modular units for two-year shifts, so most are there regularly, and are familiar with the RSAT program. Replacement officers are assigned on holidays, weekends and when the assigned CO is out.

### **Program Environment**

The Huntingdon program is notably more relaxed than the program at Graterford. It benefits from being outside the prison walls, in a low-security unit where inmates are usually free to walk around. Access to cells is not an issue, as there are neither cell doors nor full walls, and this allows inmates to socialize more readily. However, both program staff and the DOC unit manager expressed concern about the security risks of the double-bunking.

Another concern raised by Huntingdon participants is that all group activity is both heard and observed by the corrections officers in the security station. Inmates say they are reluctant to express their real thoughts and emotions, particularly those relating to corrections, parole, and their drug use, because they fear repercussions from corrections staff. Some participants expressed skepticism that there was any distinction to be made between corrections and treatment program staff. On the other hand, our exit interview data suggested participants were engaged in group activities and nearly all of them judged the groups to be "somewhat" or "very" helpful. The suspicion expressed by inmates in informal conversations and the more favorable attitudes reported in responses to direct questions in structured interviews likely reflect participants' conflicted views about the program and its long-term benefits.

***3. How are new RSAT participants processed upon entry? What are the program's rules and how are they enforced? Were there any particular successes or problems in implementing this aspect of the program?***

### **Participant Intake and Monitoring**

The participant intake process generally takes longer for the Huntingdon RSAT program than for the Graterford program. TPVs designated for the program are initially held in western Pennsylvania, and are transferred to SCI-Huntingdon. Inmate transfer between correctional institutions involves additional paperwork and administrators and, therefore, takes longer. TPVs

who have been identified and approved for entry into RSAT are held for several weeks at the local correctional facility before being transferred to the state facility at Huntingdon. Officials expect this period to become shorter as RSAT implementation is more routinized.

The Gateway program director maintains regular contact with the Pennsylvania Board of Probation and Parole, so that the Gateway staff know when a TPV has been designated for program entry. However, once TPVs arrive at Huntingdon, they join the general population within the prison walls until they receive classification approval to enter the low-security modules where the RSAT program is located. The classification process results in additional delays of, on average, about 20 days. In some cases, inmates have been held for two months or longer before being approved to enter the modules for the RSAT treatment program.

Program staff can and do use the time during which the inmate is being classified in the central prison facility to conduct RSAT intake and assessment interviews. In addition to the Addiction Severity Index used in this research, Huntingdon participants are administered a Gateway intake battery which includes: a sociodemographic baseline; substance use and treatment history; physical and mental health; family history and relations; and an assessment measure that includes items on drug use, treatment experience, abuse, and social and criminal history.

In addition to the extensive intake assessment, staff complete a "needs assessment," which is a battery composed primarily of psychological measures. It is completed during the first two weeks of program participation, based on observations and interviews with the new participant. The assessment uses several instruments, including a 42-item substance use self-control inventory, the Burns Anxiety Index, the Burns Depression Checklist, and a clinical needs checklist, which notes individual history as well as psychological, and emotional needs.

The inmate is assigned a primary counselor upon intake into the program. By the time the inmate arrives in the program, the intake is generally completed and the participant begins attending groups. As at Graterford, the counselor uses the needs assessment to focus participant attention on a treatment plan that identifies specific goals, such as managing anger or building family relations. However, the treatment plan is based on a general model developed by Gateway, and, again as in the CiviGenics program, the content and structure of group programming remains the same for all inmates.

New participants are introduced to other members and to program regulations by the Orientation Committee, made up of senior participants. Committee members explain program regulations and expectations, and provide some support to new residents as they adjust to the move from prison into the therapeutic community. The Orientation Committee also assigns a "big brother" to provide additional assistance and support on an individual level, a role which participants explicitly said they value.

Client status and progress is measured regularly throughout the six months. Staff complete a "mental status exam" within the participant's first two weeks, using a three-point scale to assess appearance, behavior, perception, affect, thinking, treatment readiness, and relapse potential. Treatment plans are reviewed in individual counseling sessions and counselors record all client

infractions, as well as progress, in case file notes. Staff complete weekly checklists on adherence to program rules for each participant. Additionally, every two weeks counselors measure the level of resident participation and self-disclosure using five-point scales developed by Gateway.

### **Requirements and Sanctions**

All participants are required to attend all sessions and complete homework assignments designed for each session. Assignments include regular journal writing, additional written assignments and therapeutic jobs. The daily schedule for inmates follows a preset schedule that is coordinated with institutional requirements. Inmates must conform to all "house rules," such as respectful interaction with staff and peers, in addition to DOC regulations.

As at Graterford, there are very few tangible incentives available to participants for progressing in the program. Participants who have seniority, have complied with program and DOC regulations, and made significant progress in treatment may be moved from a four- or six-man sleeping cubicle into one for only two men. This possibility, however, is limited because there are only ten two-man cubicles.

Program participants are subject to both DOC and Gateway regulations, and sanctions are imposed on all program infractions. Program staff have worked with prison administrators to articulate and maintain standard procedures for addressing inmate misconduct. As at SCI-Graterford, the DOC handles serious infractions, such as violence or possession of an illegal substance, while Gateway addresses less serious infractions, such as leaving a group without permission or being disrespectful.

All acts of physical violence and possession of either weapons or drugs result in discharge from the program. Lesser offenses may result in additional time in a phase, extra work duty, a ban on speaking with other program participants, loss of privileges (such as commissary or telephone), and eventually discharge from the program. Program counselors are responsible for imposing program sanctions; however, they consult with the director before making any decisions about sanctions. When an RSAT participant is returned to the general population, DOC generally places the inmate into solitary confinement for a period that can range from a few days to a month or more. The inmate is then returned to the general population of the prison to serve the rest of his original prison sentence.

### **Implementation**

Gateway, like CiviGenics, has an extensive intake, but one that is not used to maximum value. Counselors use the intake to identify individualized treatment plans, which can be incorporated into group sessions (if the counselor is very skillful) or, more likely, in individual counseling. As noted below, however, many Huntingdon participants reported that they attended only a few individual counseling sessions. These sessions and other elective programming offers the best opportunity to utilize information gathered from the intake assessment and to tailor program lessons to the individual. Ideally, this information would also be used to formulate and modify the individual treatment plan, including the content and structure of group activities.

**4. What treatment and other services are delivered in the Huntingdon RSAT program? How does the program's phase structure work? What is the program environment? Were there any particular successes or problems in implementing these aspects of the program?**

**Program Structure**

Inmates are involved in programming Monday through Thursday between 8:00 am and 4:00 pm. Table 3A compares daily programming in the Graterford program with that in the Huntingdon program. The daily schedule remains fairly constant throughout the program. In general, Gateway provides more homogenous programming from one day to the next, with only a few variations throughout the week; by comparison, the CiviGenics schedule varies by day of the week.

**Table 3A: Typical Daily Schedule for RSAT Participants**

<b>Approximate Time</b>	<b>Graterford</b>	<b>Huntingdon</b>
8:00 – 8:15	Morning Meeting	Morning Meeting
8:30 – 10:00	Phase Meeting, 12-Step or Community Meeting	Phase Group (all participants)
10:00 – 10:30	Count (DOC)	Count (DOC)
10:00 – 11:30	Phase Group (phases 2 &3)	Lunch
11:30 – 1:00	Lunch	Committee Groups or Community Meeting
1:30 – 2:30	Individual Phase Groups	12-Step Group
2:30-4:00	Individual counseling, work, inmate services (DOC) or conflict resolution	Individual counseling or Family Issues Group
4:00 – 5:00	Dinner	Dinner
5:30 – 7:00	AA/NA or DOC time	12-Step Task

Programming takes place Monday through Thursday; on Fridays staff are on site primarily for administrative work, but are available for individual counseling if necessary. After breakfast from 7:00 to 8:00 a.m., program participants attend daily morning meetings, where the entire group discusses a “thought for the day,” which is read by a participant from one of several books of sayings. After the morning meeting, the group breaks into two phase groups. With only two

full-time counselors who lead groups, these phase groups divide loosely into participants who have been in the program longer than three months and those who have not. The groups are led by a counselor who discusses the homework or the in-class exercise using short questions to elicit responses and discussion from the group. Counselors challenge participants to consider the veracity of their responses and continually ask the group for opinions about the answers given. After lunch participants again break into groups, generally according to primary counselor. These afternoon groups focus on specific phase issues and are generally didactic in nature. Early in treatment, groups focus on facts about substance use and addiction. As treatment progresses, the focus shifts to relapse prevention skill development. Towards the end of the six-month treatment period the groups also complete the Adkins life skills curriculum. The rest of the afternoon is spent either in free time, completing homework, or in individual counseling sessions or special groups, such as family issues. Participants have a two-hour 12-Step group every night after dinner.

Structured programming is not available at either program on Friday, leaving participants to work on homework or free after the morning meeting. Gateway maintains some therapeutic content on Fridays through therapeutically oriented recreation, such as word games using treatment concepts. Gateway, like CiviGenics, does not schedule program activity on weekends or holidays. While both programs say that participants are expected to engage in treatment-oriented activity during these days, participants gave little indication that this is actually the case.

Program materials vary in the description of individual counseling. Some documents indicate that participants receive individual counseling weekly, while intake forms indicate bi-weekly individual sessions. Program staff and participants indicate that individual counseling varies tremendously. Participants who request individual sessions report receiving up to 25 individual counseling sessions, while over 50% of program graduates report they had an individual counseling session three or fewer times during the duration of the program. On average, participants reported seeing a counselor individually nine times in the six-month treatment period, for approximately 40 minutes each session. In exit interviews, almost all participants reported that they could see their counselors when they wanted to, but many added that counselors would not require individual sessions if the resident did not request them. While counseling staff cite this as a strategy they use to force participants to identify and address their own needs, it means that most Huntingdon inmates receive just a few hours of individual counseling during their six-month stay in the program.

New participants are required to work for the Department of Corrections for three hours daily. All inmates work in the modules where the program is housed, either in the kitchen or laundry. Since inmates work in these jobs until they are replaced by new intakes, they do not all work the same amount of time. Once replaced, participants do not continue to perform DOC labor. Inmates are also required to join at least one program committee. The committees include: Orientation, which works with new program entrants and updates all participants on any policy changes; Participation Monitoring, which maintains attendance and homework records; Activities, which coordinates Friday movies and recreation; Job Assignment, which assigns and monitors participants' chores on the unit; Interpersonal Skills, which mediates in all disputes

between participants; Newspaper, which produces a monthly newsletter for the program; Phase, which monitors phase activity checklists and phase advancement; and finally, Maintenance, which is responsible for the physical condition of the program.

**Program Phases and Content**

Gateway’s phases follow the traditional therapeutic community model: (1) assessment and orientation; (2) intensive treatment; and (3) leadership and transition. Table 3B highlights the goals and content of each phase. Appendix A contains a complete list of classes by phase.

Gateway’s three-phase structure is intended to parallel treatment progress, rather than provide specific activities depending on participant time in program. The first assessment and orientation phase lasts approximately one month, and encompasses the full assessment process. During the first month, the participant is oriented to program components and expectations, in addition to attending group activities. The second phase focuses on intensive treatment. The participant is expected to be an integral part of the therapeutic community, to participate in all groups, receive feedback from other members, and complete all assignments. This phase lasts approximately three months. Entry into the final phase marks the onset of reentry into the outside community. Participants are expected to practice leadership skills by acting as role models for the newer inmates, and gain additional responsibilities in program function.

**Table 3B: Content of Program Phases**

	<b>Phase I</b>	<b>Phase II</b>	<b>Phase III</b>
<b>Target Problem</b>	Lack of realistic self-assessment	Lack of skills to avoid substance use	Possible return to drug use outside program
<b>Phase Goal</b>	Develop identity as an addict	Increase skills to avoid substance use	Refine and maintain skills to live independently
<b>Phase Content</b>	Drug and addiction education; introduction to treatment concepts	Role play and discussion about triggers and relapse to substance use; develop alternatives to substance use	Continue phase II; learn to anticipate and prepare for problems which may arise in future; stress management and living skills

Staff lead participants in exercises designed to anticipate the issues they will face upon release. Phase three lasts approximately two months.

During the first year of operations, this phase structure was implemented in limited ways at Huntingdon RSAT due to the program’s limited capacity and the irregular flow of new

admissions. The program divides participants into two groups – those who have three months or less in the program and those with four or more months since admission. Phase two residents are roughly distributed between the two groups. The same topic may be covered in either session; however the counselor leading the “older” group expects more from the participants and structures the session accordingly. Unlike at Graterford, Huntingdon participants may attend different group sessions based on interest and need, in addition to core set of sessions (for example, signs of addiction) required of all inmates.

Gateway relies on two primary counselors to run most group activity.<sup>1</sup> While the group division means that most groups are large (approximately 30 participants), they remain discussion-oriented, with very little lecturing from staff. Counselors have a thorough command of the program materials, rarely hesitate in their presentation, and only refer to written materials when reading from homework exercises. Group discussion is lively and nearly all participants contribute, either on their own initiative or when called on by the counselor. While participants generally refer to the counselor, some discussion also takes place between participants. Each participant is periodically required to give presentations to the group, which generates greater interplay of opinions among participants.

The Gateway curriculum varies between treatment programs, and the organization does not maintain a standard format that must be used. Counselors in the RSAT program are encouraged to work with the Gateway treatment director to introduce new materials, exercises, and lectures, which may vary in format and in specific content but maintain the same basic approach of self-examination motivated by a group dynamic. Staff, particularly the program director, cite the fluidity of the curriculum, emphasizing that the process of therapeutic groups is more important than the content of any individual session. The program requires that all participants complete specific lectures and tasks, and watch treatment-oriented films for each phase.

### **Establishing a Therapeutic Environment**

The Huntingdon program appears to have experienced a smoother integration with DOC staff than the program in SCI-Graterford. The Huntingdon program benefits both from being in a less stressful environment outside the prison walls, and from the project director’s prior years of experience with Pennsylvania DOC. The trailer units where the program is housed are lower security and consequently less regimented than a cellblock within prison walls. The atmosphere, while still highly controlled, is more relaxed than at Graterford – an observation which was confirmed by participants, program staff, and corrections personnel. Because the project director was familiar with DOC procedures, such as classifying inmates for release to the community, the program was not significantly disrupted by DOC obligations to maintain safety.

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<sup>1</sup> One of the senior counselors left the program in early January 1999, as this report was being prepared. The program director shifted caseloads to accommodate the new staff configuration. There is one senior counselor, who has a full caseload, conducts groups, and supervises the other counselors. The program director has a small caseload, as does the counselor technician, who is primarily responsible for intake and DOC and research-related paperwork. A third counselor, who began full time work with this new configuration, has a full caseload and conducts groups.

Still, Huntingdon RSAT has experienced a few problems similar to those detailed earlier in the Graterford chapter. Program participants at Huntingdon, as in Graterford, express frustration at the correctional setting and say that corrections officers feel that the participants are "getting over" on the program staff. One correction officer did express his opinion that the inmates are "no good" and "fool" the staff; however, the other (three) correctional officers gave no indication that they regarded the RSAT population any differently from the general prison population. This issue has, to a limited extent, hampered relations between the program staff and the DOC facility staff, who complained that the program encourages inmates to harbor animosity toward corrections.

Program staff also report some concern over their relationship with corrections officers and some administrators. One incident which occurred during the summer of 1998 appears to have had a lingering impact on program-corrections relations. At one point in July, the RSAT program director asked participants not to go to corrections staff with complaints, adding that corrections officers do not care about treatment. He was reprimanded for this comment by the DOC unit manager, and apologized and retracted it the following day. However, the comment was revisited during a December meeting between treatment staff and the Huntingdon unit management team. DOC staff cited the comment as a clear example of ways in which program staff do not do enough to curb inmate resentment, indicating that the tension between the program and local DOC unit staff remained at some level.

Staff from both Gateway and the DOC have discussed this issue and are working to improve cooperation. As of spring 1999, there were no indications that program morale or participant engagement had been affected in any significant ways by staff disagreements or inmate concerns about DOC staff. As noted in our introductory chapter, however, we believe these implementation issues remain worthy of discussion, since they are so pervasive in these settings, and can substantially hamper program effectiveness if not monitored and resolved.

*5. How is the program staffed? Were there any particular successes or problems in establishing and maintaining program management and staffing?*

**Staff**

The Gateway RSAT program staff includes a project director, three full-time counselors, one of whom is the senior counselor for the program, a part-time program assistant, and an intern. New staff members are trained 40 hours and receive 40 additional hours of training annually. Staff are on site from 7:00 a.m. until 5:30 p.m. daily. The counselors are responsible for the majority of direct service, including the intake interview, client assessment, individual counseling, and most of the therapeutic groups. The intern works primarily on inmate security classification for DOC purposes and conducts the baseline interviews for this evaluation. The program director divides his time between on-site work (including staff supervision, a small caseload, and DOC interaction) and off-site work supervising the CCC outpatient treatment or working with Gateway management. Additionally, the director of treatment for Gateway regularly visits SCI-

Huntingdon, meets with the program staff, monitors program delivery, and reviews monthly reports.

### **Gateway Relationship with Corrections Staff**

The program director worked with the Pennsylvania Department of Corrections for 12 years prior to assuming his current position and this experience has significantly facilitated program implementation. Staff work with the PBPP Director of Case Analysis to track PBPP referrals into the program. As in the Graterford program, a senior parole officer is on site at least once a week to facilitate the eventual transfer to parole. The program director maintains regular contact with officials at the institution, so that his staff have access to new transfers from the western part of the state, and can interview them while they await transfer from the central prison to the modular unit.

While not all staff have experience working in corrections-based treatment, the senior counselor and the program director came to these positions with an understanding of DOC regulations which allowed them to absorb DOC requirements without interrupting program function. Tasks such as classifying inmates for transfer to the CCCs were already understood, so the difficulties of learning that system (who to contact, where to look for records, how to read inmate files, and how to process paperwork) were not as burdensome as they were for the RSAT staff at Graterford.

Some DOC staff expressed concern that the program director was more involved in Gateway program development than in directing the program, and this view apparently led to some tension between the DOC unit staff and the RSAT program staff. However, that tension was addressed in a facility meeting chaired by the deputy Superintendent, and was followed by an agreement to increase interagency meetings (between corrections staff and treatment staff) to resolve any additional concerns.

### **RSAT Program Relationship with Gateway**

Staff reports and observations during the first year of RSAT implementation showed that Gateway's central office maintained close contact with Huntingdon program staff. Staff indicated that contact with the agency, as well as with staff from other Gateway programs, provides ongoing information about treatment methods, materials, and development. The program director is very involved in Gateway program development, and frequently described agency plans to expand RSAT programming, both for additional sites and extending beyond 12 months. Senior administrators from the agency are present at all statewide RSAT meetings and are available to clarify any issues for the DOC or other state officials.

***6. Where do RSAT participants go after completing the in-prison treatment phase at Huntingdon? Were there any particular successes or problems in implementing the program's aftercare components?***

#### **Aftercare in the CCC**

Aftercare preparation and linkage for Huntingdon RSAT differs from Graterford because Gateway operates the outpatient treatment programs that are available for Huntingdon graduates, both while the graduates are in the CCCs and when they live independently. The Gateway RSAT program director maintains regular telephone contact with CCC staff, and explicitly incorporates information about living in the DOC-run centers into programming delivered at the Graterford site. Recently, a senior treatment counselor from one of the CCCs initiated weekly visits to the Huntingdon program to observe programming, meet with RSAT staff, and occasionally conduct sessions for inmates about the CCCs.

The CCCs in the western part of the state are all run by the DOC rather than by contracting agencies. Each facility has a capacity of 40, and RSAT participants are not segregated from the rest of the residents. According to RSAT staff, both CCCs are in relatively stable commercial areas. Transition to aftercare is enhanced by the fact that the program director at Huntingdon supervises the treatment at the two outpatient sites used for those in the CCC phase. He meets with staff at each facility at least once a month and has weekly telephone contact with both programs. Outpatient treatment provides the same orientation as the in-prison stage of treatment, and outpatient staff are expected to consult with the program director of the in-prison stage for any treatment modifications. A parole supervisor visits the RSAT program at Huntingdon weekly. He is the PBPP liaison with inmates while they are in that phase and he maintains regular contact with them when they are released to the Community Corrections Centers.

#### **Aftercare Implementation**

To a large degree, the program has successfully integrated the aftercare portion of the RSAT sentence into the first six months of treatment. Gateway initiated contact with PBPP and CCC administrators and has worked to improve relations as necessary. This initiative on the part of the program helped maintain the RSAT structure, and serves as a model for interagency cooperation.

***7. Did the program reach and maintain full capacity? What are the early program outcomes regarding participant retention and completion rates? What do findings on those who fail say about the program?***

#### **Program Census**

Huntingdon RSAT received slightly fewer program referrals for most of the first year of programming than did the Graterford program. Huntingdon also accepted several participants from the Philadelphia area who would have gone to the Graterford program had space been available. While the program was at full capacity by the end of December, for most of the calendar year the program was approximately five percent below capacity. The slightly lower numbers in

this program may result from delays in the referral process, underutilization of RSAT by parole officers and hearing examiners, or possibly different characteristics of the parole population in the western part of the state.

### **Program Completion**

By the end of 1998, 118 technical parole violators (TPVs) had entered Huntingdon RSAT. Table 3C on the next page details admissions and discharges from the program. As at Graterford, very few men terminated during the in-prison phase of RSAT, and of those, half were inappropriate referrals – a screening problem rather than a program failure. The other half failed for program infractions, specifically fighting with other participants and not adhering to basic treatment requirements.

Five participants graduated from both phases of Huntingdon RSAT. Eleven of the 50 CCC admissions failed, including three who were returned for violating curfew stipulations, three for positive drug tests, and four for other program infractions such as threatening a counselor or another resident. Additionally, one Huntingdon participant escaped – that is, left the CCC and failed to return. These early figures indicate that participants who fail in the western region are more likely to do so for non-drug-related infractions, when compared to the Graterford site. Several termination reports from CCC staff working with Huntingdon graduates refer to their poor attitude, a tendency to be “manipulative,” “defiant,” or to “not take the RSAT program seriously.” While these were consistent with verbal reports from the Philadelphia CCC, the results suggest that CCC staff in the western region may be more willing to act on these judgments.

Overall, the 22% CCC failure rate for Huntingdon participants is notably better than the 38% rate recorded for Graterford. Any number of factors may have contributed to better performance of Huntingdon men – greater cohesion between RSAT components at this site, DOC’s management of the CCCs in western Pennsylvania, or pre-program participant differences. Should this difference in group outcomes remain as the samples build and the programs mature, we will submit these explanations to statistical tests under our impact analysis. As discussed in chapter two, these retention rates are inflated by counting those still in the program as retained, while they may still terminate before completion; over time, the rates will decline to some extent.

**TABLE 3C: Huntingdon Program Performance**  
(through December 31, 1998)

<b>Admitted to RSAT</b>	118
<b>Currently in Treatment</b>	60
<b>Terminated During Prison Phase</b>	8
Medical or Psychiatric Reasons	4
Program Infractions	4
<b>Graduated from Prison Phase/ Admitted to CCC</b>	50
Currently in CCC	34
<b>Terminated During CCC Phase</b>	11
Curfew Violation	3
Positive Drug Test	3
Other Program Infractions	4
Absconded/Escaped	1
<b>Graduated from CCC Phase</b>	5

## Chapter Four

### Findings from the Participant Interviews

#### Introduction

Intake interviews, administered by program staff to RSAT participants soon after admission to the program, provide data about participants' background, history, and status on such factors as medical and mental health, and substance abuse. This information indicates participants' service needs and will be valuable in identifying factors that put individuals at risk of failure in the program and after completion. If we find, for example, that relatively recent immigrants or those who indicate Spanish as their primary language tend to fail RSAT at high rates, the programs may need to develop greater cultural sensitivity or look to hire Spanish-speaking staff. Similarly, if high numbers of participants have mental health needs, but can still be treated in the RSAT programs, program administrators may facilitate mental health counseling participants released to the CCCs.

The exit interviews, administered by Vera on-site researchers, were used to gather participants' views about program services, staff, and environment. Results from these interviews are described below, and assessed for their consistency with the program observation findings presented in the previous chapters. In combination with our observations, staff interviews, and program performance data, the participants' views help us assess the programs' implementation. If participants see the same things we do, we can place greater confidence in our program descriptions and discussion of program strengths and weaknesses of the program.

Participant perceptions and overall satisfaction with the programs are also useful indicators of their bond or connection with the programs. Implicit, at least, in the RSAT programs' logic model is that participants will find the program environment supportive and therapeutic. While there has been surprisingly little research on the influence of participant perceptions on long-term treatment outcomes, the assumption is that some degree of program satisfaction is a prerequisite to gains from treatment (Hiller et. al., 1999). Once the sample size is sufficient, we will examine the relationship between a participant's aggregate measure of satisfaction and his later outcomes (i.e., retention in aftercare and recidivism). Scores on individual measures and subscales will also usefully indicate the program content areas and techniques that most engage RSAT participants. It will be interesting to see how their scores on these different program measures predict completion of the CCC aftercare phase, and success upon release to the community.

## Description of RSAT Participants

### Participant Characteristics

Table 4A, on the next page, summarizes findings gathered at admission.<sup>1</sup> Averaging 37 years of age, the typical RSAT participant was relatively old. Most were African-American (70%) and unmarried (80%). There were no Hispanics in Huntingdon (compared to 9% at Graterford); Huntingdon also had roughly twice the proportion of whites (32% vs. 12%) and married participants (34% vs. 17%). Too little is known about the selection process and the pool of potential TPV candidates for each site to provide explanations for these differences. We will explore the reasons for them in the impact research if they remain evident in larger samples. Across the two programs, about half the men did not have a high school diploma or GED, and a similar proportion were unemployed at the time they were brought in for violating parole mandates.

Just over one-fourth of the participants said they currently suffered from chronic medical problems and about one-fifth reported current or past psychological problems (depression, family or social problems). The medical and mental health data were similar across the two programs. About two-thirds of the men reported using heroin or cocaine in the 30 days before the violation and about the same proportion reported a serious need for drug treatment.

Huntingdon participants were much more likely to report a prior admission to drug treatment (82% vs. 46% at Graterford) and showed twice the rate of injection drug use (31% vs. 16%). Program differences were also evident on the self-reported criminal history information, where Huntingdon men had about twice the number of prior convictions (an average of eight compared to four at Graterford), but half the total lifetime incarceration time (47 months vs. 99 months). The last finding may be due to regional variations in enforcement and sentencing practices, which will be assessed with the larger samples available in future research. There is no ready explanation for the drug use and treatment history differences; again, these will be assessed further in the impact evaluation.

In sum, the intake interview documents the depth and variety of life problems RSAT participants bring to the prison setting. While, as expected, the vast majority of participants report recent use of heroin or cocaine and express need for drug treatment, substantial minorities also have medical and psychological issues that must be taken into account. Also typical of offenders in treatment programs, these men show a history of unemployment and nearly half of them do not have a high school diploma. Based on their self-reports, these men have extensive criminal histories. It is encouraging that the RSAT programs in Pennsylvania have succeeded in engaging in treatment a population this disadvantaged and entrenched in drug use and criminal activity.

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<sup>1</sup> The choice to have program staff administer the intake interview was driven by our limited budget for this study. We prefer to collect interview data using research staff because of possible validity problems with subjects' self-reports to program counselors. However, funding constraints forced us to choose whether Vera's site researcher should administer the intake or exit interview. We chose to administer the exit interview, which included queries about counselor competence, rapport, and other sensitive topics. Concerns about the validity of intake interview responses are diminished because of the highly structured nature of the ASI measure, which forms the core of the interview; there is little room for interpretation by the interviewer on the ASI.

**Table 4A: Background Data from the Intake Interview**

<b>Variable Description</b>	<b>Graterford [N=99]</b>	<b>Huntingdon [N=61]</b>	<b>Both Programs [N=160]</b>
<i><u>Demographic and Employment Data</u></i>			
Age (mean)	37	36	37
(median)	37	39	37
Race/Ethnicity			
Hispanic	9%	0	6%
Black	74%	63%	70%
White	12%	32%	20%
Other	5%	5%	4%
Married	17%	34%	20%
High school diploma or GED	49%	62%	54%
Unemployed at time of violation	59%	60%	60%
Weeks worked in past year (mean)	32	17	21
Employment income, past 30 days	\$789	\$560	\$704
Depends on others for support	40%	32%	37%
<i><u>Medical, Psychiatric, and Family Problems</u></i>			
Bothered by chronic medical problem(s)	26%	29%	27%
Experienced emotional abuse in lifetime	17%	20%	16%
Experienced serious depression in lifetime	30%	28%	23%
Had thoughts of suicide in lifetime	10%	11%	10%
Very troubled by family problems	22%	19%	19%
<i><u>Substance Abuse History</u></i>			
Any prior admission to drug treatment	46%	82%	53%
Used heroin/cocaine, past 30 days	67%	66%	67%
Prior IV drug use	16%	31%	22%
Reports serious need for alcohol treatment	46%	37%	43%
Reports serious need for drug treatment	78%	69%	75%
<i><u>Criminal History</u></i>			
Number of prior convictions (mean)	4	8	6
Months incarcerated (mean)	99	47	70

The data also suggest, however, that many of these men have service needs – such as job training, schooling (GED classes), and psychological assistance – not being met by the substance abuse-specific programming offered at the two RSATs. The programs do address these indirectly by emphasizing socialization, and such principles as taking responsibility for behavior and considering long-term consequences. Once the samples are of sufficient size it will be useful to examine the relationships between participant needs, program content, and outcomes in the aftercare phases of RSAT.

Future analyses will also assess whether background differences in participants at the Graterford and Huntingdon sites can be linked to any differences in outcomes. At this point, the group differences do not fall into a pattern that clearly favors one site over another with regard to the participants' probability of success. While Huntingdon has, for example, twice the proportion of married participants and more men with high school diplomas, this group is also almost twice as likely to report a history of IV drug use and some prior experience with drug treatment.

## Participants' Perceptions of Treatment

### **Counselor, Staff, and Program Ratings**

Table 4B shows results from a measure of respondents' perceptions of various staff, peer, and program components developed by researchers at the Institute for Behavioral Research at Texas Christian University (TCU). Respondents' ratings of each item are used to compute domain scores in such areas as counselor rapport, competence, and program structure. These mean scores reflect participant perceptions of the program's relative strengths and weaknesses. They confirm many of our on-site observations and informed chapters two and three of this report. The scores will also be used in future analyses to explore possible relationships between service elements and outcomes in the CCCs and in the community.

Participants generally rated program areas as neutral to good – between three and four (on a scale of one to five), with most closer to four. Counselors received favorable ratings in both programs, with highest scores in the areas of counselor competence and rapport. These findings confirm other data from the exit interview which indicate relatively high levels of satisfaction with the individual relationships participants formed with their counselors. Predictably, corrections officers (generically termed "security staff" in the TCU measure) do not fare so well. Especially at Graterford, participants had low opinions of COs' caring and helpfulness. These likely reflect the higher level of security at this site and perhaps the more specific tensions identified in Chapter Two surrounding cell access and lockdowns. The other item that received low ratings in both programs was the "unit structure," referring to the program's physical plant. This view is consistent with our observations about the stark and noisy cellblock at Graterford and the overcrowded program unit at Huntingdon.

While program differences were not dramatic, Huntingdon participants gave higher ratings in all six domains, with the biggest differences in the areas of counselor competence and program staff (i.e., COs).

**Table 4B: Perceptions of Staff, Peers, and Program Components**

Scale Items and Subscales	Average Rating (1=Very Bad; 5=Very Good)	
	Graterford (N=49)	Huntingdon (N=28)
Easy to talk to	3.9	4.2
Speak in a way that you understand	4.1	4.5
Respect you and your opinions	3.6	3.7
Understand your situation and problems	3.6	3.7
Are trusted by you	3.3	3.5
Help you view problems and situations more realistically	3.9	4.0
Focus your thinking and planning	4.0	3.8
<b>Counselor Rapport (average of above items)</b>	<b>3.8</b>	<b>3.9</b>
Motivate and encourage you	4.1	3.9
Help you develop confidence in yourself	3.9	3.6
Are well organized and prepared for each counseling session	3.2	3.6
Develop a treatment plan with reasonable goals for you	3.3	3.7
Keep you focused on solving specific problems	3.8	4.0
Remember important details from earlier sessions	3.6	4.5
Teach you useful ways to solve your problems	4.0	4.1
Help you make changes in your life	3.9	3.7
<b>Counselor Competence</b>	<b>3.7</b>	<b>4.3</b>
Organization of meetings and activities	3.4	3.4
House rules	2.9	3.7
Work assignments	3.7	3.8
Privileges	3.2	3.6
Unit structure	2.6	2.8
Morning meetings	3.6	3.6
Evening meetings	3.5	4.0
<b>Program Structure</b>	<b>3.3</b>	<b>3.6</b>
Lecture classes	3.4	4.3
Discussion/process groups	3.6	4.1
Individual counseling	3.9	4.0
<b>Program Sessions</b>	<b>3.6</b>	<b>3.9</b>

Table 4B continued

Scale Items and Subscales	Average Rating (1=Very Bad; 5=Very Good)	
	Graterford (N=49)	Huntingdon (N=28)
Amount of time for individual counseling	3.5	4.1
Caring of treatment staff	3.9	4.0
Helpfulness of treatment staff	3.9	4.0
Caring of security [corrections] staff	2.1	3.2
Helpfulness of security [corrections] staff	2.2	3.2
<b>Program Staff</b>	<b>3.1</b>	<b>3.7</b>
Caring of other program members [inmates]	3.4	3.4
Helpfulness of other members [inmates]	3.3	3.7
Your similarity to other members [inmates]	3.0	3.7
General sense of community	3.0	3.1
<b>Peer Support</b>	<b>3.2</b>	<b>3.5</b>
<b>Overall Rating</b>	<b>3.4</b>	<b>3.8</b>

Compared to Graterford staff, Huntingdon counselors were rated high on their preparation for sessions, individualized treatment planning, and retaining information from group sessions. Huntingdon also received high ratings on the quality of lecture classes and groups. Graterford participants provided slightly higher ratings on some counselor skills, notably building confidence and helping to focus thinking and planning. These findings suggest these staff bring valued skills to the program, but could improve their preparation and attention to individual participants and to spontaneous discussion topics that extend over multiple sessions.

#### Program Environment

The COPES measure assesses the environmental characteristics of various types of programs. It yields ten subscale scores, listed in Table 4C, which focus on staff-client relationships and therapeutic interactions, and program maintenance dimensions such as order, clarity, and control. The instrument is designed to describe a program and not to provide ratings along a positive-negative continuum. Program clarity, which refers specifically to clarity of program rules, is rated the highest in both programs; scores also reflected perceptions of strong staff control and support (from both staff and peers) in the programs. Conversely, and not surprisingly given the setting and highly developed curriculum at each site, the spontaneity subscale had the lowest scores in both programs. At Graterford, in particular, program spontaneity is perceived as minimal; this finding is consistent with our observations. Personal problem orientation – the extent to which staff and program activities focused on the individual’s problems – also had low ratings.

**Table 4C: Perceptions of Program Environment**

COPEs Subscales and Domains	Average Score	
	Graterford	Huntingdon
Involvement	2.6	2.6
Support	3.0	2.9
Spontaneity	0.9	1.7
<b>Relationships</b>	<b>2.1</b>	<b>2.4</b>
Autonomy	2.4	2.7
Practical	2.7	2.4
Personal Problem Orientation	2.0	2.3
Anger and Aggression	2.8	2.5
<b>Personal Growth/Goal Orientation</b>	<b>2.5</b>	<b>2.5</b>
Order and Organization	2.7	2.8
Program Clarity	3.4	3.4
Staff Control	3.1	2.9
<b>System Maintenance and Change</b>	<b>3.0</b>	<b>3.0</b>

**Table 4D: Views of Individual Counseling**

Variable	Graterford	Huntingdon
Total number of individual counseling sessions (mean)	11	9
Length of typical individual session (minutes, mean)	47	38
Percent reporting they can see counselor when needed	75	100
Time spent during individual counseling sessions on: (mean; 1=never; 5=all the time)		
Case management	3.2	3.3
Drug or alcohol treatment	3.8	4.1
Mental health	2.1	2.7
Legal	2.5	1.6
Education	2.7	1.9
Employment	2.8	1.6
Family and social relations	3.1	3.6
Health	1.7	2.0

**Table 4E: Perceived Utility of Program Elements**

Service Area	Graterford				Huntingdon			
	% Not Helpful (0)	% Somewhat Helpful (1)	% Very Helpful (2)	Mean Rating	% Not Helpful (0)	% Somewhat Helpful (1)	% Very Helpful (2)	Mean Rating
Medical	4	32	64	1.6	0	32	68	1.7
Legal	13	47	40	1.3	23	23	54	1.3
Education and Employment	4	37	59	1.5	0	50	50	1.5
Family and Social	10	45	45	1.4	0	29	71	1.7
Psychological and Emotional	4	42	54	1.5	4	39	57	1.5
Drugs and Alcohol	4	27	69	1.7	0	36	64	1.6

**Utility of Treatment Components**

Individuals graduating from the prison treatment phase were administered a battery of questionnaires on different elements of the program. They were asked to rate the utility of program services on a scale of 0 (“not helpful”) to 2 (“very helpful”). Questions identified standard service domains such as substance abuse, vocational assistance, and medical treatment, and respondents were asked to consider both direct and indirect assistance they had received in each area while in the program. As the results in Table 4E show, in all but the legal area, 90% or more of the men in both programs judged services to be at least somewhat helpful. Averaging responses across the domains and programs, about half the respondents said services were very helpful. Perhaps most notable were the high marks given “Education and Employment” since neither program provides direct services in these areas; for example in, job training and GED classes. Apparently, most participants were convinced that the CiviGenics and Gateway curriculums did address these areas through their focus on such topics as planning, consequential thinking, and socialization.

There is little distinction between the programs in perceptions of service utility. One exception is the family and social services area, which was rated highest by Huntingdon participants and among the lowest of the service areas by Graterford participants. This difference may reflect a greater effort at Huntingdon to engage participants in discussing personal and emotional issues in groups and individual sessions. It may also reflect staff turnover problems at

Graterford. Tracking and integrating an individual's family and social issues into treatment requires attention at the initial assessment and throughout the treatment stay. Still, there were no large differences between the sites in participants' overall satisfaction with the programs, suggesting that staffing problems at Graterford had a limited impact on participants' perceptions. It is also interesting that the restrictions on the inclusion of psychological counseling at this site, noted both in staff interviews and CiviGenics literature, were not reflected in participants' ratings of services in these areas.

**Table 4F: Beliefs About Program Improvements**

Variable	Graterford	Huntingdon
I would have gotten more out of this program if... (mean score on scale: 1=not at all; 5=a lot)		
I had more time to talk with my counselor.	2.9	3.0
more groups were led by peers, without staff in the room.	2.3	2.2
more groups were led by peers with staff.	3.6	2.9
groups were smaller.	2.9	3.8
there were more groups for education, like a GED class.	2.8	3.3
there were more groups to help me get a job.	2.9	3.5
more groups focused on how to make decisions.	3.1	3.6
there were more groups to help me figure out alternatives to using drugs.	3.2	3.5
there were more focus on relapse prevention.	3.8	3.7
there were more focus on mental health.	2.2	3.3

#### **Beliefs About Program Improvements**

Program participants were asked to rate possible changes that might improve the program's effectiveness (see Table 4F). Mean responses for the two groups did not differ greatly, falling around three on a one to five scale. Participants gave low scores to increasing peer-led groups, echoing other findings that showed low ratings for peer support. At Graterford, where psychological counseling is not emphasized, participants generally did not see a need for more mental health programming. Conversely, at Huntingdon, where participant psychological needs are seen as integral to the therapeutic process, participants want more such programming. Huntingdon participants wanted smaller groups, and participants in both programs wanted greater focus on relapse prevention – that is, practical tools to avoid returning to drug use.

## Summary

Background data on RSAT participants indicate that the program succeeds in its goal of serving parole violators in need of the drug treatment; participants present a number of other service needs, as well, which are, for the most part, similar for participants at Graterford and Huntingdon. The program satisfies basic tenets of its logic model by having implemented a highly structured curriculum, and by engaging participants in the therapeutic community.

Participant views on program staff and program components are favorable, averaging near 3.5 on a one (“very bad”) to five (“very good”) scale. Participants showed discriminating opinions on the perceptions measure, with low ratings (near 2.5) given to corrections staff and unit structure, and high ratings (near 4) to counselor skills, group sessions, and individual counseling. Program ratings were similar across the sites, although there was a cumulative effect with Huntingdon participants giving higher ratings in all six program and staffing areas covered by the questionnaire (3.8 overall, compared to 3.4 at Graterford). Responses on the perceptions and COPES measures were largely consistent with results described earlier from site observations, adding credence to both sets of judgments. Examples include the low ratings at Graterford for inmate relations with DOC staff, and the view that both programs (and especially the CiviGenics site) are highly structured.

Favorable assessments of the programs were also evident in measures assessing program utility and possible improvements. Even though some areas, such as education at both sites and psychological counseling at Graterford, are not central components of treatment, participants still report positive views of services in these areas. The findings suggest that staff at Huntingdon are more likely to discuss emotional and family concerns, compared with a focus on education, employment, and legal status at Graterford.

The positive opinions of participants no doubt reflect their feelings about the programs. But they may also indicate the positive interpersonal relationships between staff and inmates (particularly in contrast with that between inmates and corrections staff), and a corresponding reluctance to criticize. With these sample sizes it is difficult to ascertain the reasons for the slightly higher scores for Huntingdon, the lower-security site. Over time, we should gain a better sense of how several factors – the more casual environment at Huntingdon, staff turnover, the difference in service delivery between the programs – might affect participants’ judgments about the programs. Most important, we will also learn about the post-program outcomes of these RSAT participants, and be able to assess whether these early indicators of program performance predict how well graduates do after they leave the program.

# Chapter Five

## Summary, Discussion, and Conclusions

### Background

As part of growing system of treatment for offenders with substance abuse problems, Pennsylvania has established two new, 60-bed programs in state prisons. Funded under the federal Residential Substance Abuse Treatment initiative, Pennsylvania's RSAT programs are the only ones nationally that specifically target technical parole violators (TPVs). By providing six months of prison treatment followed by aftercare, the state has sought to address the drug treatment needs of parolees, while also reducing the costs incurred by 12 to 36 month prison stays that can result from parole revocations. The Vera Institute of Justice has begun an impact evaluation that will assess whether RSAT in Pennsylvania is achieving some of these long-term program goals. This current report presents findings from our process evaluation of the first year of RSAT implementation.

Initially identified and selected for RSAT at local parole offices, male TPVs are further screened by the Board of Probation and Parole and the Department of Corrections, and then transferred to SCI-Graterford, serving Philadelphia and five counties in the east, or to SCI-Huntingdon, serving five western counties. Participants spend their first six months in a therapeutic community (TC) at the prison, segregated from the rest of the inmate population. The DOC has elected to contract with private treatment providers – CiviGenics at Graterford and Gateway at Huntingdon – to operate and staff the programs at each site. A parole officer works at each site to maintain parole contact with RSAT participants throughout the sentence. RSAT participants then receive outpatient aftercare in residential halfway houses, known as Community Corrections Centers (CCCs), that are operated by the Department of Corrections or a private organization under contract to the DOC. Participants who have completed both stages of the program are released on parole. Beginning in October 1999, RSAT graduates will attend treatment after release under a Continuing Care initiative that the state has established with other federal and state funds (federal mandates specify that RSAT funds cannot be used to support treatment in the community after inmates leave DOC custody).

The RSAT programs are maintained through the joint management of state Corrections, the Board of Probation and Parole, the Pennsylvania Commission on Crime and Delinquency, and the private service providers. Frequently, several different divisions within each agency are involved in RSAT. This combination of agencies, of public and private sectors, and of personnel, requires careful coordination and ongoing attention to differing priorities. An interagency working group was formed to oversee RSAT implementation and program development, and works to identify, monitor, and resolve implementation issues as they arise.

## Early Performance Indicators and Findings on Program Participants

### **Program Admissions**

The programs filled to capacity within the first months of opening in February 1998. Both programs expanded from 50 to 60 beds to meet demand and have remained at or near capacity. Through December 31, 1998, 237 TPVs had entered the two RSAT programs. The demand, as measured by program referrals, was slightly lower for the Huntingdon program, and this site admitted some TPVs from Philadelphia who would have attended Graterford if space were available. It is not possible, at this point, to identify which of several factors may have contributed to lower referral numbers at Huntingdon; if the pattern continues, we will assess this further in future research. Huntingdon also experienced some delays in transferring and placing participants in treatment after they had been identified and approved as RSAT participants at the local level. This is one of several issues that officials from the interagency working group identified early and are addressing in coordinated efforts.

### **Participants**

Program staff have aided the research by conducting extensive, standardized assessment interviews with participants soon after admission to RSAT. These data show that RSAT participants have high levels of self-reported drug use and need for treatment, indicating that these men are appropriate referrals for the program. Substantial minorities (25 to 30 percent) also have medical and psychological problems and most have poor vocational and educational histories.

Neither treatment program is designed to directly address these needs and deficits; instead, in the limited time allowed, the providers have chosen to focus on substance abuse problems and the "criminogenic thinking" that underlie the various life problems experienced by these parole violators. Our early data support this approach – while there are no structured sessions focused on job readiness or earning a GED degree, for example, RSAT residents reported in interviews that they were receiving useful vocational and educational assistance.

The impact analysis will afford a further test of this treatment strategy; it will be useful to assess whether poor vocational and educational histories are related to failure upon reentry to the community. It will also be important to assess the role of age in post-RSAT success or failure, since these men are quite old (mean age=37 years) and many individuals "age out" of crime and drug use without the benefit of treatment. Another set of future analyses will examine whether differences in background characteristics of participants at the two sites are related to any differences in outcome. The early data showed Graterford and Huntingdon participants to differ on some important variables (such as marital status and drug treatment history), but these did not follow a pattern that would indicate participants at either site are more or less likely to succeed in the RSAT program.

### **Completion and Advancement in the Prison Phase**

There is very little dropout in the first, six-month phase of prison treatment. Only 15 participants – less than 10 percent of those admitted – failed during this period. So far there is no pattern of differences between the programs in terms of participant characteristics or dropout during the prison phase. At both sites, only about half of those who failed did so because of poor program performance or rules infractions (the others were transferred because they had medical or psychological problems that could not be handled by RSAT staff).

Generally, retention and completion are valuable interim indicators of success in substance abuse treatment. In secure programs, however, where participants are essentially captive, program policies and standards are central determinants of retention. One interpretation of these findings, then, would be that the RSAT programs employ modest standards for retention and completion – that they “set the bar low.” A related criticism that may be due the programs is that they are overly generous in advancing participants through treatment phases in prison. While both programs employ a three-phase structure that is traditional among TCs, only rarely were RSAT residents demoted or not advanced to the next phase once they had completed the time period typically associated with the phase (e.g., at 60 or 120 days after admission). In practice, phase advancement was primarily based on the inmate staying the requisite period without committing cardinal rule infractions rather than showing he had internalized critical phase-specific lessons.

There are, however, other interpretations to consider. The low rates of expulsions and dropouts may reflect that these programs are willing to work with a diverse and sometimes resistant population, and do not engage in “creaming” by terminating inmates who are not overtly motivated or do not readily “get with the program.” Perhaps most pragmatically, the programs may choose not to apply stringent criteria for participant progress because they feel implicitly compelled to retain, advance, and graduate the great majority of RSAT admissions. This kind of pressure (implicit or explicit) is almost inevitable in new or high-profile programs that have a moderate capacity and an uncertain flow of referrals. Larger and longer programs have the luxury of working on the indifferent or reluctant attitudes and motivation that many offenders bring to legally-mandated treatment. Viewed from this light, the programs’ practices of advancing and graduating inmates during the prison phase are adaptive responses to circumstances which do not permit staff to take full advantage of the traditional TC phase structure.

### **Completion in the CCC**

Retention in the non-secure CCC phase is a more straightforward, if preliminary, indicator of program performance. While certainly in the range of expectations for parole violators, failure rates in this phase of RSAT were high enough in the first year to be of concern to the interagency working group. By the end of 1998, 38 percent of the Graterford graduates, who attend a CCC in Philadelphia, had failed; 22 percent of Huntingdon graduates, who attend CCCs in the western region, had failed. These figures are based on small samples (of about 50 each), and they may

change as we track larger, more stable samples of parolees.<sup>1</sup> Nearly half the failures are drug-related; a significant portion (40%) stem from such infractions at the CCC as curfew violations and fighting with another resident. The working group and their parent agencies have targeted implementation issues involving the CCC that should bolster retention in this phase of RSAT. Discussed below, they include preparing inmates in the latter weeks of the prison phase for transition to the CCC and informing CCC staff what to expect from RSAT participants.

## Findings on Program Structure, Services, and Implementation

In funding dozens of process evaluations of RSAT programs across the country, the National Institute of Justice acknowledged the challenge of establishing substance abuse treatment programs in prison settings, and the need to document implementation barriers and how states identify and overcome them. This section summarizes the key elements of the Pennsylvania RSAT programs and the implementation issues that emerged and were addressed by the various involved agencies.

### Program Setting and Staff

The clearest difference between the two RSAT sites are their settings. Although the inmates in the two programs must meet the same minimum security classification standards (to be eligible for the CCC phase), the Graterford program is located in a cellblock within a very large maximum security institution, while the Huntingdon RSAT unit is in lower security trailers located outside the central prison facility. The setting alone makes for a more relaxed atmosphere at the Huntingdon program. The Huntingdon unit is, however, cramped for space, to the point that staff there expressed concerns about the effects of widespread double-bunking on their safety. Program counselors and inmates at both sites also cited the need for more private classroom space (and this wish was granted at Graterford as this report was reaching completion).

The Graterford program is staffed with a director, two fulltime counselors and a part-time counselor. Huntingdon RSAT has a director, three fulltime counselors, a part-time program assistant, and an intern. Graterford experienced staff turnover problems, with three different program directors during the first year of implementation and similar movement in the counselor positions. Because of the turnover (and CiviGenics policy of managing most relations with DOC through the central office), the second and third program directors did not have close, working relationships with DOC and other agencies' staff; on occasion they were uninformed of program developments and seemed reluctant to make requests of the DOC staff (e.g., for program materials). In early 1999, increased involvement of the CiviGenics regional supervisor and central office staff helped to enhance relations at the site and to resolve concerns about acquiring program materials.

In interviews done at exit from the program, graduates of the prison phase gave favorable ratings to program counselors at both sites, with the highest scores assigned to groups of items tapping counselor competence and counselor rapport. Huntingdon participants gave relatively

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<sup>1</sup> Data from the first several months of 1999 show that the two sites' retention rates are now similar.

high ratings on counselor preparation and retention of information from group sessions, while Graterford graduates judged counselors higher on building confidence and helping to focus thinking and planning.

### **Service Content**

CiviGenics and Gateway have both implemented sophisticated, highly structured curriculums during the prison phase. Although they include traditional 12-Step (AA and NA) groups and principles, both programs (especially CiviGenics at Graterford) devote much of their curriculum to more contemporary, research-based lessons that focus on changing thoughts, emotions, and behaviors that are associated with drug use and criminal acts. While programming at both sites is focused on these kinds of life skills as a means of breaking the cycle of drugs and crime, participants reported receiving other services as well. Consistent with our observations and staff interviews, participants at Huntingdon reported higher levels of family and socially-oriented programming, compared with a greater educational and vocational focus at Graterford. Counselors at Graterford delivered the curriculum using CiviGenics' very extensive, detailed, highly structured program manual. Huntingdon counselors also referred to a Gateway manual and curriculum documents provided by their central office, however these staff were more flexible in incorporating new and evolving lesson plans and sessions.

At both sites, participants had positive views about the gamut of RSAT services, rating them moderately to very useful. Residents in the Huntingdon program gave slightly higher ratings than Graterford participants on all four program domains (structure, sessions, peer support, and program staff). This likely reflected a combination of factors, including the different treatment settings at the two sites, staff turnover problems at the Graterford site, and other implementation issues that are discussed below.

### **Service Quantity**

Structured, mandatory programming is provided at both sites between about 8am and 4pm Monday through Thursday. This kind of schedule is typical of residential treatment programs in prisons, which are sometimes erroneously advertised as offering "intensive, 24-hour-a-day" programming. In fact, most experienced program operators believe that more than seven or eight hours of compulsory daily treatment would be counter-productive for both participants and staff. We know of no research that points to an optimal daily dose of treatment; rather, findings simply show that more days in treatment (beyond a threshold of at least 90 days) are associated with long-term, favorable behavior change (e.g., Hubbard et al., 1997; Gerstein & Harwood, 1990).

The eight-to-four, Monday-through-Thursday schedule nonetheless means that RSAT participants spend less than half their time in required treatment. Keeping with traditional TC practice, the CiviGenics and Gateway models seek to provide additional therapeutic opportunities in the form of low-level labor and community work duties, homework assignments, elective 12-Step and individual counseling sessions, and recreational activities that are designed to build peer support or to reward positive behavior. Our site observations indicated that RSAT residents did not take advantage of these opportunities as much as they could. Staff should continually

encourage inmates to participate in community work and elective therapeutic activities (particularly individual counseling, as noted below), especially on Fridays and weekends, when multiple days with much down time fall in succession.

### **Individualized Treatment**

Programs attempt to balance individualized treatment plans with the demands of limited staff and resources. While both the CiviGenics and Gateway programs conduct extensive individual assessments, neither program tailors treatment in any substantial way to meet the unique needs revealed in that process. The curricula used in both programs assumes that all participants will benefit from the same skill development and group counseling. The large size of group meetings at both sites and the programs' reliance on a highly structured, consistently applied curriculum make it especially difficult for staff to incorporate elements from individualized plans into these groups. For the most part, individual sessions (and work assignments) provide the only opportunity for counseling in the various life areas that are assessed at intake and comprise much of the treatment plan. Our interviews showed, however, that most inmates participated in few individual sessions (at Huntingdon, for example, half the participants averaged less than one a month).

These areas identified in the treatment plan – psychological and medical health, social and family relations, employment and education – inevitably interact with the individual's substance use and criminal behavior. Practically speaking, the programs' extensive intake assessments and individualized treatment plans are only useful if counselors have the flexibility and skills needed to incorporate individual lessons into the general curriculum. Staff should also initiate more individual sessions and consider individual needs in making work assignments. Finally, the individualized assessments should inform discharge plans that can ease transition to the CCC and improve retention in this second RSAT phase.

### **Establishing a Therapeutic Environment in the Corrections Setting**

Issues surrounding the conflicting priorities of treatment and correctional security surfaced in both programs, echoing findings from some previous process research on prison-based treatment (e.g., Wexler and Love, 1994; Inciardi et al., 1992). Our observations and interviews with staff and participants suggested this was more of an issue at the Graterford site, where program staff appeared unwilling to address or even acknowledge inmate objections about restrictions imposed by correctional staff regarding cell access and inmate movement on the unit. Among an extensive battery of questions asked of RSAT graduates, those about correctional staff and "house rules" were the only items that elicited negative ratings, and we observed and were told by inmates that they at times disengaged from active participation in the program because of anger and frustration over these issues.

New and more assertive leadership by the Graterford program director and CiviGenics' and regional and central offices emerged in early 1999, helping to ease these tensions and to establish stronger relationships among staff and the central offices. The Huntingdon program was mostly spared from these issues, at least in part because the program's director brought extensive

personal experience in dealing with the DOC and the primacy of security concerns. Still, evidence of the near inevitability of conflicts between correctional and treatment priorities emerged at this site, as well, where facility administrators have appealed to program staff to reduce inmate resentment toward corrections staff and security policies.

### **CCC Aftercare**

In addition to operating the RSAT program at Huntingdon, Gateway is contracted to provide outpatient treatment to Huntingdon graduates at CCCs in the state's western region. This has aided participants' transition to aftercare, as Gateway staff provide those nearing completion of the prison phase an orientation to the CCC services and the expectations (such as obtaining employment) they will face there. The program director and other Gateway staff spend time at Huntingdon and the CCC facilities, and Huntingdon staff can track the progress of prison graduates in the CCC phase. This also describes the situation that exists for Graterford RSAT graduates at the CCC in Philadelphia at the time of the completion of this report. During the first year, however, there were problems with the delivery of outpatient treatment at this CCC, which is handled by another private provider under a subcontract with CiviGenics.<sup>2</sup> One subcontractor pulled out soon after the program opened and had to be replaced, and for a short time an insufficient amount of treatment was being provided at the site. Concerns were also raised about the preparedness of Graterford participants for community living (and working) in the CCC. Attention to these issues by the interagency working group, and particularly by CiviGenics central and regional office staff, and DOC and parole staff at the CCC have caused this situation to improve in recent months.

### Lessons Beyond Pennsylvania

Vera's research on the impacts of these programs on post-program recidivism will be the real test of their effectiveness. Implementation evaluations such as this one, however, are a necessary first step in understanding the treatment model and how it can be improved. The Pennsylvania experience provides useful lessons to states developing similar programs. They include:

- ***States should establish an interagency monitoring and response system that identifies and resolves RSAT implementation issues.*** Anticipation and early identification of problems facilitates their resolution. In Pennsylvania, the RSAT programs benefit from steady monitoring by a management group that includes all involved agencies, public and private. This group reviews all implementation issues and problems, and has both the authority and the initiative to implement policies designed to improve programming. For example, when monitoring of CCC outcomes showed unacceptably high failure rates for the first set of participants, the Pennsylvania working group devised plans to improve communication, release preparation, and oversight. Coordinated interagency responsibility

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<sup>2</sup> Under their contracts with DOC, Gateway and CiviGenics are responsible for treatment in the CCC, and have the option of staffing it themselves or subcontracting with another provider.

and initiative was critical to identifying these issues and implementing a possible solution. The group is now attuned to CCC performance, and will continue to assess and adjust the response to this issue.

- ***Program administrators and staff should anticipate issues relating to the conflicting priorities of security and treatment.*** Inmate movement and access to space on the cellblock, privacy for treatment sessions, and the perceived importance of an infraction are examples of issues on which corrections and treatment staff in Pennsylvania expressed differing, and in some cases conflicting, views. Both program and corrections staff must have the freedom and authority to express their concerns and reach common solutions on these issues. Staff need to address their professional concerns in partnership and reach consensus on program goals and objectives. New initiatives may challenge staff who are reluctant to change acculturated work roles. Administrators should devote the necessary resources to train staff to ensure they are invested in successful implementation.
- ***Staff stability and experience in the correctional setting is invaluable.*** While highly structured, detailed, and pilot-tested program curriculums are very useful in assuring consistent service delivery to participants, they do not guarantee effective implementation. Managers and staff must be prepared to enforce rules and perform time-intensive reporting requirements that are unique to correctional settings. Counselors in both programs, but particularly Graterford, wrestled with balancing the DOC demand to complete inmate paperwork while carrying a full caseload and running meetings and sessions. At Huntingdon, this task was integrated into the staffing plan, reducing the strain on counselors.
- ***Program participants and staff should be prepared for transition to aftercare phases.*** Reflecting the priorities expressed in federal announcements on RSAT, there is a tendency to focus attention on the quality of the program's prison phase rather than the aftercare phase. However, typifying the pattern observed in other programs, in Pennsylvania, failure was much more likely to occur in the CCC aftercare phase. Both participant behavior and CCC staff's perception of that behavior contributed to higher than anticipated RSAT failure rates in aftercare. Prior to their release to aftercare, participants should be prepared for the responsibilities they will assume when they return to their communities and have clear, realistic expectations about community reintegration. Correctional staff in the aftercare phase must also have clear expectations about treatment participants and how they differ from general population residents. Mixing of RSAT participants with general population inmates/parolees raises issues (e.g., special rules, privileges) that must be anticipated and resolved in advance. Staff linkages between phases ease transitions and may reduce failures in aftercare.
- ***Prison treatment programs should be given the opportunity to develop and stabilize before they become the subject of impact evaluations.*** Implementing therapeutic interventions in secure correctional settings is a complex and difficult undertaking. Even with the extensive prior experience and preparation the private treatment providers brought to the

Pennsylvania programs, implementation barriers inevitably emerged during the first several months of each stage of operations. The programs developed continuously over the course of this research; this experience provides support for NIJ's approach of requiring process evaluations of the RSAT programs prior to studies of their outcomes.

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## **APPENDIX A**

## Comparison of Program Content by Phase Level

Phase	Graterford	Huntingdon
Phase I	<p><u>Orientation</u></p> <p>Addiction and Recovery</p> <p>Key Terms and Concepts</p> <p>Learn to Live</p> <p>Giving and Receiving Feedback</p> <p>Inner Self vs. Habit Self</p> <p>Criminal Addictive Thinking (2)</p> <p>HIV Education</p> <p><u>Core Skills</u></p> <p>Affirming</p> <p>Asserting</p> <p>Brain-Storming</p> <p>Calming</p> <p>Danger-Spotting</p> <p>Focusing</p> <p>Forecasting</p> <p>Tension Sensing</p> <p>View Switching</p> <p>Humanizing</p> <p>Prioritizing</p> <p>Resourcing</p> <p>Self-Listening</p> <p><u>Principles of Recovery</u></p> <p>Don't Feed Your Monsters</p> <p>Avoid Your Triggers</p> <p>Stick to Your Structure</p> <p>Think It Through</p> <p>Trust the Truth</p> <p>Learn to Practice</p> <p>Step Slow and Steady</p> <p>Reach Out and Open Up</p> <p>Be a Member</p> <p>Make the Moment Count</p> <p>Remembering the Past</p> <p>Nourish Your Spirit/ Respect Life</p>	<p>What is Addiction</p> <p>How to Sabotage Treatment</p> <p>Disease Concept</p> <p>Denial</p> <p>Cross Addiction</p> <p>Withdrawal</p> <p>Specific Drugs Lectures (5)</p> <p>12-Steps</p> <p>Assertiveness</p> <p>Coping Skills</p> <p>Drunk Driving</p> <p>Medical Aspects of Addiction</p> <p>Signs of Addiction</p> <p>Stages of Addiction</p> <p>Dual Diagnosis</p> <p>Mistaken Beliefs</p> <p>Johari Window Exercise</p> <p>Conflict Resolution</p> <p>Developmental Model of Recovery</p> <p>Trust, Honesty, Openness, Willingness, Control</p> <p>Reducing Recidivism</p>

Phase	Graterford	Huntingdon
Phase II	<u>Criminal Addictive Thinking (CRT)</u> Too Proud To Learn Life Is Not Fair Authority and Freedom Wishing Up the Negative Mind Why It's Called Getting Wasted Getting Over Challenges & Excitement Goals & Dreams Doing Good Times Out-Thinking Violence Fighting for Pride Gang Ups Anger Triggers/ Violence Traps Say It Right/ Hear It Right Gunning Wounded Love Reaching Agreement Source of Strength Creating Peace <u>Learn to Work</u> A Working Life Honesty at Work Self-Presentation Job Safety Job Search Resume Writing Interviewing (2) Handling the Green Drug <u>Intro to 12-Step Fellowship</u> Getting to know 12-Step Guide to 12-Step Groups (4) What is an AA/NA Group The Twelve Traditions What an AA/NA Group is Like Getting into a Home Group All About Sponsors	Relapse Leisure Issues Reducing Recidivism 37 Warning Signs/Relapse High Risk Situations Rational Emotive Therapy Resentment Relapse Circle Stress Management Grief/Loss 12 Steps of Relapse Prevention Conflict Resolution Nutrition Relapse Prevention Skills Values/Behavior Decisions Anger Management Addictive vs. Healthy Relationships Mistaken Beliefs Mental Health Management

Phase	Graterford	Huntingdon
Phase III	<u>Correctional Recovery Training</u> Pastoral Partners Guilt Kills Untold Pain Beating the Hunger Memory Warning Signs Triggers and Traps Craving Skills Slip Stoppers Keeping On Self-Assessment Old Friends New Friends New Groups Taking Root in a Self-Help Community Using Help Friendly Support Recovery Partners Family Ties Preparing for Homelife Your First Day Out <u>Relapse Preparation (REPAC)</u> Relapse Preparation Questions (8)	Conflict Resolution Coping Skills Leisure Skills Warning Signs Stress Management Spirituality Self-Esteem Benefits of Sobriety Nutrition Anger Management Relationships/Discharge Aftercare Planning

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