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TREATMENT BEHIND BARS: SUBSTANCE ABUSE TREATMENT IN NEW YORK PRISONS 2007–2010

A Report by the Correctional Association of New York

FEBRUARY 2011

The Correctional Association of New York (CA) was formed in 1844 by citizens concerned about prison conditions and the lack of services for inmates returning to their communities. In 1846, the New York State Legislature granted the CA authority to inspect prisons and report on its findings. Through four projects — Juvenile Justice, Prison Visiting, Public Policy/Drug Law Repeal, and Women in Prison — the CA advocates for a more humane prison system and a more safe and just society.

The **Prison Visiting Project (PVP)** is the arm of the Correctional Association that carries out this unique legislative authority for the male prisons. PVP visits seven to ten of New York's 67 state correctional facilities each year and issues facility specific reports on prison conditions to both policymakers and the public. In addition to its general prison monitoring, PVP conducts in-depth studies on specific corrections issues and publishes comprehensive reports of findings and recommendations. Current in-depth research areas include: healthcare, mental health care and substance abuse treatment. PVP produces reports, presents at forums, and engages in activities aimed at educating the public about prison conditions, the high cost of incarceration and the need for alternatives. The Project also works with legislators, corrections officials, former prisoners, service providers and community organizations to develop more humane prison policies. All the prison reports prepared by the Project since 2004 are available on the Correctional Association web page.

For more information about the Prison Visiting Project, please call 212-254-5700 or visit http://www.correctionalassociation.org/PVP/index.htm

Treatment Behind Bars: Substance Abuse Treatment in New York Prisons

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ACKNOWLEDGMENTS

Substance Abuse Treatment in New York Prisons, 2007–2010 was principally authored by Cindy Eigler, Associate Director of Special Projects for the Correctional Association's Prison Visiting Project and coordinated by Jack Beck, the Director of the Prison Visiting Project. Significant editorial assistance was provided by Amber Norris, former Associate Director of General Monitoring for the Prison Visiting Project, Darcy Hirsh, current Associate Director of General Monitoring for the Prison Visiting Project, Rosemary McGinn, Project Consultant, and Gerald Melnick, Project Consultant. Ms. McGinn's input and expertise and detailed editing of the report proved invaluable and considerably improved the quality and scope of this report. This report could not have been completed without the hard work of all of our interns, with special recognition of Monica Barrera Contreras, Rachael Feeney, Britt Fremstad, and Allyson Walker for their significant contributions. Robert Gangi, Executive Director of the Correctional Association, guided the project from inception to completion. Correctional Association Board members Gail Allen, M.D., Nereida Ferran, M.D., Clay Hiles and Ralph Brown, Jr., Chair of the Prison Visiting Committee, provided very beneficial input through the Advisory Committee for this project. We especially thank Mr. Brown and Dr. Allen for their careful review of the report and their editorial input. We would also like to thank Troy Lambert for generously volunteering his time and talent to design the cover for this report.

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We would also like to express our gratitude to the individual members of the Advisory Committee, whose significant efforts and extensive expertise were so important to the preparation and completion of the report (please see next page for more details about this distinguished group).

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ADVISORY COMMITTEE

An Advisory Committee of experts in the field of substance abuse treatment and corrections directly informed and guided the project from its beginning. Their input was crucial in helping us design the study, improving data collection, refining data analysis, evaluating study results and suggested findings and recommendations, and providing recommendations for best practices. In addition, members of the Advisory Committee provided important editorial input and review.

We extend our deep appreciation to the following individuals, each of whom have endorsed the report's findings and recommendations.

Project Consultants

Rosemary McGinn, JD, is an attorney and a Credentialed Alcoholism and Substance Abuse Counselor, and has acted as a principal consultant for the Correctional Association on the Prison Substance Abuse Treatment Project. She has extensive experience in research and practice related to the intersection of the justice system and substance abuse.

Gerald Melnick, PhD, is a Senior Principal Investigator at the Center for the Integration of Research to Practice and the National Development and Research Institutes (NDRI). Dr. Melnick developed the Multimodality Quality Assurance Instrument (MQA) that evaluates the quality of substance abuse treatment programs and which has been used to examine program quality in prison and community settings (Melnick & Wexler 2004; Melnick et al., 2004; Melnick et al. 2006a). The CA used a modified version of the MQA in its Prison Substance Abuse Treatment Project, and Dr. Melnick has also served as a consultant throughout the project.

Expert Members

Gary Bartlett is Deputy Director of Treatment & Prevention Services at the Osborne Association. He is responsible for Osborne's community-based low-threshold substance abuse treatment and HIV/AIDS prevention programs for people involved in the criminal justice system who are at risk for, or coping with, substance abuse and HIV/AIDS or other infectious diseases such as hepatitis C.

George De Leon, **PhD**, a nationally recognized expert on therapeutic communities is the Director of the Center of Therapeutic Community Research at NDRI and the author of the book *Therapeutic Community: Theory, Model and Method*.

Ernest Drucker, PhD, is a Professor in the Departments of Epidemiology , Family and Social Medicine, and Psychiatry at Montefiore Medical Center/Albert Einstein College of Medicine in New York City, and Adjunct Professor of Epidemiology at Columbia University's Mailman School of Public Health and at the University of British Columbia. He is a licensed Clinical Psychologist who is active in AIDS, drug policy, and prison reform and human rights efforts in the U.S. and abroad.

Howard Josepher, LCSW, is the President and Chief Executive Officer of Exponents, a minority-led organization dedicated to improving the quality of life of individuals affected by drug addiction, incarceration and HIV/AIDS. Serving clients from the entire New York City area, Exponents' programs

assist individuals and their families through difficult transitions — from addiction to recovery, from incarceration to civilian life, and from welfare to work.

Anita Marton, JD, is the Vice President of the Legal Action Center (LAC). During her tenure at LAC, Ms. Marton has provided legal advice and assistance to individuals with alcohol and drug histories, criminal records, and HIV and has participated in ground-breaking litigation on all these issues.

Frederick Rotgers, **PsyD**, is a member of the Clinical Psychology faculty at Walden University. Dr. Rotgers' areas of interest include forensic substance abuse assessment, assessment and treatment of addictive disorders, motivational interviewing, harm reduction approaches to working with substance users, and methods of enhancing the working therapeutic alliance. He is a Fellow of the American Psychological Association's Division 50 (Addictive Behaviors) and has published several books on addiction treatment. He is American Editor-in-Chief of the journal Addiction Research and Theory and a member of the Editorial Board of the Journal of Drug Issues.

Stanley Sacks, **PhD**, is a clinical-research psychologist and is the Director of the Center for the Integration of Research & Practice at the National Development and Research Institutes, Inc. (NDRI) in New York City. The author of numerous publications, Dr. Sacks was the Chair and Lead Author for the Treatment Improvement Protocol #42, Substance Abuse Treatment for Persons with Co-Occurring Disorders. He is also Expert Leader on SAMHSA's Co-occurring Center for Excellence, a national effort to provide training and technical assistance to states and agencies in the area of co-occurring disorders.

Christine Toner, LCSW, has over 20 years experience working with youth, individuals and families involved in the criminal and juvenile court system. She currently consults with community corrections and corrections departments throughout the U.S. in evidenced-based practices, including Motivational Interviewing (MI), cognitive behavioral programming and effective case management techniques. Ms. Toner is also an adjunct professor at Fordham University in New York City.

Elizabeth Tremaine, MSW, is Vice President and Director of Adult Programs at Phoenix House in New York City. She is responsible for the supervision and management of five New York Office of Alcohol and Substance Abuse Services (OASAS) licensed residential programs, including the clinical and administrative operations, planning, development, supervision and coordination of policies and programs of these facilities. She is a Credentialed Alcohol and Substance Abuse Counselor and was appointed to the New York State OASAS Credentialing Board in 2000.

Harry K. Wexler, PhD, has been with NDRI since 1977 and a senior staff member of the Center for the Integration of Research Practice since its inception. Dr. Wexler was the Co-Chair of a recent Treatment Improvement Protocol, Substance Abuse Treatment for Adults in the Criminal Justice System, and is the Principal Investigator on two current government-funded projects studying elements of prison treatment, community re-entry, and the effectiveness of sealing records as a method of reducing recidivism by eliminating stigma. He has written numerous articles, has co-authored a book on substance abuse treatment for women, and has served as co-editor of special issues of the Prison Journal.

Damien Cabezas, MSW, MPH, Vice President for Program Services at The Fortune Society, is responsible for the oversight of Fortune's Substance Abuse Treatment Services, ATI Programs, Family Services, Group Services, Drop In Center and Health Services, which includes HIV prevention and risk reduction. He holds a Master of Social Work degree from Fordham University and a Master of Public Health degree from New York Medical College.

Robin McGinty, MPA, CASACT, is formerly incarcerated and has extensive experience in working with diverse and disenfranchised communities. Currently, Ms. McGinty works as a Program Associate with a SAMSHA/CSAT funded program in New York City, targeted specifically to assist formerly incarcerated women who are homeless, with histories of chemical dependency and PTSD, as well as co-occurring psychiatric disabilities. In addition to being licensed (CASAT) by the NYS Office of Alcohol Abuse and Substance Abuse Services (OASAS), Ms. McGinty is a current candidate for a Master of Public Administration (MPA) degree at Baruch College School of Public Affairs (SPA) in New York City.

CA Board Members

Gail Allen, MD, is a member of the CA Board and the CA's Prison Visiting Project's Steering Committee. A psychiatrist specializing in chemical dependence, she was the director of substance abuse treatment services at St. Luke's Roosevelt Hospital and founded the hospital's Comprehensive Alcoholism/Addictions Treatment Program. Dr. Allen is a longtime board member of the New York Therapeutic Communities Inc., has served on the New York Governor's Advisory Council on Alcoholism Services, and was chair of the NYC Federation of Mental Health, Mental Retardation and Alcoholism Services from 1993-95.

Ralph Brown, JD, is a member of the CA Board the Chair of the CA's Prison Visiting Project's Steering Committee. He has participated in dozens of prison visits. Mr. Brown also serves on the boards of The New York Society Library and The Osborne Association.

Clay Hiles, JD, is a member of the CA Board and past Chairperson of the CA Board. He is the Executive Director of the Hudson River Foundation for Science and Environmental Research.

Nereida Ferran, MD, a CA board member and member of PVP's Steering Committee, is an internist who specializes in HIV Medicine, as well as prison healthcare, chemical dependency and nutritional interventions in HIV care. Dr. Ferran is currently an Attending Physician at the Jacobi Medical Center HIV Specialty Clinic in the Bronx, and an Attending Physician at Odyssey House, a long-term drug program in Harlem. Dr Ferran has served on the Board of Directors of several prisoners' advocacy organizations, was former Medical Director at Bedford Hills Correctional Facility and has been a consultant for several organizations, including the AIDS Institute, NYC Human Rights Commission, and Prisoners Legal Services, as well as several pharmaceutical companies involved in developing HIV treatments.

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1. INTRODUCTION

Substance abuse is a daunting problem for the majority of prison inmates nationally and more than three-quarters of those in New York State. The devastation that often accompanies substance abuse places notoriously heavy demands on the criminal justice, correctional and substance abuse treatment systems, as well as on inmates, their families and their communities. The prison system has the unique potential to provide effective drug treatment to this captive population, addressing not only the individual needs of inmates but public health and public safety as well. Not only is the prison system in a unique position to provide drug treatment, but a substantial body of research documents that treatment is, on the whole, more effective than incarceration alone in reducing drug abuse and criminal behavior among substance abusers and in increasing the likelihood that they will remain drug- and crime-free.[1]

The need to provide more comprehensive substance abuse treatment services in New York State prisons, similar to the increasing need to provide mental health services in prisons as a result of deinstitutionalization of mental hospital patients, has directly been impacted by the Rockefeller drug laws. With their rigid requirements of mandatory minimum sentencing, the Rockefeller drug laws of 1973 radically restricted judicial discretion in utilizing alternatives to incarceration as a response to drug offenses. The result: 11% of the total prison population in 1980 were individuals incarcerated for drug-related offenses; as of January, 2008, that figure was 33%. Though this past year brought significant reform to the Rockefeller Drug Laws, several mandatory minimum sentences are still on the books and a large number of individuals remain ineligible for alternative to incarceration programs. The considerable increase in this population illustrates one of the many factors that make provision of prison-based substance abuse treatment paramount, as the majority of incarcerated individuals will participate in treatment due to the nature of their offense.

As of April 2010, the New York State Department of Correctional Services (DOCS) operated 68 facilities, with 57,650 inmates under custody. Eighty-three percent of inmates were designated by DOCS as "in need of substance abuse treatment."[2] To address their needs, DOCS operates 119 substance abuse treatment programs in 60 of its facilities. As of April l, 2009, two of those programs were licensed as treatment programs by the State's Office of Alcoholism and Substance Abuse Services (OASAS); the remainder are operated solely under the aegis and oversight of DOCS. The 2009 reforms to the Rockefeller drug laws call for change, however, requiring OASAS to guide, monitor and report on DOCS substance abuse treatment programs.

In 2007, the Correctional Association launched a project to evaluate the needs of inmates with substance abuse problems and the State's response to their needs. The information presented in this report is a result of this effort and presents our findings and recommendations based on visits to 23 facilities, interviews with experts, prison officials and correction officers, more than 2,300 inmate surveys and systemwide data provided by the Department of Correctional Services.

[1] Fletcher and Chandler, *Principles of Drug Abuse Treatment for Criminal Justice Populations: A Research-Based Guide*.

[2] This is the number of inmates DOCS has identified with its screening process, not the number of inmates in New York State prisons with a diagnosis of substance/alcohol abuse or dependence.

2. EXECUTIVE SUMMARY

The majority of individuals incarcerated in New York prisons come from urban communities characterized by poverty, unemployment, crime and substance use. These conditions, coupled with the State's law enforcement approach to drug use and sale, inevitably leads to large numbers of individuals with some history of substance use being confined in our prisons. Along with this confinement, however, comes the concomitant obligation that the State should provide services to address the significant substance abuse treatment needs of this population.

A substantial body of evidence has established that effective prison-based substance abuse treatment reduces the likelihood of relapse and recidivism for participants.[3] Moreover, the benefits of successful treatment go beyond the recovery of participants to enhancing the quality of life within the prison itself and heightening public health and safety in the greater community. Successful substance abuse treatment programs can lead to increased safety for inmates and prison staff by decreasing prison violence associated with inmate drug use and trafficking, and can foster positive attitudes and behaviors that frequently result in increased participation in educational, vocational and other prison-based programming. Additionally, successful prison-based treatment reduces drug use by formerly incarcerated individuals on the outside, leading to reductions in crime and more productive and healthy lives for the individuals involved, their families and other members of their community.

The New York State Department of Correctional Services (DOCS) reports that 83% of the State's prison population, or approximately 47,850 of the 57,650 [4] current inmates, are in need of substance abuse treatment.[5] Many inmates have struggled with addiction for years prior to their incarceration, and many have participated in prison- and community-based treatment programs before their current sentence. Sixty of New York State's 68 correctional facilities operate 119 substance abuse treatment programs, making DOCS the single largest provider of substance abuse treatment in the State. Developed and monitored by the DOCS Office of Substance Abuse Treatment Services, these programs comprise approximately 10,000 treatment slots; about 34,000 inmates are enrolled in these programs annually. Each year, 27,000 individuals—nearly 40% of the prison population—return home. How well inmates with substance abuse histories are prepared for their reentry into society has a significant impact on their overall success on the outside and on quality of life in their communities.

Given the inmate population's considerable need for treatment and the large number of inmates participating in treatment programs, it is crucial that these programs be effective. Successful prison-based treatment is realized only when that treatment is based upon sound strategies carefully matched to the needs and strengths of program participants, and delivered by competent, committed staff. Prison-based treatment can also provide an opportunity to address the unhealthy behaviors that often lead to involvement with the criminal justice system in the first place. Providing appropriate education about substance abuse and clinical treatment

[3] Peters, Wexler, and Center for Substance Abuse Treatment (U.S.), *Substance Abuse Treatment for Adults in the Criminal Justice System: Treatment Improvement Protocol (TIP) Series 44 -- SAMHSA/CSAT Treatment Improvement Protocols -- NCBI Bookshelf*.
[4] As of April 1, 2010.
[5] NYS Department of Correctional Services, *Identified Substance Abusers 2007*.

services makes it more likely that these individuals can better manage their behavior and take care of themselves, their health and their communities. An additional ancillary benefit to providing substance abuse treatment in prisons is not only the reduction in drug use and crime, but the decrease in the spread of many injection-related chronic health conditions such as HIV and hepatitis C.

The Department's substance abuse treatment programming has been subject to little analysis or outside monitoring. Consequently, in 2007 the Correctional Association of New York's Prison Visiting Project (PVP) undertook a multiyear study to evaluate the substance abuse treatment programs in New York State's prisons. PVP visited 23 correctional facilities that included more than half of the Department's treatment slots. PVP staff met with DOCS treatment staff and facility management, interviewed treatment participants, observed treatment sessions, visited housing units set aside for treatment participants and reviewed treatment case records. We collected more than 2,300 surveys from inmates in prison treatment programs and those waiting to enroll in such programs.

The information gathered by PVP shows that though most of DOCS treatment programs use the same program curriculum, the implementation of these programs demonstrates wide variation in the content and quality of prison substance abuse treatment, revealing some programs that exhibit good practices run by dedicated and skilled staff and others that need significant improvement. Of the 23 programs visited, there was considerable variation among programs in content, structure and satisfaction. The variations were apparent in all aspects of the programs: clinical content, staffing patterns and qualifications, participant satisfaction, treatment strategies, program structure and program oversight. We visited programs where the vast majority of participants (96%) were satisfied with their treatment, and other programs where two-thirds of the participants were dissatisfied.

Our review of programs at individual facilities resulted in a number of findings that apply to the overall treatment approach Department-wide. First, DOCS's broad standards for designating inmates as "in need of substance abuse treatment" result in considerable variation among treatment participants with regard to the severity of their substance abuse and motivation to complete treatment. Second, despite this variability, most programs adhere to a single design, a six-month residential program of daily half-day sessions with groups of 20 to 50 participants. Some programs better support participants in gaining insight and make meaningful progress in addressing their addiction, but other programs are much less successful in engaging and assisting the participants. Third, although some treatment staff have frequent and meaningful one-on-one meetings with program participants, the individual counseling sessions in many programs are brief and only occur monthly. Fourth, the Department does not have a detailed curriculum, and therefore there is limited standardization of program content or materials. As a result, some facilities use best practices and up-to-date materials while others rely on outdated materials and conduct poorly designed treatment sessions. Fifth, the experiences, training and overall competence of the treatment staff vary greatly, and there is little clinical guidance and oversight. Finally, discharge planning is limited, with little coordination between in-prison treatment programs and community-based treatment providers. Some DOCS treatment providers attempt to assist soon-to-be-released inmates in identifying aftercare programs, but in most programs, treatment staff do not help the participants develop effective aftercare plans. Instead, inmates are

often left to identify their own post-release care or to rely on parole officers, who have little knowledge of individuals' treatment needs or community resources.

After reviewing practices in New York State's prisons, researching current standards in the field, and identifying the most up-to-date evidence-based practices, we identified several concrete steps the State can take to improve its treatment programs. (See **Section 18, Recommendations**, for more detailed descriptions.) We urge State officials and DOCS to consider implementing five critical changes that could have the greatest positive impact. First, the Department should implement a comprehensive system of screening and assessment to identify the severity of each inmate's substance abuse and corresponding treatment needs. Second, the Department should develop a continuum of treatment options, from education to intensive residential treatment. Third, the Department should place each inmate in the program that best addresses his/her needs. Fourth, DOCS and other State agencies should enhance and coordinate discharge planning that connects inmates with appropriate community-based treatment and other support services upon release. Finally, the Department should collaborate with the Office of Alcoholism and Substance Abuse Services (OASAS) to develop a more comprehensive curriculum for each program and implement an effective system of monitoring and oversight of programs and staff. Implementing these recommendations would not only greatly increase the likelihood that formerly incarcerated individuals with substance abuse histories can avoid both relapse and reincarceration, but also significantly benefit general public health and the safety of all communities.

Major Findings

Screening/Assessment

- **DOCS assesses inmates at reception to determine their need for substance abuse treatment using five methods and a broad definition for what constitutes need for treatment. Many inmates object to the Department's determination that they need treatment.** Corrections staff use two nationally recognized screening instruments, the Michigan Alcohol Screening Test (MAST) and the Simple Screening Instrument (SSI), to assess need for treatment, but the scores used to make this evaluation are set at a low threshold so that inmates with a limited history of substance use are designated to need treatment. For example, a score of 5 to 8 is specified by the MAST to be indicative of alcohol abuse, but a score of 4 is used by DOCS to designate an individual as in need of treatment; thus many individuals are inappropriately screened into treatment programs, resulting in a high rate of false positives, which in turn overwhelms the treatment resources and leaves programs with high numbers of individuals not in need of treatment diluting the treatment resources for those with more severe need. These instruments were designed only to screen inmates for a potential substance abuse problem and to determine who should be further evaluated for potential treatment. A determination of an individual's diagnosis and actual treatment needs should be made only after a more comprehensive assessment by a qualified substance abuse professional who can distinguish between substance abuse and substance dependence, a procedure recommended by the Substance Abuse and Mental Health Services Administration

(SAMHSA).[6] The Department does not follow this process, as individuals with positive scores on the screening tests will have substance abuse treatment added to their required program list.[7] In addition, individuals may be designated to need treatment as a result of self-reporting during reception or based upon information included in his/her pre-sentence report. For example, if an individual has been convicted of a drug-related offense such as possession, use or sale, he/she would generally be designated as needing substance abuse treatment. The exact criteria for who will have treatment added to their required program list are unclear, and the process for making this assessment is not well defined, resulting in numerous reviews by DOCS staff of the same information without a clearly designated person responsible for making the final determination of treatment need. Finally, there is no Department training or requirement for specific experience in treatment assessment for the staff involved in the process, resulting in inconsistent application of the standards for who is required to enter a program.

- **The Department's definition of substance abuse issues that justify treatment is very broad and includes any individual who is at moderate risk of substance abuse, has any history of substance use or has been involved in drug sales in any capacity.** As a result, the Department estimates that approximately 83% of the inmate population has a "substance abuse problem" and, therefore, would benefit from treatment.[8] In determining the need for treatment, the Department lacks guidelines instructing correction counselors to consider how recently an individual used an illegal substance when assessing treatment need, nor is there a threshold for frequency or consequences of substance abuse before a determination of need is made.

- **Many inmates we interviewed questioned their designation as in need of treatment by DOCS because they believed they did not have a substance abuse problem.** This group includes inmates who were convicted of selling drugs, or whose pre-sentence reports indicated involvement in drug sales, but who asserted they did not use drugs. Department officials suggest that the individuals are appropriate candidates for treatment because, despite assertions to the contrary, many of them are in fact substance users, and the others can still benefit from treatment that addresses the issues of individual responsibility, life skills, addiction behavior and criminal thinking. Other inmates who complained about their designation reported using only marijuana on occasion or stated that their substance use occurred many years prior to their current incarceration. In 2007, DOCS reported that the most serious drug used by 36% of the male identified substance abusers was marijuana, a percentage significantly greater than alcohol only (23%) or the other identified substances (all under 18%).

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[6] Peters, Wexler, and Center for Substance Abuse Treatment (U.S.), *Substance Abuse Treatment for Adults in the Criminal Justice System: Treatment Improvement Protocol (TIP) Series 44 -- SAMHSA/CSAT Treatment Improvement Protocols -- NCBI Bookshelf*.

[7] Though substance abuse treatment is not mandated, if an inmate refuses to participate in a program on his/her required program list, the consequences are extremely negative and can result in a loss of good time or merit time and being denied early release by Parole. Many inmates expressed feeling forced to complete a treatment program or face spending more time in prison.

[8] NYS Department of Correctional Services, *Hub System: Profile of Inmate Population Under Custody on January 1, 2008*.

- **The screening process used by DOCS to determine whether an inmate needs substance abuse treatment while incarcerated does not provide an assessment of the severity of the individual's substance abuse problem and criminal risk or a recommendation for the type of program most beneficial to the inmate. Even if such recommendations are made, only a limited number of types of programs are available for individuals who have been designated as needing substance abuse treatment.** Substance abuse treatment programs offered by the Department are primarily a "one size fits all" approach. Although there are programs for some special populations,[9] representing approximately 16% of all treatment slots, these programs follow similar curricula as the general Alcohol and Substance Abuse Treatment (ASAT) program with additional topics being discussed (mental health, for example) and an extended length of time spent to complete the curriculum in order to accommodate different learning abilities. Other DOCS substance abuse treatment programs such as the four Shock programs, the Willard Drug Treatment Campus and Edgecombe Correctional Facility accept individuals based not necessarily on treatment needs, but on sentence and other factors. Treatment matching requires that different types of individuals are assigned to the most appropriate kind of treatment to achieve different types of treatment goals. Most experts consider this kind of precise approach not only to be cost effective, as individuals are matched to the level of services most appropriate to their need, but to improve the effectiveness and quality of services offered.[10] This type of treatment matching generally does not occur in DOCS.

- **Largely due to the over-inclusive screening process and the failure to institute a more comprehensive assessment of need, significant variation exists among treatment participants regarding their substance abuse histories and needs.** Mixed together in the sessions that we observed were inmates with active substance abuse histories with substances such as heroin or crack, inmates who reported only using marijuana occasionally, inmates who had previously had substance abuse problems but had been abstinent for many years and inmates who were drug dealers but who asserted they never used drugs themselves. For example, 15% of individuals we surveyed not in treatment at the time of our visit, but who had previously completed prison-based treatment, reported only occasional marijuana use and limited alcohol use, and said they had no or only a slight substance abuse problem. Common criticisms from inmates included that they often could not relate to some of their fellow participants and felt pressure from their peers and the treatment staff to admit to more drug use then they had actually done. They also reported that some of the subjects covered in group sessions were either not specific or comprehensive enough to address their needs or were about topics that were not applicable to them.

[9] Programs for special populations include: two DWI programs, four CASAT programs, 13 programs for individuals with co-occurring disorders, three programs for the special needs or sensorially disabled population and four programs for inmates residing in regional medical units.

[10] Peters, Wexler, and Center for Substance Abuse Treatment (U.S.), *Substance Abuse Treatment for Adults in the Criminal Justice System: Treatment Improvement Protocol (TIP) Series 44 -- SAMHSA/CSAT Treatment Improvement Protocols -- NCBI Bookshelf*.

- **Most treatment programs we visited prioritize admission to the program based on the inmate's proximity to his/her earliest release date. Treatment programs generally do not give priority to inmates who have current substance abuse problems.** Because it is DOCS policy to prioritize individuals for treatment based upon the proximity to their release dates, inmates facing lengthy incarcerations will not receive any treatment for many years, regardless of demonstrated need. At many prisons, inmates must be within one year of their potential release dates before they are offered treatment. We understand the challenges associated with completing a substance abuse treatment program soon after beginning one's incarceration. For example, the inmates would then have to return to general population to complete their sentence, where continued recovery support is limited and the chance of relapse is high, also negatively impacting on prison management and safety. Moreover, at the beginning of one's prison term, it is more difficult to plan appropriate continuity of care for eventual discharge to one's community. Inmates definitely need treatment support toward the end of their incarceration to prepare them for returning to the community. But we also observed during our visits a portion of the inmate population with a significant need for treatment earlier in their incarceration. Many inmates entering prison with a history of substance abuse end up using drugs in prison and thus becoming subject to considerable disciplinary sanctions. Inmates found possessing or using drugs or alcohol are routinely given disciplinary sentences of several months to a year or more and are placed in a Special Housing Unit (SHU) where they spend 23 hours of their day in lockdown and are denied programming. In addition to being disciplined, inmates using drugs are simultaneously moved to the back of the waiting list for substance abuse treatment and will still have to wait for treatment until one to two years before their release.

Treatment Programs, Processes, Content and Structure

- **Though many of the treatment programs we visited had some type of modified hierarchy structure in place, the hierarchy roles were not generally associated with an increase in privileges nor were all members of the community given a role in the hierarchy structure.** In a therapeutic community program, the treatment model for the majority of DOCS treatment programs, hierarchy is defined as a system that allows for positions of increasing responsibility and associated privileges through commitment to and mastery of therapeutic community and counseling concepts. Sanctions and incentives serve an equally important function. Many treatment programs we observed punished individuals for failure to conform to the rules. However, we did not witness or learn about many incidents in which individuals were rewarded for their progress. Incentives are a principal function of a structured hierarchy and can help build self-esteem, model appropriate behavior and develop important social skills. In most cases we observed and heard about from inmates, it seemed that occupying one of the multiple hierarchy positions was often based on staff preferences or inmate volunteerism rather than upon actual progress in the program.

- **The role of inmates in the treatment programs varied significantly. At some programs, inmate-participants facilitated a significant portion of the group sessions, while at other prisons staff took a more direct role.** At many facilities, inmate

hierarchy members facilitated all or most community meetings. At other facilities, inmates with hierarchy positions such as coordinator or assistant coordinator played a central role in group sessions ranging from facilitating the entire session, to assisting in engaging fellow participants, to assisting staff with materials or other assignments. Though treatment staff were often present as inmates facilitated part or all of some sessions, at some facilities the treatment staff would leave the group and allow the inmate to facilitate on his/her own. This was also reported to us by treatment participants at some facilities. While it is important that inmates take a leadership role in treatment programs, appropriate supervision by treatment staff is key. Many inmates have a significant amount to offer to other participants regarding their own experiences with substance abuse and recovery, but they rarely possess the clinical background, training or expertise necessary to provide a full range of treatment services. Being a facilitator can be an important learning experience for the inmate and a meaningful opportunity to model behavior and develop self-esteem. This type of development can only be accomplished with the assistance and supervision of qualified treatment staff.

- **Program structure varied a great deal from program to program.** Group sizes in most treatment programs ranged from 15 to 60 inmates, with typical groups of 25 to 30 participants. This group size is more appropriate for educational or informational lectures and generally considered too large by experts for effective group therapy. In a significant number of the programs we visited, groups rarely divided up to work in smaller groups. Treatment participants also said they spent a considerable amount of the program listening to educational presentations or watching informational videos and much less time talking about their own substance abuse issues. As most programs use some type of modified therapeutic community, they had some type of community meeting, but again these sessions differed in length, frequency and format, with the typical program having group meetings once a week. The variability from program to program and within programs did not appear to reflect any differences in the population or program design, but rather the style and preference of the individual treatment staff.

- **Most of DOCS treatment programs are designed as modified therapeutic communities. The DOCS ASAT Manual does not provide detailed guidance as to clinical content or treatment modalities, and loosely states that programs can utilize various techniques, such as cognitive-behavioral therapy, within their programs. Consequently, significant variations are present in program content and treatment modality within and among the prison treatment programs.**

Program Content

- **The lack of a detailed curriculum with supporting documents in the treatment manual leaves program staff without adequate direction concerning the daily content of the program.** The amount of skills training in areas such as anger management, stress management and communication skills varied amongst programs. For example, 83% of treatment participants at Greene Correctional Facility reported receiving communication skills training, compared with 29% at Oneida. We observed some effective presentations and program sessions, but also saw sessions that were

poorly planned and lacking coherent content. Each prison, and often each staff member within a prison, collects and maintains different handouts, worksheets and other tools. Some of these materials are inaccurate and/or outdated, resulting in treatment programs that are very inconsistent.

Treatment Modality

- **Though most DOCS treatment programs utilize some components of a therapeutic community, cognitive-behavioral and 12-step approach, the degree to which these are utilized varied among facilities.** Inmates voiced differing perceptions of the importance of these treatment modalities among the programs, rating cognitive behavior as both the most important component (77%) and the modality which provided them higher levels of satisfaction (77%). Survey participants next expressed the importance of and satisfaction with therapeutic community (63% importance of and 67% satisfaction with) and 12-step elements (53% importance of and 60% satisfaction with).

- **Individual counseling is limited, with wide variations among programs.** There is no clear requirement for significant one-on-one counseling beyond monthly meetings that serve as the basis for the monthly evaluations. Some of these monthly meetings last only a few minutes or less per inmate. Some treatment staff reported, however, that they have frequent informal individual meetings with program participants who request them. It does not appear that these sessions are documented in participants' treatment records.

- **The written materials and handouts used in the treatment programs varied significantly, at times were outdated and were made up of individual documents brought in by treatment staff with limited to no guidance from DOCS Central Office.** Both treatment staff and inmates voiced concerns about the lack of up-to-date materials, written and video, available for use in the treatment programs. They expressed frustration with the limited amount of resources available to update these materials. It is challenging to find innovative ways to engage a population that is oftentimes resistant to treatment, and using videos and handouts that do not reflect current trends or evidence-based practice make this task even more difficult. Facilities such as Bare Hill, Franklin, Five Points, Oneida, Shawangunk and Taconic added supplemental materials from outside sources, though these were not always consistently up to date.

- **Individual treatment records vary in content from program to program and the documents in the records provide no real indication or detail about an individual's treatment needs, substance abuse history, or treatment objectives**. We received substance abuse treatment records from some facilities that did not represent an adequate or holistic view of the individual and the many factors that will impact his/her current treatment, including information about the individual's previous treatment history, results of his/her initial screening by DOCS, medical history, educational/vocational needs or social support assessment. We also were unable to find any results of individuals being tested for drug use while incarcerated. In many records, treatment objectives or other important questions were left blank or filled in with one word answers. In addition, the monthly evaluations and discharge assessments contained limited substantive feedback

and few, if any, notes indicated the content of individual counseling sessions. Overall, the treatment records were not sufficiently individualized. Also, it appears that no clinical supervisors ever reviewed the charts.

Program Climate

- **Treatment participants' views on staff support, communication within the program and engagement in the program varied considerably from facility to facility.** The program environment can either assist a program's effectiveness and improve outcomes for the participants, or hinder them. We observed both the positive and negative impacts that program climate can have on programs during our visits.

  Staff Support

  We observed variation among treatment staff in their commitment to inmates, including some treatment staff who seemed to possess a negative attitude toward inmates, viewing the role of prisons as containment rather than rehabilitation. In contrast, 32% of all treatment participants we surveyed reported that it was *mostly* or *very true* that staff believed in them and 30% stated it was *mostly* or *very true* that staff were interested in helping them. In some programs, such as Taconic (63% and 48%, respectively) and Lakeview Female (64% and 68%, respectively), survey respondents reported significantly higher positive responses to the above questions, and we were able to observe some staff who appeared sincere and dedicated to the work and the population.

  Communication

  For individuals to gain the most from a treatment program and their community of peers, it is important that they feel the program is a safe space for sharing personal information and viewpoints. We observed some programs that clearly had created a safe environment conducive to honest and open discussion and others where levels of tension appeared high and participation was lower. For example, survey respondents from Lakeview Female (71%), Oneida (59%), Bare Hill (60%) and Washington (56%) reported it was *mostly* or *very true* that participants were afraid to speak up for fear of ridicule or retaliation, whereas survey respondents at other prisons expressed much less fear about participating in a discussion (Shawangunk (27% *mostly* or *very true* afraid to speak), Eastern (28%), Taconic (33%) and Hale Creek (32%)).

  Engagement

  At some treatment sessions we saw programs participants who were actively engaged and demonstrated a clear sense of ownership for the program, while at other facilities, participants appeared bored and disengaged. Of the total number of survey respondents, 34.5% stated that it was *mostly* or *very true* that they enthusiastically participated in the program and 37% reported that it was *mostly* or *very true* that they felt an attachment to and ownership of the program. The survey results also illustrated the variation we observed among programs with facilities such as Lakeview Female (63%), Lakeview

Male (55%), Taconic (52%) and Sing Sing (50%) reporting higher percentages of individuals who found it to be mostly or very true that they felt an attachment and ownership to the program, compared with Gouverneur (15%), Oneida (17%), Willard Drug Treatment Campus Male (21%) and Bare Hill (22%).

- **Treatment participants at many programs reported feeling high levels of anxiety and stress based on their concern that they would be removed from the program for a small infraction, losing their good/merit time and having to spend more time incarcerated.** Many programs appeared punitive in nature, often relying on disciplinary, rather than therapeutic responses, to minor violations. A large focus was placed on keeping areas tidy, and individuals reported receiving sanctions for minor transgressions such as not having their shoes in a straight line under their bed. In contrast, we observed some programs whose staff made a genuine effort to ensure that participants would succeed in the program and who used minor violations as a learning opportunity for the individual.

Staffing

- **The staffing ratio at most treatment programs is inadequate to meet the needs of the participants. Most ASAT programs are staffed with only one ASAT correction counselor and two program assistants (PAs) for every 120 program participants, with the PAs facilitating most of the group meetings. We observed significant program staff vacancies at many of the prisons we visited.** The programs are primarily run by PAs and class sessions range from 15 to 60 inmates, with an average size of 25 to 30. At several prisons, we not only found a high number of staff vacancies, but also a high level of staff turnover. It appears that some professionals use the PA position as an entry-level job and then seek promotions once they have met the minimum standards for advancement. Inmate participants often facilitate the classes, sometimes with limited oversight by the PAs. In the current economic environment, most facilities are not being granted the authorization to fill vacancies, resulting in treatment program staff being stretched beyond capacity and inadequate treatment attention often being given to program participants.

- **There was wide variation in staff's commitment to the program.** We observed substance abuse staff that were enthusiastic and engaged with the participants in their classes, evidencing a commitment to the program and the success of its participants. We also observed some substance abuse staff that appeared to be indifferent to the daily activities of the treatment program. These staff members often exhibited a lack of concern about the need for updated materials and innovative approaches for engaging participants in the treatment process. Many survey respondents were highly critical of the staff's efforts and did not believe they were receiving effective support for their recovery. Satisfaction with such key services as providing treatment plans and general counseling varied considerably at some facilities. For example, a minority of survey respondents at Bare Hill (31%), Cayuga (33%), Oneida (33%) and Gouverneur (40%) reported that they were *somewhat* or *very satisfied* with the counseling process, compared with the vast majority of survey respondents voicing satisfaction at Taconic (77%), Hale

Creek (84%), Lakeview Male (84%) and Lakeview Female (96%). We found similar variation with regard to satisfaction with the treatment plan.

- **Wide variations were apparent in competence and skills among DOCS treatment staff.** Some treatment staff had extensive substance abuse training and experience working in community-based treatment programs, while others possessed considerably less experience and training. Very few treatment staff possessed higher level degrees and only 23% of the treatment staff we spoke with reported being credentialed alcoholism and substance abuse counselors (CASACs).

- **Many staff are not actively engaged in continuing professional education and development or engaged in professional organizations that focused on substance abuse treatment. Though all treatment staff participate in the mandatory 40 hours of training required by DOCS, they receive minimal training on substance abuse topics such as new counseling techniques and preparation for working with special populations.** DOCS Office of Substance Abuse Treatment Services provides limited professional training, focused on an average of two or three different topics a year. It appears that training on therapeutic communities is the only topic offered on a more regular basis by this office. We observed some staff actively engaged in professional training programs or professional organizations outside of DOCS. The Office of Alcoholism and Substance Abuse (OASAS) has an extensive training catalog on a variety of topics, but participation in this training is not a requirement for DOCS treatment staff. We observed significant variation in answers among staff when asked if they have participated in OASAS trainings. In addition, when asked about trainings they had participated in during the past two years, a number of staff were unable to recall the topic covered in the training session.

- **Staff/inmate relations varied from facility to facility and were often marked by inmate distrust of staff and frustration with the power many staff held over participants.** Inmates we spoke with often felt that staff were not sincere in their efforts to help them and that they did not appear to be invested in the treatment program. Only 39% of survey respondents said it was *mostly* or *very true* that treatment staff supported their goals and 40% reported as *mostly* or *very true* that treatment staff sincerely wanted to help them. Several inmates also reported that some staff would use their ability to remove them from the program as a means of intimidation. In our conversations and meetings with treatment staff, we observed staff who appeared truly committed to assisting treatment participants and were able to see the individuals holistically. We also observed staff who seemed disengaged and did not express much empathy for them.

Program Completions and Removals

- **The number of removals and completions among programs varies significantly. The removals policies and procedures in place differ from facility to facility.** Some programs we visited removed nearly as many participants as they graduated, while others had considerably higher graduation rates. Facilities with high removal rates include Five Points, Washington, Greene and Mid-State, whereas Wyoming, Taconic, Wende and

Eastern had much lower removal rates. Treatment staff at some programs we observed worked closely with treatment participants to ensure their successful completion and utilized learning experiences rather than punitive responses to program violations. In contrast, other programs were more likely to remove individuals for repeated relatively minor infractions. Individuals in treatment programs receive a monthly evaluation from staff, and oftentimes, two or more negative monthly evaluations lead to a participant's removal from the program. The various elements that may result in a negative monthly evaluation differ among programs and treatment staff.

Drug Use and Testing

- **The frequency of drug use and possession among inmates varies significantly among the DOCS facilities we visited.** Dedicated substance abuse treatment facilities such as Lakeview Shock, Willard DTC and Hale Creek had low occurrences of both drug use and possession. Facilities such as Five Points, Sing Sing and Wende had high rates of both drug use and possession, whereas Gowanda, Greene and Franklin had lower rates. Forty-two percent of survey respondents from all facilities we visited stated that contraband drug use was *very common*, with Sing Sing (73%) reporting the highest percentage and Taconic (25%) the lowest.

- **Inmates who test positive for illicit substances are frequently sent to the Special Housing Unit (SHU), where little to no substance abuse treatment is offered.** Eighty-six percent of survey respondents at the facilities we visited who had received a positive urine test were given a SHU sentence and, if at the time enrolled in a treatment program, were removed from their substance abuse treatment program. Only 14% of the individuals surveyed who received a SHU sentence as a result of drug use or possession were provided with a cell-study workbook on substance abuse treatment during their SHU sentence; no out-of-cell treatment program is offered by the Department for disciplinary inmates.

Reentry/Aftercare

- **Most treatment programs make little effort to develop specific in-prison and post-release aftercare recommendations for program graduates.** Treatment programs generally do not require or provide assistance to inmates in contacting community-based aftercare programs or developing a concrete plan for continuum of care, even for those participants who are nearing release. In addition, program staff in many prisons make little effort to develop prison-based aftercare programs, and treatment staff frequently do not emphasize the importance of participation in voluntary programs such as Alcoholics Anonymous (AA) or Narcotics Anonymous (NA). Programs at some facilities, such as those at Lakeview Shock, Sing Sing and Hale Creek, did engage in aftercare planning and support both in prison and in preparing for release. In addition, Mid-State had developed an aftercare dorm for program graduates.

- **Discharge planning is minimal, and many of the staff responsible for this task lack the expertise and resources to execute it effectively. The treatment staff who have worked with the inmates for a minimum of six months and are in the best position to assess an individual's readiness for, and make recommendations to, appropriate community-based treatment programs are not charged with the responsibility of developing a detailed discharge plan. No detailed discharge plan is produced for an inmate in any program, as the responsibility of determining program and housing placement upon release lies with parole. In practice, the treatment staff at most facilities provide little to no support or assistance to inmates who have been graduated from prison-based substance abuse treatment and are being released.** Discharge planning for inmates with substance abuse problems is the responsibility of the DOCS Transitional Services (TS) unit and the New York State Division of Parole. The discharge planning process for inmates with substance abuse problems varies greatly among the prisons we visited. The Transitional Services units are primarily staffed by inmate program assistants, with varying degrees of professional staff oversight. The Division of Parole created a special unit of parole substance abuse counselors called ACCESS that is responsible for interviewing, assessing and referring individuals who are required to participate in community treatment and are being released in New York City. This effort by Parole focuses on New York City, so many inmates discharged in other parts of the state are not provided these important services.

Clinical Case Records

- **Substance abuse treatment records we reviewed were often not individualized and did not present a holistic or comprehensive view of the treatment participant or his/her experiences or history.** Many treatment records lacked basic information such as full substance use or treatment histories. They also contained minimal information about other needs or issues that may impact on recovery such as social supports and employment and educational opportunities. In addition many of the long- and short-term goals in the treatment plans were broad and unspecific and were repeated verbatim among various treatment records.

- **The treatment record forms and process outlined in the ASAT manual do not encourage collaboration between inmates and treatment staff in the development of critical treatment elements such as treatment and discharge plans.** The treatment plan and discharge forms did not appear to include space for substantive participant input, nor was there evidence of such input in the treatment staff's comments on the forms themselves. The records we reviewed seemed to contain mostly the views of the treatment staff and less the voice of the participant.

- **No clear process exists for clinical supervisors to regularly review and ensure the quality and content of treatment records.** Only one form in the treatment records included a line for documentation of a clinical supervisor review. Other than annual site visits from Central Office in which some treatment records may be reviewed, there appeared to be no formal process by program supervisors to review treatment records.

This type of review is integral to ensuring appropriateness of content, proper completion of forms and quality and effectiveness of treatment services provided.

Monitoring/Oversight

- **Protocols or procedures for prison management oversight of treatment programs do not exist; prison staff responsible for this oversight have little relevant expertise.** On most of our visits, prison administrative staff reported limited experience or expertise in treatment programs. They typically performed no monitoring of the program other than visiting the area and reviewing grievances and complaints from participants. At some facilities, however, the supervising correction counselor, who was directly responsible for the program, had expertise in the area, but even in these situations there was no protocol defining these officials' duties in managing and monitoring the program. There appears to be very little clinical supervision in the daily operations of the treatment program, particularly in terms of observing sessions, case consultations and chart reviews.

- **Only recently has there been any outside monitoring of DOCS substance abuse treatment services.** Language was included in the Rockefeller drug law reforms passed in April 2009 that required the Office of Alcoholism and Substance Abuse Services (OASAS) to monitor prison-based substance abuse treatment programs, develop guidelines for the operation of these programs and release an annual report assessing the effectiveness of such programs. Previously, OASAS certified both the Willard Drug Treatment Campus (Willard DTC) and the treatment program at Edgecombe Correctional Facility. OASAS's involvement with correction, such as the new standards created for Willard DTC in 2009, has helped to reduce the size of group counseling sessions and increase the qualifications necessary for certain treatment staff positions. OASAS' first report on NYS DOCS Addiction Services published in December 2009, lays out plans for 2010 that include site visits to 8-10 facilities (including a reception center and maximum security facility) as well as the development of new basic operating guidelines for both the ASAT and CASAT programs.

Special Populations

- **Inmates with both substance abuse problems and mental health needs do not consistently receive appropriate substance abuse treatment.** The State has created only 13 Integrated Dual Diagnosed Treatment (IDDT) programs, designed for individuals with both substance abuse and mental health problems, some of these taking place in general population while most are held in the mental health residential units at Office of Mental Health (OMH) level one facilities. These represent approximately 294 of the nearly 10,000 DOCS treatment beds. No clear policies or criteria exist for including general population inmates with mental health needs in existing treatment programs. We received varying descriptions from the prisons we visited concerning these inmates' participation in general substance abuse treatment programs. Nearly 14% of New York's prison population is on the OMH caseload, representing more than 8,500 inmates, of whom 3,500 to 4,000 have significant mental health needs. The State is not providing an adequate number of treatment slots for this patient population. The majority of

individuals on the OMH caseload are placed in general population, and it is unclear whether they receive treatment geared to their needs. However, the Department has reportedly recently developed a new treatment manual for its IDDT programs, and it appears the Department wants to enhance these services.

- **At most prisons, services for participants with limited English skills are inadequate.** Few DOCS treatment staff are Spanish-English bilingual, and very few treatment activities are conducted in Spanish. Since approximately 6% of the State's inmate population has limited English skills, the needs of many individuals are not adequately being addressed. At many prisons, some materials are available in Spanish. However, for most programs, the inmates must rely on other bilingual inmates to translate for them. The inmate translators have received no training in performing these functions. Moreover, most substance abuse treatment staff cannot read Spanish, so it is unclear to what extent they are able to review the materials prepared by Spanish language–dominant program participants.

- **Gender-appropriate topics and materials for substance abuse treatment programs in DOCS facilities housing women varied significantly.** Approximately 88% of women in New York State prisons are assessed as having an alcohol or substance abuse problem. Eight out of 10 women in prison in New York State experienced severe abuse as children, and nine out of 10 have had incidents of physical or sexual violence in their lifetimes. Compared with nearly 13% of the male inmate population in the State, 42% of women have been diagnosed with a mental illness, and 73% of incarcerated women are mothers. Incarcerated women have specific experiences that will influence their recovery process. These perspectives must be addressed in substance abuse treatment programs serving women in order to ensure effective treatment.

Major Recommendations

As mentioned above, the Office of Alcoholism and Substance Abuse Services released its first annual report on DOCS treatment services in December 2009. The OASAS report outlined a number of promising developments and future plans for improving DOCS substance abuse treatment programs, including: reviewing the Department's screening/assessment instruments and processes; developing new operating guidelines for the Alcohol and Substance Abuse Treatment (ASAT) and Comprehensive Alcohol and Substance Abuse Treatment (CASAT) programs currently offered by DOCS; providing assistance in identifying additional training opportunities for treatment staff; exploring the use of medication-assisted therapy (MAT) within DOCS facilities; and assisting the Department in monitoring the effectiveness of its programs. These plans are positive and necessary first steps in improving the current substance abuse treatment offered in NYS prisons and the following recommendations build upon and further develop many of these points. We have included a more complete list of recommendations in **Section 18** of this report.

Screening/Assessment

- **Develop and implement a more comprehensive and standardized assessment process and an instrument that enable the guidance/reception staff to distinguish among types and severity of need for substance abuse treatment as well as risk of future criminal behavior, and to distinguish between substance use, substance abuse and substance dependence.** The addition of a more comprehensive assessment tool for use for individuals who screened positive for substance abuse and a clear, formal definition of who should receive treatment would reduce the number of individuals being inappropriately placed into treatment programs, would ensure that individuals were being placed into the program that most accurately reflects their level of need, would make the best use of limited staffing and financial resources and would be most effective in reducing risk of relapse and recidivism due to drug use.

- **Require staff conducting assessments regarding substance use to receive training to administer the standardized assessment instrument.** Decisions regarding appropriate placement for substance abuse treatment programs are more effective when done by trained professional staff. A degree of understanding about the different levels of severity of substance abuse, the types of prison-based programs available, and the program that best suits an individual's needs can reduce inappropriate referrals and increase treatment effectiveness. Specialized training covering basic counseling techniques, essential mental health terms, symptoms, relationship building and reflective listening should be offered to counselors administering screening and assessment instruments. Office of Mental Health (OMH) staff should work in coordination with counselors assessing inmates for substance abuse treatment, sharing mental health information as needed and collaborating when necessary to make an appropriate recommendation for substance abuse treatment services for individuals with mental health problems.

- **Develop a variety of treatment and educational programs for individuals with differing needs and match individuals who have been identified as needing some substance abuse treatment to appropriate treatment programs based on their individual needs and severity of substance abuse.** Matching programs to individual needs greatly increases the chances that an individual will be successful in his/her treatment placement. Treatment matching or determining appropriate level of care requires that a continuum of services be available, ranging in levels of intensity, length, treatment modality and location (residential or outpatient). To create a successful therapeutic environment, inmates with similar types and severity of substance abuse issues should be placed together to maximize the effectiveness of the treatment and to make the best use of treatment staff resources. Correctional facilities in Colorado[11] and Maine have had success with treatment matching; these programs could serve as models for a similar approach in New York State.

- **Allow for prioritizing of substance abuse treatment programs according to need and severity of substance abuse problem for inmates demonstrating circumstances such**

[11] https://exdoc.state.co.us/secure/combo2.0.0/userfiles/folder_5/Overview_SA_Treatment_Services_FY08_2.pdf

as active substance dependence when entering prison and drug use inside prison. Inmates with a significant need for substance abuse treatment at admission to DOCS or who repeatedly receive disciplinary sanctions for drug use inside prison should be prioritized for substance abuse treatment services regardless of the length of their prison sentence. Though individuals will still be required to participate in a substance abuse treatment program toward the end of their incarceration, the State should explore the creation of a separate voluntary substance abuse treatment program for individuals first entering the prison system who need treatment services more urgently. This option should also be available for inmates who receive a misbehavior report for use or possession of drugs while incarcerated. It is important to note that the Substance Abuse and Mental Health Administration (SAMHSA) also recommends that inmates with significant substance abuse needs and high recidivism risk should be prioritized for initial placement into a substance abuse treatment program.[12]

Treatment Programs, Processes, Content and Structure

- **Standardize program content and material using evidence-based workbooks, handouts and videos.** The DOCS Office of Substance Abuse Treatment Services (OSATS) should provide a more detailed curriculum to treatment programs including handouts and videos to be used in the program. Treatment staff with community-based treatment experience should introduce relevant materials that they believe would add value to the program, but such materials should be reviewed by OSATS staff during their routine monitoring of the programs to ensure the appropriateness of such materials and to identify useful materials to distribute to all treatment programs. Centralizing materials and program content can assist in making certain that materials and content are up to date and include new evidence-based practices and approaches.

- **Increase frequency and length of individual counseling sessions.** Individual counseling in a setting with such a diverse population and large group sessions allows inmates to address more sensitive issues that they might hesitate to discuss in a group setting. DOCS should offer individual counseling sessions in substance abuse treatment programs in accordance with OASAS standards for community-based programs. It is also essential that treatment staff ensure the confidentiality of such individual sessions and accurately document their duration and content.

- **Reduce the size of group sessions and increase frequency of use of small group sessions.** Large group sessions are conducive to didactic instruction, but do not create an appropriate environment for open communication, sharing and discussion. Group size should be limited to ensure best clinical effectiveness; groups should routinely break into small groups that can facilitate greater interaction, dialogue and support among peers.

- **Fidelity to therapeutic community and cognitive-behavioral principles should be improved.** Efforts should be taken to ensure that key elements of therapeutic

[12] Peters, Wexler, and Center for Substance Abuse Treatment (U.S.), *Substance Abuse Treatment for Adults in the Criminal Justice System: Treatment Improvement Protocol (TIP) Series 44 -- SAMHSA/CSAT Treatment Improvement Protocols -- NCBI Bookshelf*, 148.

communities and a cognitive-behavioral approach are more fully integrated into the program. This approach includes placing a greater focus on role playing and skills development, as well as use of incentives and privileges in the community.

Staffing

- **Increase substance abuse treatment staffing numbers.** State policymakers should take action to promptly fill authorized DOCS treatment staff positions. Staff-to-participant ratios should be in accordance with OASAS community regulations

- **Increase qualifications and skills necessary for treatment staff**. Treatment staff should meet the necessary requirements and qualifications as outlined by OASAS, resulting eventually in a substantial portion, if not all, of treatment staff having some type of outside credential or license, such as CASAC.

- **Provide more comprehensive and frequent training for treatment staff covering topics such as evidence-based counseling approaches used in substance abuse treatment, working within the criminal justice setting and working with special populations.** The State should develop additional mandatory ongoing training sessions and encourage greater participation in training by providing monetary support, approved absences and other incentives to enhance the skills of the treatment staff. Training for all DOCS substance abuse treatment programs should be offered by a consistent set of trainers able to inspect treatment plans and observe programs to best identify needed areas for training. The Department should explore creating "model training programs" where all new staff can receive training, prior to placement at a permanent facility.

Program Completions and Removals

- **Standardize the removal process for all prison-based substance abuse treatment programs and develop program retention committees at all treatment programs with the aim engaging individuals in treatment and decreasing the number of inmates removed from the program.** Substance abuse and dependence are chronic, reoccurring conditions; relapse, acting out, noncompliance and multiple experiences with treatment programs are typical and expected. Many inmates resist being forced into treatment and may act out in various ways, and it is up to treatment staff to find ways to engage participants in the recovery process. Every substance abuse treatment program in DOCS should develop a program retention committee, which should work resourcefully with individuals who demonstrate problems in the program. These committees should use removals as a last resort.

Drug Use and Testing

- **Institute less punitive responses to drug usage inside prison and develop appropriate programs for inmates who use drugs.** We recognize that drug use inside prisons can impact on the safety of inmates and staff and must be regarded seriously. Inmates testing positive for drug use are often in urgent need of intensive treatment services.

Disciplinary responses should be tempered, not eliminated, and efforts should be made to guarantee that individuals placed in disciplinary housing because of a positive urine test are offered treatment preparation or services during this confinement. In addition, once an inmate completes a disciplinary sentence, he/she should be prioritized for intensive treatment services.

Reentry/Aftercare

- **Increase aftercare services for inmates completing treatment programs and returning to general population, including possibly an aftercare dorm.** The creation of an aftercare dorm for inmates completing residential substance abuse treatment programs, more formal and diverse aftercare services, and continuity of services from treatment staff are important elements for reducing recidivism and relapse, as well as adding an incentive for inmates to complete the program. In addition, we recommend that the Department allows inmates to run AA and NA programs when volunteers from the outside community are not available.

- **Develop a more comprehensive, coordinated and integrated discharge planning policy, including recommendations from treatment staff on the type of program that would best suit individuals' substance abuse treatment needs in the community.** To promote successful reentry for individuals graduating from prison-based substance abuse treatment programs, the State should develop a prison-based, reentry oriented, integrated process that includes input from, and coordination with, treatment staff, Parole, and community-based organizations. The State should create a comprehensive discharge plan that includes specific recommendations for the type and length of treatment program or services that would most benefit the individual. These programs should range in level of intensity from outpatient services to halfway houses and inpatient treatment programs. In addition, each facility should provide every individual leaving prison with documentation from the treatment staff outlining the treatment services he/she received while incarcerated. This information would enable community-based treatment staff to provide a more effective and appropriate continuity of services.

Clinical Case Records

- **Work with the Office of Alcoholism and Substance Abuse Services (OASAS) to design new treatment record forms that are concise, individualized, intuitive and comprehensive.** OASAS has the expertise and experience to assist DOCS in developing forms that more effectively capture the information necessary to offer the highest quality of services to treatment participants. They may also be able to offer training or assistance in developing training for treatment staff on completing these forms in a manner that is both individualized and concrete. DOCS should take advantage of the existing resources and work with OASAS towards improving these forms.

- **Promote better inmate participation in the treatment and discharge planning process.** Treatment staff should be encouraged to involve treatment participants in developing their treatment and discharge plans in order to increase ownership and

investment in the program and their recovery. This collaboration should be documented in the treatment records, and should be viewed as an important learning experience for the participant and an opportunity to engage in important therapeutic conversations.

- **Develop formal process for regular review of treatment records by a clinical supervisor.** Without a process in place to ensure accountability, even the most comprehensive of forms can become ineffective. Proper auditing and supervision of treatment records and their content not only provides this accountability, but allows treatment staff to develop their professional skills while increasing the quality of services beings offered to treatment participants.

Monitoring/Oversight

- **Develop and implement written policies and procedures on how individual facilities and DOCS Office of Substance Abuse Treatment Services provide clinical supervision to treatment staff.** A clinical supervisor should regularly monitor all individual treatment plans and records. Clinical supervision should be provided to all treatment staff by a qualified clinical supervisor in accordance with OASAS community standards. If a qualified clinical supervisor is not available at the facility, DOCS should employ a consultant to offer clinical supervision to treatment staff two to four times per month in person or through teleconferencing.

- **Develop written policies and procedures for OASAS oversight and evaluation of DOCS substance abuse treatment programs.** To address the significant variation among programs, the State and OASAS should establish formal policies requiring quality assurance and utilization review plans. In addition, documents should be developed for monitoring purposes to comprehensively rate treatment plans and records, program sessions and participant satisfaction, and to collect outcomes data.

Special Populations

- **Increase collaboration with the Office of Mental Health (OMH) to provide support and expertise in substance abuse treatment programs serving inmates with mental health issues.** The Department's efforts to increase the number of substance abuse treatment programs for inmates with mental health needs is commendable, but we are concerned by the lack of mental health training for and expertise of many of the treatment staff. OMH staff should frequently participate in the treatment sessions for IDDT programs for both general population inmates and individuals in residential mental health programs. DOCS should also schedule weekly treatment meetings should be scheduled with OMH and treatment staff working in those programs to address the special needs of this population.

- **Increase the number of Integrated Dual Diagnosed Treatment Programs available in general population.** DOCS and OMH have been able to collaboratively develop what appears to be generally successful integrated treatment programs for individuals with co-occurring mental health and substance abuse problems housed in both disciplinary and

residential mental health programs. Thousands of inmates with mental health disorders, many of them seriously mentally ill, reside in general population and the three current general population IDDT programs are not sufficient to address the needs of this population.

- **Increase resources available for limited English speakers and the number of bilingual treatment staff. Conduct a needs assessment for limited English speakers in need of substance abuse treatment and determine if a Spanish-language substance abuse treatment program should be piloted at one facility.** Treatment staff should be able to provide limited English speakers with information and materials in their native language. All materials and information made available to the group should also be available to limited English speakers, whose treatment services should not be reduced simply because of their inability to speak English. Prison administrators should make a strong effort to recruit more bilingual treatment staff, working with state officials to offer pay differentials where necessary. The Department should explore the possibility of creating at least one Spanish-only treatment program, allowing individuals with limited English skills to participate more fully in their recovery. In addition, if the Department uses inmate translators, it should establish a paid position to adequately trained individuals who are not currently in treatment.

- **Incorporate gender-appropriate topics and curriculum into the substance abuse treatment programs offered in prisons that house women.** Gender-specific programs should address issues of maintaining and developing healthy relationships; trauma; parenting; and health education. The Department should explore the use of gender-specific screening and assessment instruments such as Texas Christian University Drug Screen (TCUDS II) or TWEAK.[13]

[13] Ibid., 38.

3. PROJECT SUMMARY

3.1 SUBSTANCE ABUSE TREATMENT IN PRISON

Incarcerated individuals with substance abuse histories are at higher risk for relapse and return to criminal behavior if their need for treatment goes unmet.[14] Effective, timely prison-based treatment greatly reduces the risk of substance abuse and criminal behavior for inmates with substance use disorders.[15] This is especially true when treatment specifically addresses criminal thinking and behavior, helping inmates to identify and modify maladaptive coping strategies. Substance abuse treatment in prison has been shown to have an appreciable effect on post-release arrest, conviction and incarceration[16] and to reduce post-release alcohol and drug use.[17] A number of studies indicate that inmates who do not participate in substance abuse treatment are significantly more likely to be rearrested than those who do.[18]

Many studies, including several funded by the National Institute on Drug Abuse (NIDA) and a 1997 report by RAND Drug Policy Research Center, have demonstrated that substance abuse treatment is, on the whole, more successful than imprisonment in reducing substance abuse and crime rates and in increasing the ability of individuals convicted of drug offenses to find and hold jobs.[19] Although alternative programs are more effective and less expensive than imprisonment, many individuals in need of treatment end up in New York State prisons.

On an individual level, lack of treatment availability can prevent an inmate struggling with substance abuse from finding help throughout years of a lengthy sentence, can postpone parole for an inmate who is mandated to complete treatment before release and can have negative consequences for the individual and his/her family. In contrast, prison treatment programs can be the foundation for inmates to build a lifetime of recovery, whether inside prison walls or after release. For example, we found that participants in the comprehensive programs of Lakeview Shock and the Hale Creek CASAT had considerably higher GED graduation rates than those of other Department of Correctional Services (DOCS) treatment programs we visited. These facilities also had low levels of inmate violence. Strengthening and expanding these ancillary benefits should be factored into any consideration of prison-based treatment programs.

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[14] Fletcher and Chandler, *Principles of Drug Abuse Treatment for Criminal Justice Populations: A Research-Based Guide*.

[15] Peters, Wexler, and Center for Substance Abuse Treatment (U.S.), *Substance Abuse Treatment for Adults in the Criminal Justice System: Treatment Improvement Protocol (TIP) Series 44 -- SAMHSA/CSAT Treatment Improvement Protocols -- NCBI Bookshelf*.

[16] Inciardi et al., "An effective model of prison-based treatment for drug-involved offenders," 261-278; Prendergast et al., "Reducing Substance Use in Prison," 265-280; WEXLER et al., "Three-Year Reincarceration Outcomes for Amity In-Prison Therapeutic Community and Aftercare in California," 321-336; Wexler, "The Success of Therapeutic Communities for Substance Abusers in American Prisons," 57-66; Melnick, Hawke, and Wexler, "Client Perceptions Of Prison-Based Therapeutic Community Drug Treatment Programs," 125-25.

[17] Anglin, M.D. and McGlothlin, W.H., "Outcome of narcotic addict treatment in California"; De Leon, G., "Program-based evaluation research in therapeutic communities"; Simpson and Friend, "Legal status and long-term outcomes for addicts in the DARP followup project."

[18] Andrews et al., "Does Correctional Treatment Work - A Clinically Relevant and Psychologically Informed Meta-Analysis," 369-404.

[19] Caulkins, Jonathan P., C. Peter Rydell, William Schwabe and James Chiesa. Mandatory Minimum Drug Sentences: Throwing Away the Key or the Taxpayers' Money?

The repercussions of prison-based treatment range far beyond that of individual drug-involved inmates, however, with the potential to enhance both public safety and public health. Many of New York State's inmates come from communities ravaged by poverty, unemployment and chronic health problems such as HIV/AIDS and hepatitis C. If they return to these communities armed with knowledge about substance abuse, as well as valuable coping and social skills, they are more likely to contribute to the health and safety of their communities. There are also considerable positive multigenerational effects of recovery on families and communities. In addition, effective substance abuse treatment has been proven to reduce drug sales, the incidence of driving while impaired/intoxicated, public disorder, prostitution, homelessness and physical and sexual abuse.[20] Communities with higher levels of drug use have increased rates of both personal and property crimes as well as driving while intoxicated or impaired.[21]

National attention has shifted to these issues with NIDA's establishment in 2002 of the Criminal Justice Drug Abuse Treatment Studies (CJ-DATS), a multisite research program that aims to improve the treatment of individuals involved with the criminal justice system who have substance use disorders and to integrate criminal justice and public health responses for these individuals.[22] [23]

The majority of substance abuse treatment programs in New York State have not been thoroughly evaluated or assessed for effectiveness by either an external or internal body. Other prison-based treatment programs or state correctional systems at times have worked with universities and other outside agencies to conduct evaluations of their prison-based treatment programs. For example, in 1999 a study of Ohio's prison-based therapeutic community treatment programs was conducted by Wright State University Boonshoft School of Medicine.[24] In 1999, researchers evaluated the therapeutic community program at Amity Prison in California.[25] Based on the lack of evidence-based in-prison substance abuse treatment, the Correctional Association (CA) decided to embark on a multiyear study of prison-based substance abuse treatment provided by New York's Department of Correctional Services.

3.2 PROJECT DESCRIPTION

The CA's Substance Abuse Treatment Project aimed to determine whether New York State prison-based substance abuse treatment meets the needs of inmates with substance abuse through achievement of three objectives: developing a thorough and comprehensive understanding of

[20] Magura et al., "Substance User Treatment Program Quality: Selected Topics," 1185-1214.
[21] McLellan et al., "Evaluating the effectiveness of addiction treatments," 51-85.
[22] Criminal Justice Drug Abuse Treatment Studies (CJ-DATS). http://www.cjdats.org/Wiki%20Pages/Home.aspx.
[23] The overall objective of CJ-DATS was to bring together a group of nationally recognized researchers to study the drug treatment services available in the U.S. criminal justice system in an effort to improve their quality and effectiveness. Research was begun in a variety of key areas including: screening and assessment, reentry services, performance monitoring, working with special populations, and improving treatment engagement and retention. Phase Two was launched in 2008 to expand on previous research as well as to improve the quality of treatment services available for drug-involved offenders.
[24] Siegal, Harvey A., Wang, Carlson, Falck, and Fine. "Ohio's Prison-Based Therapeutic Community Treatment Programs for Substance Abusers: Preliminary Analysis of Re-Arrest Data." *Journal of Offender Rehabilitation* 28(3/4):33-48.
[25] Siegal et al., "Ohio's Prison-Based Therapeutic Community Treatment Programs for Substance Abusers," 33-48; Wexler et al., "The Amity Prison TC Evaluation," 147-167.

how New York State prisons respond to these inmates; identifying current evidence-based standards in the field; and creating recommendations for DOCS to adjust its services as needed in order to meet those standards.

To achieve these aims, the CA assessed the screening process by which inmates are designated as "in need of treatment"; analyzed the effectiveness of treatment through observation of treatment sessions, interviews with inmates and staff, reviews of case records, evaluation of program policies and procedures and (where available) outcomes as related to program completions and removals; identified the degree to which DOCS adheres to recognized guidelines for evidence-based treatment; assessed the provision of in-prison aftercare for inmates who have completed treatment; and assessed the efforts made by prisons to assist inmates as they make the transition to community-based treatment upon their release.

The Project was implemented in two phases. In the first phase, the CA visited 23 correctional facilities in New York State, where we encountered 15 of the 17 types of substance abuse treatment programs operated by DOCS.[26]

The Project sought to examine the needs of and services for inmates with substance use histories, whether or not they were in treatment at the time of our visits. Thus, we surveyed and interviewed inmates not currently in treatment programs (see **Appendix C**). With this strategy, we reached people who asserted their need for treatment but reported that they were not designated as such by DOCS's screening system. It also ensured that we engaged inmates not currently in treatment, but who had already participated in DOCS treatment, had been removed from treatment for disciplinary or administrative reasons, or were on a waiting list for treatment as they approached the end of their sentence. We also gained valuable insights and information from inmates not in treatment who had no need for it; they provided information about drug-related activity in the prisons. Overall, inmates not currently in a program provided great insight into treatment program removals and disciplinary processes for prison-based drug use/possession and provided an assessment of drug trafficking in DOCS facilities (for more information about the questions included in the survey for individuals not in treatment, refer to **Section 3.3, Methodology**).

In addition, we observed treatment sessions, residential treatment areas, and discharge planning services (the DOCS Transitional Services program). Over the course of the Project, we received more than 2,300 surveys detailing inmates' experiences in New York State correctional facilities, specifically with regard to substance abuse treatment programs. The programs we visited represented more than half of the treatment beds available throughout DOCS.

The Project's second phase sought to evaluate the reentry process for individuals with substance abuse histories being released from New York State prisons by examining their access to community-based treatment and how well their prison-based treatment prepared them for it. CA staff facilitated a limited number of focus groups with formerly incarcerated individuals enrolled

[26] We did not include the following DOCS programs for the stated reasons: CASAT Phase II Outpatient Services are provided by outside contractors or agencies; participants of the Nursery and Female Trauma Recovery Programs attend the same six-month ASAT or CASAT program described throughout the report; and the Parole Violators Relapse Prevention Program was not in operation at the time of our visits.

in selected community-based substance abuse programs. We asked them to complete a survey about their experiences accessing community-based treatment programs and the prison-based substance abuse treatment they received in New York State prisons. In addition, we had brief discussions with a small number of staff from community-based treatment programs to assess their impressions of in-prison treatment (via their experiences working with formerly incarcerated individuals) and of the reentry process for inmates with substance abuse histories. We spoke with 35 formerly incarcerated individuals and treatment staff in New York City and throughout New York State. This phase also included in-depth interviews with model prison-based substance abuse treatment programs in other jurisdictions to better understand the components of effective treatment. These included telephone interviews with the administrators of prison-based treatment programs in Pennsylvania, Virginia, Texas, Missouri and Illinois as well as site visits to three programs in New Jersey.

3.3 METHODOLOGY

Launched in 2007, the CA's study on substance abuse treatment in New York State prisons visited 23 correctional facilities (see **Table 3.1** below). The facilities visited represent a broad cross section of the various types of treatment programs offered by DOCS; to get the most information, the CA visited many of the largest treatment programs. We visited maximum, medium and minimum security facilities, but focused primarily on the medium security facilities where most of the prison-based treatment programs occur. The Project employed a range of research methods including but not limited to: inmate surveys, site visits, interviews and focus groups, in-depth communication with experts, record reviews, systemwide data and policy analysis, and comparison with models employed by other states.

Interviewers and site visitors for the current study were trained for interviewing this population, and the interviewers emphasized the confidential nature of the data.

3.3.1 Inmate Surveys

During phase one of the Project, we employed two survey instruments to interview inmates: one designed for inmates enrolled in a prison-based substance abuse treatment program, and another for those not enrolled. For inmates enrolled in a program, we used a modified version of the Multimodality Quality Assurance Scales (MQA) Participant Survey, developed by the National Development and Research Institutes, Inc. (NDRI)[27], to evaluate participant assessment of substance abuse treatment programs (see **Appendix B**).

NDRI developed the Multimodality Quality Assurance Instrument (MQA) to collect program information from participants and staff at 13 prison-based drug treatment programs across the United States, and 80 community-based residential substance abuse treatment programs. Briefly,

[27] National Development and Research Institutes, Inc. (NDRI) was established in 1967 and is a not-for-profit, tax-exempt non-governmental agency whose primary mission is to advance scientific knowledge in the areas of substance abuse, mental health, HIV/AIDS and other related social and health concerns in order to contribute to the prevention and solution of these social problems. NDRI collaborates with a wide array of hospitals, treatment and prevention programs, publishes in leading journals and scientific books and works with a variety of diverse communities.

the MQA was designed to: 1) fill the gap between the reliance on descriptive documents produced by program directors and expensive field audits, 2) compare programs with different treatment approaches (e.g., therapeutic communities, cognitive-behavioral therapy and 12-step), as well as eclectic programs that incorporate a combination of elements, and 3) provide a wide range of treatment, organizational, financial and client information to support "data-driven" decision-making.[28]

The instrument is self-administered and assesses five domains considered critical to the effectiveness of substance abuse treatment programs, organizational characteristics, client characteristics, program policies and services, treatment elements, program climate, and staff and client satisfaction. The domains are based on the standards for health care organizations formulated by the Joint Commission on Accreditation of Healthcare Organizations, the substance abuse treatment research literature, and a panel of experts in community- and prison-based substance abuse treatment. The reading level is at the 5th grade or less, and the instrument takes approximately 30 to 45 minutes to complete.

For inmates not enrolled in a treatment program, the CA developed a separate survey to assess need for treatment (See **Appendix C**). This instrument asks inmates about substance abuse histories prior to incarceration; desire for treatment; how DOCS screens inmates for treatment; how DOCS responds to illegal drug use/possession during incarceration; the length of time that inmates must wait for treatment; reasons for removal from treatment programs; discharge planning services; and inmate access to volunteer or other programs such as Alcoholics Anonymous or Narcotics Anonymous.

The survey instrument utilized for phase two was built upon the MQA and assesses formerly incarcerated individuals' experience of in-prison substance abuse treatment programs and the reentry process. The survey includes questions about experiences and assessment of prison-based substance abuse treatment, need and desire for substance abuse treatment, discharge planning, aftercare services, level of preparedness for release from prison, and the overall reentry process.

3.3.2 Site Visits

The CA conducted one- or two-day visits to the 23 prisons in this study. In most cases, the primary purpose of the first day was to gather information for the CA's general prison monitoring work, with a limited amount of information relevant to the substance abuse study also collected. The second day of the two-day visits was for the sole purpose of gathering data for the study. The process consisted of interviewing inmates and staff directly involved with substance abuse treatment programs and observing the implementation of these programs.

During these visits, we spoke with inmates about our study and signed up individuals to receive the surveys in the mail. Within a few days of completing a visit, the CA mailed surveys and consent forms to each inmate in the treatment program and to those not in the program who had agreed to participate in the study.

[28] Melnick, Hawke, and Wexler, "Client Perceptions Of Prison-Based Therapeutic Community Drug Treatment Programs," 121-138.

In phase two, the CA staff conducted site visits to four community-based programs serving formerly incarcerated individuals in New York City and upstate New York. We held focus group sessions with individuals who had been incarcerated in a New York State correctional facility within the past two years and had participated in a prison-based substance abuse treatment program during this incarceration bid. Prior to the focus group session, focus group participants completed the individual survey described previously, which was based on the MQA and described in **Section 3.3.1.**

3.3.3 Systemwide Data

In response to a Freedom of Information Law request by the CA, the Department provided the CA with updated systemwide policies and data as of August 2009 for the following materials: Alcohol and Substance Abuse Treatment (ASAT), Comprehensive Alcohol and Substance Abuse Treatment (CASAT), Driving While Intoxicated (DWI), and Chemical Dependency/Domestic Violence manuals; description of each DOCS substance abuse treatment programs; monthly department-wide reports summarizing all prison programs, including substance abuse treatment services; listing of substance abuse treatment programs and their capacity at each prison; current job descriptions for substance abuse treatment staff; site visit reports by DOCS Office of Substance Abuse Services for all prisons for January 2007 through April 2009; lists of prison-based, voluntary substance abuse aftercare programs at each prison; and lists of substance abuse treatment staff at each facility. In evaluating the Department's response to the needs of inmates with substance use histories, we have used these policy statements and systemwide data to assess DOCS treatment programs.

3.3.4 Advisory Committee

A panel of experts in the fields of substance abuse treatment and correction informed the work of the Substance Abuse Treatment Project. These experts have helped to guide the Project's design, evaluation of data, and recommendations. Specifically, the advisory committee provided: critique of study design; suggestions to improve data collection and analysis; suggestions on triangulation of data; analysis of study results and possible findings; recommendations based on study results; and recommendations concerning best practices for caring for inmates with substance abuse problems. In addition to frequent communication with members of the advisory committee to troubleshoot emerging issues and receive feedback, the CA held two formal advisory committee meetings.

3.4 VISITS OVERVIEW

The following tables provide a summary of the facilities and treatment programs the CA visited during its two-year study. **Table 3-1** details general information about each facility at the time of the site visit, including: the date of visit; the facility's security level; the total prison population; the types of substance abuse treatment programs available; the number of treatment staff and vacancies; and the enrollment in each program. **Table 3-2** illustrates the number of both MQA and non-program surveys we received from inmates at each facility.

The information gathered from the site visits and surveys provides a broad view of the substance abuse treatment programs offered by DOCS. We compared and contrasted responses and information provided by the executive and treatment staff, inmate surveys and interview responses, systemwide data and our own observations to arrive at a thorough and comprehensive evaluation of the DOCS treatment programs. The following sections provide detailed analysis of specific program areas such as screening, staffing, clinical content, and program monitoring. In the Recommendations section of this report, our objective is to propose strategies to improve on the current state of DOCS treatment and add to the dialogue and movement toward restructuring these services for future participants.

Table 3-1 CA VISITS TO PRISONS AND SUBSTANCE ABUSE TREATMENT PROGRAMS

Prison	Date of Visit	Prison Population	Substance Abuse Treatment Programs*	Treatment Staff (Vacancies)**	Enrollment in Each Program
Albion (medium)	1/29/2009	1,052	ASAT, DWI, MICA	Data Pending	188, 25, 14 Total = 227
Arthur Kill (medium)	4/10/2007	945	CASAT, MICA, Stay'n Out, ASAT, SNU ASAT	1 SCC (0) 2 CC (1) 3 PA (0) 1 SW (0)	45, 10, 60, 12 Total = 127
Arthur Kill (medium)	6/2/2009	964	CASAT, MICA, ASAT, SNU ASAT	1 SCC (0) 1 CC (1) 2 PA (1) 1 SW (0)	57, 50, 11, 14 Total = 132
Bare Hill (medium)	6/3–4/08	1,691	ASAT	2 CC (1) 5 PA (1)	240
Cayuga (medium)	07/14–15/08	1,015	ASAT	1 CC (0) 2 PA (0)	120
Eastern (maximum)	6/27/2007	1,170	CD/DV, ASAT, SDU ASAT	2005: 4 CC (0) 9 PA (0) 2007: 1 SCC (0) 1 CC (0) 3 PA (0)	161, 100, 17 Total = 278
Five Points (maximum)	11/17–19/08	1,386	ASAT	2 CC (1) 5 PA (0)	184
Franklin (medium)	6/5–6/08	1,680	ASAT	2 CC (0) 5 PA(1)	240
Gouverneur (medium)	4/29–30/08	1,054	ASAT	1 CC (0) 2 PA (0)	120
Gowanda (medium)	1/26/2009	1,625	ASAT, DWI	1 SCC (0) 7 CC (4) 14 PA (6)	98, 155 Total = 253
Green Haven (maximum)	7/11/2007	2,134	ASAT	1 CC (0) 2 PA (1) 1 MICA CC (1)	65
Greene (medium)	10/2–3/08	1,754	ASAT, RSAT	5 CC (1) 4 PA (1)	159, 87 Total = 246
Hale Creek (medium)	10/28–29/08	459	CASAT	2 SCC (1) 8 CC (3) 1 Span CC (0) 18 PA (4)	459
Lakeview Shock (minimum)	10/23–24/07	Male 420	Shock ASAT	3 Network Admin(0) 1 SCC (0) 5 CC (1) 10 PA (2)	Male 420
		Female 76			Female 76
Mid-State (medium)	04/1–2/09	1,434	ASAT, MICA, Evening ASAT, ICP ASAT, PC ASAT, SHU Workbook	1 SCC (0) 3 CC (0) 6 PA (0)	92, 46, 24, 21, 9, 8 Total = 200

Prison	Date of Visit	Prison Population	Substance Abuse Treatment Programs*	Treatment Staff (Vacancies)**	Enrollment in Each Program
Oneida (medium)	3/14–15/07	1,173	ASAT	2 CC (1) 4 PA (0)	210
Shawangunk (maximum)	7/1–2/09	547	ASAT, SOCTP ASAT	1 SOCTP CC(0) 2 PA (0)	40, 30 Total = 70
Sing Sing (maximum)	04/24–28/09	1,703	ASAT, MICA	1 CC (1) 3 PA (2)	76, 17 Total = 93
Taconic (medium)	2/26/2009	320	ASAT, CASAT, Relapse, Nursery, FTRP	1 SCC 4 CC (1) 4 PA (2)	50, 65, 0, 8, 16 Total = 139
Washington (medium)	07/28–29/09	868	ASAT	1 CC (0) 2 PA (0)	120
Wende (maximum)	1/27–28/09	914	ASAT, RMU ASAT, SNU ASAT, Mental Health ASAT	2 CC (0) 1.5 PA (1) 0.5 RMU PA (0)	100, 9, 8, 8 Total = 125
Willard DTC	2/14–15/08	Male 748	DTC ASAT	Male: 2 SCC (0) 10 CC (1) 3 Network Prog Admin (1) 18 PA (2) 5 KBS (0)	Male 748
		Female 58		Female: 1 SCC (0) 1 CC (0) 1 PA (0)	Female 58
Wyoming (medium)	5/30–31/07	1,684	CASAT, ASAT	1 SCC (0) 2 ASAT/CASAT CC (0) 1 CASAT CC (0) 3 ASAT PA (2) 3 CASAT PA (0)	95, 140 Total = 235
TOTALS		**27,967**			**5,365**

* MICA: Mentally Ill, Chemically Addicted
SNU: Special Needs Unit
CD/DV: Chemically Dependent/Domestic Violence
FTRP: Female Trauma Recovery Program
SOCTP: Sex Offender Counseling Treatment Program
SHU: Special Housing Unit
ICP: Intermediate Care Program
RMU: Regional Medical Unit
DTC: Drug Treatment Campus
SDU: Sensorially Disabled Unit

** CC: Correction Counselor
SCC: Supervising Correction Counselor
KBS: Keyboard Specialist
PA: Program Assistant
SW: Social Worker

Table 3-2 SUMMARY OF SURVEYS RECEIVED BY THE CA

PRISON	Date of Visit	MQA Surveys from Treatment Participants	Non-Program Surveys from Inmates Not in an SA Program	Total Inmate Surveys
Albion	1/29/09	22	NA	22
Arthur Kill	4/10/07	36	42	78
Arthur Kill	6/2/09	28	39	67
Bare Hill	6/3–4/08	85	40	125
Cayuga	7/14–15/08	44	70	114
Eastern	6/27/07	62	37	99
Five Points	11/17–19/08	51	121	172
Franklin	6/5–6/08	97	159	256
Gouverneur	4/29–30/08	30	29	59
Gowanda	1/30/09	54	58	112
Green Haven	7/11/07	27	36	63
Greene	10/2–3/08	45	87	132
Hale Creek	10/28–29/08	97	NA	97
Lakeview Shock	10/23–24/07	41 male 28 female	NA	69
Marcy	3/2–3/08	72	35	107
Mid-State	4/1–2/09	59	71	130
Oneida	3/14–15/07	41	40	81
Shawangunk	7/1–2/09	35	35	70
Sing Sing	4/27–28/09	39	91	130
Taconic	2/26/09	27	30	57
Washington	07/28–29/09	37	51	88
Wende	1/27–28/09	41	62	103
Willard DTC	2/14–15/08	23 male 9 female	NA	32
Wyoming	5/30–31/07	54	38	92
TOTALS		**1,184**	**1,171**	**2,355**

4. POPULATION DESIGNATED AS IN NEED OF TREATMENT

This section describes the sector of the prison population that the New York State Department of Correctional Services (DOCS) designated as in need of substance abuse treatment. All information presented herein is based on data provided by DOCS in its public reports: *Identified Substance Abusers 2006*; *Identified Substance Abusers 2007*;[29] *Profile of Inmate Population Under Custody on January 1, 2007*; *Profile of Inmate Population Under Custody on January 1, 2008*; and *Profile of Inmate Population Under Custody on January 1, 2009*. It should be noted that the Department has not published a summary of its identified substance abusers since the data presented for 2007, and it is unclear if DOCS plans to continue its annual reporting of statistics about this population, which it had done since at least the 1990s.

Of the 83% of the inmate population that DOCS identifies as in need of substance abuse treatment, the highest percentage of substances used among both males and females was marijuana (36% in 2007), followed by alcohol (22% in 2006; 23% in 2007;), and cocaine (22% in 2006; 18% in 2007). As more fully described in **Section 5, Screening and Assessment**, alcohol use was measured by the Department using only the Michigan Alcohol Screening Test (MAST) instrument in both years and therefore may be underestimated. Heroin (11% in 2006; 10% in 2007) and crack (9% in 2006 and 2007) were the substances least reported as the single most serious drug used by individuals identified as in need of substance abuse treatment in both 2006 and 2007, although the category of "other drugs" was reported even less (6% in 2006; 5% in 2007). [30]

Males and females reported different patterns of alcohol and other drug use. Among individuals identified as in need of substance abuse treatment in 2007, females most often reported using crack (24%), alcohol (22%), and marijuana (22%) as their primary substance, while males most often reported using marijuana (36%), alcohol (23%) and cocaine (18%). The percentage difference between men and women who reported marijuana as the most significant substance remained constant from 2006, although the actual percentages then were slightly lower, with 31% of males and 17% of females identifying marijuana as the primary substance used. Females, however, reported using crack significantly more than males in both years, with 26% of females in 2006 and 24% of females in 2007 identifying crack as the most serious substance used, compared with only 8% of males in both years. Female inmates identified as in need of substance abuse treatment also reported more serious heroin use in both years (15% in 2006; 14% in 2007) than male inmates identified as in need of treatment (10% in 2006; 9% in 2007).

For individuals identified by DOCS as substance users,[31] the type of commitment crime, region of commitment, felony offender status, and maximum/minimum sentence do not vary significantly from the overall prison population. This is primarily because identified substance abusers constitute the majority (83%) of the State's general prison population, thus their

[29] NYS Department of Correctional Services, *Identified Substance Abusers 2007*.
[30] The Department has developed a ranking system modeled on the schedule developed under the Comprehensive Drug Abuse Prevention and Control Act of 1970.
[31] Occasionally used by DOCS interchangeably with "substance abusers."

characteristics dominate the overall description of the prison population. As a result, a review of isolated data about the remaining 17% of the prison population identified as non-users provides a richer context for highlighting the differences and similarities between individuals identified as needing substance abuse treatment (51,748 in 2007) and individuals *not* so identified (8,676 in 2007). In comparing users with non-users, the contrast between individuals identified as needing substance abuse treatment and the overall population becomes even more pronounced. For example, in 2007 DOCS noted that 55% of identified substance abusers were committed for violent felonies—only 3% less than the general population (58%), but nearly 20% less than non-users (74%) similarly committed for violent felonies. **Table 4-1** summarizes the major characteristics of the general population, substance users and non-users as of 2007.[32]

Table 4-1 COMPARISON OF SUBSTANCE USERS AND NON-USERS AS OF 2007

Characteristics	Category	Non-User Total (N = 8,676)	User Total (N = 51,748)	General Population Total (N = 62,599)
Gender	Male Female	97.6% 2.4%	95.3% 4.7%	95.6% 4.4%
Race/Ethnicity	White African-American Hispanic	17% 56% 25%	21% 51% 26%	21% 51% 26%
Age	Average Age	37.1 years	36.4 years	36.7 years
Average Sentence	Average Minimum Sentence Average Maximum Sentence	10.6 years 13.0 years	8.5 years 11.2 years	9.0 years Not available
Commitment Region	From New York City	64%	50%	52%
Crime	Violent Felony Drug Felony Second/Persistent Felony	74% 6% 43%	55% 25% 49%	58% 21% 44%

Not surprisingly, when compared with non-users, individuals identified as substance abusers were much more likely to have been committed for drug offenses (25%, compared with 6% in 2007). In large part, this is due to the fact that the majority of individuals convicted of drug use, sale, and possession are required to complete substance abuse treatment during their incarceration. Of the 13,426 inmates in the entire prison population who were committed for drug offenses (as reported in DOCS's *Hub Report: Profile of Inmate Population Under Custody on January 1, 2008*), nearly all (96%) were also identified as needing substance abuse treatment.

As for general demographic information, individuals identified as in need of substance abuse treatment were, on average, 36 years of age (36.3 in 2006; 36.4 in 2007), similar to the average age of the inmate population referred to by DOCS as "non-users" (35.7 years in 2006; 37.1 years in 2007). The majority of inmates identified as in need of substance abuse treatment were African-American (50% in 2006; 51% in 2007), followed by Hispanic inmates (27% in 2006;

[32] Data presented in Table 4-1 is based on information contained in DOCS reports: NYS Department of Correctional Services, *Identified Substance Abusers 2007*; NYS Department of Correctional Services, *Under Custody Report: Profile of Inmate Population Under Custody on January 1, 2009*.

26% in 2007), and white inmates (22% in 2006; 21% in 2007). These percentages, compounded by the knowledge that the severe criminal penalties enforced under the Rockefeller drug laws disproportionately impacted communities of color, reflect the overrepresentation of racial minorities in the criminal justice system overall.[33] When compared with non-users, individuals identified as in need of substance abuse treatment represented a relatively higher percentage of white inmates (21% in 2007, compared with 17% of non-users in 2007), a lower percentage of African-American inmates (51% in 2007, compared with 56% of non-users in 2007), and the same percentage of Hispanic inmates (25% for both in 2007). **Table 4-2** compares non-users and users by race and gender, as reported in Table 12 of DOCS's *Identified Substance Abusers 2007*.[34]

Table 4-2 RACIAL COMPARISON OF SUBSTANCE USERS AND NON-USERS IN 2007

Race/Ethnicity	Non-User Male	User Male	Non-User Female	User Female
White	17%	21% (+4%)	34%	30% (-4%)
African-American	56%	51% (-5%)	44%	47% (+3%)
Hispanic	25%	27% (+2%)	18%	22% (+4%)
Total	**98%**	**99%**	**96%**	**99%**

As demonstrated in **Table 4-2**, a comparison between non-users and identified substance abusers reveals some racial differences that persist across gender lines, with female users representing a lower percentage of white inmates and male users representing a higher percentage of white inmates than non-users (see **Table 4-1** for additional information regarding reported racial differences). The disparate racial composition of the non-user and user subpopulations may be attributed to a number of factors, such as the increasing enforcement of DWI laws upstate, referrals to alternative to incarceration programs for drug offenders downstate, or the imposition of harsher sentences for drug offenders in various geographic regions. These differences may also be influenced by the trends observed with regard to region of commitment, with DOCS reporting that approximately half of the inmates identified as in need of substance abuse treatment were committed from New York City (Bronx, Kings, New York, Queens and Richmond Counties) in 2006 and 2007 (51% and 50%, respectively). This is notably less than the majority of non-user inmates (64%) who were also committed from New York City. It should further be noted that the percentage of all incarcerated inmates from New York City has declined over the last several years (from 58% in 2005 to 50% in 2009), supporting the possibility that a greater percentage of inmates from upstate regions may be incarcerated for substance abuse.

Differences were also observed among inmates with respect to sentencing. The percentage of individuals identified as in need of substance abuse treatment who were sentenced as

[33] Results from the National Epidemiologic Survey on Alcohol and Related Conditions determined that lifetime drug abuse is actually *higher* among whites (8.6%) when compared with blacks (6.4%) or Hispanics (2.9%), yet blacks and Hispanics continue to represent the vast majority (over 85% combined) of inmates incarcerated for drug sale and possession in New York State prisons (Compton et al., "Prevalence, Correlates, Disability, and Comorbidity of DSM-IV Drug Abuse and Dependence in the United States.").

[34] The information provided by DOCS in it report *Identified Substance Abusers 2007*, the most recent report issued by DOCS concerning this population, excludes missing data (nN = 2,175) and does not represent 100% of the total (totals for each column are noted in the last row of the chart). The numbers enclosed in parentheses in **Table 4-2** represent the numerical difference between the race/ethnicity users and non-users by gender.

second/persistent felony offenders (49%) in 2007 was more than the percentage of non-user inmates (43%). Female inmates in need of substance abuse treatment were more than twice as likely as non-user females to be sentenced as second/persistent felony offenders (39%, compared with 16% in 2007).

The average minimum sentence for identified substance abusers in 2007 was 8.5 years and the average maximum sentence was 11.2 years. This represents an increase from 2006 when the average minimum and maximum sentences were 7.9 years and 11.0 years, respectively. For non-users, both the average minimum sentence (10.6 in 2006 and 2007) and maximum sentence (13.0 years in 2007, 13.1 years in 2006) were higher, as would be expected with a greater population of "violent felony offenders." Among identified substance abusers, there were considerable differences in sentence length by gender, with the average minimum sentence for males being nearly double that of females in both 2006 and 2007 (8.0 years for males and 4.8 years for females in 2006; 8.7 years for males and 4.8 years for females in 2007). Males identified as needing substance abuse treatment also had a longer average maximum sentence in both years (11.2 years in 2006; 11.3 years in 2007) when compared with females (7.6 years in 2006; 7.3 years in 2007). It is also worth noting that differences in commitment crime across gender lines may account for the discrepancy in sentence length between male and female identified substance abusers: in 2007, males (56%) were more likely to be committed for violent felonies than females (35%), while females (37%) were more likely to be committed for drug offenses than males (24%).

Although considerable data about the individuals indentified as needing substance abuse treatment was presented in the 2006 and 2007 DOCS reports, it is notably less than that provided about the overall prison population in the *Profile of Inmate Population* reports. Additional information about the inmate population identified as in need of substance abuse treatment, such as English language fluency, educational attainment, reading level, prior prison term, marital status, religious affiliation, and veteran status (as is collected and presented about the general prison population) would be useful. This information could be analyzed to assist DOCS in developing substance abuse treatment that best meets the needs of this significant subpopulation. Moreover, it is particularly unfortunate that the Department has not made efforts to provide the public with updated information about this population, especially given the amendments in the drugs laws that could result in changes in the prison population requiring substance abuse treatment.

5. SCREENING, ASSESSMENT AND DESIGNATION AS IN NEED OF TREATMENT

FINDINGS

DOCS designates inmates as "in need of substance abuse treatment" based on five primary sources: two standardized screening instruments; inmate self-report; and two sets of automated data. A low threshold is set for these sources and a positive indicator from any one source results in a designation for being in need of substance abuse treatment (83% of all inmates in 2007).

Interpreting these standards, the Department's definition of "identified substance abuser" includes any individual who is at moderate risk of substance abuse, has any history of alcohol or other drug use, or has been involved in drug sales or possession in any capacity. Many of the inmates interviewed and surveyed by the CA asserted that the designation was inappropriate for them because they used alcohol and other drugs minimally or not at all.

The system used by DOCS to designate inmates as needing substance abuse treatment does not generate the information considered essential for screening and assessment by current evidence-based standards, such as risk, need, and recommendation for appropriate treatment level or modality. With the exception of special populations, substance abuse treatment programs offered by the Department are nearly identical and use the Alcohol and Substance Abuse Treatment (ASAT) curriculum as their foundation.

There is no clear, written centralized policy or process as to how individuals are identified for special programs such as Integrated Dual Diagnosed Treatment (IDDT), Driving While Intoxicated (DWI), Comprehensive Alcoholism and Substance Abuse Treatment (CASAT), or Special Needs Unit (SNU) ASAT.

DISCUSSION

5.1 INTRODUCTION TO SCREENING AND ASSESSMENT

Clinically sound screening and assessment are critical for effective treatment of substance abuse. *Screening* does not aim to diagnose a specific disorder, but to determine whether an individual needs further, more comprehensive assessment and evaluation. Although a screening process may be used to identify individuals at high risk for a diagnosis, it is never diagnostic in and of itself. An individual with a positive screening test must undergo a clinical assessment before a diagnosis can be made and before clinical management can begin. Screening instruments are often intentionally designed to achieve high sensitivity, to identify large numbers of persons with the disease or condition. Therefore, screening tests may have low positive predictive value; in other words, many individuals with a positive screening test will later be found not to have the disorder.[35]

[35] Winters, *Simple Screening Instruments for Outreach for Alcohol and Other Drug Abuse and Infectious Diseases.*

An a*ssessment* gathers information and engages the individual in a process with the aim of establishing (or ruling out) the presence of a disorder. The assessment process should also determine readiness for change, identify strengths or problem areas that may affect the processes of treatment and recovery, and engage the individual in the development of a therapeutic relationship. A screening is typically a single event; an assessment, by contrast, is a process that extends over time and taps multiple sources of information.

5.2 DIAGNOSIS OF DRUG-RELATED CONDITIONS

Mental health disorders are classified using the criteria set out in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM),[36] currently in its fourth edition after minor text revisions several years ago. The drug-related diagnoses in the DSM are called "substance use disorders" and include substance abuse (a pattern of using alcohol or other drugs with substantial negative consequences) and substance dependence (continued use of alcohol or other drugs with substantial negative consequences *and* physiological symptoms of tolerance or withdrawal). (See **Appendix D** for an outline of each condition.) The term "addiction" is not used in the current DSM but can be defined as a compulsion to use alcohol and other drugs despite negative consequences. New York's Office of Alcoholism and Substance Abuse Services (OASAS) uses the term "chemical dependency" to reflect its blending of alcoholism and substance abuse treatment programming; this, too, does not have a technical definition in the DSM.

5.3 DOCS DESIGNATION OF INDIVIDUALS AS IN NEED OF TREATMENT

New York's prisons, however, do not use the DSM system for classifying inmate need for substance abuse treatment, nor does a designation by DOCS as being in need of substance abuse treatment require a formal drug-related diagnosis. Rather, DOCS designates inmates as "substance abusers" or "in need of substance abuse treatment" by an eclectic process of screening, assessment, and data analysis that can be both under- and overinclusive. Individuals entering the DOCS system are initially sent to a reception facility where, in order to determine an appropriate prison placement, they undergo medical and mental health reviews, evaluation of educational needs, determination of security level, and assessment for vocational and other programs. During this process, which averages 21 days, a classification counselor establishes the programs each inmate is offered during incarceration.

It is primarily, though not exclusively, at this point that DOCS utilizes four primary screening methods to determine whether an inmate will be told they should undergo substance abuse treatment: (1) the Guidance System (KGNC), which "identifies inmates who have a need for substance abuse treatment based on interviews and evaluations conducted by facility program counselors;"[37] (2) inmate self-reporting of using any substance; (3) the Simple Screening

[36] The DSM is used in a wide array of settings by clinicians, researchers, health care insurers, funders and many others, providing a common language and shared perspective that are indispensable to efficient, effective care and management in our fragmented health care system. Each edition is developed by consensus of panels of experts. The DSM can be a source of heated discussion and disagreement, especially when the next edition is in development as it is now. Nonetheless, it is almost universally accepted as the standard in the field.

[37] NYS Department of Correctional Services, *Identified Substance Abusers 2007*, 1.

Instrument for Outreach for Alcohol and Other Drug Abuse (SSI-AOD),[38] administered at reception; and (4) the Michigan Alcohol Screening Test (MAST),[39] also administered at reception.[40]

In addition to the above instruments or reporting methods that are used to screen inmates, DOCS also uses the Inmate Payroll System (KIPY), which documents inmates who are actively participating in substance abuse treatment programs, in order to identify all individuals who have already been designated as in need of treatment. The information from the four screening methods and the KIPY result in DOCS's estimate that 83% of the total inmate population on December 31, 2007, had "an identified substance abuse need." Nearly half of the inmate population (45%) at that time had completed, or were enrolled in, substance abuse treatment programs provided by DOCS. DOCS estimated, however, that approximately 78% of *all* inmates discharged in 2008 needing substance abuse treatment had completed, or were enrolled in, prison-based treatment prior to their release.[41]

The process that DOCS utilizes to identify individuals in need of substance abuse treatment is *over-inclusive* in many ways, due in large part to the low threshold that DOCS sets for its screening instruments. On the other hand, it is likely that inmates identified as in need of treatment through KIPY *under-represents* the actual figure, because it counts only those inmates enrolled in substance abuse treatment programs on the date that DOCS evaluates the system. Consequently, it does not include inmates who completed treatment programs before or started treatment after that date, and who had no other indicators of a need for treatment. It is unclear why DOCS relies on the payroll system for these data rather than maintaining a census of its treatment programs. In analyzing the data from screening and other sources, DOCS is also likely to be inaccurate because a significant proportion of important data is missing.

5.3.1 Guidance System: Verbal Self-Reporting and Pre-sentence Reports

The majority (56%) of inmates in need of substance abuse treatment in 2007 were identified through self-report. DOCS does not describe how it determines that an inmate's statements indicate a need for treatment. Furthermore, the DOCS Reports *Identified Substance Abuser 2006* and *Identified Substance Abusers 2007* do not account for self-reported alcohol use, implying that DOCS is either not collecting or not recording that information. We recommend that DOCS refine the alcohol-use screening process to include self-report and track this data in the same way that it tracks self-reported use of other drugs.

We have been told by DOCS Office of Substance Abuse Treatment Services that at reception, inmates are asked if they "have used drugs." Those who respond positively are asked "to specify the drugs used during six months preceding their incarceration," though they are not asked about frequency or duration of use at this point. The CA visited Downstate Correctional Facility,

[38] Winters, *Simple Screening Instruments for Outreach for Alcohol and Other Drug Abuse and Infectious Diseases*. http://www.oasas.state.ny.us/asian/documents/SSI-English.pdf.
[39] National Institute on Alcohol Abuse and Alcoholism, "Michigan Alcoholism Screening Test (MAST)." http://pubs.niaaa.nih.gov/publications/assesing%20alcohol/instrumentpdfs/42_mast.pdf.
[40] The references provided for the SSI and MAST instruments provide links to the standard tests. The Correctional Association has been unable to access DOCS's forms for these instruments.
[41] New York State Division of Criminal Justice Services, *2008 Criminal Justice Crimestat Report*, 54.

which serves as one of DOCS's four reception facilities, and obtained information from approximately 130 reception inmates.[42] These individuals reported that the entire interview with classification counselors lasted between five and 15 minutes and comprised a series of questions, including questions about previous use of alcohol and other drugs. They indicated that the classification counselor interview does not include typical screening and assessment questions regarding issues like age of onset, frequency, duration, and so on. The classification counselors conducting these interviews do not undergo training in assessing substance abuse treatment needs.

Under the Freedom of Information Law, we requested a list of the interview questions asked by the classification counselors at Downstate with regard to substance use but were told this list and/or document did not exist. We strongly recommend that DOCS develop a clear list of questions to be used during this screening process so that all staff conducting these interviews are provided the necessary guidance and are able to get the same key information from all inmates entering DOCS custody.

Inmates may also be recommended for substance abuse treatment by a guidance counselor on the basis of a review by correction staff of other documents in the inmate's departmental record, including pre-sentence reports and criminal history. Inmates whose crimes are drug-related, such as use, possession, or sale of illegal substances, are generally designated as in need of substance abuse treatment regardless of MAST or SSI-AOD scores or the inmate's denial of alcohol or other drug abuse. DOCS reported that 18% of individuals entering a State prison in 2007 identified as in need of substance abuse treatment were so designated based on these reviews. Finally, individuals can also be referred to substance abuse treatment by a correction counselor any time during his/her incarceration.

5.3.2 Simple Screening Instrument for Alcohol and Other Drug Use (SSI-AOD)

DOCS uses two standardized self-report screening instruments in the reception process to designate individuals as in need of substance abuse treatment. The Simple Screening Instrument for Alcohol and Other Drug Use (SSI-AOD), which comprises 16 items, was developed by the Center for Substance Abuse Treatment (CSAT) through selection of items from 13 existing screening instruments.[43] This paper-and-pencil test is administered to groups of approximately 30 to 35 individuals by a DOCS staff member who is available to answer questions and to read the instrument aloud on request. DOCS has been using the SSI-AOD since 2002.

The official guide for administering and interpreting the SSI-AOD scores one point for each *yes* answer and zero for each *no*. The guide establishes a score of 0 to 1 as indicating no risk or low risk for alcohol or other drug abuse; 2 to 3 as minimal risk; and 4 or greater as moderate to high risk. The SAMHSA Treatment Improvement Protocol describing the instrument emphasizes that it does not yield a clinical diagnosis but only an indication as to whether further comprehensive assessment is necessary. The SSI-AOD does not identify the types of substances used, but covers both alcohol and other drug use. It explores consumption patterns, self-awareness of a

[42] A "reception inmate" is an inmate newly admitted to the Department of Correctional Services who has entered a reception facility to be screened and assessed for his/her future facility and program placements.
[43] Winters, *Simple Screening Instruments for Outreach for Alcohol and Other Drug Abuse and Infectious Diseases*.

substance abuse problem, loss of control of alcohol and other drug use, and adverse physical, psychological and social consequences of substance abuse. In addition, the instrument asks about any physiological effects of tolerance or withdrawal. DOCS reported that 5% of individuals entering into DOCS custody in 2007 were designated as in need of substance abuse treatment based solely on the SSI-AOD.[44]

According to CSAT, administration of the SSI-AOD requires specialized skills on the part of the interviewer in order to establish a rapport with the client. These skills include good listening techniques, communicating empathy, support, and understanding, and fostering an atmosphere of mutual trust and respect.

5.3.3 Michigan Alcoholism Screening Test (MAST)

The second screening instrument used by DOCS is the Michigan Alcoholism Screening Test (MAST), a self-administered paper-and-pencil test that comprises 25 items regarding social, vocational, family and other problems resulting from alcohol use.[45] Because the test asks about these problems over a lifetime, individuals may receive high scores even after many years of abstinence. Nineteen percent of individuals under DOCS custody in 2007 were determined to be in need of substance abuse treatment based solely on MAST results, and not as a result of any other triggers.[46]

According to the instructions provided with the instrument, a score of 5 to 8 is "suggestive" of alcohol abuse or, as the instructions describe, a "problem drinker." A score of 3 to 5 is suggestive of early or middle problem drinking, and scores of 0 to 2 indicate no apparent problem.[47] Though the MAST, similar to the SSI-AOD, is a screening instrument intended only to be used to determine whether further assessment is necessary, DOCS considers a MAST score above 4 to be indicative of alcohol abuse and of the need for substance abuse treatment.

The CA visited the reception facility at Downstate in 2009. However, the facility reported that detailed data on the number of individuals designated there as needing substance abuse treatment through the SSI-AOD or MAST are not maintained and thus unavailable to us.

5.3.4 Analysis of Automated Data Sources

The percentage of inmates identified as in need of substance abuse treatment in the 2007 population (83%) is 11% higher than the 2006 figure (72%). DOCS notes, however, that this does not represent an increase in substance abuse among the prison population. Rather, it springs from a "refinement" in how the automated data sources (KGNC and KIPY) are analyzed "for the purpose of developing an enhancement in the method of calculating the prevalence of substance abuse" among inmates. Consequently, the percentage of inmates who were designated through KGNC and KIPY as needing substance abuse treatment combined doubled in 2007

[44] NYS Department of Correctional Services, *Identified Substance Abusers 2007*.
[45] Selzer, "The Michigan Alcoholism Screening Test," 89-94.
[46] NYS Department of Correctional Services, *Identified Substance Abusers 2007*.
[47] National Council on Alcoholism and Drug Dependence of the San Fernando Valley, Inc., "Michigan Alcohol Screening Test."

(22%) when compared with 2006 (11%). A similar jump occurred in 2003, when DOCS "made use of additional data sources in an effort to determine whether inmates with substance abuse treatment needs were being undercounted."[48] As a result, the percentage of inmates identified as in need of substance abuse treatment increased from 65% in 2002 to 73% in 2003. Between 2003 and 2006, the percentage of individuals identified as in need of substance abuse treatment remained steady at 72% to 73%.

5.3.5 Lack of Adequate Criteria for Substance Abuse Treatment Need Designation

One of the most significant issues that emerged from the CA's review of the treatment programs is the absence of accurate, consistent criteria for the designation of inmates as "identified substance abusers" or "in need of treatment." The overreliance on a single criterion, or on criteria that are not diagnostic of substance abuse (such as *any* lifetime drug use), can create a treatment population with many participants who have a low severity of substance abuse. According to the National Institute on Drug Abuse (NIDA), a history of drug use does not in itself indicate the need for drug abuse treatment for individuals involved in the criminal justice system.[49] Research shows that those with low severity also have low motivation, often resulting in low engagement and program disruption that hinder the treatment of those with higher motivation.[50]

A substantial body of research indicates that coerced substance abuse treatment can be as effective as voluntary treatment.[51] There has been some concern about the soundness of those studies, however, because of inconsistent methodologies, different program types and outcome measures, and differing types and degrees of coercion.[52] Studies that take these variables into account are growing in number and validity, and promise to shed much-needed light on the factors in effective mandated treatment.[53]

5.3.6 Screening Recommendations

The CA commends the Department's goal of decreasing "false negatives"—inmates who are in need of treatment but are not identified as such by the system. However, we believe that the multiple redundancies that DOCS has built into its system for identifying individuals in need of treatment more than compensates for this possibility. The current cutoff scores seem appropriate if the MAST and SSI-AOD tests are used for initial screening only. We strongly recommend that these test results be used for a screening purpose only to indicate the need for a more comprehensive evidence-based assessment. We also suggest that DOCS investigate the use of other well-regarded screens, such as the Alcohol Use Disorders Identification Test (AUDIT), the Alcohol Dependence Scale (ADS), and the Texas Christian University Drug Screen (TCUDS),

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[48] NYS Department of Correctional Services, *Identified Substance Abusers: 2006*, 3.
[49] Fletcher and Chandler, *Principles of Drug Abuse Treatment for Criminal Justice Populations: A Research-Based Guide*.
[50] Anglin et al., "Studies of the functioning and effectiveness of Treatment Alternatives to Street Crime (TASC) programs."
[51] Anglin and Maugh, "Ensuring success in interventions with drug-using offenders," 66-90; Fletcher and Chandler, *Principles of Drug Abuse Treatment for Criminal Justice Populations: A Research-Based Guide*.
[52] Farabee et al., "Barriers to implementing effective correctional drug treatment programs," 150-162.
[53] Young, Fluellen, and Belenko, "Criminal recidivism in three models of mandatory drug treatment," 313-323.

consulting appropriate research in the area.[54] This use of appropriate and effective screening instruments, such as the TCUDS, is important to achieving the objective of reducing inappropriate referrals to services.[55]

At a time of fiscal crisis for many State agencies, matching individuals to appropriate treatment programs would allow the Department to make the best use of limited resources.

Given the high likelihood of inaccuracy or deception in the three self-report screens (verbal at reception; SSI-AOD; and MAST), DOCS would do well to rely on one-on-one interviews with trained staff to detect and assess the need for substance abuse treatment.

5.4 INDIVIDUALS WITH INDICATIONS OF INVOLVEMENT IN DRUG TRADE WITH LIMITED OR NO SUBSTANCE ABUSE HISTORIES

One of the most common objections from inmates we interviewed was that they were placed in a substance abuse treatment program even though they believe they had no—or only a limited—need for it. Primary among these are inmates convicted of selling drugs or whose pre-sentence report indicated an involvement in drug sales, but who asserted they did not use drugs.

> *I have been drug free for over 25 years, don't have any positive drug tests during my continuous years of prison and have clarified that I don't have a need for the program. But they have made the claim that if I don't participate in the program, they will take away my good time which will stop me from going home.*
>
> Anonymous Inmate (Bare Hill C.F.)

Department officials claim these individuals are appropriate candidates for treatment because, despite inmate assertions to the contrary, many of them are in fact substance users, and the few who are not can benefit from treatment concerning issues of individual responsibility, life skills, addiction behavior[56] and criminal thinking.

> *Why is it that DOCS is making people take ASAT when they don't have a drug problem? I've admitted to using marijuana and cocaine once back in 1985 and never used a drug since and have never drunk alcohol. I have not been arrested or ever convicted of drug use, drug possession or drug trafficking, and when I was arrested, no drugs were found on me or in my possession, and I have no charge of drugs on my indictment, but yet I was told by a counselor that I needed ASAT.*
>
> Anonymous Inmate (Gowanda C.F.)

Other inmates who complained about their designation reported occasionally using only marijuana or stated that their substance use occurred many years prior to their current incarceration or the time when they were being offered treatment.

[54] Peters et al., "Effectiveness of screening instruments in detecting substance use disorders among prisoners," 349-358.
[55] Ibid.
[56] The definition of addiction behavior includes any activity, substance, object, or behavior that has become the major focus of a person's life to the exclusion of other activities, or that has begun to harm the individual or others physically, mentally, or socially. Adapted from Engs, *Alcohol and Other Drugs*.

5.5 TREATMENT MATCHING

A substantial body of research supports the strategy of treatment matching: seeking to place individuals with substance abuse in the treatment modality and with the treatment services that best suit their needs and strengths.[57] For example, those with stronger social and economic supports and fewer psychiatric problems do well in most treatment modalities, while those with more severe substance abuse and less social and psychological stability do best in highly structured treatment such as long-term residential programs. Careful matching of participants to treatment helps improve treatment retention and thus outcomes, since they are so closely tied to length of stay.[58]

Without objective strategies, treatment staff tend to assign participants to treatment subjectively, often using clinically irrelevant information.[59] A variety of tools and systems have therefore been developed in order to systematize the process of matching individuals to the treatment that is most likely to be effective for them. These include the patient placement system of the American Society of Addiction Medicine and New York State's LOCADTR system (described below). A treatment matching protocol has also been developed and validated for use in the therapeutic community, the dominant treatment modality in New York's prisons.[60]

Level of Care for Alcohol and Drug Treatment Referral (LOCADTR) is a patient placement criteria system designed for use in making level of care decisions in New York State. Level of care determination is a clinical procedure provided by OASAS-certified alcoholism and substance abuse treatment services or by qualified health professionals as defined in OASAS chemical dependence regulation (refer to **Appendix E** for more information regarding OASAS standards). It is the responsibility of the provider to make an appropriate placement.

The Office of Alcoholism and Substance Abuse Services (OASAS, the State agency that licenses drug treatment programs in New York), has formulated a set of patient placement criteria to guide treatment providers in placing clients in the least restrictive but most clinically appropriate level of care available. OASAS guidelines distinguish among four primary levels of care: crisis services, outpatient services, inpatient rehabilitation services, and residential services, with additional sublevels for each. The OASAS guidelines require that every treatment participant undergo the determination, which must be completed by a clinical staff member with clinical oversight by a qualified health professional.[61]

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[57] Peters, Wexler, and Center for Substance Abuse Treatment (U.S.), *Substance Abuse Treatment for Adults in the Criminal Justice System: Treatment Improvement Protocol (TIP) Series 44 -- SAMHSA/CSAT Treatment Improvement Protocols -- NCBI Bookshelf*; Finney and Moos, "Matching patients with treatments," 122-134; Committee on Treatment of Alcohol Problems, Institute of Medicine, *Broadening the Base of Treatment for Alcohol Problems*, 122-134; Leshner, "Drug abuse and addiction treatment research," 691-694; Melnick et al., "A client-treatment matching protocol for therapeutic communities," 119-128.

[58] Simpson et al., "A national evaluation of treatment outcomes for cocaine dependence," 510-514.

[59] Westenberg, Koele, and Kools, "The treatment of substance addicts," 39-46.

[60] Melnick et al., "A client-treatment matching protocol for therapeutic communities," 119-128.

[61] New York State Office of Alcoholism and Substance Abuse Services, *Guidelines for Level of Care Determination LOCADTR 2.0*.

DOCS does not currently use OASAS's level of care system; we recommend they implement a similar system, with appropriate modifications for the correctional setting, to place inmates in the most appropriate level of care available. It is important that individuals incarcerated in New York State prisons receive assessment, evaluation and placement services consistent with standards in the community, with necessary adjustments made to account for the unique circumstances and environment of this population. It is our view that community standards developed by OASAS based upon best practices in the field should be applied to the Department's substance abuse treatment programs.

In addition to determining the severity of an individual's drug or alcohol problem, it is important to distinguish among types of drugs used. The number of individuals who reported their "most serious" drug use as marijuana has risen significantly in the past few years. In 2006, 30% of inmates designated as needing substance abuse treatment listed marijuana as the most serious drug they used. This number rose to 36% in 2007, and marijuana leads as the most prevalent drug used, followed by alcohol (23%), cocaine (18%), heroin (10%) and crack (9%). Though individuals who use marijuana on a regular, non-recreational basis may indeed be in need of substance abuse treatment, the level and content of services needed for this population would differ greatly from the services needed for opioid users.[62] As we observed during the study, mixing these two very different populations in one treatment program can reduce the effectiveness of treatment and decrease the engagement and motivation of all program participants.[63]

It is our understanding through conversations with DOCS executive staff, treatment staff and inmates that a comprehensive assessment that would generate a diagnostic impression is rarely conducted. Once inmates are "screened in" as needing treatment, substance abuse treatment is added to their required program lists.

The manual for ASAT, the primary DOCS treatment program, requires that treatment staff conduct an interview with every inmate admitted to the program. Many of the treatment staff the CA interviewed stated that the purpose of this interview is to familiarize themselves with the incoming inmate's needs and orient the inmate to the program—not to conduct a comprehensive assessment that could result in a decision that the inmate is not in need of treatment. The perception of treatment staff is that the decision to admit the inmate to treatment is made before this interview and that their role does not include assessing the validity of that decision. Treatment staff rarely reported instances in which, once this interview was conducted, an individual was deemed not to be in need of substance abuse treatment.

5.5.1 Inmate Objection to Designation as In Need of Treatment

When an inmate objects to placement in a substance abuse treatment program, this assignment is reviewed by the treatment staff, including a psychosocial assessment of the potential program participant. If the inmate continues to disagree with the determination of treatment need

[62] Prendergast and Podus, "Drug treatment effectiveness."
[63] Peters, Wexler, and Center for Substance Abuse Treatment (U.S.), *Substance Abuse Treatment for Adults in the Criminal Justice System: Treatment Improvement Protocol (TIP) Series 44 -- SAMHSA/CSAT Treatment Improvement Protocols -- NCBI Bookshelf*.

following the staff's evaluation, the objection is forwarded to the DOCS Office of Substance Abuse Treatment Services (OSATS), with supporting documentation such as pre-sentence reports, screening results, and the psychosocial assessment. At this point, OSATS makes a determination as to whether the individual is in need of substance abuse treatment. When questioned about the frequency with which such objections result in an individual being determined to *not* be in need of substance abuse treatment, staff from the OSATS office reported it to be rare. Facilities also reported a low number of decision reversals on this matter.

Many treatment staff and inmates were unclear as to the process for submitting an objection, nor did the CA observe any written policy provided to inmates outlining the steps to take if an individual wanted to place an objection. In contrast, the CA did observe materials outlining the negative consequences for refusing to participate in recommended programming. The document stated, "I understand that refusal to participate in recommended programming may result in the denial of Parole, the loss of Good Time, denial of Merit Time and/or Earned Eligibility Program certificate and ineligibility for an area of preference transfer. In addition, refusal to participate may affect placement in an outside clearance assignment, honor program housing and the family reunion program." This emphasis on the negative consequences of program refusal, coupled with the lack of written policy outlining an objection process, works to limit the number of individuals attempting to engage in the process and may result in individuals feeling coerced into participation when they believe such treatment is unwarranted.

5.6 ASSESSMENT/INTAKE WHEN ENROLLED IN A PRISON TREATMENT PROGRAM

Every inmate undergoes an intake interview after enrollment in a DOCS substance abuse treatment program. The intake forms that guide the interview and are retained in the inmate's case records vary widely among facilities. Most of them are very brief; some are one side of a single page, with very little space to record answers to the interview questions that include minimal information about patterns of use, symptomatology, and motivation; previous substance abuse treatment; medical, mental health, criminal, educational and employment histories; family and other supports; and the interviewer's impressions of the inmate's strengths and needs. Most of the forms reviewed by the CA were confusing and provided little or no guidance or opportunity to record anything but the most basic data. No space is provided for important data such as date of birth. Refer to **Section 13, Treatment Records**, for a more detailed analysis of the treatment documents.

5.7 COERCIVE TREATMENT FOR INDIVIDUALS WITH MINIMAL SUBSTANCE ABUSE TREATMENT NEEDS

> *As far as ASAT, I believe the biggest problem is that people are forced to take the program, in that if they don't take the program they lose their good time. This creates an atmosphere where you have a few who want the help and truly want to change and the big percentage doesn't want to be there. I know this does not stop one for getting help and staying with the few who want the help, yet it creates a very negative and overall untrustworthy atmosphere that affects the few who want and need the help.*
>
> Anonymous Inmate (Arthur Kill C.F.)

Though there is not full agreement as to the effectiveness of coercive treatment, mandating individuals into treatment who do not have a substance abuse problem, or who feel forced to participate, can lead to a disruptive and fragmented therapeutic environment, as a balance must be maintained in a program between individuals who are committed to, and enthusiastic for, treatment and more reluctant coerced participants.[64] Furthermore, any treatment program is likely to have participants with varying degrees of severity and motivation. An array of evidence-based interventions is available to enhance treatment readiness and engagement, creating a more promising treatment experience for everyone involved.

Committed individuals may motivate and engage coerced participants; conversely, if the majority of participants are coerced and disengaged, this will also impact the quality of the treatment for the individuals who are serious about engaging in treatment. Of the inmates not in treatment that we surveyed, 70% were told during their intake to DOCS that they should enroll in a substance abuse treatment program during their incarceration. Eighty-seven percent of these individuals reported being asked about their history of alcohol and other drug use; 25% reported no such history, but were told they needed substance abuse treatment nonetheless.

Matching individuals to clinically appropriate treatment programs requires a trained clinician to explore a variety of factors, such is the severity of the individual's substance abuse problem, the length of the problem, and the impact on his/her life. In addition to specific questions regarding the individual's history of substance abuse, a clinician must also determine how motivated the individual is to begin treatment, as some treatment modalities or programs are more suited to engaging individuals resistant to treatment. The individuals identified by DOCS as being in need of substance abuse treatment vary greatly in the severity of their substance abuse, their motivation for treatment, and their risk for future relapse and criminal behavior. However, the vast majority will be enrolled in a residential therapeutic community ASAT program regardless of the severity of their substance abuse problem, use history or risk. See **Section 6, Overview of DOCS Substance Abuse Treatment Programs**, for a more detailed description of the ASAT program.

5.8 INMATES NOT IN TREATMENT

The goal of the CA is to assess the DOCS response to inmates with substance abuse problems, not just those in DOCS treatment programs. Thus, we interviewed and surveyed 1,163 inmates not currently in treatment, most of whom had already participated in DOCS treatment or were

[64] Ibid.

waiting to begin a substance abuse treatment program. These inmates completed the CA's Non-Program survey (see **Appendix C**), which assessed through self-report the severity of their substance abuse problems, as well as their motivation to participate in a prison-based substance abuse treatment program. Of the surveyed inmates, 1,028 respondents indicated they had already participated in some prison-based treatment. Of the remaining 135 respondents with no prior prison-based treatment, only 15 had been told by DOCS officials that they did not need substance abuse treatment, reported no substance abuse history, and expressed no interest in treatment.

When asked, "How serious do you think your drug or alcohol problems are?" 35% answered *not at all serious*; 14% *slightly serious*; 13% *moderately serious*; 18% *considerably serious*; and 20% *extremely serious*. Though these replies are based on self-assessment, it remains significant that there is so much variation in levels of substance abuse severity. Inmates were also asked about how important it was that they got treatment in prison. Forty-two percent of inmates surveyed stated that it was *not at all important*; 9% *slightly important*; 9% *moderately important*; 13% *considerably important*; and 26% described receiving prison-based treatment as *extremely important*.

Of the individuals who described their substance abuse problem as *moderately*, *considerably* or *extremely serious*, 89% reported during admission some alcohol or drug abuse; 80% had been told that they needed a treatment program; and 74% said they were interested in enrolling in a treatment program. In addition, 72% of this group had been in some prison-based treatment and 27% had been removed from prison-based treatment previously. In contrast, of those survey participants who said they had *no* substance abuse problem or described their substance abuse problem as *slight*, 45% reported some alcohol and/or drug abuse during their reception interview, 63% were told they needed a prison treatment program, and 73% said it was *not at all important* or only *slightly important* that they get treatment while incarcerated. In addition, 51% of this group had been in a prison treatment program already and 29% failed to complete their most recent treatment program.

Though the surveys do not accurately capture overall motivation for treatment, they offer a preliminary indication of an inmate's interest in treatment services. The data clearly illustrate that inmates in New York State prisons significantly differ in their motivation for substance abuse treatment. In order to provide effective and appropriate substance abuse treatment services to a population with such significant differences, treatment matching is key.

We also asked the inmates not in treatment to respond to 12 questions about their use of substances and the impact of this use on their lives in the 12-month period prior to their incarceration. These questions are similar to the Texas Christian University Drug Screen (TCUDS), an instrument used to perform initial screens for community- and prison-based treatment programs. According to the TCUDS guidelines, a score of 3 or more indicates relatively severe drug-related problems, corresponding approximately to DSM drug dependency diagnosis.[65] Although our survey is missing one question from the latest TCUDS form, a review of the results from the 1,100 non-program survey respondents is informative. Fifty-six percent of the respondents who answered all the questions had scores of 3 or more, with 34% scoring in

[65] Institute of Behavioral Research, Texas Christian University, *TCU Drug Screen Scoring Guide.*

the 6 to 8 range. Forty-four percent of the respondents had a score of 2 or less; 6% scored 2, 10% scored 1; and 28% had a 0 score. Of those scoring 0 or 1, 63% had been told that they would need a treatment program during their incarceration, although 90% felt they had no drug problem or only a slight one, and 63% had reported at reception no alcohol or drug abuse. Sixty-six percent of this group was not interested at all in getting treatment and an additional 10% had only a slight interest. Despite these indications of little need or interest, 47% of this group had already been in a prison treatment program.

These data demonstrate the great variability between severity of substance abuse problems on one hand and interest in substance abuse treatment on the other. These figures also confirm that DOCS makes aggressive efforts to place individuals into more intensive treatment who have low problem severity and low motivation—a combination that predicts poor treatment outcomes for them and perhaps others in their programs.

5.9 SPECIAL POPULATIONS

Treatment matching becomes even more critical with individuals who have special needs, both to accommodate varying treatment goals and to maximize cost-effectiveness.[66] The DOCS programs for special populations, such as those with mental health disorders and inmates residing in in-patient regional medical units, follow curricula similar to those of the mainstream programming, with the addition of appropriate topics or extended duration of the program. Refer to **Section 16, Special Populations** for more information.

[66] Peters, Wexler, and Center for Substance Abuse Treatment (U.S.), *Substance Abuse Treatment for Adults in the Criminal Justice System: Treatment Improvement Protocol (TIP) Series 44 -- SAMHSA/CSAT Treatment Improvement Protocols -- NCBI Bookshelf*.

6. OVERVIEW OF DOCS SUBSTANCE ABUSE TREATMENT PROGRAMS

6.1 INTRODUCTION

This report looks at the DOCS treatment programs observed by the CA during the course of the Substance Abuse Treatment Project. The manual for the main DOCS treatment program sets a performance objective of "offering a diversity of treatment approaches and strategies to meet the needs of all inmates."[67] However, the majority of DOCS treatment programs aim to utilize a modified therapeutic community (TC) approach. Thus, this section presents first a brief overview of the TC model generally; next, the TC model as it is widely utilized in the nation's prisons; and finally, the TC model described in the DOCS program manuals. This information is based on widely accepted academic sources and empirically validated research; it was not provided by DOCS.

This section also provides basic descriptive information about the different treatment programs we visited.[68] These program descriptions are based solely on manuals, guidelines and protocols provided by the Department, *not* on the observations or findings from our visits. The differences we observed between the content of the program manuals and actual practice in the programs are discussed in detail throughout the remaining sections of this report.

6.2 THERAPEUTIC COMMUNITY MODEL, GENERALLY

This section looks at academic, expert and clinical research on the TC model that was not provided by DOCS and does not necessarily describe how DOCS implements the TC model in its programs.

A substantial body of theory, clinical practice and research supports the stature of the modified therapeutic community as the most effective in-prison modality.[69] The therapeutic community utilizes a model that is highly structured and hierarchical, with progress upward through the hierarchy linked with increasing levels of responsibility and privilege.[70] It views substance abuse as a problem of the whole person and focuses its treatment approach on the entire individual.[71] Residents live and work together, creating a strong sense of community that engenders a feeling of safety and facilitates sharing among participants, transforming the

[67] State of New York Department of Correctional Services, *Alcohol and Substance Abuse Treatment (ASAT) Program Operations Manual*, 3.
[68] This section discusses only programs that the Prison Visiting Project visited for this project. The remaining DOCS programs (not covered in this section) consist of programs with limited enrollment, programs that no longer appear to be in operation, and programs we were unable to observe.
[69] National Institute on Drug Abuse, *Therapeutic Community*.
[70] LaBarbera and Bush, "Introduction to the Therapeutic Community Model: Training for Correctional Staff - A Manual on the Elements Common to Therapeutic Communities."
[71] De Leon and Wexler, "The Therapeutic Community for Addictions," 167-177.

community into the primary therapeutic agent.[72] Individuals participating in a TC are considered members, not patients, of the program, and they play an important part in managing the TC's day-to-day operations. They serve as role models and peer support for each other.[73]

The earliest therapeutic communities, founded in the 1960s, were built on the concept that participants needed to be broken down and then rebuilt into responsible adults through structure and very rigorous rules and interventions. Treatment included requiring members to wear signs, scrub bathrooms with a toothbrush, or undergo a haircut in front of the entire house community. Most staff were former addicts with no professional training. The model has evolved to meet the needs of a changing population and to become part of the substance abuse treatment continuum.[74] Staff training is encouraged, coercion and confrontation have been toned down, and changes are made to accommodate the needs of special populations like juveniles and women. Contemporary TCs increasingly integrate aspects of other approaches, such as cognitive-behavioral treatment and social learning techniques. This model is often referred to as the modified TC; for the most part, this report references that model when discussing the TC.

For more on DOCS implementation of treatment models and interventions, see **Section 8, Treatment Programming and Materials**.

A length of stay in a TC, both in prison and in the community, ranges from 12 to 24 months, though as budgets are being cut nationwide, the duration of many TC programs is decreasing. As with other treatment modalities, length of stay strongly correlates with positive outcomes, even for those who do not complete the program. TCs usually consist of three primary stages: induction and early treatment or orientation phase; primary treatment phase; and relapse prevention/reentry phase.[75] During the first stage, participants are introduced to the program and TC ideas, and they begin to establish trust with both staff and peers. The following stage consists of more intensive treatment services, and the relapse prevention/reentry stage assists the participant to prepare for program completion.

Standards of behavior provide safety, structure and accountability, with corresponding sanctions and rewards. A contingency-based system of rewards and sanctions encourages compliance with community norms. Sanctions are clinical interventions that help the individual and the community understand and correct behavior that violates community norms and rules. Ideally, sanctions are corrective, tied to the underlying behavior, and supportive of community cohesion. Verbal sanctions for failure to conform to community expectations (e.g., persistent lateness or rudeness) can include minor rebukes by peers and staff ("pull-ups") and confrontation or encounter groups (sometimes called "haircuts"). Participants are expected to monitor and report on each other's behaviors, with failure to report misbehavior considered the equivalent of condoning it.[76] Violations of explicit facility rules are likely to draw disciplinary sanctions that are both punitive and corrective, including loss of privileges. "Learning experiences" and

[72] Peters, Wexler, and Center for Substance Abuse Treatment (U.S.), *Substance Abuse Treatment for Adults in the Criminal Justice System: Treatment Improvement Protocol (TIP) Series 44 -- SAMHSA/CSAT Treatment Improvement Protocols -- NCBI Bookshelf*.
[73] *Therapeutic Communities of America*, 2008. http://www.therapeuticcommunitiesofamerica.org/main/.
[74] White, *Slaying the Dragon*, 241 ff.
[75] National Institute on Drug Abuse, *Therapeutic Community*.
[76] De Leon, George, *The Therapeutic Community*, 169.

"contracts" provide extended opportunities for individuals to explore problematic attitudes and behaviors with the support of the community. The most severe sanction, of course, is removal from the program.[77]

Structure is an essential aspect of the TC. Individuals move up through a hierarchy as they demonstrate improvements in attitudes and behavior as well as clinical progress. Privileges can include promotions in work assignments, passes, a key to the house, increased phone or visiting time, or improved living quarters.[78] At the same time, responsibilities also grow, and may include assisting in assigning and monitoring chores, escorting peers off-site for appointments, assisting staff in clerical jobs, or facilitating group sessions. The TC model relies on a community of concerned peers working together to facilitate individual change.[79] Daily community meetings of all program participants anchor the process, helping to ensure maintenance of a therapeutic milieu.

6.2.1 The Prison-Based Therapeutic Community

The TC must be modified for the unique conditions of prisons, such as the focus on security and prison culture. The tendency to define "substance abuse" broadly results in participants with low severity and motivation mixed with those who have the highest of both.[80] Nonetheless, the modified TC is one of the most successful in-prison treatment modalities. A prominent feature of successful modified prison models is the involvement of correctional officers, prison administrators, and mental health and TC treatment professionals.[81]

The rapid expansion of prison-based TCs has created problems with consistency and quality control, however. Research has found "considerable confusion" as to what a TC is, and that many programs describing themselves as TCs integrate substantial features of cognitive-behavioral therapy and the 12-step approach. The effectiveness of the prison-based TC model was demonstrated in studies of relatively sophisticated or "pure" TCs. Thus, as the model is diluted, it loses its grounding in research and the experience of other prisons.[82] This need for consistency has prompted a variety of efforts to develop national standards for prison-based TC.

While the size of a typical TC residential unit may vary, almost every state in the United States operates a TC program in at least one of its prisons.[83]

6.2.2 The Therapeutic Community In DOCS

Though a report on the current state of treatment programs in New York State prisons could

[77] Ibid., 211 ff.
[78] National Institute on Drug Abuse, *Therapeutic Community*.
[79] *Therapeutic Communities of America*, 2008. http://www.therapeuticcommunitiesofamerica.org/main/.
[80] Welsh and McGrain, "Predictors of therapeutic engagement in prison-based drug treatment," 271-280.
[81] The Criminal Justice Committee of Therapeutic Communities of America, *The Prison Based TC Standards Development Project: Final Report of Phase II*.
[82] Melnick, Hawke, and Wexler, "Client Perceptions Of Prison-Based Therapeutic Community Drug Treatment Programs," 121-138.
[83] LaBarbera and Bush, "Introduction to the Therapeutic Community Model: Training for Correctional Staff - A Manual on the Elements Common to Therapeutic Communities."

benefit from an overview of the evolution of such programs, the CA was unable to find a concise account of the history of substance abuse treatment in New York State prisons. In addition to researching the legislative history of the development of some DOCS treatment programs, efforts were made to reach out to individuals and organizations involved in past treatment programs in the prisons and we were able to put together a brief account of the growth of these programs. The CA recently contacted the Department for a more formal and accurate account of the history, but at the time of publishing we had not yet received a response.

The early history of substance abuse treatment in New York State prisons must give credit to the efforts of Father Peter Young, along with Department officials. Father Young helped to introduce a bill in the early 1960's that removed public intoxication as a violation of penal law as part of his push to provide treatment to such behavior rather than a criminal justice response. As an advocate, he has worked closely with the Department and state officials to advocate for treatment as opposed to punishment. Also in the 1960's, Father Young initiated a small program at Woodbourne C.F. to provide voluntary substance abuse treatment to inmates. After the positive experience at Woodbourne C.F., in the late 1970's Father Young started a similar and larger program at Mt. McGregor C.F. where he was the prison chaplain.

What started out as a small, voluntary program where inmates would be "called-out" to the program run out of the chapel grew into a full-fledged, residential, modified therapeutic community program serving over 800 inmates at Mt. McGregor. The program utilized a 12-Step approach and for the first few years, inmates served as the only staff, strongly developing their ownership and commitment to the program. Father Young also brought in other individuals in recovery from the community to act as mentors and facilitators. The inmates reported that they found a great deal of inspiration from hearing from others who had similarly battled addiction. The success of the substance abuse treatment program at Mt. McGregor, with some calling it the birth of the current Alcohol and Substance Abuse Treatment (ASAT) program, was due not only to the dedication of both Father Young and the inmates, but also to a innovative and willing superintendent, Joe Kennedy.

Formal substance abuse treatment programs in the prisons appeared to expand exponentially in the late 1970's and 1980's. What began as a program at a few facilities grew into substance abuse treatment programs at 60 of the 63 New York State correctional facilities by 1992.[84] These programs served approximately 15,000 inmates each year.[85]

In 1977, Stay'N Out, a program of New York Therapeutic Communities Inc. opened at Arthur Kill C.F and Bayview C.F. The original design of the program included six months of in-prison treatment which would allow the inmate to be granted parole six months early if the individual agreed to participate in six months of community-based treatment. Although the early parole program was not implemented, the in-prison program continued to operate even without the assurance of early release. The two programs operated by Stay'N Out were originally not monitored by DOCS, but by the Division of Substance Abuse Services (currently OASAS). From 1977 to 1980 the program was supported as a pilot by federal funds, and DOCS provided

[84] Murphy, Johnson, and Edwards, "In the Decade of the Child: Addicted Mothers, Imprisonment and Alternatives."
[85]National Institute of Corrections, "State Corrections Agencies' Substance Abuse Treatment Programs: Results of an NIC Information Center Survey."

the funding starting in the early 1980's when federal funds were no longer available. The Stay'N Out programs were initially 9 to 12 months in length, but DOCS reduced the program length to six months in order to increase the number of inmates who could enter the program. As an outside provider, Stay'N Out received outside certification and ran with a great deal of documented success[86] until 2008 when funds for the program were eliminated. Though Stay'N Out made requests to expand their successful program to other facilities, DOCS did not agree as the trend was for treatment programs to be run by DOCS instead of outside contractors.
In 1987 legislation passed that mandated DOCS to create a six-month program that could prepare young, non-violent inmates for early release consideration. This was the beginning of the State's Shock programs. Between July 1987 and September 2006, 51,522 inmates were sent to Shock, of which 35,102 graduated successfully and were granted early release to parole supervision. DOCS originally established five Shock facilities: Monterey C.F., 1987; Summit C.F., 1988; Moriah C.F., 1989; Butler C.F., 1989; and Lakeview C.F., 1989. Butler Correctional Facility closed in 1993, but the remaining four programs remain in existence.

In late 1989, the New York Prison Omnibus Act was passed providing for the expansion of existing alcohol and substance abuse treatment programs administered by DOCS, and resulting in the creation of the three-phase Comprehensive Alcohol and Substance Abuse Treatment (CASAT) programs. With the exception of one program at Marcy serving 200 inmates and run by outside contractor, Phoenix House, the remaining programs were run by DOCS staff. The legislation called for the creation of six, 200-bed alcohol and substance abuse treatment annexes with the intent of providing more of a continuum of substance abuse treatment. In 1990, four CASAT programs were developed at Marcy C.F., Hale Creek C.F., Butler C.F. and Chateaugay C.F. These four programs were followed by the creation of CASAT programs at Arthur Kill C.F. (1992), Taconic C.F. (1992), Cape Vincent C.F. (1993), Livingston C.F. (1994) and Wyoming C.F. (1998). The CASAT program at Livingston C.F. closed after only one year (1995) followed by the closing of the program at Cape Vincent C.F. (1998), Chateaugay C.F. (2002), Butler C.F. (2002) and Marcy C.F. (2005). Some of these closures were a result of a change in 1995 of the State's temporary release criteria, which greatly reduced the number of inmates eligible for the CASAT program.

The CASAT program run by Phoenix House at Marcy C.F. operated for 15 years and was able to achieve many successful outcomes. In addition to their work at Marcy C.F., Phoenix House was able to make a convincing case to DOCS that women also needed the continuity of care that Phoenix House could provide. As a result, in the late 1990's/early 2000's, Phoenix House was awarded a contract to run a six-month reintegration program for women being released from Taconic C.F. Phoenix House has also been able to develop close relationships with staff at Bayview C.F. and a few other correctional facilities in order to provide community treatment after an inmate's release.

In addition to the Shock and CASAT programs developed as a direct result of legislation, the federal Violent Crime Control and Law Enforcement Act of 1994 established state correctional facilities to enhance and develop residential, prison-based substance abuse treatment services.[87] DOCS has received funds to operate these Residential Substance Abuse Treatment Programs

[86] Wexler et al., "Outcome evaluation of a prison therapeutic community for substance abuse treatment."
[87] National Institute of Justice, "Violent Crime Control and Law Enforcement Act of 1994."

(RSAT) since 1996, though these funds have decreased considerably throughout the years. The addition of RSAT funding resulted in many of DOCS ASAT programs transforming into residential programs. As of January 2009, DOCS received an annual RSAT grant of $336,000, which has been used to sustain the project staff of the programs. Twenty-three RSAT programs were in operation in 2006, in contrast to six in 2010, though most of the terminated DOCS RSAT programs were converted to ASAT treatment programs and continue to be residential programs. A major change to the substance abuse treatment programs in DOCS occurred in 1996 with the case of Griffin v. Coughlin.[88] David Griffin was an inmate at Shawangunk who had been told his continued eligibility for the Family Reunion Program was contingent upon his participation in the facility's ASAT program. As previously mentioned, prior to this time the treatment programs in DOCS used a 12-step approach. Mr. Griffin filed a petition, which he eventually won, as the court ruled that under the Establishment Clause of the First Amendment, an inmate could not be deprived eligibility in a program, such as the Family Reunion Program, for refusing to participate in the only treatment program available whose curriculum adopts religiously-oriented practices and philosophies.[89] Following this decision, the subsequent years saw DOCS treatment programs switching from a 12-step approach to the modified therapeutic community model found in nearly all DOCS substance abuse treatment programs today.

The DOCS ASAT Program Operations Manual (hereinafter referred to as the ASAT Manual) serves as the primary guide for nearly all DOCS substance abuse treatment programs.[90] The ASAT Manual describes many of the basic elements of TCs as mentioned above, though significant differences exist between the Manual's guidelines and actual implementation.

For a detailed analysis of the DOCS treatment programs and models, see **Section 8, Treatment Programming and Materials**.

6.3 ALCOHOL AND SUBSTANCE ABUSE TREATMENT (ASAT)

The Alcohol and Substance Abuse Treatment Program (ASAT) is the most widely utilized DOCS program, operated in the majority of all medium- and most maximum-security DOCS facilities, a total of 56 prisons.[91] The ASAT program is administered and supervised by DOCS Central Office under the Office of Substance Abuse Treatment Services.

The six-month program aims to provide education and counseling through "the Substance Abuse Program," a competency-based curriculum consisting of nine subject areas, and individual treatment plans. Individuals do not proceed through the competencies in chronological order as the Department's ASAT programs have continuous enrollment, and inmates may join the program at any point in the curriculum. Inmates are generally not eligible to enroll in ASAT until they are within 6 to 18 months of the end of their sentence. According to the 2002 ASAT Manual, residential (segregated) treatment programs are preferred but ASAT facilities "may

[88] *Griffin v. Coughlin*. 88 N.Y.2d 674 (1996).
[89] Ibid.
[90] The Manual provided to the CA by DOCS is dated October 2002. We have not identified any updates or revisions.
[91] The CA observed ASAT in operation at these correctional facilities: Albion, Arthur Kill, Bare Hill, Cayuga, Eastern, Five Points, Franklin, Gouverneur, Gowanda, Green Haven, Greene, Marcy, Mid-State, Oneida, Shawangunk, Sing Sing, Taconic, Washington, Wende, and Wyoming.

choose to employ alternative single treatment strategies, such as cognitive-behavioral or therapeutic community, or an approved eclectic treatment strategy approach"[92] (The majority of ASAT treatment programs are residential, in that the treatment participants are housed together in the same housing block). The ASAT Manual clearly details components of the therapeutic community model, including community meetings, pull-ups, work assignments and a structured hierarchy. Finally, although self-help groups such as Alcoholics Anonymous (AA) or Narcotics Anonymous (NA) are no longer a required or formal component of any ASAT program, the ASAT Manual states that weekly participation in such groups is recommended.

The ASAT program is structured around nine competency areas: (1) drug use/abuse consequences; (2) understanding self and others; (3) understanding criminal thinking; (4) decision making and communication skills; (5) the process of addiction;(6) the process of recovery; (7) the relationship of alcoholism/addiction to a multitude of problems (e.g., health, family, social, legal); (8) the process of relapse prevention; and (9) the process of maintaining a drug-free lifestyle. According to the ASAT Manual, the goal of the ASAT program is "to help the participant progress through the stages of recovery in each of the nine competency areas." The "recovery stages" listed are: information, body of knowledge, discovery and assessment, conceptualization, understanding, internalization, and actualization.[93]

The manual provides a definition for each stage. For example, the information stage introduces facts and definitions "to establish a foundation for communication … alcohol is a drug, denial is symptom of addiction." The body of knowledge stage is "the grouping of facts and definitions necessary to achieve insight about a specific subject area." In the actualization stage, "the process of recovery becomes the person." See the ASAT Manual for definitions of all stages.

It is unclear how the ASAT program accounts for variations among inmates regarding the different stages they may be starting at or advancing to throughout their participation in the program.

The Manual lists "treatment objectives" for each competency in bullet form, extending over six pages. A "sample curriculum" is provided in the form of a week-by-week breakdown of the competencies over six months, with several bullet points for each week. The curriculum does not support/address rolling admissions in this form. In the first week, for example, the learning objectives that address the competency area of drug use/abuse consequences include the classification of drugs, the concept of tolerance, and physical/psychological dependence and withdrawal. Learning objectives for the second competency area (understanding self and others) include "development of values, attitudes, and behavior," "the role of drugs in meeting social and emotional needs," and "the defense mechanism [sic] associated with alcoholism and addiction." This entire "curriculum" is laid out in five pages.

Neither the list of competencies nor the sample curriculum provides guidance regarding program content, didactic strategies, therapeutic techniques, or participant materials.

[92] State of New York Department of Correctional Services, *Alcohol and Substance Abuse Treatment (ASAT) Program Operations Manual*.
[93] Ibid., 13 ff.

According to the ASAT Manual, the ASAT program consists of one or two program modules per day, five days per week. The Manual calls for program participants to receive a minimum of 200 hours of "direct treatment services" addressing some or all of listed program activities, which include "group discussion of educational material," group counseling/therapy, individual counseling, and self-help group participation. A minimum of 130 hours is to be devoted to "treatment program support activities," which include community meetings, "self-growth and self-development assignments," "lifestyle and relapse prevention assignments," and "family and interpersonal relationships." The ASAT Manual recommends a weekly minimum of two hours of discussion groups, a minimum of one hour of seminars/lectures, one hour of audio/visual presentations, and a minimum of two hours of group counseling.

Ancillary support services needed to support specific substance abuse treatment, such as health, mental health, educational, vocational, ministerial, and recreational services, are considered an important component of the ASAT program. The ASAT Manual states that these programs should be available to treatment participants, though not provided directly by ASAT staff.

The ASAT Manual calls for individual counseling to "focus on a particular topic pertinent to a participant's experiences and/or problems," which is to be used to "establish and review goals" from the treatment plan. The Manual states that these sessions are to occur monthly on a one-to-one basis as needed. The Manual does not specify a required minimum length of time for this individual counseling session. Our case record reviews indicate that individual counseling sessions are infrequent; when they do occur, they consist primarily of the inmate signing off on a monthly review or other document requiring his/her signature. See **Section 9, Individual Counseling**, for further discussion.

According to the ASAT Manual, an "ASAT team" consists of one ASAT correction counselor and two ASAT program assistants (PAs). The Manual states that each team "typically carries a treatment caseload of 120 inmates" and each ASAT correction counselor maintains a guidance caseload of 50 inmates who are ASAT participants. "Minor" adjustments to this staffing pattern can be granted by the Office of Substance Abuse Treatment Services.

Participation in ASAT is voluntary; however, inmates who are designated by DOCS as needing treatment may face serious consequences (e.g., more prison time) for refusing to participate in or complete the program. ASAT staff are instructed to interview each participant on admission to the program and complete an ASAT intake form (included in the Manual) within seven days of admission. The information gathered during this process is to be used to collaborate with the inmate in developing an initial treatment plan that indicates the inmate's strengths, weaknesses, and treatment goals. The ASAT Manual indicates that the initial plan is to be updated after two months, with subsequent updates if needed.

As described in the ASAT Manual, inmates are expected to "take a sincere and active role in the treatment/recovery process while being honest and accountable with themselves and staff regarding addiction and recovery issues." According to the Manual, ASAT staff evaluate inmate participants on anything from a weekly to a monthly basis, depending on the intensity of the program. The purpose of this evaluation is to provide ASAT staff with "a holistic view of the

inmate's progress and provide inmates with feedback regarding their progress in meeting treatment goals."

According to the Manual, participants are discharged from the program with a "satisfactory completion" after a minimum of six months in the program if they receive a satisfactory rating on the ASAT discharge evaluation; demonstrate "a functional understanding of the dynamics and consequences of addiction;" and "have convinced ASAT staff" that they have acquired knowledge, attitudes, and skills that are critical to achieving and maintaining a drug-free lifestyle." Inmates may be removed from an ASAT program for disruptive behavior (unsatisfactory completion) or administrative reasons (administrative termination). See **Section 11, Treatment Program Completions and Removals**.

6.4 RESIDENTIAL SUBSTANCE ABUSE TREATMENT PROGRAM (RSAT)

The Residential Substance Abuse Treatment Program (RSAT) is a federally funded program that requires participant housing to be segregated from the general population.[94] DOCS operates six RSAT programs at six facilities. RSAT was established by the Violent Crime Control and Law Enforcement Act of 1994 to encourage state correctional facilities to enhance and develop prison-based substance abuse treatment services.[95] DOCS has received RSAT funds since 1996, though these funds have decreased considerably throughout the years. As of January 2009, DOCS received an annual RSAT grant of $336,000, which has been used to sustain the project staff of the programs. Twenty-three RSAT program were in operation in 2006, in contrast to six in 2010. The RSAT curriculum is based on the ASAT Manual and utilizes the same nine competency areas. It also employs similar screening, staffing, treatment modality, and removal policies as ASAT. As federal funding has decreased, many RSAT programs have closed or been converted to ASAT programs. A condition of the federal funding is that the State provide quarterly performance measures and semiannual reports.

6.5 COMPREHENSIVE ALCOHOL AND SUBSTANCE ABUSE TREATMENT (CASAT)

Comprehensive Alcohol and Substance Abuse Treatment (CASAT) is a residential intensive three-phase substance abuse treatment program offered at four correctional facilities: Arthur Kill, Hale Creek, Taconic, and Wyoming.[96] Phase I consists of treatment similar to ASAT, including a six-month residential treatment program. Phase II focuses on community reintegration, and is designed to occur within six to 18 months of an inmate's earliest release date. Phase II involves a transitional period in a work-release facility for inmates who are approved for Presumptive Work Release by the Director of Temporary Release Programs in DOCS Central Office and is intended to allow participants an opportunity to use recovery principles and coping skills acquired during Phase I. This phase typically lasts a minimum of six months. During this time, participants are to find and maintain employment, while participating in an outpatient alcoholism

[94] We observed RSAT programs at these correctional facilities: Greene and Marcy.
[95] National Institute of Justice, "Violent Crime Control and Law Enforcement Act of 1994"; US Dept of Justice and Bureau of Justice Assistance, *Residential Substance Abuse Treatment for State Prisoners (RSAT) Program*.
[96] We observed CASAT programs at all four correctional facilities where it is operated: Arthur Kill, Hale Creek, Taconic, and Wyoming.

and substance abuse treatment program. Inmates who are court-ordered to CASAT but not approved for Presumptive Work Release participate in Phase I only and are then transferred to general population in the prison system, or discharged from custody if they are paroled or complete their sentence.

Phase III of the CASAT program includes aftercare for participants who have been released on parole and are enrolled in community-based treatment. This phase is based on individual needs of inmates with a focus on relapse prevention.[97] In order to be eligible to participate in the three phases of CASAT, an inmate must have a minimum of nine months to earliest release. The staff-to-inmate ratio in CASAT programs is lower than in ASAT programs, averaging between 1:16 and 1:20.

6.6 DRIVING WHILE INTOXICATED (DWI) TREATMENT PROGRAMS

The Driving While Intoxicated Treatment (DWI) Program is intended to help DWI (or related-offense) offenders develop a foundation for positive change in their lives through assessment, education, counseling, relapse prevention, and discharge planning.[98] The program is residential and runs between six and 12 months. It is currently conducted at Albion C.F. for female inmates, with a capacity of 20 and enrollment of 25 as of January 2009, and at Gowanda C.F. for male inmates, with a capacity of 155 and enrollment of 155 as of January 2009.

To be eligible for the DWI program, an inmate must have been assessed as being in need of alcohol abuse treatment, have sufficient time remaining in his/her sentence to complete the program, and have an alcohol-specific crime of commitment or an offense that involves operating a motor vehicle under the influence of alcohol. The program described in the revised DWI manual is 26 weeks long and uses the therapeutic community approach. It is divided into five five-week sections: (1) alcoholism/substance abuse as a disease; (2) the role of drugs/emotions in relapse prevention; (3) alcoholism and the family; (4) evaluation of one's stages of change; and (5) criminal thinking and maintaining recovery. At the end of each five-week module, the inmate undergoes an evaluation.[99]

6.7 INTEGRATED DUAL DIAGNOSED TREATMENT PROGRAMS: ICP

A modified ASAT program is provided in Intermediate Care Programs (ICPs) for inmates with mental health disorders who are designated as in need of substance abuse treatment.[100] An ICP is a segregated supportive living/treatment program that provides 24-hour "care and custody" for inmates with serious and persistent mental illness. ICPs are jointly operated by DOCS and the New York State Office of Mental Health (OMH), which has statutory responsibility for providing a continuum of mental health services to inmates through its Central New York Psychiatric Center (CNYPC).[101] ICP inmates with a substance abuse history are eligible for the

[97] New York State Department of Correctional Services, *Comprehensive Alcohol and Substance Abuse Treatment Program Manual*.
[98] We observed DWI programs at these correctional facilities: Albion and Gowanda.
[99] Metz, *Felony Driving While Intoxicated Treatment Program Curriculum Manual*.
[100] We observed ICP ASAT programs at these correctional facilities: Albion, Arthur Kill, Five Points, Mid-State, Sing Sing, and Wende.
[101] Smith, Sawyer, and Way, "Central New York Psychiatric Center," 523-534.

ICP ASAT if they have a primary Axis I or Axis II diagnosis. The program runs for a minimum of nine months, in either half-day modules or two- to three-hour sessions, five days a week.[102] ASAT programs are operated in 12 ICPs with a total capacity of 182. [103]

According to the DOCS and the OMH ICP Manual, the ICP core curriculum includes psychiatric rehabilitation therapy, individual and group therapy, medication management, recreation therapy, task and skill training and development, educational instruction, vocational instruction, security services, crisis intervention, substance abuse, and pastoral counseling.[104] The nine ASAT competencies are utilized in the ICP ASAT program and combined with the ICP core curriculum to meet both the mental health and substance abuse needs of these inmates. Individual facilities differ in the extent to which they incorporate therapeutic community elements into this program, with most eliminating the structured hierarchy and elements such as pull-ups and push-ups.[105] The staff-to-inmate ratio in these programs is much lower than in general ASAT programs, between 1:3 and 1:10. Therapy and groups are sometimes cofacilitated by OMH staff.

6.8 INTEGRATED DUAL DIAGNOSIS TREATMENT PROGRAMS: GENERAL POPULATION

The Integrated Dual Diagnosis Treatment (IDDT) Residential ASAT programs are intended to provide treatment in the general population to inmates with mental health disorders who have been designated by DOCS as in need of substance abuse treatment. Bedford Hills C.F. and Mid-State C.F. currently offer this program.[106] The IDDT programs combine the ASAT competencies with a specialized treatment curriculum tailored to meet the individual needs of each participant who has mental health problems. The program length is a minimum of nine months, with one half-day module five days per week.

In order to be eligible for this program, an inmate must have an identified substance abuse history and an Office of Mental Health (OMH) classification of service level one, two, three or four. As part of the aftercare discharge evaluation process, Mentally Ill, Chemically Addicted (MICA) ASAT staff coordinate substance abuse treatment recommendations with mental health discharge recommendations from OMH staff.

6.9 SPECIAL HOUSING UNIT (SHU) PRE-TREATMENT WORKBOOK PROGRAMS

Inmates serving sanctions in a Special Housing Unit (SHU) who have been designated by DOCS as needing substance abuse treatment can complete a three-part workbook entitled *Time to Think About Change*, based on the ASAT nine competencies. This workbook does not satisfy the

[102] All DOCS programs operate in module format, with four time slots: morning, afternoon, early evening, and late evening.
[103] We observed ICP ASAT programs at these correctional facilities: Albion, Arthur Kill, Five Points, Mid-State, Sing Sing, and Wende.
[104] NYS Department of Correctional Services and NYS Office of Mental Health, *Intermediate Care Program Manual*.
[105] A pull-up is a verbal reprimand given by participants or staff to a participant who is seen as inappropriately handling emotions, behaviors, or tasks. Push-ups, in contrast, are positive acknowledgements of self or other participants. See **Section 8.12** for further discussion.
[106] We observed general population MICA programs at the following correctional facility: Mid-State.

requirement of substance abuse treatment for the purposes of the Earned Eligibility program. Rather, it is intended to motivate SHU inmates to participate in a substance abuse treatment program after completing their SHU sentence. The completion of the workbook takes approximately 14 to 16 weeks. The program is offered at seven facilities: Albion, Five Points, Greene, Lakeview, Mid-State, Southport, and Upstate.[107]

In order to be eligible to participate in the SHU Pre-Treatment Workbook Program, an inmate must first have a minimum SHU sentence of six months, and second, have been issued a misbehavior report that is alcohol/drug related or have a documented history of substance abuse. Inmates are ineligible for the program if they have received previous disciplinary sanctions for violence or sex offenses within one year prior to their review for participation. Interested inmates must also submit a request for a transfer to a SHU Pre-Treatment Workbook site if they are not already housed in one. Priority placement in the program is given to inmates who are pre-screened and transferred to the Pre-Treatment Workbook site. A SHU Pre-Treatment Workbook Coordinator reviews all requests for participation. This staff member also distributes the necessary materials and reviews the weekly written material submitted by program participants.

6.10 SPECIAL NEEDS UNIT (SNU) ASAT PROGRAMS

ASAT programs operated in Special Needs Units (SNUs) treat the unique needs of SNU inmates who are developmentally disabled and require substance abuse treatment. According to DOCS, the TC model and the competencies are "tailored to meet the functioning level of the inmates with frequent repetition and review of skills." The SNU ASAT Program requires a minimum of nine months of participation in a half-day module per day, five days a week. In order to participate, an inmate must be housed in a Special Needs Unit. Though the program utilizes the ASAT curriculum, it moves at a slower pace and limits utilization of some of the principal TC elements such as a hierarchy and pull-ups and push-ups. There is a higher staff-to-inmate ratio than in general population ASAT programs. This program is offered at Arthur Kill, Sullivan, and Wende.[108]

6.11 NURSERY MOTHERS ASAT PROGRAM

The Nursery Mothers ASAT Program operates at Taconic C.F. and has a capacity of 16 women. It is offered to mothers who are chemically addicted to address substance abuse issues, parenting, and pre-release planning. The substance abuse treatment component involves enrollment in either an ASAT or a CASAT program. The Nursery Mothers Program allows infants to remain in the nursery with their mothers for a maximum of 18 months. Participants in the Nursery Mothers ASAT Program live together in the nursery, but attend the regular ASAT/CASAT sessions.

[107] We observed SHU Pre-Treatment Workbook programs at the following correctional facilities: Albion, Five Points, Greene, Lakeview Shock and Mid-State.
[108] We observed SNU ASAT programs at the following correctional facilities: Arthur Kill and Wende.

6.12 SENSORIALLY DISABLED UNIT ASAT PROGRAM

The Sensorially Disabled Unit (SDU) ASAT Program is a modified therapeutic community for SDU inmates with documented substance abuse issues. The program meets for three hours a day, five days per week, for between six and 12 months. The program is conducted at the Eastern C.F. SDU and has a capacity of 10. Though it utilizes a TC approach, certain aspects are modified to meet the needs of this specific population.

6.13 SHOCK INCARCERATION PROGRAMS

Shock Incarceration is an intensive boot camp-style treatment program that emphasizes substance abuse treatment, military-style discipline, physical labor and fitness, a variety of life skills, and education in a TC setting. Shock programs are voluntary. Successful completion of a Shock program entitles inmates to reduced sentences, as brief as six months. Male and female inmates are first screened at one of the State's reception facilities for Shock eligibility based on the statutory requirements for the program. To qualify for Shock, inmates must have been between 16 and 50 years of age at the time of the commitment crime; must have no prior felony convictions for which a prison sentence was ordered; and must not have been convicted of a violent crime. At its inception in 1987, New York's Shock Incarceration program accepted only inmates aged 23 or younger. Since then, the legislature has broadened the eligibility criteria to include older inmates. In 1988, only inmates up to 25 were included. In 1989 the age limit was raised to 29, in 1992 to 34, in 1999 to 39 and in 2009 to 50. The Shock program runs for 26 weeks, during which participants receive approximately 500 hours of alcohol and substance abuse education and treatment from the Network [109] and ASAT Programs. Shock programs are run at Lakeview C.F. (600 capacity), Monterey C.F. (250 capacity), Moriah C.F. (183 capacity), and Summit C.F. (120 capacity).

6.14 WILLARD DRUG TREATMENT CAMPUS

The Willard Drug Treatment Campus is an intensive 90-day boot camp-style substance abuse treatment program. Willard is a sentencing option for individuals convicted of a nonviolent drug-related offense and for parole violators who otherwise would have been returned to a State prison (in most cases for a year or more). Because of their special status, the men and women detained at Willard are referred to as parolees, not inmates.

Willard is operated by DOCS in conjunction with the Division of Parole and is one of the two DOCS facilities that are licensed as treatment programs by OASAS, the other is Edgecombe Residential Treatment Facility. Willard has a capacity of 900 men and women. The CA issued a report about our visit to Willard in July 2008 describing our general observations about the prison and its programs.[110]

[109] The Network Program is designed to promote the positive involvement of inmate participants in an environment which has as its focus their successful community reentry. The objective of the program is to assist inmates in learning cooperative work and leadership skills, while demonstrating responsible behaviors.

[110] The report from our Willard visit is available at http://www.correctionalassociation.org/publications/download/pvp/facility_reports/Willard_7-14-08.pdf.

7. STAFFING FOR DOCS SUBSTANCE ABUSE TREATMENT PROGRAMS

FINDINGS

The staffing patterns at most DOCS treatment programs visited for the Substance Abuse Treatment Project were inadequate to meet the needs of the participants, both as designed (i.e., if they were fully staffed) and as currently implemented (i.e., with current vacancies).

Many of the programs observed had substantial vacancies in critical staff positions, hindering their ability to provide effective treatment.

DOCS treatment staff varied widely in competence, commitment and skills. Some staff had extensive community-based treatment experience and training prior to DOCS employment and exhibited commitment to employing current evidence-based practices in their prison-based treatment sessions. Other treatment staff had considerably less experience and training, and many staff used out-of-date materials and/or failed to employ well-established approaches for engaging participants in the treatment process.

Many DOCS treatment staff did not engage in continuing professional education and development or participate in professional organizations, while others appeared committed to continuing their training and education. Though all treatment staff are mandated by DOCS to participate in the 40 hours of training, the Department provides a limited amount of training on substance use disorders and their treatment.

The DOCS hiring, supervisory, and staff assignment systems did not encourage employees to remain within a specific program as they develop experience and enhance their qualifications.

Limited formal clinical supervision was provided to substance abuse treatment staff.

DISCUSSION

7.1 DOCS STAFFING MODEL

The ASAT Manual describes the staffing pattern at a "typical correctional facility" as a team comprising one ASAT correction counselor (ASAT CC) and two ASAT program assistants (PAs). A supervising correction counselor (SCC) may supervise larger treatment programs. "Minor" adjustments can be granted by the Office of Substance Abuse Treatment Services.

The Manual sets a "standard" ratio of 40 inmates per treatment worker, resulting in each team having a treatment caseload of 120 inmates. A treatment caseload refers solely to the caseload a staff person carries who is charged with maintaining participant's' treatment records, and should not be confused with a guidance caseload. The latter refers to a more general caseload that all

correction counselors are required to carry, and refers to all of an individual's needs while incarcerated, including programs, transfers and grievances. The Manual calls for each ASAT correction counselor to carry a guidance caseload of 50 inmates, all of whom are usually designated as in need of substance abuse treatment. According to the ASAT Manual, the ASAT correction counselor supervises the PAs' activities and tasks.

According to the examination notices provided to the CA by DOCS, the minimum qualifications for a PA are two years of experience in a substance abuse treatment program; one year of treatment experience plus current certification as a CASAC (Credentialed Alcoholism and Substance Abuse Counselor); or one year of experience plus an associate's degree in human services. The notice emphasizes that qualifying experience must be in substance abuse counseling; other types of counseling experience does not qualify. Correction counselors working in DOCS substance abuse treatment programs are required to have a Bachelor's Degree in social work, sociology, criminal justice, psychology, counseling or community and human services. In addition, they are required to have two years experience as an individual or group counselor in a recognized drug treatment program, though an individual with a Master's Degree in an above-mentioned discipline or who is a CASAC is only required to have one year of treatment experience. ASAT correction counselors may also have substantial general population counselor duties that are not related to the substance abuse treatment program. The job description for the ASAT SCC requires them to have had some experience (minimum of one year) in a prison-based substance abuse treatment program and one year as a CC, though it does not require any substance abuse qualifications, certifications or training.

Concerns about effective staffing go beyond the treatment staff. Unlike most OASAS programs in the community that have treatment staff present 24 hours per day, 7 days a week, DOCS treatment staff generally work from approximately 8 a.m. to 4 p.m. During the evening hours, the only staff present in the treatment program housing areas are security staff. Cross-training of both criminal justice and treatment staff can improve the program effectiveness. Security staff such as correction officers who oversee housing areas and staff who provide vocational, educational and other services should participate in cross-training that goes both ways. Security should know about treatment considerations, and treatment staff should be familiar with security and related issues. Without these training safeguards in place, the custody concerns of the correctional facility often overwhelm the concerns of the treatment program.[111] At some of the facilities we visited, interaction was sometimes lacking among these groups, who at times operated as silos rather than teams. At other facilities, we were pleased to observe effective collaboration and communication with treatment and security staff.

7.2 POSITIONS AND VACANCIES

DOCS treatment staff positions are not appropriately distributed, and a significant number of positions were vacant at the time of our visits. Some positions had been vacant for an unacceptably long time, ranging from six months to two years or more.

[111] Peters, Wexler, and Center for Substance Abuse Treatment (U.S.), *Substance Abuse Treatment for Adults in the Criminal Justice System: Treatment Improvement Protocol (TIP) Series 44 -- SAMHSA/CSAT Treatment Improvement Protocols -- NCBI Bookshelf*, 209.

In August 2009, the CA received a listing of DOCS substance abuse treatment positions at each prison. **Table 7-1** shows ASAT supervising correction counselors, ASAT correction counselors, and ASAT program assistants for all 62 DOCS treatment programs with assigned staff. The vacancy rate was 33% for supervising ASAT correction counselors, 26% for ASAT correction counselors, and 44% for ASAT program assistants.

At seven prisons,[112] the number of staff working at the time of the CA's visits was significantly less than the authorized treatment staff positions for the prison. For some programs, this may reflect a change in program design or capacity; others may have had no participants at the time the list was generated. We have therefore recalculated the vacancy rates without these programs.

Even with these adjustments, the vacancy rates were close to 25% for all positions: 27%, 24%, and 27% for supervising ASAT correction counselors, ASAT correction counselors, and ASAT program assistants, respectively. There were seven programs that had no ASAT correction counselors or ASAT supervising correction counselors to monitor the activities of the program assistants. It is unclear how these programs would be able to provide adequate clinical supervision for treatment staff, or overall program supervision, with these supervisory level vacancies.

Table 7-1 DOCS Substance Abuse Treatment Staff Vacancies, 2009

Position	Treatment Staff at All 62 Programs				Treatment Staff at 55 Programs			
	# of Prisons	# of Positions	# of Vacancies	% Vacant	# of Prisons	# of Positions	# of Vacancies	% Vacant
Supvg ASAT Corr Counselor	12	15	5	33%	8	11	3	27%
ASAT Corr Counselor	60	159	42	26%	53	135	32	24%
ASAT Prog Assist	58	301	133	44%	52	237	87	27%

The statewide monthly total for inmates in treatment averaged approximately 9,800 inmates during the period January through May 2009. Thus, the 285 ASAT correction counselors and ASAT program assistants represent one staff member for every 34 inmates in a program. The actual ratios vary program by program, however. (See **Table 7-2** for a more detailed analysis). At some facilities, the ratios are much higher for general population treatment programs than they are for programs for individuals with mental illness or developmental disabilities. These specialized programs typically have one or two treatment staff for only eight to 17 participants.

Table 7-2 shows the 2009 staffing for the 23 programs visited by the CA for the Substance Abuse Treatment Project. Of the 23 programs, 21 had at least one treatment staff vacancy, and 15 of the 23 (65%) had two or more vacancies. Many of these positions had recently become

[112] Butler ASACTC, Cape Vincent, Chateaugay, Lincoln, Livingston, Taconic and Ulster.

vacant, while others had been vacant for as long as several years. For example, Albion had a PA vacancy for more than two years; a Franklin PA position had never been filled since its authorization years earlier; at Gowanda, two counselor items were vacant for 12 and 18 months, respectively, and two PA positions were vacant for more than a year; and at Oneida, a counselor position had been vacant for more than two years.

Turnover is high at the treatment programs as well. For example, at Willard, from the time of our visit in February 2008 until the August 2009 data, the program lost one of its two supervising counselors, four of its nine counselors, and two PAs.

In the field of substance abuse services generally, turnover is higher than in other human services.[113] Research shows that turnover is even higher in prison-based substance abuse treatment programs, and positions tend to be vacant longer. Recruitment and retention are hampered by salary patterns, geographic isolation of many prisons, and reluctance of some substance abuse professionals to work in an unfamiliar setting, among other factors. Counselors who are well suited for community-based treatment programs may not be willing or able to function effectively in the prison setting. In particular, problems related to over-familiarization and resistance to rigid custody regulations are common among treatment providers who lack experience in criminal justice settings.[114]

The CA is concerned that DOCS may not approve positions because of the State's dire fiscal situation and that as new vacancies arise, the prisons will be unable to fill them for some time. The CA recognizes the State's need for fiscal prudence. However, it is critical for the public safety and public health that DOCS ensure adequate effective treatment is available as long as State criminal justice policies result in the incarceration of so many individuals in need of treatment.

Table 7-2 Treatment Staff at Programs Visited by the CA as of 2009

Prison Capacity	ASAT SCC	CC	PA	Credentials	Vacant Items	Staff : Inmates
Albion 235		4	5	3 CASACs 1 CASAC-T*	1 CC 2 PAs	N/A
Arthur Kill 140	1	1	12	N/A	10 PAs	SNU – 1:15 IDDT – 1: 6 ASAT – 1: 25 CASAT – 1: 60
Bare Hill 240		2	5	2 CASACs	1 PA	1:40
Cayuga 120		1	4	1 CASAC	2 PAs	1: 40 overall (1:20 in AM, 1:20 in PM)
Eastern 128		1	5		3 PAs	ASAT – 1:20 SDU – 1:15
Five Points 217		2	5	1 CASAC 1 CASAC-T*		1:33

[113] Mulvey, Hubbard, and Hayashi, "A national study of the substance abuse treatment workforce," 51-57.
[114] Farabee et al., "Barriers to implementing effective correctional drug treatment programs," 150-162.

Prison Capacity	ASAT SCC	CC	PA	Credentials	Vacant Items	Staff : Inmates
Franklin 180		2	5	2 CASACs 1 CASAC-T*	1 PA	1:30
Gouverneur 120		2	2		1 CC	1:30
Gowanda 253	1	7	14		3 CCs 6 PAs	1:20
Green Haven 65		3	4		2 CCs 3 PAs	1:33
Greene 410		5	6	4 CASACs	4 PAs	1:40
Hale Creek 480	3	10	20	16 CASACs	1 SCC 3 CCs 3 PAs	1:20
Lakeview 600	1	5	10		2 PAs	1 to a platoon
Marcy 360	1	3 Total: 1 ASAT 2 RSAT	6 Total: 2 ASAT 4 RSAT		1 PA	1:40
Mid-State 231		7	6	1 CASAC 1 CASAC-T*	1 CC	General Pop – 1: 15 ICP – 1: 10 Evening Mod – 1:25 PC Unit – 1:15
Oneida 151		3	6		2 CCs 4 PAs	1:50
Shawangunk 40		1 Sex Offender Program (SOP) CC	2	3 CASACs		ASAT: 2:20 SOP: 1: 30
Sing Sing 97		2	5		1 CC 2 PAs	ASAT: 1:27 IDDT: 1 to 17
Taconic 282	1	5	11	4 CASACs	1 SCC 2 CCs 6 PAs	PAs 1:18 CCs 1:30-35
Washington 120		2	3	1 CASAC-T	1 CC 1 PA	1:30
Wende 143		2	3 total 0.5 RMU	1 CASAC	1 PA	ASAT: 1:20 SNU: 1:9 MH: 1:8
Willard DTC 980	2	11	20		1 SCC 4 CCs 4 PAs	1:50 for males 1:60 for females
Wyoming 300	1	3 Total 2 ASAT 1 CASAT	8 Total 3 ASAT 5 CASAT		3 PAs	CASAT: 1:20 ASAT: 1:40

* Counselors who have fulfilled a substantial portion of the credentialing requirements are designated CASAC Trainees or CASAC-Ts.

Individuals in need of more intensive treatment can be placed in programs with a higher staff-to-inmate ratio, whereas individuals with less need would require less frequent and individualized staff attention. Similarly, most DOCS treatment programs run groups of the same size each day.

With limited staff, group size could differ daily depending on the activity. For example, a lecture can be presented to a large group on one day requiring fewer staff and the following day, with additional staff, groups could be divided into smaller sizes in order to discuss the material presented.

> *[M]y ASAT counselor works with the ASAT participants to the best of his ability, but he's only one man dealing with 60 guys.*
> Anonymous Inmate (Bare Hill C.F.)

As discussed in **Section 8, Treatment Programming and Materials**, group size varied among the programs visited by the CA. While large groups are appropriate for educational programming, groups for interactive or skills-based counseling should be small enough to allow all to participate. However, most of the programs we observed did not make this distinction, and many groups comprised 50 or more participants. Staff-to-participant ratios differed among programs, though the average was one staff for every 30 participants. When taking into consideration that the program assistants are generally responsible for providing the direct-services components of the program, these staff-to-inmate ratios rise even more. For ASAT programs in general population, we observed staff-to-participant ratios of as low as 1:15 and as high as 1:70. With such a high number of participants for every treatment staff member, it can be challenging to provide adequate, individualized treatment services, a situation that is problematic when working with such a varied population with complex needs.

7.3 FUNDING FOR DOCS SUBSTANCE ABUSE TREATMENT PROGRAMS

The Department's public budget does not detail the costs associated specifically with the prisons' substance abuse treatment programs. The treatment staff are all civilian DOCS employees included in the budget under the broader category of DOCS program services, which includes all educational and vocational programs as well as any other specialized program services. There are a total of approximately 3,050 DOCS program staff members, of whom about 350 are allocated to the Department's substance abuse treatment programs.[115] Within the last two years, DOCS's program services budget has been significantly reduced. In fiscal year 2009-10, the staffing for program services was scheduled to be reduced by 140 employees (approximately 5%), although the budget proposal for fiscal year 2010-11 suggests that the program staff is down almost 400 items since March 2009.[116] For fiscal year 2010-11, the governor's current proposal is to reduce the funds for DOCS program staff by an additional $5.3 million. Based upon conversations with facility administrative staff during 2009-2010, it appears that restrictions have been placed on the prisons' ability to fill program vacancies in order to reduce

[115] The treatment staff consists primarily of supervising correction counselors, ASAT counselors and ASAT program assistants, as well as approximately 10 other support staff, including two social workers, five teaching assistants, an educational counselor and a clerk. The ASAT program also has keyboard specialists at 21 prisons. Finally, there are 12 employees assigned to DOCS Central Office who oversee the treatment programs throughout the Department.

[116] The FY 2009-10 budget presentation for DOCS estimated that the Department employed about 3,480 full time equivalency (FTEs) DOCS program staff as of March 31, 2009 and projected that there would be 3,340 program FTEs (reduction of 140 items) by the end of the fiscal year (March 31, 2010). New York State Division of the Budget, *2009-10 Executive Budget Agency Presentations*, 340. In the proposed FY 2010–2011 budget for DOCS, however, the estimated program FTEs as of March 31, 2010 was only 3,050 employees. New York State Division of the Budget, *2010-11 Executive Budget Agency Presentations*, 340.

the Department's overall budget, which the governor is proposing to reduce by nearly 10% in terms of State general funds in fiscal year 2010-11.[117] We are concerned that these reductions in the program service budget will result in further reductions in the substance abuse treatment staff in the prisons and greater divergence from the staff requirements specified in the standards of care (treatment manuals).

Without official DOCS figures, we have attempted to estimate the personnel costs for DOCS prison-based substance abuse treatment programs. The salaries for all treatment staff, including those running the federally funded Residential Substance Abuse Treatment (RSAT) programs, are controlled by the New York State Department of Civil Service job title grades and compensation schedules. Based upon these schedules as of April 2010, the cost for all prison-based treatment staff actually employed as of August 2009 is in the range of $16.5 to $17.7 million for the total number of staff occupying the three primary treatment positions (10 supervising correction counselors, 117 ASAT correction counselors and 169 ASAT program assistants).[118] The additional support staff of a few social workers, educational counselors and teaching assistants represent costs of about $500,000. The costs for the 12 staff at DOCS Office of Substance Abuse Treatment Services, according to current civil service rates, would be about $825,000. In addition, there are 32 clerical positions filled and assigned to the substance abuse program. Throughout our visits we did not observe clerical staff directly involved in the treatment program, but these items would increase the substance abuse program personnel costs by about $1 million. In addition to personnel costs, each treatment program has a small budget for supplies and materials, but these costs appear to be limited based upon staff reports during our visits. Combining these items, we would estimate that the entire DOCS treatment program is under $20 million for direct services, not including security staff or ancillary services for this inmate population.

The DOCS treatment program is funded both by State and federal monies. Specifically, in addition to State funding, the Department receives federal funds for its Residential Substance Abuse Treatment (RSAT) programs, which was operational at six facilities in 2009. In documentation for the current State fiscal year 2010-11, it appears that the State will receive $1 million for the RSAT program.[119] This represents a significant increase from the federal monies provided in recent years. In federal fiscal year 2009, DOCS received $373,706, and for the years 2006 through 2009, the State annually received approximately $400,000. The more recent RSAT funding (2006 through 2009) had declined significantly since fiscal year 2005, when New

[117] NY State Senate Finance Committee, *Senate Finance Majority Staff Analysis of the 2010-11 Executive Budget*, 163-164. (Hereafter *Senate Finance Committee's 2010 Budget Blue Book*.)

[118] The supervising correction counselors (SCC) are grade 22 and have a salary range of $63,041 to $79,819; the ASAT correction counselors (grade 19) salary range is $54,045 to $68,637 and ASAT program assistant (grade 14) salaries are $49.140 to $52,552. The lower total calculated assumed maximum salary for all supervising CCs (job rate) and an average of five years experience for ASAT CCs and ASAT PAs; the higher total assumed job rate pay for all employees.

[119] See *Senate Finance Committee's 2010 Budget Blue Book*, 164. It is unclear from this document the exact source of the federal funds. These monies could represent newly authorized federal support for the RSAT program and/or reauthorization of federal RSAT funds from the previous year. We were informed by DOCS officials in 2009 that they had not utilized all the federal RSAT funds provided in prior years. In fact, in the fiscal year 2009-10 budget, the Department listed federal funds for the years 2005 through 2008 as part of its fiscal year 2009-10 budget for substance abuse treatment. We anticipate a similar mechanism may be used in fiscal year 2010-11 budget, which has not been passed at the time of this writing.

York received $1,402,396 from the federal sources supporting programs at 23 facilities. As a consequence of the reduction of federal funds since 2005, the State has had to absorb the cost for the previously DOCS-run RSAT programs, which generally have been converted to ASAT programs.

Clearly the Department is expending significant funds, both from State and federal sources, to support its treatment program. Given the fiscal crises the State is currently experiencing, however, we are concerned that inadequate resources will be allocated to the treatment program in this and future years. State officials should ensure that this essential service is not undermined by inadequate funding, and creative efforts should be undertaken to identify and secure additional resources to properly fund the State's prison-based treatment programs.

7.4 STAFF QUALIFICATIONS

During each site visit, we met for approximately one hour with substance abuse treatment staff. Twenty-three percent reported that they were credentialed alcoholism and substance abuse counselors (CASACs), the State's credential for direct-service treatment professionals. Counselors who have fulfilled a substantial portion of the credentialing requirements are designated CASAC-T (CASAC Trainee). [120] The credentialing system is administered by the New York State Office of Alcoholism and Substance Abuse Services (OASAS), which also licenses programs and operates residential treatment centers around the State.

Several staff members who were eligible to obtain or renew their CASACs said they would not do so because it would mean they could do—and would most likely be assigned—paperwork that noncredentialed counselors could not do. Thus, the effort and expense of acquiring the credential would bring them only more work.

In a related issue, CASAC standards require that CASAC candidates complete a minimum of 6,000 hours (approximately three years) of supervised, full-time-equivalent experience in "an approved work setting" (usually an OASAS-licensed treatment program, though exceptions can be granted). Most DOCS substance abuse treatment programs are not currently OASAS certified, which limits opportunities for treatment staff to work toward the CASAC. We believe these circumstances may contribute to the low percentage of CASACs (23%) and CASAC Trainees (3%) we encountered. OASAS's role in DOCS treatment programs has grown as a result of the 2009 Rockefeller drug law reforms, and this new role may address this issue to some extent. OASAS plans to eventually certify all DOCS treatment programs. Similarly, their new role may impact on levels of treatment staff certifications within in DOCS programs as new staff and training requirements and opportunities take effect.

The treatment staff we interviewed reported a wide range of education, training and experience. Many had worked in community-based inpatient or outpatient counseling or treatment programs, halfway houses and other human-service settings. Some held bachelor's degrees in fields such as counseling, criminal justice, forensic science or psychology, while others had associate's degrees in related areas. We encountered very few treatment staff with master's-level degrees.

[120] For a complete description of the CASAC and CASAC-T, including credentialing requirements, see the OASAS website: http://www.oasas.state.ny.us/sqa/credentialing/casacprocess.cfm.

7.5 TRAINING AND PROFESSIONAL DEVELOPMENT

DOCS staff are mandated to receive 40 hours of training by DOCS annually on correctional topics. Treatment staff reported that little of that training relates to substance abuse treatment. Each year, treatment staff receive three professional days for additional training, which is not mandatory. At some facilities, management encouraged professional development, including training, but other prisons did not seem to make it a priority.

Nine of the 23 facilities we visited reported sending both security and clinical staff to training on therapeutic communities (TCs), making that the most common topic for training. (This is a result of DOCS's ongoing shift to the TC model from previous treatment models structured around the 12-step model.) While many staff described these programs as "helpful" or even "outstanding," they also expressed frustration that very little of the training was specific to the prison setting, where the TC model is substantially altered.

OASAS maintains an online statewide catalog of more than 10,000 training programs offered by OASAS and its certified education and training providers (of which DOCS is listed as a certified trainer for certain courses).[121] In addition to training programs in every area of the State, the catalog includes distance learning programs that can be conducted entirely online. Many programs are provided at no charge. The OASAS Bureau of Workforce Development's Training Unit attempts to ensure that the range of available training programs matches credentialing requirements and other professional development needs of substance abuse professionals throughout the State. Training and other professional development activities are also available through the Association of Substance Abuse Providers of New York State (ASAP NYS) at its conferences and meetings, and other professional associations.[122]

Staff interviewed had attended trainings on dual diagnosis/co-occurring disorders (Five Points, Washington), women in corrections (Albion, Cayuga), cultural diversity (Cayuga), domestic violence (Cayuga), counselor wellness (Five Points), meth labs and rave drugs (Gouverneur), mental health (Marcy), trauma (Taconic), and motivational interviewing for mental health, substance abuse, and HIV (Wende). Continuing education trainings by DOCS on substance abuse were lacking in general, and staff from several facilities expressed a need for more training in this area, as well as to address the needs of the rising population of individuals in substance abuse treatment programs with mental health problems. In addition, staff wanted more training on group work techniques and youth addiction. Staff at Albion, Cayuga and Gowanda reported more participation in training courses than staff at Bare Hill, Arthur Kill and Five Points.

Although treatment staff are entitled to three professional days for training annually, staff vacancies have sometimes prevented staff from taking advantage of training opportunities. For instance, staff at Gouverneur were well informed about available training programs but believed they could attend only if they obtained coverage for their shifts. Willard staff had similar grievances and were frustrated that OASAS provides training courses about which prison treatment staff were not always informed. In contrast, Lakeview staff described DOCS as very accommodating when a staff member expressed interest in attending a training program, but they

[121] "NYS OASAS Training Catalog."
[122] "Alcoholism and Substance Abuse Providers." http://www.asapnys.org/.

also noted their impression that both DOCS and OASAS have sponsored less training lately than in the past. Not surprisingly, staff holding a CASAC or a CASAC-T reported attending more trainings. We recommend that in order to reduce variability in practice and programs and address fidelity issues, DOCS set up a model program or "teaching hospital" to serve as a training institute for all new treatment staff.

7.6 PROGRAM PARTICIPANT ASSESSMENT OF STAFF

Treatment staff at the 23 treatment programs observed by the CA varied considerably in their qualifications, experience and how they related to treatment participants. Though we were impressed with the commitment and knowledge of some treatment staff, we were equally concerned by the apparent lack of skills among others. Our observations were reinforced by participants' comments and survey results. A substantial body of research indicates that motivation is a shared responsibility, with counselor knowledge, attitudes and competence having significant impact on treatment participant resistance.

> *I have been a heroin addict since the age of 10, and my need to stop using is very strong. Counselor X and Program Assistant Y are instrumental and supportive in my needs to change.*
> Anonymous Inmate (Marcy C.F.)

> *The counselors are very disrespectful. They call you stupid, loser, dumb, ignorant words that break a person's character. If I am an addict, I need to be built up, not broken down. Counselors want to exercise authority like a CO [corrections officer]. Any little discrepancy and they want to threaten to kick you out of the program. Comply or goodbye.*
> Anonymous Inmate (Gouverneur C.F.)

> *At first it was just a program to complete for me, however Mrs. X stayed on me until I got involved in the program. She allowed me to see my messed up thinking for what it was.*
> Anonymous Inmate (Sing Sing C.F.)

The counselor's ability to clearly express empathy and support is key in engaging and helping to motivate the participant, thus we sought to measure inmate perceptions of support by their program staff.[123] NIDA's guide to principles of effective treatment for this population includes motivational enhancement as an appropriate evidence-based practice to enhance engagement.[124]

As more fully discussed in **Section 8.14** there are numerous studies that have demonstrated that program participants' satisfaction with their treatment is strongly correlated with program retention and, more importantly, with reduction in relapse following completion of treatment.[125] The Multimodality Quality Assurance Scales (MQA) survey for prison-based treatment participants was specifically designed as a tool to measure participants' assessment of the treatment program's therapeutic approach (TC, cognitive-behavioral therapy[CBT] and 12-step), program climate, community-related interactions between participants and program staff, rapport

[123] Hiller et al., "Problem Severity and Motivation for Treatment in Incarcerated Substance Abusers"; Welsh, "Inmate responses to prison-based drug treatment."
[124] Fletcher and Chandler, *Principles of Drug Abuse Treatment for Criminal Justice Populations: A Research-Based Guide*.
[125] Zhiwei Zhang, Gerstein, and Friedmann, "Patient Satisfaction and Sustained Outcomes of Drug Abuse Treatment"; Hser et al., "Relationship between drug treatment services, retention, and outcomes," 767-774; Melnick, Hawke, and Wexler, "Client Perceptions Of Prison-Based Therapeutic Community Drug Treatment Programs," 124-125.

with the counseling process, communication within the program, and participants' assessment of their engagement and commitment. Finally, the survey contains participants' assessments of their satisfaction with multiple elements of their program.

7.6.1 Survey Participants' Satisfaction with Treatment Staff Services

Specifically, the MQA survey asked treatment participants to rate their satisfaction with aspects of their treatment program on a four-point Likert scale from *very dissatisfied* to *very satisfied*. **Table 7-3** lists the percentage of survey participants at each prison who responded that they were *somewhat satisfied* or *very satisfied*, and the responses of all program participants are summarized in the last column labeled "Total." Concerning services provided primarily by the treatment staff, the participants were asked about their satisfaction with the treatment plan (see response to question 6) and with the counseling process (MQA Q18 series).

Overall, 57% of the survey respondents were *somewhat* or *very satisfied* with their treatment plan, and 58% were similarly satisfied with the counseling process. The survey respondents rated these two elements generally lower than their satisfaction with the other components of the program; 65% of respondents were *somewhat* or *very satisfied* overall with all the elements of the program.

But these overall satisfaction ratings are somewhat misleading because there was significant variation in the percentage of respondents who were *somewhat* or *very satisfied* with the counseling process, ranging from a low of 31% to a high of 96%. There were several facilities with satisfaction rating in the 30% to 40% range, including Bare Hill (31%), Cayuga (33%), Gouverneur (40%) and Oneida (33%). The prisons with high counseling process satisfaction included: Albion (76%), Hale Creek (84%), Lakeview Male (84%), Lakeview Female (96%), Sing Sing (74%) and Taconic (77%).

Similarly, there was also significant variability in the survey respondents' satisfaction with the treatment plan, ranging from a low of 22% to a high of 96%. There was a cluster of prisons with satisfaction rates well below 50%, including Bare Hill (26%), Cayuga (39%), Oneida (22%) and Willard Male (43%). Conversely, there were several prisons with treatment planning satisfaction rates of 70% or greater, including Hale Creek (83%), Lakeview Male (95%), Lakeview Female (96%) and Taconic (70%).

Table 7-3 SUMMARY OF THE PERCENTAGE OF PROGRAM PARTICIPANTS SATISFIED WITH PROGRAM ELEMENTS

Quest #	Description	AL	AK I	AK II	BH	CY	EA	FP	FR	GV	GO	GH	GR	HC
6	Satisfaction with the Treatment Plan	68	68	47	26	39	66	61	48	47	60	60	47	83
6	Satisfaction with the Discharge Planning	59	41	37	18	33	60	50	30	22	45	29	53	66
10	Satisfied with Safety	71	72	75	66	61	87	85	72	76	78	69	76	90
10	Satisfied with Educational and Vocational Programs	90	27	24	42	67	57	73	67	61	72	50	50	75
11	Satisfaction with Social Skills Training	91	55	48	34	36	51	61	49	48	48	57	57	71
12	Satisfaction with Services	67	42	46	20	38	60	49	40	44	50	44	46	63
13	Satisfied with Menu A (TC)	75	51	67	49	51	82	87	60	63	76	69	71	76
14	Satisfied with Menu B (CBT)	90	74	72	56	68	81	87	62	82	78	93	79	90
15	Satisfied with Menu C (12 Steps)	62	52	56	36	46	63	73	47	57	48	70	55	82
17	Satisfaction with your Own Involvement	96	89	96	75	88	89	87	80	81	85	93	81	94
18	Satisfaction with the Counseling Process	76	71	50	31	33	60	67	50	40	61	56	57	84
19	Satisfaction with your Commitment	90	89	89	78	93	90	93	85	100	94	92	93	93
	Average of All Questions	77	61	58	44	54	71	73	58	60	66	65	64	81

Quest #	Description	LVM	LVF	MA	MS	ON	SH	SS	TA	WA	WE	WIM	WIF	WY	Total
6	Satisfaction with the Treatment Plan	95	96	53	52	22	69	68	70	55	53	43	56	61	57
6	Satisfaction with the Discharge Planning	76	91	34	42	N/A	37	63	50	50	23	50	63	47	44
10	Satisfied with Safety	92	96	70	64	54	97	89	96	61	83	74	78	78	77
10	Satisfied with Educational and Vocational Programs	83	89	80	59	78	53	61	50	70	24	73	78	59	62
11	Satisfaction with Social Skills Training	82	83	48	74	49	66	74	81	59	54	50	57	60	58
12	Satisfaction with Services	76	74	48	40	50	43	46	56	64	43	48	38	52	49
13	Satisfied with Menu A (TC)	85	93	65	53	31	68	72	78	73	65	44	67	76	67
14	Satisfied with Menu B (CBT)	98	86	78	71	58	74	81	85	71	80	68	67	85	77
15	Satisfied with Menu C (12 Steps)	93	89	62	44	40	72	63	60	68	61	73	63	69	60
17	Satisfaction with your Own Involvement	90	96	89	82	56	83	84	96	87	74	70	89	84	85
18	Satisfaction with the Counseling Process	84	96	56	55	33	69	74	77	57	50	55	57	51	58
19	Satisfaction with your Commitment	100	100	99	91	81	85	97	96	94	87	86	100	87	91
	Average of All Questions	88	91	65	61	55	68	71	78	67	56	61	68	67	65

Prison Abbreviations: AL-Albion, AK I-Arthur Kill (2007), AK II-Arthur Kill (2009), BH-Bare Hill, CY-Cayuga, EA-Eastern, FP-Five Points, FR-Franklin, GV-Gouverneur, GO-Gowanda, GH-Green Haven, GR-Greene, HC-Hale Creek, LVM-Lakeview Male, LVF-Lakeview Female, MA-Marcy, MS-Mid-State, ON-Oneida, SH-Shawangunk, SS-Sing Sing, TA-Taconic, WA-Washington, WE-Wende, WIM-Willard Male, WIF-Willard Female, WY-Wyoming.

These satisfaction ratings with direct treatment staff activities (treatment plan and treatment process) were consistent with other aspects of the participants' assessment of rapport with staff, communication in the program and their assessment of their overall satisfaction with their treatment (MQA Q18(d)).

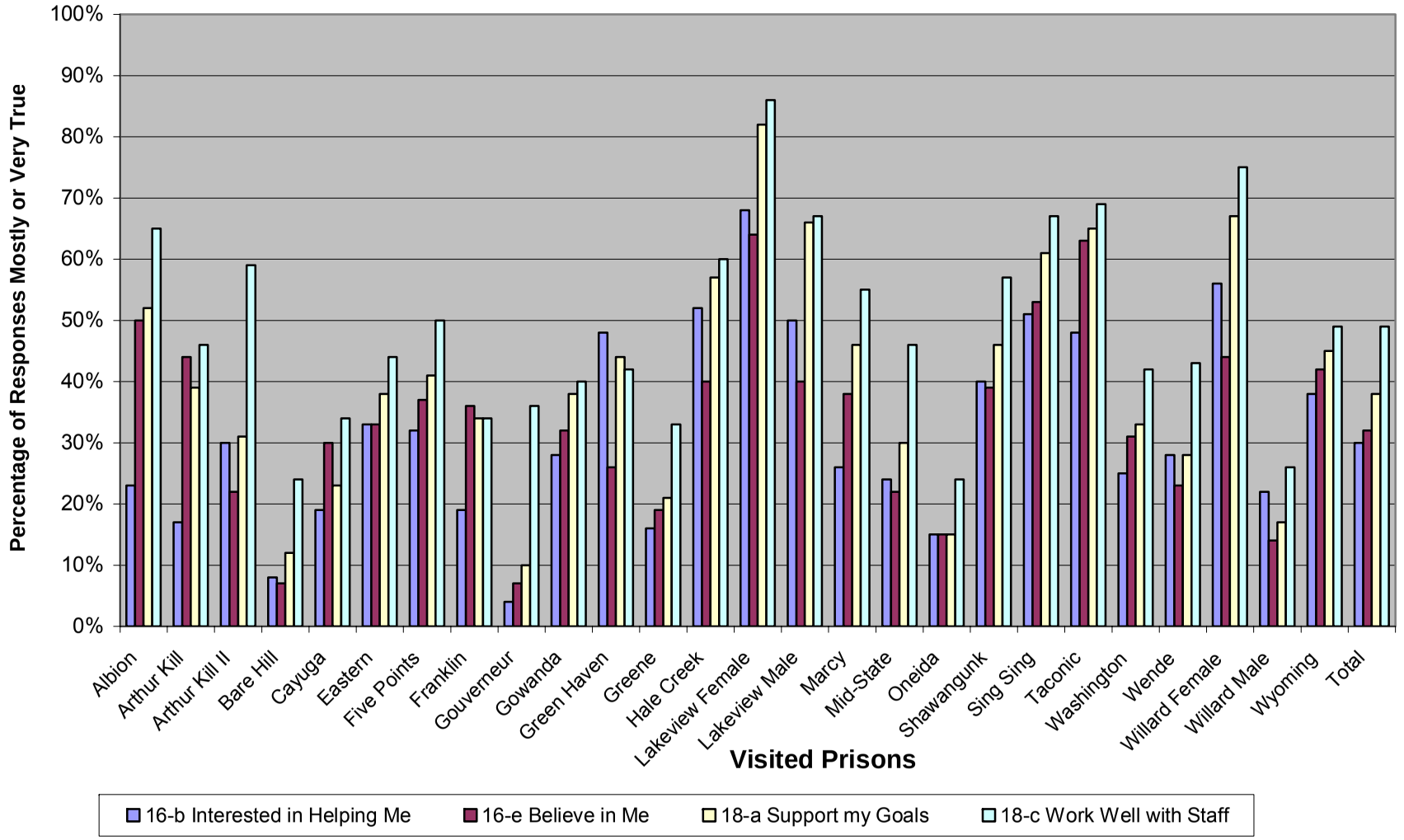
7.6.2 Survey Participants' Assessment of Treatment Staff Support and Help

The MQA also sought the participants' evaluation of their rapport with, and perception of, the treatment staff. Specifically, the MQA survey posited the following four specific statements to which the survey participants could reply as *not true*, *somewhat true*, *mostly true* or *very true*: (1) "I feel that people in this program are interested in helping me" (MQA Q16(b)); (2) "I think that the staff believes in me" (MQA Q16(e)); (3) "The substance abuse treatment staff supports my goals" (MQA Q18(a)); and (4) "I work well with my substance abuse treatment staff" (MQA Q18(c)).

Chart 7-1 illustrates the percentage of survey participants at each prison who responded to these four statements as *mostly true* or *very true*. In addition, the percentage of all survey participants responding as *mostly* or *very true* to these statements are indicated in the last entry in the chart under the label "Total." Overall, survey respondents gave mixed reviews of the treatment staff and their support for program participants, with a significant majority of the group expressing doubt that staff genuinely supported their recovery. As illustrated in **Chart 7-1** under "Total," only 30% of all survey participants said it was *mostly* or *very true* that program staff were interested in helping them, 32% said it was *mostly* or *very true* that staff believe in them, and 38% reported that it was *mostly* or *very true* that treatment staff support their goals. On the other hand, 49% said it was *mostly* or *very true* that they worked well with treatment staff.

Analyzing the data by prison, the survey participants' responses to the questions of staff helping them, believing in them and supporting their goals were very consistent for all prisons.[126] This consistency existed at both prison programs with more favorable responses and those with more negative analysis of staff support. For example, at some programs more than 40% of survey participants said these statements were *mostly* or *very true* (Hale Creek, Lakeview Male and Female, Sing Sing and Taconic), while less than 20% of the survey participants at other programs (Bare Hill, Gowanda and Oneida) replied that these statements were *mostly* or *very true*.

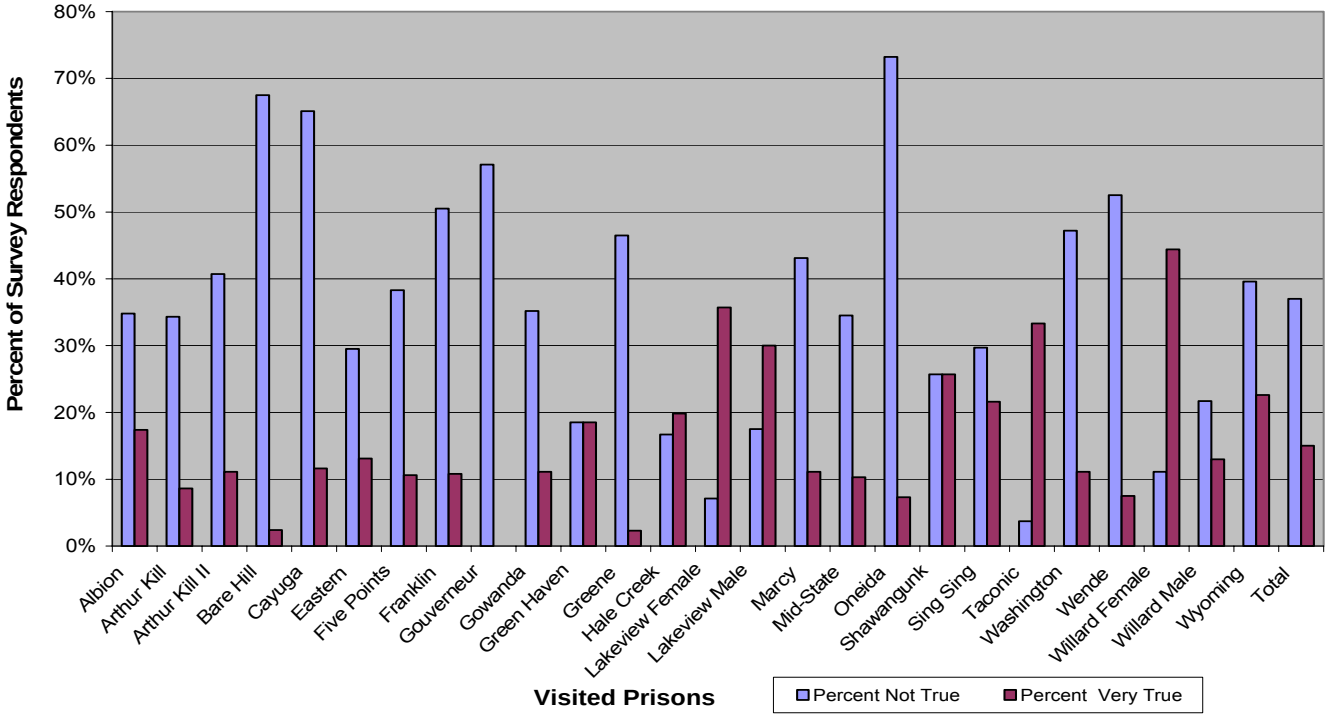
Chart 7-1 MQA Survey Responses of Mostly or Very True to Questions on Staff Support and Help



7.6.3 Variability of Survey Participants' Assessment of Rapport with Staff

The survey results indicate significant variability among the treatment programs concerning participants' assessment of rapport with staff. The degree of variability is best illustrated by examining the responses of survey participants at the two ends of the Likert scale, that is, the percentage of program participants who said a given statement was *not true* and those who replied it was *very true*. **Chart 7-2** illustrates the survey participants' responses of *not true* and *very true* to the statement whether the program staff was interested in helping them. For example, 23 to 44% of survey respondents at several prisons said it was *very true* that people in the program were interested in helping them; in contrast, at others prisons the percentage of responses of *very true* was 0 to 2%.[127] Forty percent of all treatment participants reported that it was *not true* that people in the program were interested in helping them, but similar to the *very true* responses, the range of negative evaluations among the facilities varied significantly.[128] Overall, the percentages of positive and negative responses for the best programs were five to *nearly 20 times* higher than the responses for the most problematic treatment programs, demonstrating very high variability among treatment programs.

Chart 7-2 Participants' Responses of Not True or Very True to Whether Program is Interested in Helping Them (MQA Q16b)

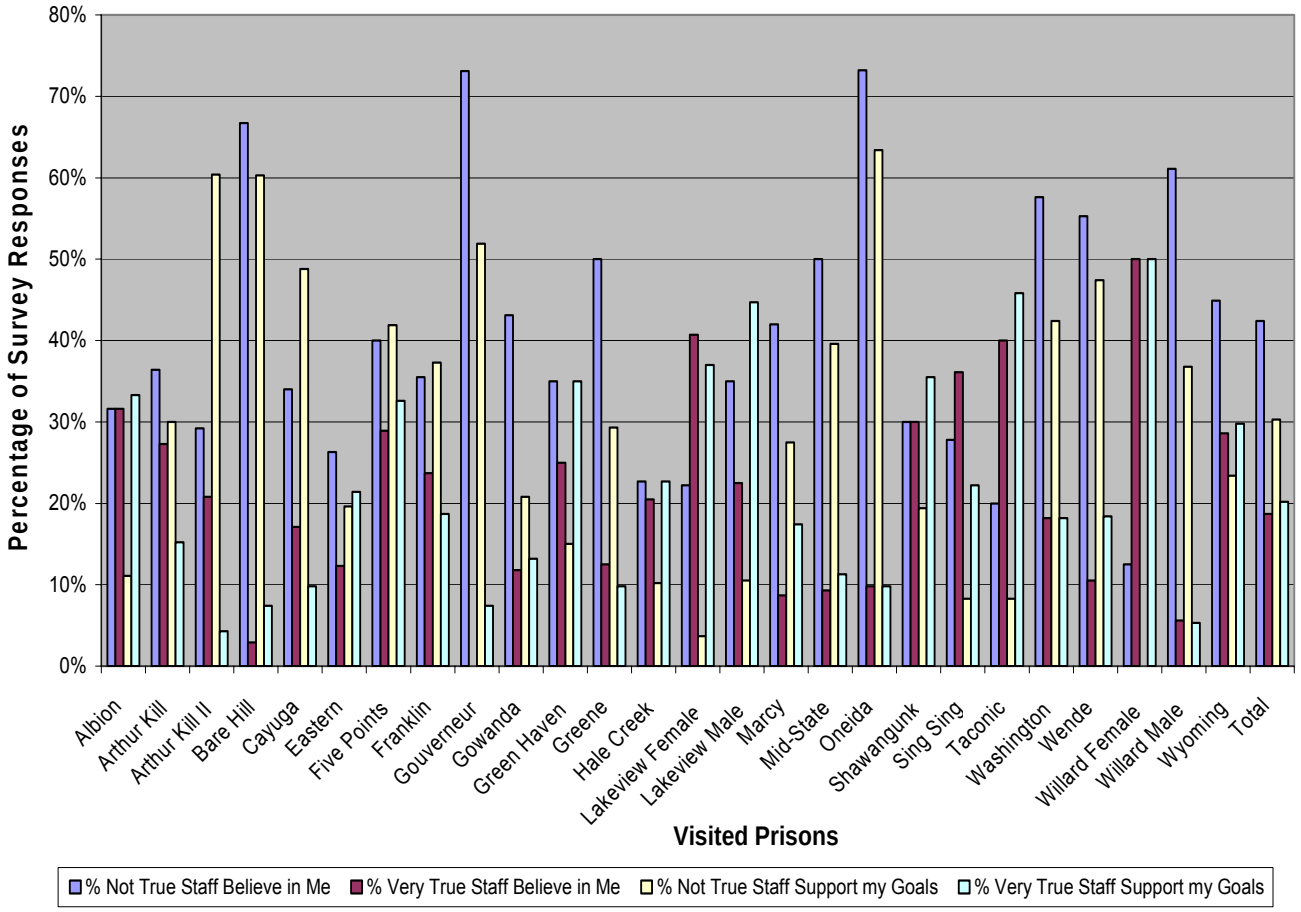


[127] The prisons with high and low percentages of very true responses included: Bare Hill (2%), Gouverneur (0%), Greene (2%), Lakeview Male (30%), Lakeview Female (36%), Oneida (7%), Shawangunk (26%), Taconic (33%), Willard Female (44%) and Wyoming (23%).

[128] Oneida (73%), Bare Hill (68%), Cayuga (65%), and Gouverneur (57%) represent the highest number of participants expressing it was *not true* that staff was interested in helping them, while survey assessments at Taconic (4%), Lakeview Female (11%), Willard Female (11%), and Hale Creek (17%) represent the lowest percentages of *not true* responses.

Responses to other questions about treatment staff also demonstrated significant variability among programs. **Chart 7-3** shows responses indicating *not true* and *very true* to the statement whether staff believe in the participant and whether staff support the participant's goals. As with the question about staff interest in helping the participant described earlier, the variability in the percentages of *very true* or *not true* responses was extremely high. Respondents at some treatment programs, such as the Willard Female, Lakeview Female, Taconic and Hale Creek, had responses that were five to 10 times better than the survey participants' assessments at Gouverneur, Oneida, Bare Hill and Wende.[129]

Chart 7-3 Participants' Responses of Not True and Very True to Questions about Staff Believing in Me (MQA Q16e) and Supporting My Goals (MQA Q18a)



[129] See **Appendix F** for the responses by prison of survey participants to statement on whether staff believe in the participant (question 16(e)) and whether staff support their treatment goals (question 18(a)).

7.6.4 Survey Participants' Composite Mean Score Assessing Treatment Staff

An analysis of all seven staff-related survey questions provides an overview of respondents' attitudes toward staff.[130] We combined responses to these questions and calculated a combined average score on the four-point scale. This combined mean score was then converted to a percentage of the maximum possible score for all questions, resulting in 0% if the survey respondent answered *not true* to all the questions and 100% if the survey answers were *very true* to each staff-related question. The mean scores and the corresponding percentage of the maximum possible score for each prison and for all survey responses are listed in **Table 7-4** and illustrated in **Chart 7-4**.

Table 7-4 Mean MQA Survey Responses to Seven Questions Concerning Program Staff

Description	AL	AK I	AK II	BH	CY	EA	FP	FR	GV
Treatment Staff Assessment	1.46	1.15	1.12	0.49	0.77	1.24	1.24	1.00	0.57
% of maximum mean score*	49%	38%	37%	16%	26%	41%	41%	33%	19%

Description	GO	GH	GR	HC	LVM	LVF	MA	MS	ON
Treatment Staff Assessment	1.13	1.37	0.90	1.57	1.80	2.02	1.17	0.99	0.55
% of maximum mean score*	38%	46%	30%	52%	60%	67%	39%	33%	18%

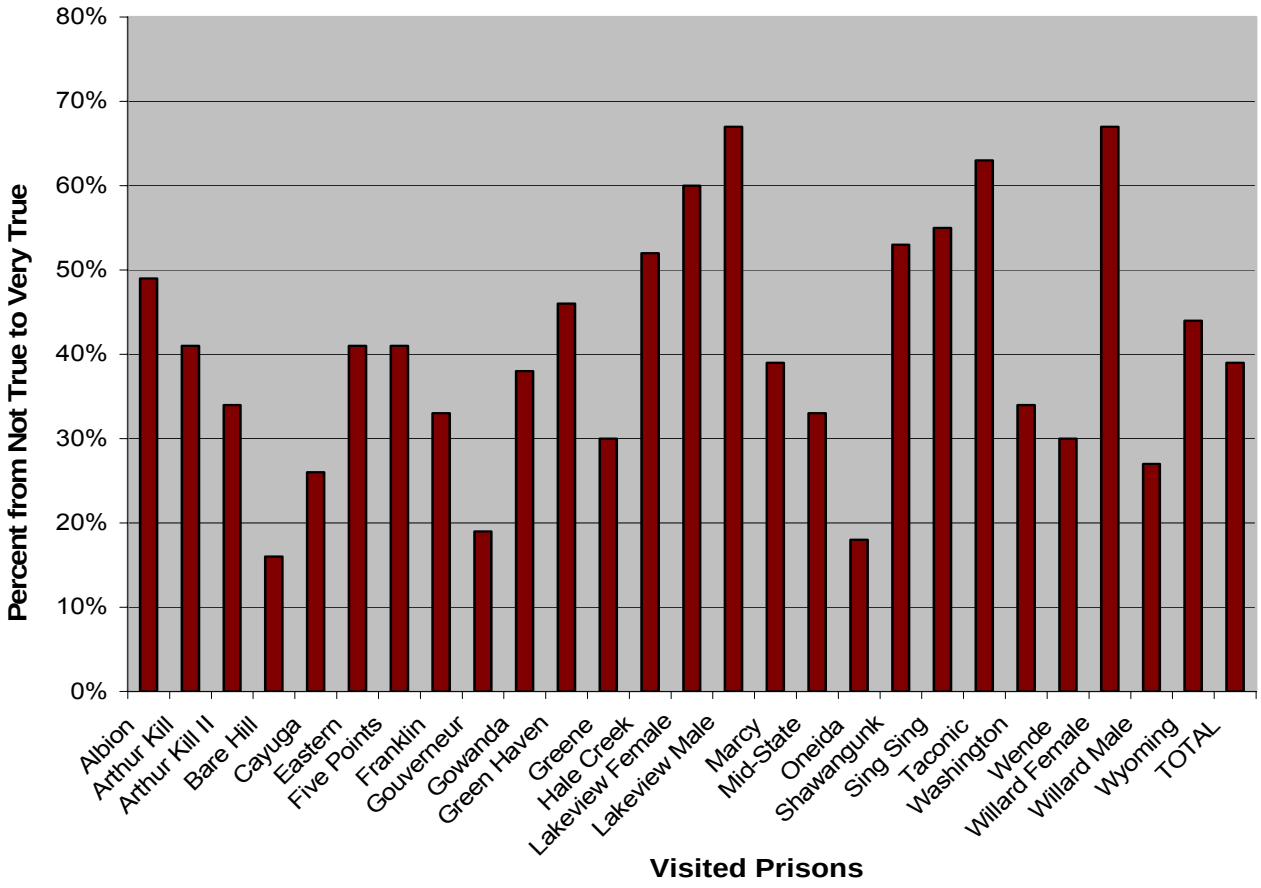
Description	SH	SS	TA	WA	WE	WIM	WIF	WY	Total
Treatment Staff Assessment	1.58	1.65	1.90	1.01	0.90	0.82	2.02	1.33	1.16
% of maximum mean score*	53%	55%	63%	34%	30%	27%	67%	44%	39%

*Combined mean score converted to a percentage from 0% if all responses were *not true* to 100% if all responses were *very true*.

These data demonstrate the overall variability of treatment participants' attitudes and assessments of the treatment staff. Several observations are noteworthy. First, the composite scores represent a negative assessment of staff. A majority of respondents felt it was *not true* or only *somewhat true* that staff supported them and their recovery. Second, responses to the seven statements were highly correlated and relatively consistent internally for most programs. Third, the differences among programs were substantial, with the five highest-ranking programs (Willard Female, Lakeview Female, Taconic, Lakeview Male and Sing Sing) having an average percentage (62%) that was approximately *three times* greater than the percentage (21%) for the five lowest-ranking programs (Bare Hill, Oneida, Gouverneur, Cayuga and Willard Men).

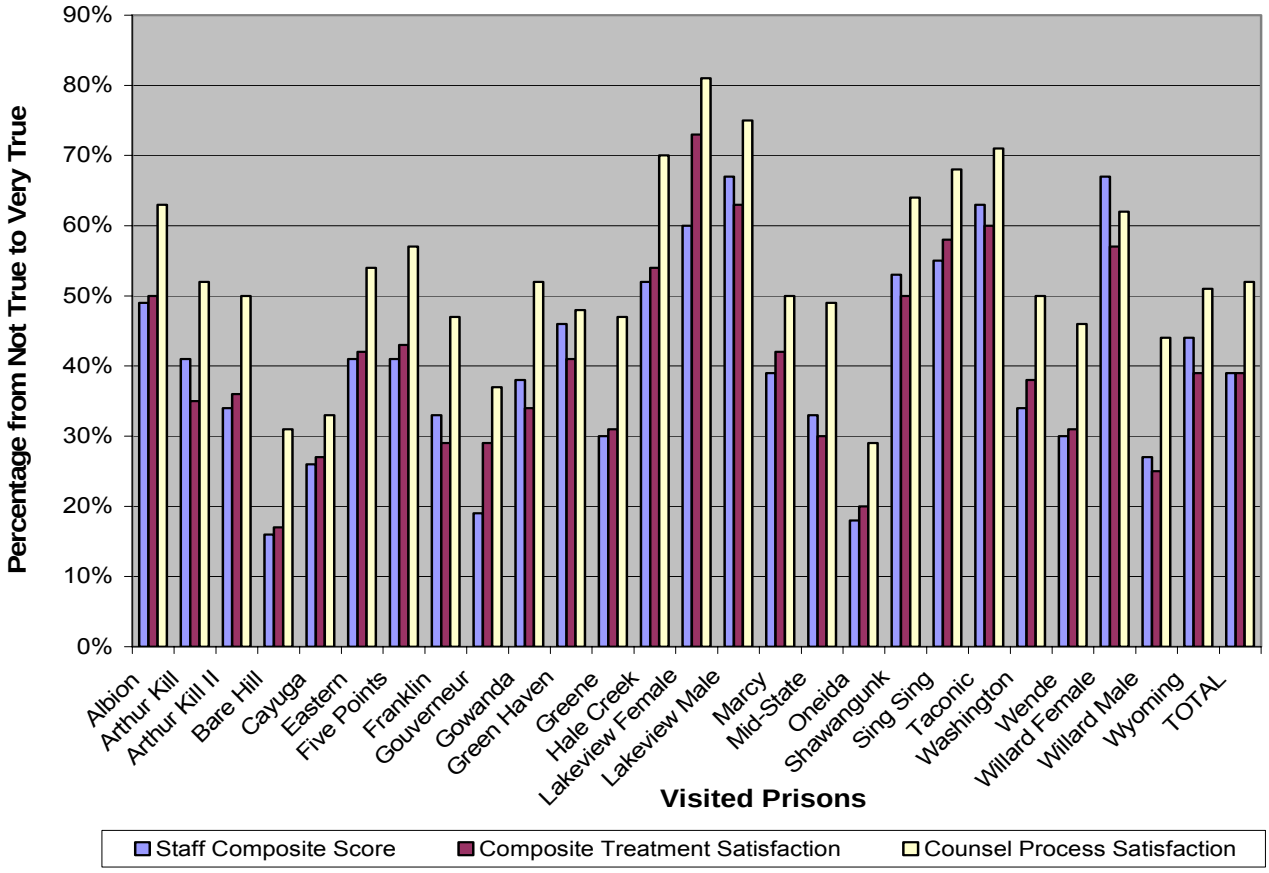
[130] These included MQA statements from items 16 and 18, including: 16(b) I feel that people in this program are interested in helping me; 16(c) I think that the people in the program are trying to do what is best for me; 16(d) I think that the program is well organized (runs smoothly); 16(e) I think that the staff believes in me; 18(a) The substance abuse treatment staff supports my goals; 18(b) The substance abuse treatment staff is sincere in wanting to help me; and 18(c) I work well with my substance abuse treatment staff.

Chart 7-4 Survey Respondents' Composite Mean Score Assessing Treatment Staff



Finally, survey participants' responses to the questions on staffing were very consistent with their assessment of the treatment program, as illustrated in **Chart 7-5**. We compared three items from the surveys: (1) the composite mean staffing scores; (2) the composite scores for responses about satisfaction with treatment (MQA Q18(d)) and whether treatment meets or exceeds expectations (MQA Q18(e)); and (3) ratings of satisfaction with the counseling process (counseling satisfaction rating following MQA Q18).

Chart 7-5 Comparison of Composite Staff Assessment and Treatment Satisfaction Scores



These data also support the conclusion that treatment participants who experienced program staff as unsupportive were also significantly less satisfied with their treatment and the counseling process. Overall, 52% of survey participants reported they were *mostly* or *very satisfied* with the counseling process. Similarly, all survey participants had a combined score of 39% on a scale from 0% (*not true*) to 100% (*very true*) in response to the statements that they were satisfied with their treatment and that their treatment experience meets or exceeds their expectation. The survey participants at the five prisons with the lowest composite mean staff assessment scores, however, had counseling process satisfaction scores in the range of 29% to 44% and treatment satisfaction scores in the range of 17% to 27%. In contrast, the survey participants at the five prisons with the highest composite mean staff assessment scores had counseling process satisfaction scores in the range of 62% to 81% and treatment satisfaction scores of 57% to 73%, percentages in both categories that were twice as high as the results for those prisons with low staff assessments. These marked differences in survey participants' responses to the staff and their treatment program strongly suggest that efforts must be made to improve staff performance at some prisons experiencing low participant satisfaction.

8. TREATMENT PROGRAMMING AND MATERIALS

FINDINGS

Program structure and content varied a great deal from program to program.

Treatment approaches and interventions were applied inconsistently within and among programs.

Many treatment strategies and interventions we observed were not drawn from evidence-based practices.

Fidelity to treatment models was low; while most staff labeled their programs as therapeutic communities, many programs did not fully adhere to the generally accepted definition of an in-prison TC.

Based on our observations, analysis of the ASAT Program Manual, inmate interviews and surveys and review of materials provided to us by facility staff, the large group sizes and broad curricula of the treatment programs resulted in an inability to successfully implement effective therapy approaches.

> In general, drug treatment should address issues of motivation, problem solving, skill-building for resisting drug use and criminal behavior, the replacement of drug using and criminal activities with constructive nondrug using activities, improved problem solving, and lessons for understanding the consequences of one's behavior.
>
> — *Principles of Drug Abuse Treatment for Criminal Justice Populations: A Research-Based Guide.* National Institute of Drug Abuse, U.S. Dept. of Health & Human Services (2006), page 2.

DISCUSSION

8.1 INTRODUCTION

Over three years, the Substance Abuse Treatment Project sought to assess the effectiveness of New York's prison-based treatment programming using a variety of strategies, both qualitative and quantitative. We visited 23 DOCS substance abuse treatment programs, observing large and small group sessions, visiting housing areas, reviewing and analyzing case records, interviewing and surveying current and former treatment participants as well as inmates who had not participated in treatment, interviewing staff and management, and reviewing manuals, data and other material provided by DOCS. The CA observers were staff members, board members, and experts in the fields of correction and substance abuse treatment. All were trained and advised of confidentiality requirements.

We found significant variations in clinical programming among and even within programs. Overall areas in which we observed difficulties included: variation in content and presentation of topics as a result of a curriculum that was too broad and lacking in sufficient detail; low fidelity to stated treatment models; low emphasis on motivational enhancement or other engagement strategies; and group size that often made meaningful therapeutic interaction difficult. Many of our observations suggest that several programs were a patchwork of interventions and strategies that most often reflected the experience and preferences of program staff.

The above observations reflect systemwide challenges in DOCS substance abuse treatment and illustrate the frequent differences we found from program to program. It is important to note that the CA also observed some programs with extremely dedicated staff and high levels of participant involvement, engagement and satisfaction.

While there is much to be said for individualizing treatment to address the unique needs of inmates at each facility, a wide variety of well-tested models is readily available for use, obviating the need for patchwork and improvisation. Furthermore, it is difficult for DOCS to adequately monitor treatment programming that fluctuates constantly. The CA suggests that DOCS provide more-substantial guidance and indicate where customization is appropriate with approval. Monitoring and auditing of programs will be facilitated. This will be especially important as OASAS plays a growing role.

8.2 EFFECTIVE PRISON-BASED SUBSTANCE ABUSE TREATMENT

Prison-based treatment for substance abuse can be effective, according to a substantial body of evidence, clinical experience and expert consensus.[131] Over the last two decades, specific interventions, strategies and models have been identified that can help inmates prepare for a drug- and crime-free life, both inside the facility and after release to the community.

A large body of research, clinical experience and expert opinion has declared the therapeutic community (TC) highly effective at reducing drug use and crime.[132] As its growth has skyrocketed, the model has been modified to accommodate the demands of the prison setting, including the focus on security, the inmate goal of early release, the constraints of space and scheduling, and the prison culture.[133] Researchers have noted that some of these variations actually have low fidelity to the model and may lack the elements responsible for the success of the programs studied.[134] For a detailed discussion of the treatment models that DOCS seeks to utilize, see **Section 6, Overview of DOCS Substance Abuse Treatment Programs**. Thus, in

[131] Inciardi et al., "An effective model of prison-based treatment for drug-involved offenders," 261-278; Peters, Wexler, and Center for Substance Abuse Treatment (U.S.), *Substance Abuse Treatment for Adults in the Criminal Justice System: Treatment Improvement Protocol (TIP) Series 44 -- SAMHSA/CSAT Treatment Improvement Protocols -- NCBI Bookshelf*. Prendergast, M. L. & Wexler, H. K. (2004). Correctional Substance Abuse Treatment Programs in California: A Historical Perspective. *The Prison Journal*. 84(1), 8-35.

[132] Hiller, Knight, and Simpson, "Prison-based substance abuse treatment, residential aftercare and recidivism," 833-824; Gaes et al., "Adult Correctional Treatment."

[133] Taxman, F.S. & Bouffard, J.A. (2002). Assessing therapeutic integrity in modified therapeutic communities for drug-involved offenders. *The Prison Journal 82*(2): 189–212.

[134] Rockholz, "National update on therapeutic community programs for substance abusing offenders in state prisons," 49, 56-59.

assessing DOCS therapeutic communities, one strategy the Substance Abuse Treatment Project used was to identify the use of these elements, by observation and by surveying inmates.
A major component of effective substance abuse treatment is unlearning old habits associated with drug use and learning new skills and habits that support a drug-free life. For prison-based treatment, evidence-based interventions include cognitive-behavioral approaches that teach coping and decision-making skills.[135] Researchers and clinicians have made great strides in the last 20 years toward identifying these skills and developing effective approaches for training inmates to use them. Incorporating this training into a clear, step-by-step curriculum can help to ensure that they are covered thoroughly and accurately in a treatment program. Working from this kind of plan is consistent with the TC's view of incremental learning.[136]

A 2007 study of correctional treatment nationwide found that most drug treatment provided to this population consists not of clinical services but of drug education: lectures on pharmacology, the process of addiction, its impact on the family, and so on.[137] While these programs may have aimed for an interactive intervention, the actual result was often didactic, leaving inmates without the practice and feedback that is important for effective skill building.

Our observations of DOCS programs agreed with this finding. This concern can be addressed by creating and using detailed curricula, which were not used by most of the DOCS programs we observed. (The ASAT Manual does not provide guidance in this area, but does not bar facilities from developing their own curricula.) In addition to lectures, there was a tendency to talk about skills such as refusal or anger management, rather than learning and practicing them.

8.3 DOCS TREATMENT PROGRAM AND CLINICAL APPROACHES

8.3.1 Treatment Prioritized at the End of Inmates' Sentences

DOCS' policy for enrolling inmates into substance abuse treatment programs prioritizes inmates for admission based upon the proximity to their parole board hearing. Consequently, individuals who have been designated as in need of treatment upon reception into DOCS custody will often spend a considerable amount of time in prison before becoming eligible to enroll in a treatment program. The DOCS Office of Substance Abuse Treatment Services has developed this policy so that individuals completing prison-based treatment are close to their release date and better able to access

> *I've been upstate for over seven years and I need help with my drug problem. I used drugs a few times while I've been in prison…and have been waiting and trying to get into a program for years, but I never get close on any list…I don't see how I can get the help I need. If I don't get help, I'll end up stressing, then I'll smoke weed and catch another ticket and lose more good time. I don't feel it is fair I'll have to be stuck in prison longer because I was not allowed the help prison is supposed to offer me.*
>
> Anonymous Inmate (Collins C.F.)

[135] Evidence-based practices can be defined as interventions that have shown consistent scientific evidence of being related to preferred client outcomes. They are identified by multiple randomized controlled trials; consensus reviews; expert opinion based on clinical observation; and analyses of the aggregated results of scientifically sound studies. Interventions and tools that are proven effective in the controlled environment of a clinical trial often cannot be transferred intact into the real-world clinical setting. Nonetheless, along with expert opinion and clinical experience, evidence-based practices provide signposts to effectiveness.
[136] De Leon, "The Therapeutic Community and Behavioral Science," 74.
[137] Taxman, Perdoni, and Harrison, "Drug treatment services for adult offenders," 239-254.

the continuity of care critical to their recovery when they complete the program. As discussed in **Section 15, Aftercare, Continuing Care and Reentry Support**, we found inadequate continuity of care efforts by the treatment staff and other Department officials in facilitating program graduates' connection to community-based programs, but we generally endorse the value of promptly following prison-based treatment with community care for those individuals with a significant risk of relapse when they return home.

> *Inmates should be afforded the opportunity to address their addictions early and continue to maintain the afforded tools from these therapeutic programs to sustain during incarceration. The earlier the treatment, the less likelihood for continued use.*
>
> Anonymous Inmate (Sing Sing C.F.)

Though the importance of establishing continuity of care for individuals with substance abuse problems is clear, our observations of current prison practices have led to several concerns. Primary among these is that some individuals entering DOCS custody are arriving with substantial substance abuse problems that require more immediate attention. These individuals are being forced to wait for long lengths of time before their treatment needs are addressed; they are often the same individuals who end up receiving multiple disciplinary sanctions for drug use and possession in prison. Requiring these individuals to wait years before they are offered enrollment into a treatment program is nearly equivalent to denial of treatment. Second, because it is the Department's policy to delay treatment, DOCS has not made any significant effort to develop a prison-based aftercare program (see **Section 15** for a more detailed discussion).

In order to work toward the most successful reentry experience possible, it is important that treatment services are offered at the end of an individual's incarceration, but additional treatment services should be made available at the beginning of one's sentence if he/she feels there is a significant need. These programs could be voluntary and would not exempt an individual from then completing the treatment program at the end of their sentence. The provision of such additional voluntary programs can help to reduce drug use and possession inside prison, increasing prison safety for both staff and inmates. Finally, DOCS should develop more prison-based aftercare planning and programs for those inmates who remain incarcerated for significant periods after program completion.

8.3.2 Length of DOCS Treatment Programs

> *"With a longer program, I could have gained more vital information."*
>
> *Anonymous Inmate (Marcy, C.F.)*

Expert opinion asserts that up to a point, the positive outcomes of substance abuse treatment programs are associated with longer lengths program, though this no longer holds true for programs longer than one year.[138] It is widely

[138] Swartz, Lurigo, and Slomka, "The impact of IMPACT: An assessment of the effectiveness of a jail-based treatment program"; Wexler et al., "Outcome evaluation of a prison therapeutic community for substance abuse treatment."

accepted that a nine to twelve month TC program is most effective with at least three months of community aftercare treatment.[139]
The ASAT program has been designed as a competency-based continuum of care treatment model. Successful completion of the program is supposed to be based on demonstrating a "functional" understanding of the dynamics and consequences of addiction, as well as showing staff one has developed the skills and attitude necessary to maintain a drug-free lifestyle.[140] Treatment participants are also required to have completed a minimum of six months in treatment and received a satisfactory rating on their discharge evaluation.

Based on our observations and on comments from inmates, the majority of ASAT programs we visited appeared to function more as a time-limited program, with the vast majority of graduating inmates completing the program in approximately six months. The individuals we observed who had been in the program longer than six months generally were there because they had at least one unsatisfactory monthly evaluation. Most programs use no oral or written testing or other objective method to evaluate the program participants' understanding of the materials and/or development of skills. Though all graduates of the treatment programs received successful discharge evaluations, we did not find these forms to be comprehensive or particularly descriptive of an individual's progress within the program. See **Section 13, Treatment Records**, for a more detailed description of DOCS treatment forms.

8.3.3 Clinical Strategies

According to the DOCS manual for its Alcohol and Substance Abuse Treatment program (referred to as the ASAT Manual in this report), ASAT may be implemented in one of these modalities: residential therapeutic community; modular;[141] shock incarceration; Willard Drug Treatment Campus; residential substance abuse treatment (RSAT); and the cell-study program.[142] They are all to be structured around the nine competencies specified in the ASAT Manual. Residential units "are preferred but facilities are free to select the treatment modality (residential and/or modular) that best meets the needs and staff resources of the facility."[143] Facilities have the choice to employ a single treatment strategy such as cognitive-behavioral or TC, or an *approved* eclectic treatment strategy approach. (The ASAT Manual does not specify a process for securing approval of an eclectic approach, nor did we hear of any such process during the course of the Project.)

Staff and management of most of the programs we observed stated that the programs were TCs or modified TCs. We found that most of these programs included some TC features related to sanctions such as pull-ups (see **Section 8.12**), and some form of hierarchy. Though we observed several TC elements in the majority of DOCS treatment programs, the implementation of these

[139] Peters, Wexler, and Center for Substance Abuse Treatment (U.S.), *Substance Abuse Treatment for Adults in the Criminal Justice System: Treatment Improvement Protocol (TIP) Series 44 -- SAMHSA/CSAT Treatment Improvement Protocols -- NCBI Bookshelf*.
[140] State of New York Department of Correctional Services, *Alcohol and Substance Abuse Treatment (ASAT) Program Operations Manual*.
[141] In a modular setting, inmates participate in ASAT program for one to two program modules (periods) per day, five days per week, but are not housed together with other program participants.
[142] State of New York Department of Correctional Services, *Alcohol and Substance Abuse Treatment (ASAT) Program Operations Manual*, sec. IV. B.
[143] Ibid., sec. IV. A. 4.

was often not consistent with their stated therapeutic objective, and many important TC elements were not fully utilized.

We were unable to discern cohesive clinical strategies in most of the programming we observed. Rather, clinical content usually reflected the knowledge, training, and sometimes the personal experience of staff managing the programming at a given time.

8.4 ENGAGEMENT IN TREATMENT

Motivation and engagement in treatment are highly predictive of positive outcomes.[144] A substantial body of research shows that motivation, which drives engagement, is not static and can be strengthened at most stages of treatment.[145] Accordingly, a variety of clinical tools and strategies have been developed over the past three decades to build and strengthen the motivation of treatment participants.[146]

Some may question the need for enhancing the motivation and engagement of a prison's captive audience, but it is exactly for this population that treatment staff should focus on increasing intrinsic motivation. Engagement strategies need special attention with this population because of the natural temptation to rely on institutional control.[147] For example, in a community-based therapeutic community, residents who are not complying with rules or making progress are "managed" by their peers, both formally and informally; a TC resident who is frequently late to community meetings or group sessions would be confronted by the appropriate hierarchy person one-on-one or in a group. Peers would help the resident work through resistance and develop internal motivation. In a prison-based TC, however, staff may be tempted to respond to these expressions of low motivation with institutional sanctions such as a ticket (misbehavior report) or even removal from the program. Thus, an inmate who believes treatment is unnecessary or ineffective may not express those concerns for fear of sanctions.

Unfortunately, the compliance and submission yielded by institutional control can provide a false sense of therapeutic accomplishment. Once these external controls are removed at the completion of treatment, however, inmates must rely on their internal motivation—that is, their own understanding and acceptance of the legal, social, family, health, financial, spiritual and other consequences of their drug use. Strategies that have proven effective in increasing motivation include providing more individual sessions during the initial phases of treatment, demonstrating success of previous program graduates and motivational interviewing.[148]

The CA sought to assess inmate engagement in treatment and program efforts to build engagement and motivation. A survey distributed to treatment participants at the programs we observed asked them to assess their engagement in treatment. Only 34.5% of all respondents

[144] Welsh and McGrain, "Predictors of therapeutic engagement in prison-based drug treatment," 271-280.
[145] De Leon, G., Melnick, G., Wexler, H. K., Thomas, G. & Kressel, D. (2000). Motivation for treatment in a prison-based therapeutic community. *American Journal of Drug and Alcohol Abuse.* 26(1), 33-46. Melnick, G., De Leon, G., Wexler, H. K., Thomas, G. & Kressel, D. (2001). Treatment progress in therapeutic communities: Motivation, progress and outcomes. *American Journal of Drug and Alcohol Abuse*. 27(4), 633-650.
[146] Miller, "Increasing Motivation for Change."
[147] Farabee et al., "Barriers to implementing effective correctional drug treatment programs."
[148] Miller, "Increasing Motivation for Change."

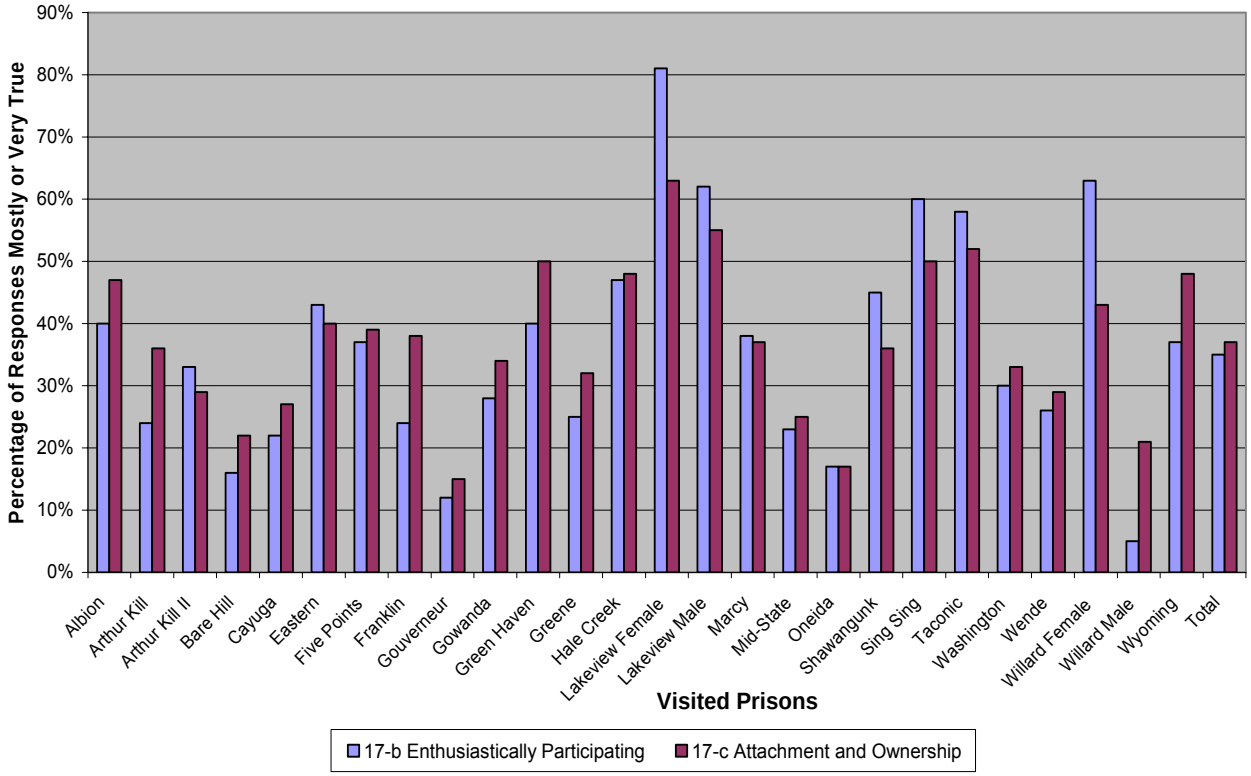
reported that it was *mostly* or *very true* that they enthusiastically participated in program activities (see **Chart 8-1**). Similarly, only 37% of all treatment participants who responded to the survey said it was *mostly* or *very true* that they felt an attachment and ownership in the program, with facilities such as Lakeview Female (63%), Lakeview Male (55%), Taconic (52%) and Sing Sing (50%) representing the highest percentages, compared with Gouverneur (15%), Oneida (17%), Willard DTC Male (21%) and Bare Hill (22%), programs in which participants had much less engagement.

Our observations and conversations with inmates were consistent with these data. Most of the programming is conducted in large groups (from 20 to 50 participants) that limited meaningful participation to a few individuals. In some groups we observed, participants were eager to speak, listening intently and appearing actively engaged in the discussion. In other groups, many group members seemed unengaged and bored. This may be a result of some staff's inability to engage participants, the manner in which the material was presented or the outdated content and structure of the material itself.

> *"One of the main reasons for this lack of enthusiasm is because the structure of the program is outdated. The material from which we study is outdated. The ASAT movies that we watch are all outdated. There's nothing about this program that's attractive or motivational."*
>
> *Anonymous Inmate (Bare Hill, C.F.)*

Although we observed many programs in which people were not or only somewhat engaged, we observed one group session consisting of training in listening and reflection skills where the staff member facilitating the session used creative strategies to keep most of the participants engaged and active in the session, even those who hung back. The session was highly structured and used a standardized model for training in cognitive-behavioral skills, as opposed to many of the more didactic and less engaging and organized sessions we observed.

Chart 8-1 Survey Respondents Reported as Mostly or Very True that They Enthusiastically Participate and Feel Attached to Their Program (MQA Q17b & c)



8.5 TREATMENT PROCESS: GROUP SESSIONS

Like all DOCS programming, treatment programs are delivered in half-day modules. Each inmate, whether in ASAT or CASAT, is assigned to a group that attends either the morning or the afternoon module. Thus, treatment participants generally spend between 1¾ and 2½ hours a day in treatment programming, for four or five days a week. Most of that time is spent in large groups.

A foundational element of the TC model is the community as the agent of change.[149] Group sessions are a major setting for this transformation to take place as peers provide each other feedback and develop communication skills, and group size is a controlling element as to whether these interactions can take place.

The size of the group sessions we observed varied greatly, from approximately 20 participants to more than 50 inmates. A larger group size may be appropriate for educational activities, such as lectures on pharmacology, and for community meetings, but is too large for the group counseling that is widely considered a mainstay of effective treatment.[150] Indeed, the New York State Office

[149] Taxman and Bouffard, "Assessing Therapeutic Integrity in Modified Therapeutic Communities for Drug-Involved Offenders," 189-212.
[150] Alonso, *Group Therapy in Clinical Practice*.

of Alcoholism and Substance Abuse Services (OASAS), the State's licensing agency, limits group size to 12 in community-based treatment programs.[151] At Willard Drug Treatment Campus, the boot camp program licensed by OASAS, counseling groups may have a maximum of 18 participants.[152] The ASAT groups in treatment programs serving special populations, such as the SNU (Special Needs Unit) or ICP (Intermediate Care Program), averaged no more than 10 participants, and such a small group size seemed to benefit the participants greatly, based on our observations, participant comments and survey results.

The topics of group sessions we observed included the effects of addiction on families; anger and related issues; decision making; defense mechanisms; the disease model of addiction; domestic violence; trust; and an extensive array of topics related to pharmacology and the physical processes of addiction and recovery such as dependence, tolerance, withdrawal, and substances of abuse. We observed several group sessions viewing videotapes on topics such as psychopharmacology. Several group discussions, both large and small, consisted primarily of inmates sharing their life stories. Discussions were often monopolized by more articulate inmates, and some staff made little effort to draw out those who seemed unengaged.

The large groups we observed did not divide into smaller working groups very frequently. In some cases, this was due to staffing shortages. We interviewed 75 treatment participants at TCs in seven facilities in an effort to measure the program fidelity to the TC model. We asked these treatment participants to rate the frequency with which they worked in smaller groups, using a five-point Likert scale where 1 was *never* and 5 *always*. The average response to this question was 2.3. This supports our observations that small groups were held occasionally but much less often than large groups. There was some variability from prison to prison; the women interviewed at Taconic averaged 1.4 on the low end and the men at Gowanda averaged 2.7. In the small group sessions that we observed, participants appeared more engaged and open than in the large groups.

Inmates played a range of roles in group sessions, both educational and interactive therapeutic sessions. At some programs, inmates led entire educational sessions, presenting substantive material, responding to questions and comments and guiding discussion. Staff participation varied considerably among programs. Thus, one way that inmates were included was by reading aloud from material the group was studying. Treatment staff were usually present in the room or in an adjacent room, sometimes observing and at other times meeting with inmates or doing paperwork. Other programs were at the other end of the spectrum, with treatment staff (mainly program assistants) facilitating most aspects of the session and limited opportunity for inmates to take an active leadership role.

[151] OASAS, "Operating Regulations Part 819.2."

[152] Under OASAS standards for Willard DTC that were enacted in December 2009, 40 hours of structured chemical dependence treatment per week must be offered, including informational/educational sessions; group counseling; chemical abuse and dependence awareness; evaluations; parole transition and Network services; training in socialization skills, nutritional education, vocational and educational classes, and accessing community services. Only group counseling sessions have a maximum of 18 people per group. (OASAS, "Requirements for the Operation of Treatment Readiness Specialized Chemical Dependence Services at Willard Drug Treatment Campus.")

Survey respondents were asked to rate how often inmates led all or some of a group session. Using a Likert scale, when asked how often inmate led all or some of a group session, where 1 equaled *never* and 5 equaled *always*, the average response was 3. The average response from individuals at Taconic was 5, compared with 1.6 from inmates at Sing Sing.

We observed some treatment programs that seemed to strike a balance between enabling inmates to develop important new skills and ownership of the program on one hand, and benefit from staff expertise and knowledge on the other.

8.5.1 Length of Group Program Sessions

The large majority of group sessions were held either in the morning or afternoon module, and lasted between approximately two to three hours, though a prison module is comprised of a three-hour time block. Treatment staff sometimes expressed concern regarding the shortened session time due to activities that delayed participants or otherwise interrupted program activities such as count clearing, general movement or the location of the program itself.

8.6 CLINICAL CONTENT

On most visits, the CA observed two, three or four treatment group sessions. In addition, almost 1,200 treatment participants completed a survey that included questions about program content.

The DOCS Office of Substance Abuse Treatment Services (OSATS), the office responsible for providing and monitoring DOCS treatment programs, provides limited guidance to ASAT programs regarding clinical content. A "broad curriculum" lists topics in bullet form, but there is no detailed syllabus. The ASAT Manual requires facilities to provide a treatment curriculum outline and weekly schedule to OSATS.

Our observations and the survey responses indicate significant variability among facilities and even, in some facilities, within a single program. Treatment staff, though provided with broad topics to cover from the ASAT curriculum, are responsible for deciding what supporting information or additional content to include, as well as how to present the information (e.g. video, lecture, discussion). Some sessions we observed did not have a specific topic, but were focused instead on a participant recounting his/her life story. The sharing of one's life story can be effectively therapeutic if a qualified counselor is present to assist the individual and group understand the triggers for one's behavior and the impact and consequences of certain behavior, and brainstorm how different choices could have been made. Unfortunately, we did not observe this type of therapeutic feedback during most of the sessions we observed, resulting in a missed therapeutic opportunity for the group.

Some programs had developed curricula or obtained them from outside sources. These included "Commitment to Change," a fatherhood development program; and "Good Intentions, Bad Choices," a videotape and workbook package that targets criminal thinking not specific to substance abuse. Several programs integrated some materials from Hazelden Education Materials, Inc., including *Shaping a Life of Recovery and Freedom for Chemically Dependent Criminal Offenders*; *A Cognitive Behavioral Treatment Curriculum*; *Touchstones: A Book of Daily Meditations for Men*; and the video collection entitled *Understanding Self and Others*.

These materials were most often used by certain staff as additional documents and were not a central element of the program.

However, one facility we visited, Bare Hill, had recently undergone an arduous process to obtain DOCS approval for purchase of a complete system from Hazelden Educational Services entitled "A New Direction."[153] This is a "cognitive-behavioral treatment curriculum" that says it will guide participants through creating their own TC. Purchase of the program included several days of on-site training for treatment staff and extensive materials such as workbooks, manuals and even several of the medallions often distributed by 12-step groups to commemorate milestones in recovery time. In order to obtain funding from DOCS for this system, facility staff demonstrated that the system addressed the nine competencies and otherwise matched DOCS requirements. Both staff and inmates reported high satisfaction with this system.

As noted earlier in this section, the group size for most sessions made it very challenging for staff to conduct training and practice in cognitive-behavioral skills such as communication and problem solving. It was also difficult for the community to strengthen the bonds that are supposed to form the foundation of the TC and its role as the agent for change.

8.7 TREATMENT APPROACHES/FIDELITY

Most of the programs we visited were described to us as modified therapeutic communities. Since fidelity to the classic TC model has become erratic with the rapid spread of prison-based TC programs throughout the country, many of which seem to employ multiple treatment modalities, the CA attempted to quantify in New York prison-based treatment programs the prevalence of three treatment approaches: therapeutic community, cognitive-behavioral therapy, and 12-step. To do this, we asked treatment participants about services provided and about goals and activities associated with those approaches. The questions were based on the Multimodality Quality Assurance Scales (MQA) instrument, a quality-assurance tool developed by NDRI and based on research, expert consensus, and other sources.[154]

Overall, survey respondents rated cognitive-behavioral components as the most important part of their treatment programs. Of note, survey respondents also were most satisfied with the cognitive-behavioral work they did in treatment. They reported that many components of the TC approach were also present, but these were not as significant as the cognitive-behavioral elements. Finally, they reported that in most programs, elements of the 12-step approach were less important than either of the other two, but still had a significant presence

Inmate responses to the MQA survey about the three approaches are tabulated in **Table 8-1**, **Table 8-2** and **Table 8-3**, indicating the percentage of inmates who reported the treatment component was *mostly* or *very important*. For each prison, we also combined survey responses for all questions for each of the three approaches and calculated a composite score on a four-point Likert scale. This combined score for each approach was converted to a percentage of the maximum possible score for all questions, with 0% representing that the survey respondent

[153] Hazelden Foundation, "A New Direction: A Cognitive-Behavioral Treatment Curriculum -- Hazelden."
[154] Melnick and Pearson, *A Multimodality Quality Assurance instrument*. The MQA questions referencing TC are contained in Menu A, CBT (Menu B) and 12-Steps (Menu C). The specific questions for each modality are listed in **Appendix B**.

answered *not at all important* to every question for a particular approach and 100% representing that the survey respondent answered *very important* to every question. The data from these composite calculations are summarized in **Table 8-1**, **Table 8-2** and **Table 8-3**, and the results illustrated in **Chart 8-2**. The "Total" column in the tables and chart represents the responses of all survey participants from all the programs we visited.

The survey results show that a majority of survey respondents reported that all the measured components of all three treatment approaches were *mostly* or *very important* to their programs. However, the data reveal significant variability for the composite percentages among the three approaches, and within each approach, substantial variations sometimes exist among the separate components we measured.

The "Total" column of **Table 8-1**, representing the responses of all survey participants, shows their assessment of each of the measured TC components, as well as a composite score combining all of the TC elements. The overall composite percentage for the TC approach (63%) signifies that most inmates believed the measured TC elements were *somewhat* to *mostly important*. But inspecting the separate TC components reveals significant variability. For example, only 52% of survey respondents stated that increasing privileges as a participant progresses was *mostly* or *very important* (MQA Q13(h)), whereas 72% made a similar assessment concerning participants helping one another (MQA Q13(b)).

Table 8-2 tabulates the survey respondents' assessment of important components of the cognitive-behavioral approach used in their treatment program. The percentage of survey respondents who reported that components of cognitive-behavioral therapy were *mostly* or *very important* fell in the range of 77% for encouraging communication in an assertive, but polite, way (MQA Q14(c)) to 83% for encouraging finding pleasure in things other than drugs (MQA Q14(b)). These results are substantially higher than comparable values for the TC components. The average composite score for all the cognitive-behavioral components was 77%, representing that survey respondents overall felt all the cognitive-behavioral therapy components were *mostly important*.

Table 8-3 illustrates the survey respondents' assessment of the 12-step elements. About half of survey respondents reported these elements were *mostly* or *very important* to their programs. Evaluating the data concerning 12-step elements reveals less definitive responses, but still the percentage of survey participants concluding that a component of this approach was *mostly* or *very important* ranged from 51% for barriers to affiliation to a 12-step program (MQA Q15(e)) to 58% concerning the nature of the "sponsoring relationship" (MQA Q15(d)).

The data suggest that implementation of the TC model is irregular. The survey asked about eight elements of the TC approach. Survey respondents reported that the most common element was participants helping each other (72% *mostly* or *very important*) and senior participants serving as role models (70%). They also strongly affirmed that penalties or punishment were imposed for program rule violations (66%). The survey respondents were less certain about treatment staff serving as role models (57% *mostly* or *very important*) and even less sure about increasing privileges as participants advanced (only 52%). Sixty percent of the survey respondents said work was a *mostly* or *very important* part of the therapeutic program.

Our observations of the programs were consistent with these results. The punitive features of the TC model were emphasized, including excessive concern for order and cleanliness, with much less attention to rewards for progress. As detailed later in this section, we observed little evidence that privileges increased as participants advanced in their treatment. Our observations were also consistent with the survey results suggesting there was less emphasis on the integration of work in treatment programs. While staff cited the importance of work to the TC model, we observed that work assignments were not coordinated with participants' progress but focused primarily on maintaining the cleanliness of the housing area and sometimes other areas of the facility.

The data for the cognitive-behavioral approach, **Table 8-2**, illustrates more consistent responses reflecting greater importance for each element of the CBT approach than the responses for the TC, with an average of 77% to 83% of all survey respondents rating the CBT elements as *mostly* or *very important*. There was also greater consistency in the responses to the 12-step statements (**Table 8-3**), with an average of 51% to 58% of respondents saying these components were *mostly* or *very important*.

Table 8-1 Menu A (MQA Q13) – Percentage of *Mostly* or *Very Important* Responses to TC Components

Question 13 Menu A Description	AL	AK I	AK II	BH	CY	EA	FP	FR	GV	GO	GH	GR	HC
(a) Staff confront unacceptable behavior outside group sessions	80	64	59	42	59	87	50	62	56	51	75	56	73
(b) Participants frequently help each other	71	64	74	65	73	81	82	71	56	65	84	65	78
(c) Program violations receive penalty	76	81	55	56	58	77	48	63	50	65	70	67	78
(d) Work is part of therapeutic program	67	66	55	49	58	68	49	67	44	50	79	56	72
(e) Treatment staff serve as role models	67	47	46	45	50	74	64	58	56	48	85	54	64
(f) Inmate treatment staff serve as role models	65	58	70	51	55	75	65	66	60	56	80	57	73
(g) Senior participants serve as role models	67	61	72	64	60	81	80	71	67	64	85	69	77
(h) Program involves increasing privileges as participant advances	42	31	50	54	48	53	61	61	46	57	45	58	58
Menu A – Composite Score	1.93	1.79	1.80	1.60	1.75	2.23	1.85	1.96	1.65	1.68	2.33	1.76	2.07
Percentage on 4-point scale	64	60	60	53	58	74	62	65	55	56	78	59	69
Satisfied with Menu A – Q13	75	51	65	49	51	82	87	60	63	76	69	71	76

Question 13 Menu A Description	LVM	LVF	MA	MS	ON	SH	SS	TA	WA	WE	WIM	WIF	WY	Total
(a) Staff confront unacceptable behavior outside group sessions	64	73	57	49	53	66	60	80	63	49	74	86	67	62
(b) Participants frequently help each other	83	85	77	60	46	77	80	76	79	68	47	86	86	72
(c) Program violations receive penalty	80	73	62	72	93	57	63	72	63	50	63	75	58	66
(d) Work is part of therapeutic program	58	65	66	64	63	59	44	52	58	52	63	86	64	60
(e) Treatment staff serve as role models	70	74	51	59	7	72	71	80	49	58	47	71	61	57
(f) Inmate treatment staff serve as role models	60	80	54	62	100	67	68	80	76	50	42	86	70	64
(g) Senior participants serve as role models	76	76	64	77	39	59	71	80	82	63	42	71	82	70
h) Program involves increasing privileges as participant advances	69	69	53	42	7	43	43	56	61	44	53	67	55	52
Menu A – Composite Score	2.06	2.08	1.76	1.80	1.39	1.88	1.80	2.16	1.92	1.61	1.67	2.23	1.91	1.88
Percentage on 4-point scale	69	69	59	60	46	63	60	72	64	54	56	74	64	63
Satisfied with Menu A – Q13	85	93	65	54	31	68	69	83	73	63	44	67	76	67

Prison Abbreviations: AL-Albion, AK I-Arthur Kill (2007), AK II-Arthur Kill (2009), BH-Bare Hill, CY-Cayuga, EA-Eastern, FP-Five Points, FR-Franklin, GV-Gouverneur, GO-Gowanda, GH-Green Haven, GR-Greene, HC-Hale Creek, LVM-Lakeview Male, LVF-Lakeview Female, MA-Marcy, MS-Mid-State, ON-Oneida, SH-Shawangunk, SS-Sing Sing, TA-Taconic, WA-Washington, WE-Wende, WIM-Willard Male, WIF-Willard Female, WY-Wyoming.

Table 8-2 Menu B (MQA Q14) – Percentage of *Mostly* or *Very Important* Responses to CBT Components

Question 14 Menu B Description	AL	AK I	AK II	BH	CY	EA	FP	FR	GV	GO	GH	GR	HC
(a) Helps participants to identify "trigger" situations for taking drugs	90	72	84	68	81	92	84	72	79	83	96	80	94
(b) Encourages participants to find pleasure in other things besides drugs	85	69	96	75	84	96	88	77	85	82	88	78	92
(c) Encourages participants to talk with others in an assertive, but polite, way	80	69	82	70	81	86	81	75	63	76	92	70	90
(d) Emphasizes problem-solving techniques to deal with frustration	80	70	68	71	78	92	86	74	82	71	92	65	87
(e) Helps participants to recognize errors of thinking	90	76	82	71	84	94	86	78	82	78	92	73	92
Menu B – Composite Score	2.42	2.07	2.38	1.98	2.30	2.64	2.44	2.17	2.26	2.18	2.75	2.13	2.65
Percentage on 4-point scale	81	69	79	66	77	88	81	72	75	73	92	71	88
Satisfied with Menu B – Q14	90	74	71	56	68	81	87	62	82	78	93	79	90

Question 14 Menu B Description	LVM	LVF	MA	MS	ON	SH	SS	TA	WA	WE	WIM	WIF	WY	Total
(a) Helps participants to identify "trigger" situations for taking drugs	93	92	82	78	34	90	86	84	76	91	65	86	86	81
(b) Encourages participants to find pleasure in other things besides drugs	93	96	78	79	34	83	85	81	81	94	85	86	92	83
(c) Encourages participants to talk with others in an assertive, but polite, way	88	88	66	74	44	83	88	72	71	82	75	100	84	77
(d) Emphasizes problem-solving techniques to deal with frustration	90	96	74	71	29	86	88	76	72	84	70	100	90	79
(e) Helps participants to recognize errors of thinking	90	96	75	80	49	83	82	76	75	82	75	100	90	81
Menu B – Composite Score	2.63	2.67	2.23	2.28	1.26	2.52	2.42	2.39	2.19	2.52	2.14	2.77	2.48	2.32
Percentage on 4-point scale	88	89	74	76	42	84	81	80	73	84	71	92	83	77
Satisfied with Menu B – Q14	98	86	78	70	58	74	79	91	71	78	68	67	85	77

Prison Abbreviations: AL-Albion, AK I-Arthur Kill (2007), AK II-Arthur Kill (2009), BH-Bare Hill, CY-Cayuga, EA-Eastern, FP-Five Points, FR-Franklin, GV-Gouverneur, GO-Gowanda, GH-Green Haven, GR-Greene, HC-Hale Creek, LVM-Lakeview Male, LVF-Lakeview Female, MA-Marcy, MS-Mid-State, ON-Oneida, SH-Shawangunk, SS-Sing Sing, TA-Taconic, WA-Washington, WE-Wende, WIM-Willard Male, WIF-Willard Female, WY-Wyoming.

Table 8-3 Menu C (MQA Q15) – Percentage of *Mostly* or *Very Important* Responses to 12-Step Components

Question 15 Menu C Description	AL	AK I	AK II	BH	CY	EA	FP	FR	GV	GO	GH	GR	HC
(a) Goals of 12-step discussed and explained	63	24	27	24	28	46	44	57	50	27	64	46	77
(b) How to work the 12 steps is explained	53	27	32	25	40	44	53	53	52	21	64	42	82
(c) The reasons why the 12 steps succeed are explained	60	28	32	27	37	45	53	58	54	26	68	45	85
(d) Discusses the nature of the "sponsoring relationship"	63	38	46	44	49	60	54	62	60	33	76	42	83
(e) Discusses the barriers to affiliation with the 12-step program	63	36	36	33	34	45	56	55	56	21	71	39	81
Menu C – Composite Score	1.73	1.13	1.23	0.95	1.20	1.50	1.46	1.66	1.70	0.99	2.22	1.35	2.34
Percentage on 4-point scale	58	38	41	32	40	50	49	55	57	33	74	45	78
Satisfied with Menu C – Q15	60	52	54	36	46	63	73	47	57	48	70	55	82

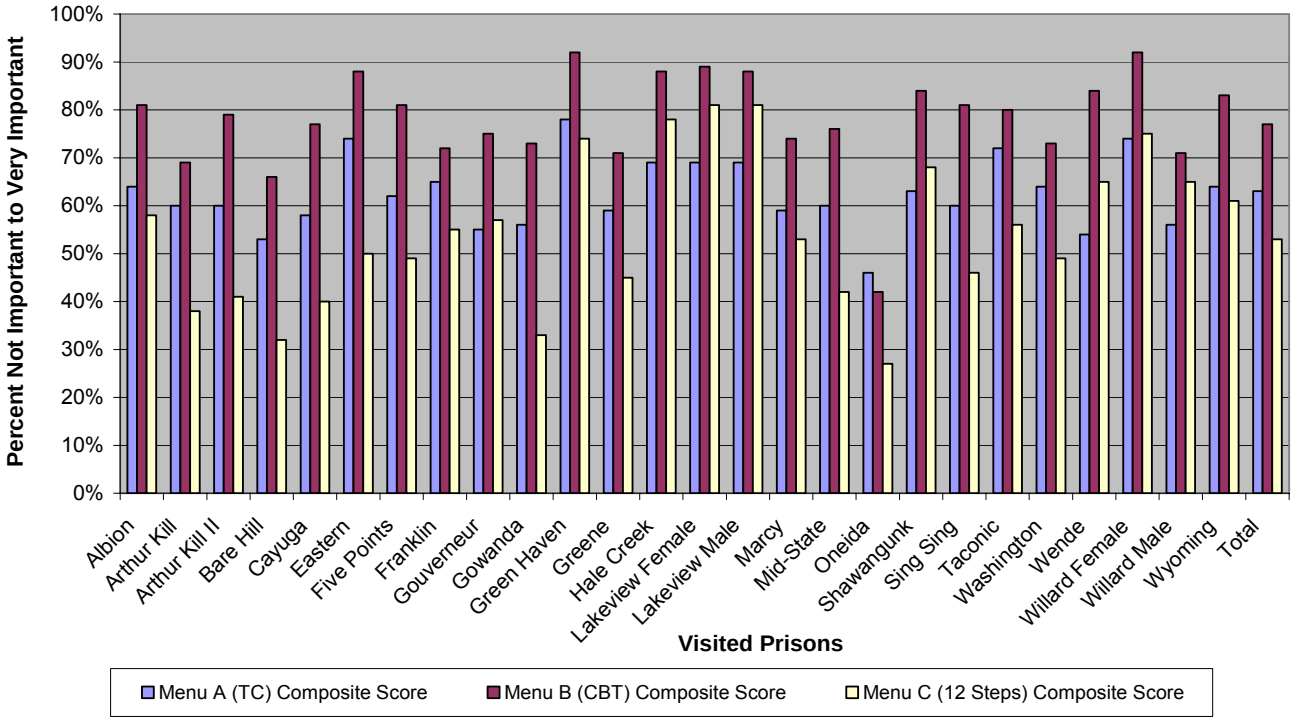
Question 15 Menu C Description	LVM	LVF	MA	MS	ON	SH	SS	TA	WA	WE	WIM	WIF	WY	Total
(a) Goals of 12-step discussed and explained	88	92	54	44	24	71	44	61	32	67	75	86	67	52
(b) How to work the 12 steps is explained	85	92	53	45	24	68	44	61	44	69	60	86	63	52
(c) The reasons why the 12 steps succeed are explained	88	92	52	43	20	68	41	61	48	66	70	71	59	53
(d) Discusses the nature of the "sponsoring relationship"	78	84	60	57	15	71	52	61	59	66	75	86	65	58
(e) Discusses the barriers to affiliation with the 12-step program	78	76	49	45	22	65	39	61	47	60	65	71	57	51
Menu C – Composite Score	2.42	2.43	1.60	1.25	0.80	2.04	1.38	1.68	1.47	1.95	1.95	2.26	1.85	1.60
Percentage on 4-point scale	81	81	53	42	27	68	46	56	49	65	65	75	61	53
Satisfied with Menu C - Q15	93	89	62	42	40	72	59	64	68	58	73	63	69	60

Prison Abbreviations: AL-Albion, AK I-Arthur Kill (2007), AK II-Arthur Kill (2009), BH-Bare Hill, CY-Cayuga, EA-Eastern, FP-Five Points, FR-Franklin, GV-Gouverneur, GO-Gowanda, GH-Green Haven, GR-Greene, HC-Hale Creek, LVM-Lakeview Male, LVF-Lakeview Female, MA-Marcy, MS-Mid-State, ON-Oneida, SH-Shawangunk, SS-Sing Sing, TA-Taconic, WA-Washington, WE-Wende, WIM-Willard Male, WIF-Willard Female, WY-Wyoming.

Despite the overall acknowledgment by the survey respondents that all three treatment strategies were important to their treatment, there was significant variability in the responses between programs. For example, the average prevalence of cognitive-behavioral components was 63%. Yet a group of programs were well below that average, including Oneida (46%), Bare Hill (53%), Wende (54%) and Gouverneur (55%). Another group had significantly higher prevalence, including Green Haven (78%), Eastern (74%), Willard Female (74%) and Taconic (72%) (see **Table 8-1** and **Chart 8-2**). As discussed in greater detail in **Section 8.14**, several of the programs with lower scores for TC, including Oneida, Bare Hill, and Gouverneur, also had overall poorer ratings by the survey participants concerning their assessment of the program and their treatment progress.

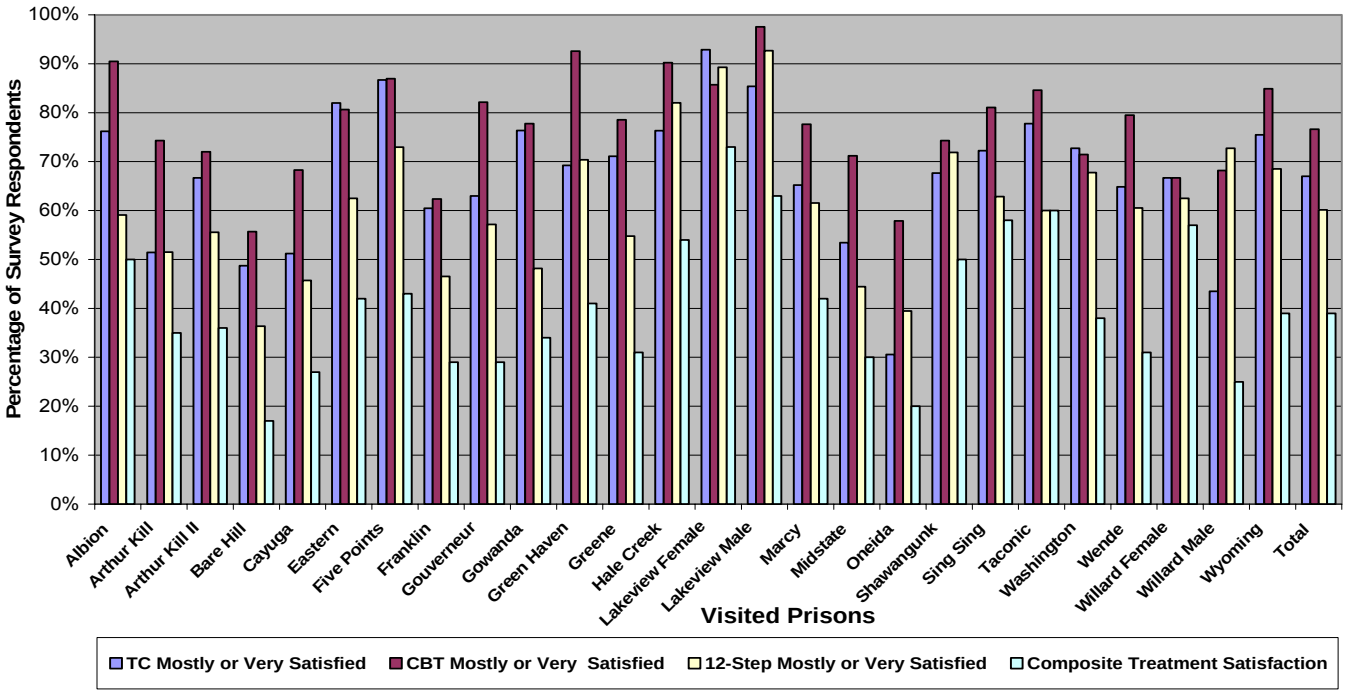
The data also demonstrate significant variability in the importance of the 12-step approach among the different programs. Despite the prohibition of coerced 12-step participation, we found that the shock and boot-camp programs (Lakeview and Willard) heavily emphasized the 12-step approach in their programming and their environment. At Willard, the 12 steps were painted on the walls in several rooms and were included in the program's handbook, slightly altered. Survey data reinforced this perception in composite scores. In contrast, at Arthur Kill, Bare Hill, Gowanda and Oneida, 40% or less of the survey respondents assessed the 12-step approach as *mostly* or *very important*.

Chart 8-2 Survey Respondent's Composite Responses for TC (Menu A), CBT (Menu B) and 12-Steps (Menu C)



We also asked program participants about their satisfaction with the components of the TC, cognitive-behavioral and 12-step treatment approaches in their programs. The percentage of survey respondents who were *somewhat* or *very satisfied* are tabulated in **Tables 8-1, 8-2** and **8-3** and illustrated in **Chart 8-3**. The level of respondents' satisfaction with each strategy generally correlated well with the importance their programs placed on those elements. In addition, their satisfaction with them was generally consistent with their overall assessment of the program's success and operation.

Chart 8-3 Survey Respondents' Mostly or Very Satisfied with TC, Cognitive Behavioral and 12-Step Approaches Compared to Treatment Satisfaction



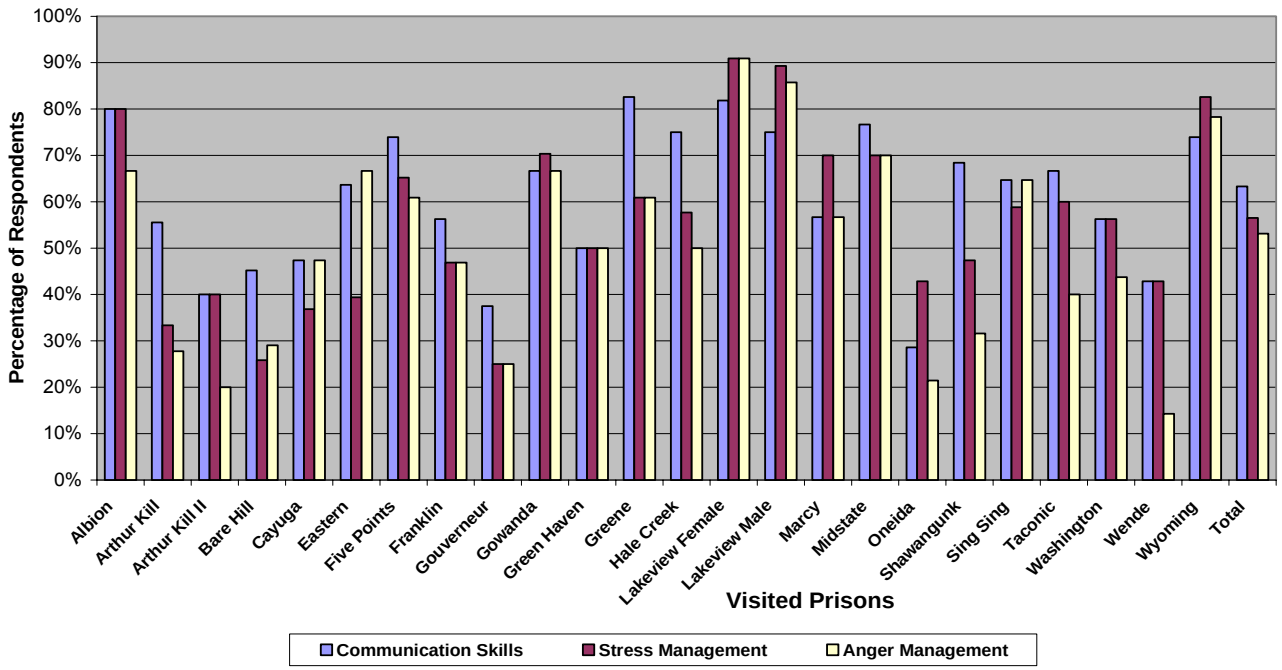
Based on our observations and on discussions with staff, the treatment approach in each program was greatly influenced by individual staff members, their professional experience, and their personal attitudes and histories. Counselor style has been clearly identified as having a major influence on treatment effectiveness.[155] [156] The use of standardized or manualized treatment interventions can help to mediate this effect, reducing variations and enhancing effectiveness. The lack of a detailed curriculum in most DOCS programs, coupled with limited monitoring and oversight, is likely to be a major reason for the inconsistency of treatment approaches among and within those programs.

[155] Najavits, Crits-Christoph, and Dierberger, "Clinicians' impact on the quality of substance use disorder treatment," 12-14.
[156] Project MATCH Research Group (1998d). "Therapist effects in three treatments for alcohol problems." Psychotherapy Research, 8, 455-474.

8.8 TRAINING IN SOCIAL AND COMMUNICATION SKILLS AND OTHER TOPICS

In addition to our observations about clinical content, inmates were asked about training in several social skills critical to recovery, including communication, anger management, and stress management. **Chart 8-4** shows the results for inmates who had participated in the treatment programs for more than 90 days at the time they responded to the survey. Note that Willard DTC, a three-month program, is excluded from these data.

Chart 8-4 Survey Respondents Received Training about Communication Skills, Stress Management and Anger Management in Their Program (Q11(a), (e) and (f))



The amount of training provided in these skills varied significantly among facilities, according to the survey respondents. For example, most participants at Albion (80%), Lakeview Male (75%), and Greene (83%) reported receiving training in communication skills, while less than half of those at Gouverneur (38%), Oneida (29%) and Wende (43%) reported that training. The differences reported regarding training in anger management were also significant: most survey respondents at Lakeview Men/Female (86%; 91%), Wyoming (78%) and Mid-State (70%) reported receiving it, with much lower percentages at Wende (14%), Oneida (21%) and Arthur Kill 2009 (28%).

Perhaps most striking is the difference between programs within a single facility, such as Willard Drug Treatment Campus. At Willard, men and women are in separate programs that follow the same curriculum. All survey respondents who participated in the Willard DTC program for women reported that stress management training was an element of their program, compared with none of the Willard men reporting that they received any training in this topic.

There were considerable and somewhat anticipated differences between programs within the same facility. These programs at times served a unique population and consisted of a more specialized curriculum, which might account for some of the differences reported by participants. For example, at Eastern Correctional Facility, 44% of survey respondents in the ASAT program felt that communications skills were incorporated into their substance abuse treatment program in contrast with 80% of survey respondents from Eastern's Chemical Dependency/Domestic Violence (CD/DV) program. Gowanda Correctional Facility also had sizeable differences between its programs with 64% of ASAT survey respondents stating that they were taught stress management skills, compared with 94% of Driving While Intoxicated (DWI) program respondents.

The CD/DV and DWI programs utilized curricula specific to the population of the program. Though the differing curricula may result in a variety of topics covered and participant satisfaction, this is less so when comparing ASAT and CASAT programs. The survey responses we received from participants in the CASAT program were from Phase I participants. See **Section 6, Overview of DOCS Substance Abuse Treatment Programs** for further information. CASAT Phase I utilizes the same curriculum that is used in the ASAT programs. Though similar curricula are employed in both programs, participants' reports on the provision of these services varied considerably. For example, 83% of survey respondents in the CASAT program at Taconic Correctional Facility said that stress management skills were included in their treatment, compared with 46% of Taconic's ASAT respondents. Another difference between the CASAT and ASAT programs was apparent from the data from Wyoming Correctional Facility. At Wyoming, 54% of ASAT participants surveyed found money management skills to be an important part of the program, compared with 90% of CASAT participants. Training in topics such as health and wellness, as well as management of chronic health conditions, should be included in more intense substance abuse treatment programs as these areas help to support an individual in recovery, develop new coping skills and reduce the risk of relapse.

8.9 MATERIALS: HANDOUTS AND WORKBOOKS

In both residential and nonresidential programs, there were variations in the frequency that materials such as workbooks and handouts were distributed to participants. Often, materials were collected at the end of the sessions, with participants retaining little or no materials for study or further work between sessions. The amount of assigned homework also varied. Occasionally inmates were asked to write a short essay or keep a journal, though inmates and staff did not report that this happened frequently.

Some treatment programs used handouts more than others. Survey respondents were asked to rate the frequency with which handouts were distributed, using a Likert scale where 1 equaled *never* and 5 *always.* Variation was clearly illustrated as Arthur Kill had an average of 2 and Mid-State an average of 4.

The content of most materials that were used by participants during sessions was provided independently by treatment staff, often without review or approval by the facility. These materials included single- and multiple-page documents that may have been handmade, some of which had been reproduced so many times they were barely legible. Some of the materials were

outdated. Treatment staff reported obtaining these materials from a variety of sources such as places where they were previously employed, training programs, colleagues, and so on.

As for materials available outside sessions, most residential programs and TCs had some recovery-related literature on hand. Several programs had 12-step materials available for interested inmates, but they were not always easily accessible or well advertised. Though some programs used these materials for their daily readings and had them in bookcases in the program area, others locked these recovery-related materials in a cabinet or in a separate room, and inmates needed to request the materials from a counselor. Some inmates reported that the process to get a book could take up to several days. Seventy-three percent of the individuals we interviewed stated that they were able to have access to recovery-oriented materials outside of group, though for some this meant a trip to the library or to an AA meeting. An exception was one program that had hundreds of copies of the basic texts of Alcoholics Anonymous and Narcotics Anonymous readily available in common space. No one was able to tell us where these came from; it seems likely they were donated by local 12-step groups or regional offices.

Staff and inmates both consistently complained that much of the videotapes and other materials were very outdated. Staff emphasized the need for new and up-to-date materials. This was confirmed by our observations of materials available in the group rooms and other shared space. We occasionally observed treatment participants viewing videotapes, sometimes followed by discussion. In some sessions, treatment staff or inmates suggested topics and encouraged discussion. Though the treatment staff generally followed the ASAT curriculum and incorporated the nine ASAT competencies into their lessons, as discussed previously, the ASAT Manual provides little direction in terms of supporting documents or evidence-based approaches to presenting the information, resulting in the wide variations we witnessed in program format.

8.10 TC COMMUNITY MEETINGS

Daily meetings of the entire treatment community are a core element of the TC model. Typically, a community's morning meeting explicitly sets the tone for the day, with a "thought for the day" and sometimes a "vocabulary word of the day" chosen by community members who have been assigned those duties as part of their role in the community's hierarchy ("inspiration coordinator"). Similarly, an afternoon or evening meeting provides closure for the day's events and facilitates planning for the next day. These events are typically highly structured, with each element carefully orchestrated. "Pull-ups" and "push-ups," the verbal reprimands and reinforcements that characterize the TC (see **Section 8.12**), are often administered at community meetings. During our visits to DOCS programs, we observed many community meetings, which varied considerably between programs. Some were as brief as 15 minutes, while others ran up to two hours.

At the programs we observed, community meetings were held once or twice a day, or weekly, depending on the program. The community meetings for most programs were standard for TCs, including the word or thought for the day, a news item, a reading from recovery-focused literature, pull-ups and push-ups, announcements, and sometimes a "feelings check." For the residential TC treatment programs, the correction officers often attended and sometimes participated in the community meetings.

Consistent with the TC model, in most programs inmates played a central role in facilitating community meetings, pursuant to their roles in the hierarchy.

8.11 OTHER TC COMPONENTS

The classic TC model places great value on work assignments within the community. Tasks such as cleaning bathrooms are assigned to residents who are low in the hierarchy. As residents progress up the hierarchy structure, their work assignments become more desirable, including those without physical labor such as organizing and facilitating community activities and assigning tasks to residents.

The programs observed for the Substance Abuse Treatment Project adhered to this model, in at times limited ways. Those programs that provided segregated housing for treatment participants required them to maintain the communal areas, including classrooms, laundry room and bathrooms. In a classic TC, every participant would be given a work assignment (separate from their position within the hierarchy and/or their prison job assignment), with the more desirable work assignments going to inmates who have been positively progressing with their treatment.

The work assignments in the DOCS therapeutic communities that we visited varied, and were not generally assigned based on clinical progress. Seventy-eight percent of the individuals we interviewed said every inmate had some type of work assignment. However, some programs housed so many inmates that at times there were not enough work assignments to go around. At the facilities where each treatment participant had an assigned task, the assignments rotated on a weekly, biweekly or monthly basis and were not based on progress in the program.

We observed an exception to this pattern at Washington C.F., where all inmates entering the ASAT program were placed in a double bunk and assigned bathroom maintenance duties. Inmates at Washington explained that after they progressed in the program, if they received a negative evaluation they could be returned to a double bunk and bathroom duty, whereas if they received positive evaluations they could remain in their single bunks and have more desirable work assignments.

In the nonresidential treatment programs, inmates were sometimes assigned tasks to keep the program area clean, though not every inmate had an assignment all the time. Any hierarchy applied only during program hours, though in many facilities inmates were still required to keep their cell areas compliant with the ASAT standards for cleanliness and order.

In a classic therapeutic community, the hierarchy is a system that allows residents to assume positions of increasing responsibility and associated privileges as they progress through treatment.[157] The ASAT Manual states that each individual program is responsible for determining the number of hierarchy positions and the tasks under each position. Each program is required to develop a formal hierarchy chart containing specific assignments and duties.

Following each visit, we issued a Freedom of Information Law (FOIL) request to each facility asking for their hierarchy chart. The majority of programs did not provide us with one, replying

[157] De Leon, "The therapeutic community."

that such a document did not exist, though we often observed a structure board with hierarchy positions in many of the programs we visited.

As with other program elements, the hierarchy can be customized to suit the unique needs and strengths of each facility. We were concerned, however, at the extreme variations in the hierarchy and the role it played in the programs we observed. Of the individuals we interviewed, 78% said that some type of hierarchy was in place in their program, though they described hierarchies of various scopes and responsibilities.

A typical hierarchy at the programs we observed included eight key positions: senior coordinator, assistant coordinator, education coordinator, expeditor, information coordinator, service coordinator, inspiration coordinator, and creative energy coordinator. Other than the senior coordinator, the positions were relevant primarily during community meetings when, for example, the inspiration coordinator selected and posted or read the thought for the day. In some facilities, individuals not assigned to a hierarchy position were assigned to a crew, such as the expeditor crew. In some programs, we observed that the senior coordinator took a leadership role, facilitating a large part of treatment sessions. Inmates retained their hierarchy positions from one to six months, depending on the program. In some programs, individuals were required to complete an application to become part of the hierarchy leadership, while at others the positions were assigned by treatment staff.

The hierarchy is a central element to the TC model, so it is important that TC participants know with some certainty the standards for movement up the hierarchy. During our visits, we were told that in order to move up, an inmate must have a good disciplinary record and be "positively engaging" in the program. Furthermore, the new role must be viewed by staff as beneficial to the inmate's treatment. There appeared to be no formal connection between clinical progress and hierarchy position.

In contrast to the definition of hierarchy in the ASAT Manual, the hierarchy positions we observed were not utilized as incentives or rewards for progress in treatment. Rather, it seemed that positions were allocated to inmate volunteers or to reliable inmates who were handpicked by treatment staff because they could assist staff in the program. Most of the inmates we spoke with said that additional privileges were not associated with hierarchy positions.

Sanctions can serve a function in a therapeutic community, but incentives serve an equally important role. In many of the treatment programs we observed, individuals were punished for failure to conform to the rules. However, we did not witness or learn about incidents where individuals were rewarded for their progress. This is one of the principle functions of using a structured hierarchy and can help build self-esteem, model appropriate behavior and develop important social skills.

8.12 REPRIMANDS AND REINFORCEMENTS: PULL-UPS AND PUSH-UPS

Another important component of a typical therapeutic community is the use of "push-ups" and "pull-ups." A pull-up is a verbal reprimand given by participants or staff to a participant who is seen as inappropriately handling emotions, behaviors or tasks. These may be delivered in

community meetings or individually throughout the day. Push-ups, in contrast, are positive acknowledgements of self or other participants. Some facilities referred to these as "regressions" and "progressions."
In some programs we visited, pull-ups were submitted without an inmate's name and read at the community meeting. The inmate who was the object of the pull-up was then expected to identify himself. In other programs pull-ups were submitted in writing with the inmate's name and read by a member of the treatment team or a senior program participant at a community meeting.

Programs had a variety of ways for participants to respond to pull-ups and push-ups. Some programs required inmates to stand up while the pull-up was delivered, to listen to comments and suggestions from peers, and to respond. In other programs, inmates responded to pull-ups 24 hours after they were administered in order to provide time for reflection. The process for giving and receiving push-ups appeared to be much less formalized.

Seventy-four percent of the inmates we interviewed stated that push-ups and pull-ups were used in their programs, though they reported considerable variation in frequency. In some programs, pull-ups and push-ups were given on a daily basis; in others once a week; and in a few programs they were reported rarely used. At least one program required treatment participants to submit a minimum number of push-ups and pull-ups on a daily basis.

In addition to the variations in forms and frequency of push-ups and pull-ups, treatment participants reported differing views on their value to treatment. Sixty-eight percent of survey respondents believed they were *very* or *extremely important* to the treatment program, while others reported feeling unsafe using pull-ups because they so resembled "snitching," which is anathema to the general prison population.

The CA supports the use of peer support and feedback as tools for recovery in a TC. However, we are concerned about the possible consequences of pull-ups and other confrontational tools in the prison setting. These are intended for use by a supportive community with a climate of trust and openness, and their effectiveness directly correlates with that atmosphere.[158] They must be carefully implemented and overseen to ensure that the person receiving the pull-up does not feel attacked and resentful. Furthermore, pull-ups can be regarded by the prison culture as "snitching." An inmate who snitches on another can be the object of retaliation that includes violence or other serious consequences. Confrontation can also be seen as a violation of inmate codes of conduct.[159] Thus, these tools need to be used even more carefully in the prison setting.

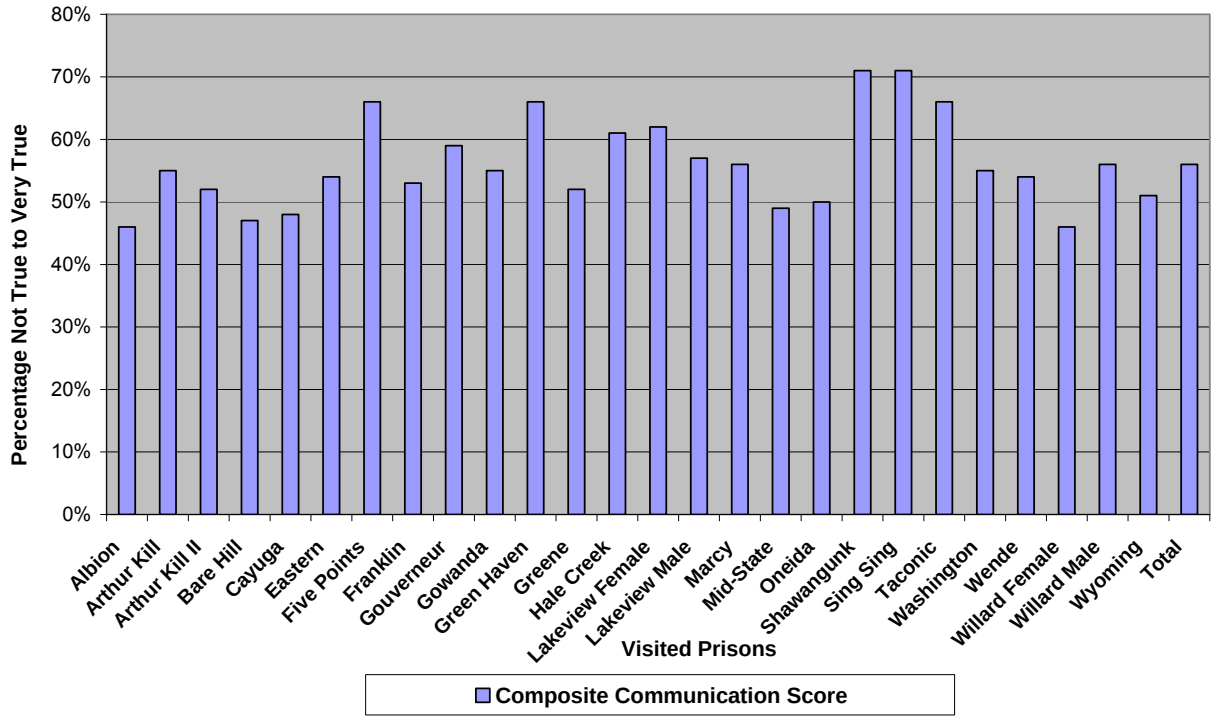
8.13 SURVEY RESPONDENTS' ASSESSMENT OF PROGRAM CLIMATE

In addition to assessing the use of the three treatment approaches, we sought to assess therapeutic milieu and program climate using several questions included in the MQA survey. There are many components that comprise an effective treatment program, and key among these is communication. It is important that participants feel safe among their peers and within group

[158] Ibid.
[159] Peters, Wexler, and Center for Substance Abuse Treatment (U.S.), *Substance Abuse Treatment for Adults in the Criminal Justice System: Treatment Improvement Protocol (TIP) Series 44 -- SAMHSA/CSAT Treatment Improvement Protocols -- NCBI Bookshelf*.

sessions. We combined the survey responses to the various communication questions with high correlations and calculated a combined score on a four-point Likert scale.[160] This combined score was converted to a percentage of the maximum possible score for all the combined questions, with 0% representing survey respondents answering *not true* to each question and 100% representing a *very true* response to every communication question. **Chart 8-5** illustrates the results for each prison program and includes the results for all survey respondents in the last column, labeled "Total."

Chart 8-5 Survey Respondents' Assessment of Communication Within Their Program as Measured by a Composite Communication Score



Overall, the composite score of 56% for all survey respondents reveals that they had a somewhat positive assessment of the communication environment within the programs. Within some programs, such as those at Five Points, Green Haven, Shawangunk, Sing Sing and Taconic, participants expressed positive impressions of the group process of frank discussions and group acceptance of alternative view. But many survey respondents were not comfortable raising controversial issues or topics that the majority of the group would not adopt, as exhibited by the survey results at Albion, Bare Hill, Cayuga, Mid-State and Willard Female. A significant portion of respondents at these facilities expressed the view that disagreements were not resolved fairly, that a variety of opinions was not sought or considered and that participants were afraid of

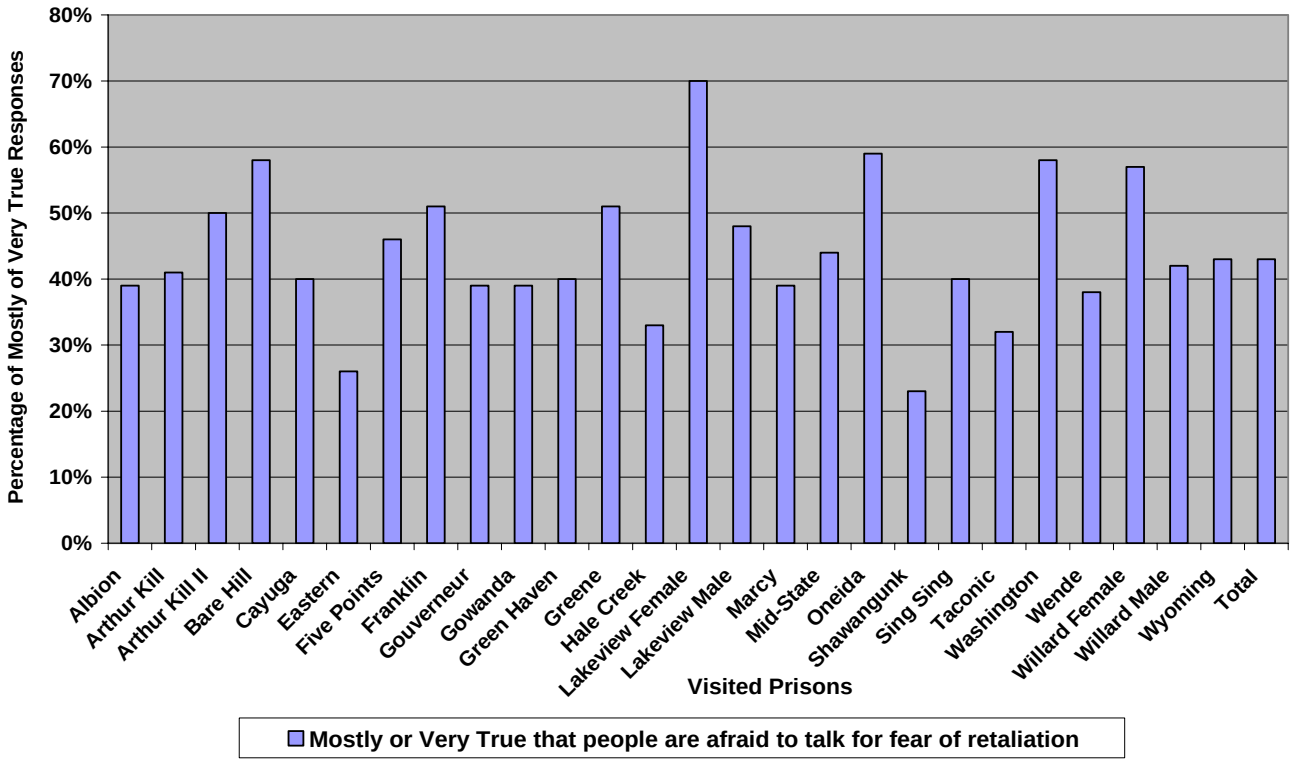
[160] The nine statements concerning communication within the program, presented in item 20 of the MQA, included: (a) We have open and frank discussions about our differences; (b) Disagreements are generally resolved fairly; (c) Participants are divided into small groups or cliques that do not communicate well; (d) We actively seek out a variety of opinions; (e) Most viewpoints are given serious consideration; (f) People are afraid to talk for fear of being made fun of; (g) We are not afraid to disagree with other participants; (h) We learn a lot from considering each other's opinions; and (i) Individuals who disagree with the majority are likely to have a hard time. In order to combine these items for a composite score, we had to reverse the responses to statements 20(c), (f) and (i).

ridicule if they offered alternative views from the group. At these facilities it did not appear that a safe environment had been created for frank discussions.

> *"Would you sit in a group of 45 criminal in a prison and talk about your personal life, feelings, beliefs, failures, pains, etc.? Maybe YOU would. I have to live here, and there's another 1,600-1,700 criminals around me every time I go out the door. Word gets around quick. That guy this, that guy that."*
>
> *Anonymous Inmate (Mid-State, D.F.)*

The variations among programs become even more apparent when looking at specific questions. As demonstrated in **Chart 8-6**, survey respondents at several prisons said it was *mostly* or *very true* that people were afraid to talk for fear of being made fun of by other participants (MQA Q20(f)) at rates that were higher than the overall average percentage of only 43%; these included: Lakeview Female (70% of survey participants), Oneida (59%), Bare Hill (58%) and Washington (58%). In contrast, at other prisons the percentage of responses of *mostly* or *very true* was much lower, including: Shawangunk (23%), Eastern (26%), Taconic (32%) and Hale Creek (33%). These data are particularly important because for a treatment program to be effective, participants must feel they have a safe environment for communication and sharing.

Chart 8-6 Participants Afraid to Speak Up for Fear of Ridicule/Retaliation (Q20(f))



8.14 PARTICIPANTS' SATISFACTION WITH AND ASSESSMENT OF TREATMENT PROGRAM COMPONENTS

Many studies have demonstrated that program participants' satisfaction with their treatment is strongly correlated with program retention, and, more importantly, with reduction in relapse following completion of treatment.[161]

In order to assess the satisfaction of participants in New York's prison-based treatment programs, the MQA survey included satisfaction questions addressed to various aspects of the content and therapeutic climate of their treatment on a four-point Likert scale from *very dissatisfied* to *very satisfied*. **Table 7-3** summarizes the percentage of survey respondents at each facility who reported that they were *somewhat satisfied* or *very satisfied* with various aspects of their treatment program. The last column of the table, labeled "Total," contains the assessments of all the survey respondents for each satisfaction question.

Examining these data reveals several key points. Overall a majority of program participants (generally 57% to 77%) reported that they were *somewhat* or *very satisfied* with most of the program elements. Although the responses by all survey participants for two components fell below the 50% threshold, signifying that a majority of the respondents were dissatisfied with that element, the remainder of the satisfaction questions showed at least a majority of somewhat favorable responses. There were, however, significant differences between the responses by all survey participants to individual satisfaction questions, ranging from a low of 44% for those satisfied with discharge planning to a high of 91% for satisfaction with the participant's own commitment. We also observed significant variability among the prisons in participant satisfaction for nearly every element. Finally, we found that the satisfaction ratings for all components were highly correlated, signifying that programs with problems in one area tended to manifest difficulties in many other areas as well.

To better understand these data, we divided the satisfaction questions into four categories: (1) staff-related questions about treatment planning, discharge planning and counseling process;[162] (2) treatment approach assessments about therapeutic community, cognitive-behavioral and 12-step modalities;[163] (3) ancillary program topics such as training on social skills and other services;[164] and (4) participants' assessment of their own involvement and commitment.[165] In order to measure these items, we added the score on the four-point scale reported for each question in a category and then converted this combined score to a percentage of the maximum possible score for all questions, with 0% representing that the survey respondent was *very dissatisfied* with every item asked in the survey and 100% signifying that the survey respondent answered *very satisfied* for every element. **Table 8-4** and **Chart 8-7** detail the results for each program with "Total" indicating the results for all survey respondents.

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[161] Zhiwei Zhang, Gerstein, and Friedmann, "Patient Satisfaction and Sustained Outcomes of Drug Abuse Treatment"; Hser et al., "Relationship between drug treatment services, retention, and outcomes," 767-774.

[162] MQA satisfaction questions Q6 about treatment planning and discharge planning and Q18 about counseling process. See also **Section 7.6, Program Participant Assessment of Staff**.

[163] Satisfaction questions about therapeutic community (Menu A, MQA Q13), cognitive behavioral therapy (Menu B, MQA Q14) and 12-step approach (Menu C, MQA Q15). See **Section 8.7, Treatment Approaches/Fidelity**.

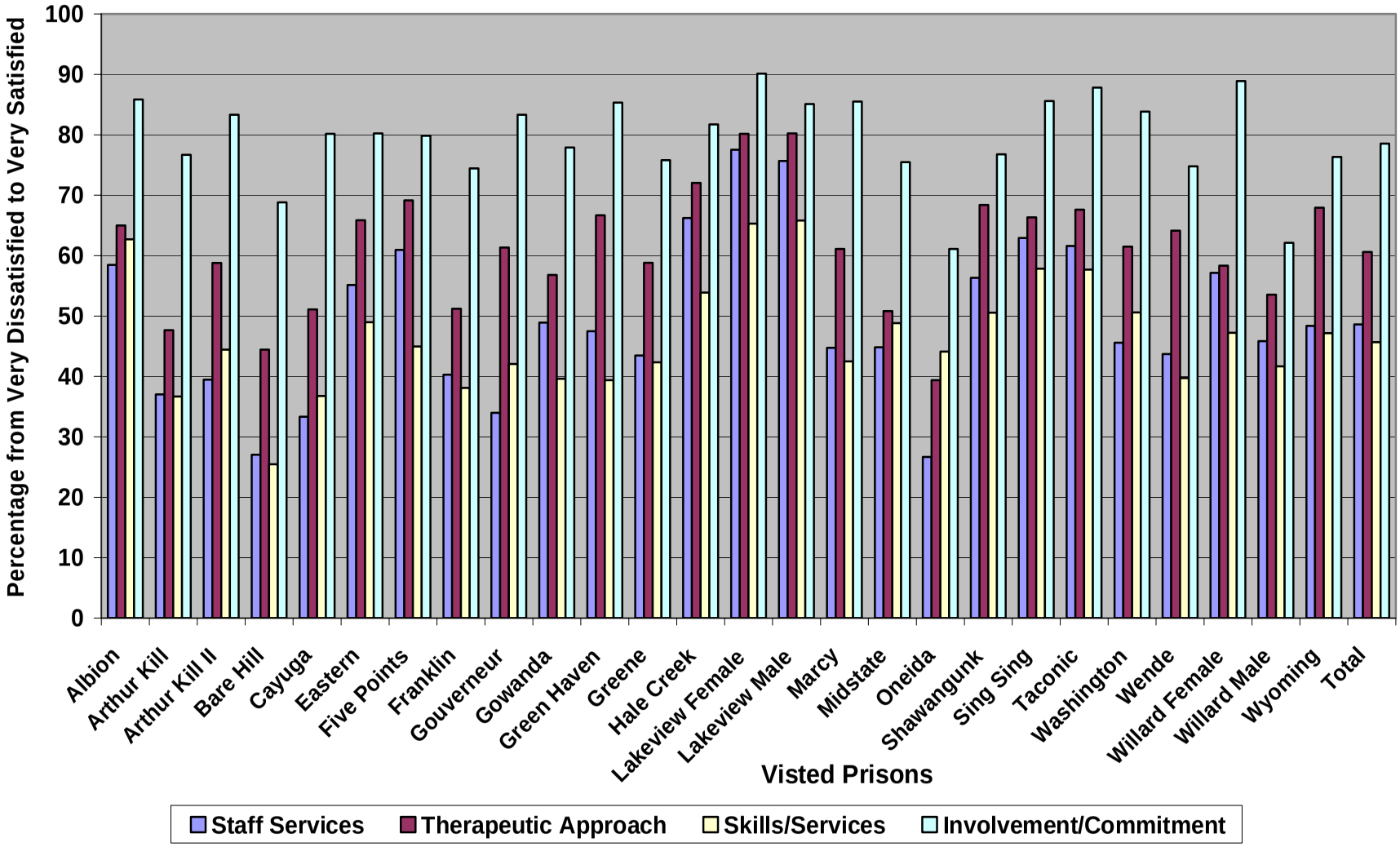
[164] MQA satisfaction question Q11 on social skills training and Q12 on services.

[165] MQA question Q17 on their own involvement in treatment and Q19 on their commitment to treatment.

Table 8-4 Survey Respondents' Combined Satisfaction Percentage Score with Staff Services, Treatment Approach, Skills/Services and Involvement/Commitment

Prison	Satisfaction with Staff	Treatment Approach Satisfaction	Skills Service Satisfaction	Involvement Commitment Satisfaction
Albion	58.5	65.0	62.7	85.8
Arthur Kill I	37.0	47.7	36.7	76.7
Arthur Kill II	39.5	58.8	44.4	83.3
Bare Hill	27.1	44.4	25.5	68.8
Cayuga	33.3	51.1	36.8	80.2
Eastern	55.1	65.9	49.0	80.2
Five Points	60.9	69.1	45.0	79.8
Franklin	40.3	51.2	38.1	74.4
Gouverneur	34.0	61.3	42.1	83.3
Gowanda	48.9	56.8	39.6	77.9
Green Haven	47.5	66.7	39.4	85.3
Greene	43.5	58.8	42.3	75.8
Hale Creek	66.2	72.0	53.9	81.7
Lakeview Male	75.7	80.2	65.8	85.1
Lakeview Female	77.5	80.2	65.3	90.1
Marcy	44.7	61.1	42.5	85.5
Mid-State	44.8	50.8	48.8	75.5
Oneida	26.7	39.4	44.1	61.1
Shawangunk	56.3	68.4	50.6	76.8
Sing Sing	62.9	66.3	57.8	85.6
Taconic	61.6	67.6	57.7	87.8
Washington	45.6	61.5	50.6	83.8
Wende	43.7	64.1	39.7	74.8
Willard DTC Male	45.8	53.5	41.7	62.1
Willard DTC Female	57.1	58.3	47.2	88.9
Wyoming	48.4	67.9	47.2	76.3
Total	**48.6**	**60.6**	**45.7**	**78.5**

Chart 8-7 Survey Respondents' Combined Satisfaction Scores for Staff Services, Treatment Approach, Skills/Services and Involvement/Commitment



The data in **Table 8-4** reveal several interesting points. The combined staffing satisfaction score was below 50%, signifying that a significant portion of the survey respondents were sufficiently dissatisfied with the staff services to lower the total for the three staffing questions to just below a minimally positive satisfaction score. As more fully discussed in **Section 7.6** on participants' assessment of treatment staff, many survey respondents expressed serious misgivings about the support they have received from the treatment team, whereas others, although a minority of respondents, were very positive about the services they had received. In addition, great variability is shown from prison to prison, with low scores for Bare Hill, Cayuga, Gouverneur and Oneida. High staffing satisfaction scores were obtained for programs at Five Points, Hale Creek, Lakeview Male and Female, Sing Sing and Taconic; these figures were approximately double those obtained for the lower performing group.

The lowest scores were recorded for the ancillary services associated with training on such topics as communication skills, anger management and stress management, as well as the presentation of information about jobs, health issues, housing and government benefits. Overall, the programs had a combined satisfaction score of 46%, representing an assessment that places the mean score on the dissatisfied side of the scale. As with other questions in the survey, there were significant differences among the programs, with the low-scoring programs (Arthur Kill, Bare Hill, Cayuga, Franklin, Gowanda and Green Haven, with scores of 26% to less than 40%) well below the programs with greater survey respondent satisfaction (Albion, Hale Creek, Lakeview Male and Female, Sing Sing and Taconic with scores from 54% to 63%).

Satisfaction with the treatment approaches—therapeutic community, cognitive-behavioral and 12-steps—is discussed in **Section 8.7**. Overall, the survey respondents were positive about all three treatment approaches (60% combined satisfaction score), with the highest satisfaction and component ratings recorded for the cognitive-behavioral approach, followed by therapeutic community and then the 12-step approach. It is important to note, however, that the overall satisfaction with the therapeutic approaches matched the trend with staff satisfaction and overall treatment satisfaction. High satisfaction with treatment approaches was recorded for Five Points, Hale Creek, Lakeview Male and Female, Shawangunk, Sing Sing, Taconic and Wyoming. The lowest scores were computed for programs at Arthur Kill, Bare Hill, Cayuga, Franklin, Mid-State and Oneida. The differences between these groups, however, were not as significant as those recorded for the satisfaction scores for staffing and skills/services.

The survey respondents were most satisfied with their own involvement and commitment. This reflects the trend in other jurisdictions around the country where the MQA has been administered and is not surprising because survey respondents are being asked to evaluate their own behavior.[166]Although uniformly high, the involvement/commitment satisfaction score trended downward in programs with lower satisfaction scores for staffing and therapeutic approaches.

The four satisfaction scores also reveal clusters of programs that appear to be consistently either in the high or low end of the satisfaction ratings. The programs with consistently greater satisfaction scores include Albion, Hale Creek, Sing Sing, Taconic and Lakeview Male and Female. The programs that had the lowest satisfaction scores were Bare Hill, Oneida, Arthur

[166] Melnick, Hawke, and Wexler, "Client Perceptions Of Prison-Based Therapeutic Community Drug Treatment Programs."

Kill, Franklin and Cayuga. Assessment of many of the other MQA indicators also placed these same programs in the high and low range of the survey respondents' assessments of content and treatment processes.

The Department should routinely survey program participants about their satisfaction with program content, staff-participant relationships, and the program's therapeutic milieu. All these elements affect treatment outcomes.

8.15 MIX OF PROBLEM AND NEED SEVERITY AMONG TREATMENT PARTICIPANTS

During our visits, the CA observed wide variations in the problem severity and motivation of participants within a single treatment group. We observed inmates with recent histories of heavy use of substances such as heroin or crack; inmates who reported smoking marijuana occasionally as their only drug use; inmates with a history of substance abuse followed by many years of abstinence; and inmates who admitted selling drugs but denied using them. All were required to undergo treatment and all were placed in the same group. Common concerns from inmates about the participants' disparities in drug history in the program included that they were often unable to identify with fellow participants, felt pressured by peers and treatment staff to exaggerate their drug use, and found that some topics in group sessions either not specific or comprehensive enough to address their needs or were irrelevant to them.

A growing body of research reinforces the need for addressing the issue of matching individuals to the appropriate level of treatment. First, no single treatment is effective for everyone. Placing individuals in the treatment that most closely matches their needs and strengths increases the chance that they will successfully complete treatment.[167]

Second, it is very difficult to individualize treatment for DOCS treatment participants because they spend so much time in large groups and receive little individual counseling. Some are therefore being "under-treated" and others "over-treated," and may not be ideally matched to services that reflect their needs. For example, staff and inmates reported to us that individuals were unable to complete or participate in training or GED programs because they needed to participate in ASAT, and vice versa. Some treatment participants may do better receiving lower-intensity substance abuse services, such as drug education and prevention, and increasing other services, such as educational and vocational. [168]

A substantial body of research has established that treatment participants benefit from treatment that is matched to the severity of their substance abuse. Furthermore, recent studies are finding that motivation for treatment directly correlates with severity of need.[169] In other words, inmates who had severe, long-term substance abuse were more motivated to participate in treatment than those with less severity. Individuals who are placed in intensive treatment but do not need or

[167] Peters, Wexler, and Center for Substance Abuse Treatment (U.S.), *Substance Abuse Treatment for Adults in the Criminal Justice System: Treatment Improvement Protocol (TIP) Series 44 -- SAMHSA/CSAT Treatment Improvement Protocols -- NCBI Bookshelf.*
[168] Ibid.
[169] Welsh and McGrain, "Predictors of therapeutic engagement in prison-based drug treatment," 271-280.

desire it may disrupt the program and even drop out or be removed, wasting valuable resources at a time when they are much in demand. Furthermore, placing casual drug users in high-intensity programs can be harmful, as it may expose them to criminal thinking and habits that they do not yet have the skills to reject.[170]

Most DOCS treatment programs are of a single level of intensity, that of the therapeutic community. The CA looks forward to OASAS working with DOCS to fine-tune its treatment matching strategies, perhaps utilizing the OASAS LOCADTR system discussed in **Section 5, Screening and Assessment**. As New York State struggles with massive budget challenges, this may be a source of savings in resources even as it improves outcomes.

[170] Peters, Wexler, and Center for Substance Abuse Treatment (U.S.), *Substance Abuse Treatment for Adults in the Criminal Justice System: Treatment Improvement Protocol (TIP) Series 44 -- SAMHSA/CSAT Treatment Improvement Protocols -- NCBI Bookshelf*.

9. INDIVIDUAL COUNSELING

FINDINGS

DOCS does not require a set amount of individual counseling for participants in its treatment programs.

Individual counseling in the DOCS treatment programs observed by the CA was limited, with wide variations among programs.

DISCUSSION

9.1 INDIVIDUAL COUNSELING IN PRISON-BASED TREATMENT

Individualizing treatment is widely considered critical to effective treatment, and individual counseling provides a foundation for that process. Furthermore, a substantial body of evidence demonstrates that group counseling in conjunction with individual counseling is far more effective than group counseling alone.[171]

The dominant prison-based treatment modality is the therapeutic community, with its strong emphasis on "community-as-method." Nonetheless, private meetings with a counselor carry special importance in prison. Prison culture may impose ridicule or retaliation on inmates who explore sensitive issues, express unpopular opinions or recount experiences that identify other inmates as engaging in criminal activity.

In addition to providing privacy, individual counseling provides the ideal setting to assess and enhance inmate motivation and engagement in treatment, in prison and beyond. It can be tempting for staff to rely on institutional controls to maintain inmate participation in treatment, especially in facilities that are understaffed. But the apparent compliance that results from prison discipline can mask low engagement and motivation. However, inmates' motivation and engagement in prison-based treatment are strong predictors that they will continue in treatment and recovery after release from prison. The best way to assess and, if necessary, enhance that enthusiasm for recovery is through an individual session.[172] Research demonstrates that providing more individual sessions early in treatment can help address low motivation and engagement, thereby increasing the chances that the inmate will continue treatment and recovery over the long term.[173]

9.2 INDIVIDUAL COUNSELING IN DOCS SUBSTANCE ABUSE TREATMENT PROGRAMS

The manual for the Alcohol and Substance Abuse Treatment programs (referred to as the ASAT Manual in this report) lists an array of direct treatment services to be provided by DOCS

[171] Crits-Christoph et al., "Psychosocial Treatments for Cocaine Dependence," 493-502.
[172] Farabee et al., "Barriers to implementing effective correctional drug treatment programs."
[173] Miller, "Increasing Motivation for Change," 67-80.

treatment programs. These include audio/video presentations, lectures and seminars, group discussion of educational material, group counseling/therapy, individual counseling, self-help group participation, and group feedback and evaluation.

As detailed throughout this report, the structure and format of treatment sessions that we observed varied considerably from program to program. Throughout our study, however, we observed a limited amount of individual counseling provided to treatment participants.

In addition to the benefits of individual counseling that have been identified by research and clinical practice, DOCS treatment programs stand to reap additional benefits. Almost all of the programs we visited had large groups and a high ratio of participants to staff. Some treatment staff with whom we spoke described their programs as "factories" that did not provide the opportunity for a significant amount of individual counseling.

The ASAT Manual mentions individual counseling only under the heading "individual counseling/treatment planning." The Manual requires only monthly individual counseling "as needed" to review treatment goals.[174] The Manual fails to specify the duration of these sessions and whether individual counseling sessions should be documented. This standard, which in effect requires no individual counseling, does not meet the American Correctional Association's (ACA) performance-based standards for therapeutic communities, which specify that counselors must meet individually with program participants at least twice each month in order to review their progress.[175]

As discussed in **Section 6, Overview of DOCS Treatment Programs**, the ASAT program conceives of the recovery process as occurring in stages: information, knowledge, discovery and assessment, conceptualization, understanding, internalization, and actualization. Not all treatment participants progress through these stages at the same pace and in the same manner. In addition, DOCS substance abuse treatment programs are not closed programs, with group participants beginning and ending with one another. Rather, the programs have rolling admission, allowing new individuals to join the group at any point, adding to the variations observed among treatment participants. It is difficult to imagine how, without more comprehensive and routine individual counseling, treatment staff would be able to address these tremendous variations and assist inmates in progressing through these stages.

9.3 IMPORTANCE OF INDIVIDUAL COUNSELING

Frequent and consistent individual counseling is widely considered critical to treatment success.[176] It is especially important with inmate populations, which typically have a wide variety of substance abuse and treatment needs. One-on-one counseling can help address these needs in a more targeted fashion, with the individualized support and insight that are difficult in large, heterogeneous group sessions. Furthermore, inmates often struggle with sensitive issues

[174] State of New York Department of Correctional Services, *Alcohol and Substance Abuse Treatment (ASAT) Program Operations Manual*, sec. VIII, A (1) (e). 33.
[175] American Correctional Association. *Performance Based Standards for Therapeutic Communities*. 2005.
[176] Robert Florentine and M. Douglas Anglin, "Does Increasing the Opportunity for Counseling Increase the Effectiveness of Outpatient Drug Treatment?"

such as trauma, abuse, and neglect, yet prison culture can discourage their open expression. Individual counseling can provide a safe place to work on these issues. Also, individual counseling can enhance and cement internal motivation early in the treatment process, which is critical in the prison setting since inmates may not openly express their resistance and low motivation.[177]

Though participating in a treatment program, the participants still remain incarcerated in a State correctional facility. This brings valid concerns for many individuals of protecting their safety, reducing the risk for being victimized and/or exploited, avoiding retaliation and protecting their reputation. Many inmates we spoke with expressed reluctance to reveal personal information in group sessions, as it may create a possibly dangerous situation for them in the prison environment. Treatment participants may also be concerned that their peers might pass along information to the general population that could make them vulnerable. Most DOCS treatment programs are residential, and there is a perceived danger in sharing personal information with individuals with whom one lives, especially as treatment staff leaves the facility in the afternoon.

To be sure, substance abuse treatment programs aim to create an environment of safety and mutual support where confidentiality is highly regarded. Nonetheless, the fact remains that these programs—and their participants— are housed in prison, with its powerful culture and persistent threats of retaliation and ridicule. Individual counseling helps to address these issues in that setting.

9.4 THE CA'S OBSERVATIONS AND TREATMENT PARTICIPANTS' ASSESSMENT OF INDIVIDUAL COUNSELING

During our site visits, the CA interviewed substance abuse treatment staff about their programs' individual counseling. The most common response was that a member of the treatment team, typically the program assistant, met individually with an inmate on a monthly basis. Consistent with the ASAT Manual's minimum requirement, the primary purpose of this session was for the inmate to sign off on a monthly evaluation form. Both staff and inmates reported that these meetings lasted from between five and fifteen minutes. In light of the very large group sizes we observed, these individual sessions are likely to be a primary opportunity for staff to become familiar with an inmate's needs and strengths and discuss any challenges. It seems unlikely that a single session is adequate for staff to acquire the full picture needed to plan treatment effectively and discern when an inmate completes each stage of recovery in each competency. We are also concerned that program assistants provided most of the individual counseling, rather than correction counselors who are required to have more clinical training and experience.

In addition to the monthly sessions, treatment staff reported that they were available to meet individually with inmates on request. According to staff, they met with some inmates daily or weekly, but met with others only for monthly evaluations. Staff initiated individual sessions primarily when inmates were noticeably slipping in program performance.

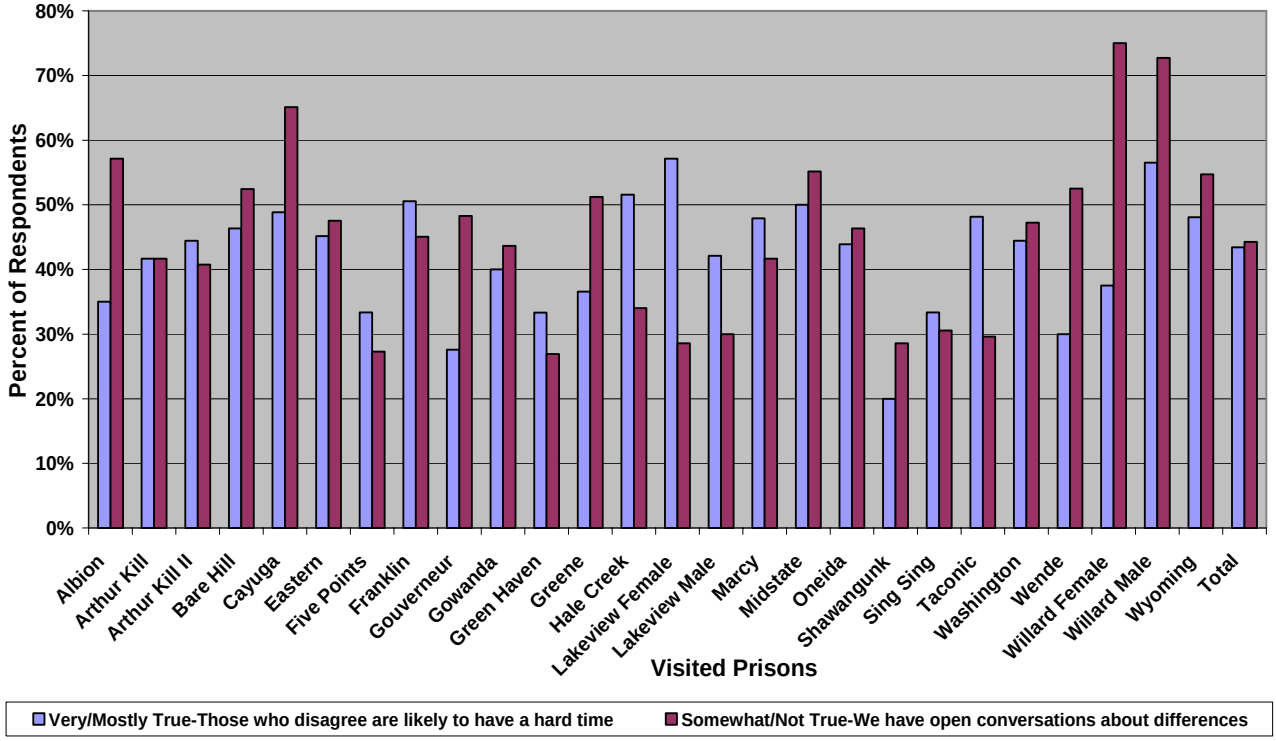
The CA commends the staff for their willingness to accommodate requests for individual counseling. However, we remain concerned that treatment participants who do not have the

[177] Welsh and McGrain, "Predictors of therapeutic engagement in prison-based drug treatment," 271-280.

insight or the self-confidence to make these requests did not have the same opportunity. It is likely that program participants who could benefit the most from individual counseling may be most hesitant to seek out the sessions.

The need for individual counseling is reinforced by our survey data, which demonstrates that many program participants believe group discussions are not entirely safe for personal dialogue and opinions that may be contrary to those shared by the majority of the group. Forty-four percent of treatment participants who responded to our survey reported that it was *mostly* or *very true* that people in their program who disagree with the majority were likely to have a hard time. As illustrated in the **Chart 9-1**, participants in some prisons had much higher levels of concern that contrary views could result in condemnation; specifically, programs with the highest percentage of respondents who said this was *mostly* or *very true* were Lakeview Female (57%), Willard Male (57%), Hale Creek (52%), and Franklin (51%). Prisons such as Shawangunk (20%), Gouverneur (28%), Green Haven (33%) and Five Points (33%) reported lower percentages for this question. Forty-four percent of those surveyed indicated that it was *not true* or only *somewhat true* that their groups had frank and open conversations about their differences. When program participants do not feel safe about open group discussions, they will need an opportunity to raise concerns in private meetings with staff. Again, our data revealed that the concern about the consequences of frank discussions was significantly higher within certain programs. Prisons with high percentages of *not true* or *somewhat true* for this question were Willard Female (75%), Willard Male (73%), Cayuga (65%), and Albion (57%).

Chart 9-1 Survey Respondents' Assessments about Communication in Their Program Concerning Disagreements and Differences



Understaffing also contributed to the lack of individual counseling sessions. Many staff reported that they did not have adequate one-on-one time with inmates because they were overwhelmed with paperwork and other responsibilities. For this reason, many treatment staff were wary of the new role that OASAS will play in overseeing DOCS treatment programs. They were concerned that OASAS may increase their paperwork while raising requirements for one-on-one counseling, which staff felt may be "too much for us to handle."

Perhaps most importantly, individual counseling is an excellent opportunity for treatment staff to establish a trusting relationship with participants and increase participants' feelings of ownership in the program. As illustrated in **Chart 9-2**, 33% of survey respondents reported it was *not true* that the people in the program were interested in helping them. When asked if they felt an attachment and ownership of the program, 39% of all treatment participants similarly responded this was *not true*. For these individuals, it will be important for the treatment staff to establish a more effective therapeutic relationship and individual counseling is the best opportunity to reestablish trust and engagement between treatment staff and participant. As with the other elements we investigated, substantial differences exist in the level of staff mistrust and lack of engagement.[178]

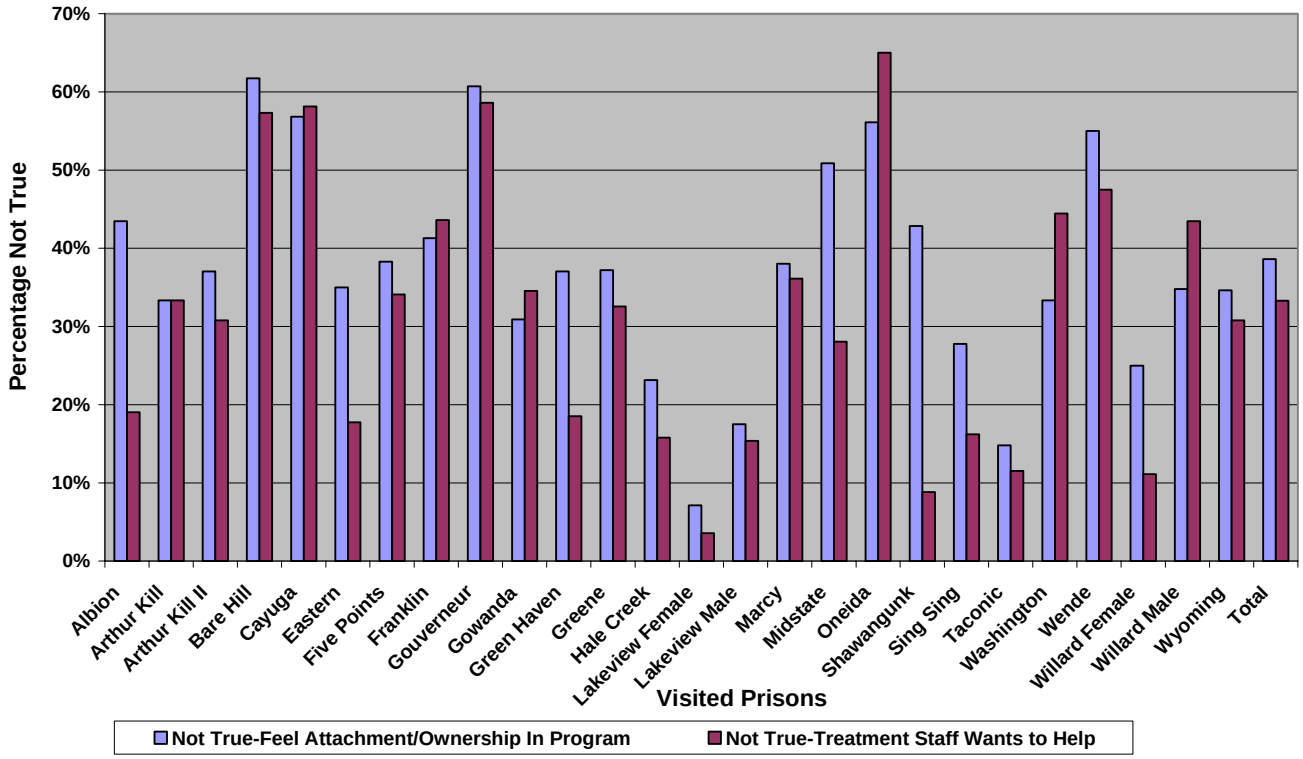
OASAS guidelines require that residential treatment programs provide individual counseling as needed, but do not specify a minimum duration or frequency for these sessions. Some residential TC treatment programs in the community with whom we spoke reported that they provide 45 minutes of weekly individual counseling for treatment participants. This was slightly more than the American Correctional Association (ACA) recommendation of 45 minutes every two weeks, and community treatment staff found such frequent individual counseling to be highly beneficial. Many staff members of the community-based treatment programs we spoke with stated that OASAS required 30 minutes of individual counseling every week, though we did not find this in the regulation provided to us by OASAS. At the OASAS-licensed Willard Drug Treatment Campus, the standards developed in 2009 require a monthly minimum of 30 minutes of individual counseling.

9.5 RECOMMENDATIONS FOR INDIVIDUAL COUNSELING

Individual counseling in DOCS substance abuse treatment programs should follow community standards set by OASAS and the prison standards set by ACA. It is clear that the current practice of meeting with individuals monthly in order to complete a monthly evaluation is not sufficient opportunity for individual counseling for this complex population. An increased minimum amount and frequency of individual counseling should be formalized and built into all treatment staff's schedules.

[178] Concerning the suspicion that staff do not believe in the participant, the programs with the highest *not true* results were at Oneida, Gouverneur, Cayuga, Bare Hill, and Wende; those programs with the best results were at Albion, Shawangunk, Taconic, Lakeview Female and Willard DTC Female.

Chart 9-2 Survey Respondents' Perceptions of Attachment to Program and Whether Staff Wants to Help Him



It is clear that not every individual requires the same amount of individual counseling and that some flexibility must be built into any policy, though a more frequent opportunity for individual counseling should be available for every treatment participant. Treatment participants should receive the type and frequency of counseling that reflects the severity of their substance abuse and their motivation, along with a host of other factors that directly affect their participation in treatment both in prison and after release. In addition, as specified in the ASAT Manual, individual counseling should be used to create and maintain a meaningful treatment plan and discharge plan.

Clearly, individual counseling can significantly improve treatment outcomes and should be an integral component of every treatment program. We encourage DOCS and OASAS to develop formalized policies regarding the amount and structure of individual counseling in DOCS treatment programs. We believe that the highly varied and complex population of these programs could greatly benefit from individualized attention, and it is our view that a brief monthly session does not achieve this purpose. Treatment inside New York State correctional facilities should mirror the standards for the community treatment programs, if not surpass them.

10. TREATMENT PARTICIPANTS WITH LIMITED ENGLISH SKILLS

FINDINGS

At most prisons, treatment services for participants with limited English skills are inadequate. These inmates are unable to effectively participate in treatment.

Bilingual treatment participants are often required to translate for their monolingual peers, depriving them of the benefit of the treatment as well.

Very limited materials are available in Spanish.

DISCUSSION

10.1 LIMITED ENGLISH SPEAKERS IN DOCS SUBSTANCE ABUSE TREATMENT PROGRAMS

Language barriers in health care have been found to have a negative impact on utilization, satisfaction, and possibly adherence to treatment. This has led to an emphasis on what the literature terms "language concordance," hiring personnel who are bilingual. Bilingual ability allows clinicians and patients to communicate more clearly about health problems, health beliefs, and treatment options.[179]

Approximately 6% of the State's inmates have limited English skills.[180] Few DOCS substance abuse treatment staff are fluent in both Spanish and English. Minimal to no treatment programming is conducted in Spanish. Thus, DOCS staff turn to bilingual treatment participants to translate for their peers. Inmate translators receive no training in this difficult, tiring function, nor are they otherwise compensated for their work. Furthermore, these individuals have themselves been designated as in need of substance abuse treatment. If any significant portion of their treatment time is spent acting as a translator, their own treatment is compromised. As we observed, these ad hoc translation efforts are also distracting to other inmates in sessions, in addition to reinforcing the impression and the effect of the sessions as educational rather than psychodynamic. Furthermore, the inmate with limited literacy in English cannot take advantage of the therapeutic milieu that is a core element of the therapeutic community (TC), remaining isolated. DOCS's inability to communicate with treatment participants thus has a ripple effect that can disrupt the entire treatment program.

It was previously thought that behavior change was a function of program participation, but a growing body of research is beginning to show that it is the quality of the therapeutic

[179] Campbell and Alexander, "Culturally competent treatment practices and ancillary service use in outpatient substance abuse treatment," 109-119.
[180] NYS Department of Correctional Services, *Under Custody Report: Profile of Inmate Population Under Custody on January 1, 2009*.

relationship, along with participation in treatment activities, that facilitates an individual's developing new social and coping skills and making cognitive and behavioral changes. In fact, all treatment services hinge on effective engagement; the treatment relationship is the foundation of effective care and all clinical and nonclinical treatment support services.[181] Inmates with limited English cannot engage with staff or other treatment participants.

DOCS officially identifies 0.4% of the inmate population as speakers of another primary language, other than English or Spanish. Throughout the study, we occasionally came across individuals participating in substance abuse treatment programs who spoke neither Spanish nor English and who appeared significantly disengaged from the program. Though we have little information or data identifying how serious a problem this presents, we are concerned that there are even fewer mechanisms in place to support these individuals who would not have easy access to inmate translators. We urge the Department to consider this population when developing new policies and procedures to accommodate limited English speakers.

10.2 LIMITED ENGLISH SPEAKERS' ASSESSMENT OF TREATMENT PROGRAMS

It was clear through our observations and discussions with both treatment staff and inmates that limited English speakers were often unable to participate meaningfully in the programs. Equally evident was their inability to participate in many of the written activities or readings because at many prisons there were very few materials available in Spanish. Finally, most substance abuse staff cannot read Spanish, so it is unclear to what extent they are able to review materials prepared by Spanish language-dominant program participants.

Though our survey for treatment participants was available in Spanish, our response rate for limited English speakers was only 10%, significantly less than our overall response rate of between 20 and 45%. It is difficult to draw conclusions from this limited sample, but some of the information gathered was informative. Not surprisingly, limited English survey respondents were more dissatisfied with their involvement in the treatment process: 29% of these respondents said they were very dissatisfied with the program, compared with the systemwide average of 8% for all respondents. In addition, compared with 72% systemwide, a lower percentage of limited English speakers, 60%, felt that it was mostly or very true that they understood and accepted the program rules, structure and philosophy. However, they also expressed a slightly greater satisfaction with other aspects of the program. The limited English speakers surveyed felt that staff often asked them (50%) for their opinions and suggestions about treatment issues, which is considerably higher than the 29% average we saw system-wide. They also seemed to view the treatment staff more positively, with 31% saying they believe it is very true that people in the program are trying to do what is best for them, compared with 14% system-wide.

As described in previous sections, we also analyzed the responses to all the staff-related questions to develop an overall assessment of individuals' views of staff. The responses from limited English speakers regarding a composite assessment of staff (44%) was slightly higher than the system-wide percentage of 39%, supporting the above results from individual questions indicating that limited English speakers demonstrated higher satisfaction with staff than English

[181] White, Schwartz, and Philadelphia Department of Behavioral Health and Mental Retardation Services, *The Role of Clinical Supervision in Recovery-oriented Systems of Behavioral Healthcare*.

speakers. There was significant variation from facility to facility, such as Gouverneur's composite staffing results for limited English speakers of 9%, compared with Hale Creek's 95%. Due to the limited number of responses we received from limited English speakers at each prison, it would be imprudent to attempt to make more specific finding about the experiences of limited English speakers at each of the visited prisons.

Though it is difficult to draw conclusions from such a limited sample of surveys, some additional observations are warranted based upon our conversations with treatment staff and limited English speakers during our site visits. Limited English speakers frequently missed out on many aspects of the treatment experience during the program, but it was equally clear that treatment staff make an effort to work with limited English speakers through inmate translators when possible. We commend staff for their efforts, but remain concerned that limited English speakers are not able to make best use of the treatment program and adequately address their substance abuse needs.

For more than 10 years, the health care field—including substance abuse treatment providers—has been striving to enhance its cultural competence (the capacity to work effectively with a variety of ethnic and racial groups). The CA strongly urges DOCS to make this issue a priority in its work with OASAS in the months and years to come. We believe that increasing the number of Spanish-speaking treatment staff, and expanding the Spanish language materials and other resources, could greatly improve treatment services for this population. In addition, we would urge DOCS to explore piloting a small treatment program solely for participants with limited English skills. We also encourage DOCS to consider the use of inmate translators trained as Inmate Program Assistants (IPAs), who are not current, but past, program participants and who have received some translator specific training. Finally, we recommend that DOCS keep a centralized list of all bilingual treatment staff working in DOCS facilities and make all possible attempts to prioritize placement of limited English speakers requiring substance abuse treatment programs at those facilities.

11. TREATMENT PROGRAM COMPLETIONS AND REMOVALS

FINDINGS

DOCS facilities vary significantly in the policies and procedures for removing participants from substance abuse treatment programs on the grounds of discipline or poor performance.

DOCS facilities vary widely in the number and proportion of participants who do not successfully complete substance abuse treatment on the grounds of discipline or poor performance.

DISCUSSION

11.1 INTRODUCTION

Successful completion is one of the soundest predictors of positive outcomes of treatment.[182] Better outcomes are also associated with treatment that lasts at least 90 days, even if treatment is not completed.[183] In community-based programs, removal or ejection from a program is the ultimate sanction, usually reserved for acts of aggression such as violence and other major disruption of the therapeutic environment. In the therapeutic community (TC) model, the community itself is the therapeutic method, so the community responds to noncompliance, such as disrupting a group, with confrontation and encouragement of appropriate behavior. The community can implement meaningful, powerful sanctions both formally (such as demotion in the hierarchy) and informally (such as exclusion from social interactions).[184]

In the prison setting, however, program noncompliance is often met with a correctional—rather than a therapeutic—response.[185] Removal, suspension or other institutional discipline can be suggested as a therapeutic response. However, our observations indicate that DOCS treatment staff and officers often implement disciplinary sanctions rather than relying on the power of the therapeutic process. There is often a failure to distinguish between sanctions for "poor program performance" (such as slow progress in completing assignments or demonstrating insight) and noncompliance with program rules (such as failure to keep one's living area tidy or repeated absences). The resulting pattern is ultimately counterproductive for the facility, staff and inmates, as individuals with a need for substance use treatment may remain untreated if removed early from the program.

[182] Price, "What we know and what we actually do: Best practices and their prevalence in substance abuse treatment," 125-155.
[183] Fletcher and Chandler, *Principles of Drug Abuse Treatment for Criminal Justice Populations: A Research-Based Guide*.
[184] De Leon, "Therapeutic communities for addictions," 1603-1645.
[185] Farabee et al., "Barriers to implementing effective correctional drug treatment programs," 150-162.

Removal for positive urinalysis is a more complicated problem. Inmates are admitted to treatment because they have a chronic condition with the primary symptom of inability to abstain from or limit the use of substances despite negative consequences. Thus, program participants are often ejected—and further punished—for the symptom that generated their need for treatment. The skills, knowledge, and attitudes needed to abstain from illicit substances comprise the desired *outcome* of treatment. Simultaneously, we understand the need from the perspective of prison security to respond quickly to drug use and trade inside the facility.

As pointed out by the National Institute on Drug Abuse (NIDA), there is no other chronic health problem where symptom manifestation is punished by terminating the treatment, even for conditions with major behavioral components, such as diabetes or hypertension, that have similar relapse rates to substance use disorders.[186] For these medical conditions, setbacks are considered confirmation of the diagnosis or a signal to reassess treatment strategy.

A national conversation is under way in the substance abuse treatment field about treatment strategies for the minority of individuals with substance use disorders who chronically relapse or act out in other ways such as profanity, untidiness, and tardiness. While the latter behaviors can be disruptive, they are often most effectively dealt with clinically, as part of the treatment process, rather than as a disciplinary issue that might lead to removal.[187]

In recent years, a host of practices have emerged through research, consensus, and clinical experience for responding to inmates who make slow progress in treatment and act out along the way. These are discussed in brief in the final part of this section.

11.2 PROGRAM COMPLETION

The DOCS ASAT Manual outlines the criteria for successful completion of treatment ("graduation"): the inmate completes at least six months in treatment and demonstrates a "functional understanding of addiction," skills, attitudes, and knowledge needed for a drug-free-lifestyle; and a satisfactory rating on the ASAT discharge evaluation.[188]

"Unsatisfactory termination" ("removal") can be imposed under one or more of these conditions: the inmate is sentenced to keeplock for 30 days or more; "disruptive behavior that cannot be managed within the program structure;" "failure to meet the criteria for successful participation;" or violation of "essential rules basic to substance abuse treatment programs;" (violence or threat of violence) use or possession of drugs, alcohol, or a weapon; theft; or sexual misconduct. When an inmate "appears to be moving in the direction of" one of these conditions, the ASAT Manual requires that treatment staff conduct a formal counseling session with the inmate.[189]

"Administrative termination" can occur when the participant is removed "through no personal fault but to meet Departmental or facility needs," or when ASAT staff determine that "it is not in

[186] McLellan et al., "Drug Dependence, a Chronic Medical Illness," 1689-1695.
[187] White et al., "It's time to stop kicking people out of addiction treatment."
[188] State of New York Department of Correctional Services, *Alcohol and Substance Abuse Treatment (ASAT) Program Operations Manual*, 35.
[189] Ibid.

the best interest of the participant to continue, e.g., new medical condition, new program assignment, psychological problem, administrative segregation, involuntary protective custody, etc." [190]

11.3 REMOVALS FROM TREATMENT PROGRAMS VISITED BY THE CA

The ASAT programs visited by the CA varied widely in their policies and procedures related to removal, and in their rates of satisfactory completions and removals. Some programs we visited removed nearly as many participants as they graduated, while others had significantly higher graduation rates. These differences cannot be explained solely by differences in the inmate population. Some former treatment participants asserted that they were removed for minor violations of program rules and that greater emphasis was placed upon rigid requirements of order and cleanliness in the residential area than on progress in treatment.

Most of the treatment programs the CA visited divided removals into three types: poor program performance, disciplinary, and administrative.

11.3.1 Removal for Poor Program Performance

Participants removed for poor program performance had usually received repeated warnings or infractions for violating program rules. Violations of program rules can result in a negative monthly evaluation, and repeated negative monthly evaluations can lead to program removal. Examples of these violations include failure to maintain order in one's cubicle area or disruptive behavior during group sessions. This category of program removal is directly related to an individual's performance in the treatment program.

> *The details are also a major problem. For miniscule reasons, such as: bed wrinkled, shoes unaligned, locker unlocked, etc. we as inmates are given details. These details, for some reason, effect our evaluations monthly and our overall release dates (merit, conditional release, etc.). How can we be discharged from the program for minor "details," when we are not using drugs and/or creating major problems?*
>
> Anonymous Inmate (Washington C.F.)

11.3.2 Removal on Disciplinary Grounds

Individuals removed for disciplinary reasons may have engaged in behavior deemed "inappropriate" by treatment or security staff—either in the program area or in another area of the prison—generating a misbehavior report. Some inmates described incidents of violence that prompted their removal from the program. Others expressed the view that they were removed or "set up" by treatment or security staff who had negative feelings toward them. Former treatment participants also expressed frustration that they had been removed from the program because of incidents in the yard or other prison areas, despite making progress in the treatment program.

Another troubling cause for disciplinary removal was positive urinalysis for drug use. Many inmates removed on this ground reported they were immediately removed from the program and

[190] In many community-based treatment programs, "administrative termination" is a sanction or disciplinary measure, also called "discharge for cause;" here it has a neutral connotation.

sent to the "box" or SHU (Special Housing Unit) cells.

To be sure, swift response to drug use can be critical for the facility's safety and security, but we are concerned that these individuals are also those most in need of substance abuse treatment. We are not suggesting that a positive drug test be ignored, but believe a more effective and appropriate response could be implemented. These individuals could be subject to a reduced disciplinary response, following which they could be prioritized for more intensive substance abuse treatment services, including focused relapse prevention groups and increased individual counseling.

11.3.3 Administrative Removals

The CA observed programs with an extraordinary number of administrative removals. These usually occurred when an inmate was transferred to another facility as a result of a transfer request, security declassification, or need for services not offered at the current facility, such as medical or mental health care.

Many inmates reported that they were transferred after completing up to five months of a treatment program but required to start the program from the beginning at the new facility, receiving no credit for any previous treatment completion. DOCS policy should provide that appropriate credit be given for treatment participation short of completion in this situation and that individuals transferred between facilities résumé treatment without a lengthy delay.

Administrative transfers disrupt not only the personal treatment process but also the group process, according to many inmates we spoke with.

Unusual circumstances may justify an immediate transfer for safety or security reasons. If possible, however, inmates who have started treatment should have a hold placed on transfers in order to allow them to complete the program before they are moved for programmatic or classification reasons.

11.4 PROCESS OF REMOVAL FROM TREATMENT PROGRAMS

The process for removing an inmate from a substance abuse treatment program varied greatly among the facilities we visited. Approximately half of the programs utilized a review process with a program retention or review committee (PRC) comprising the treatment staff and often including members of the executive or security staff. The PRC reviews the case of any individual who has received one or two negative evaluations (depending on the facility) or whose behavior is such that it could lead to eventual removal. At most facilities, the PRC meets with the individual in question, though policies differ from facility to facility. An inmate whose case is brought to a PRC may be given a therapeutic sanction (such as a "learning experience") or an educational assignment. Alternatively or in addition, these inmates may be asked to sign a behavior contract outlining the changes they must make in order to remain in the program. Finally, the PRC can determine that the inmate should receive a program extension of one to two months or be removed from the program.

Treatment staff described the PRC's objective as providing a creative, preventive response to behavior that is therapeutic rather than punitive. Ten of the facilities we visited utilized a PRC structure, although the procedures differed significantly among the facilities. For instance, staff at Eastern recently altered the PRC structure in hopes of lowering the removal rate (although it is already relatively low). Under the new policy, the committee sees inmates after one "failed evaluation" rather than two as previously. Some facilities have only recently implemented a PRC to address the issue of high removal rates, although the utilization of a PRC does not correlate with lower removal numbers.

In contrast to this structured system, some programs had no formal process in place and the practices regarding removals were ambiguous and sometimes highly discretionary. In some programs, the program assistant (PA) met with the inmate to discuss problems, followed by the PA's recommendation of removal if the inmate's behavior did not improve. These recommendations were rarely disputed by higher DOCS officials, and the inmate had no formal opportunity to challenge them. Five Points, a facility with a high removal rates, utilizes a removal process similar to the one just described. Shortly before our visit, Cayuga had been informed by the Central Office that it needed to formalize and document its removal process.

The discretionary nature of the removal process raises serious concerns regarding fairness and impartiality, because program removals carry serious consequences. For instance, at Bare Hill, counselors may remove a program participant who has spent ten days in the SHU, although at most facilities (and in the ASAT Manual) only 30-day SHU sentences warrant automatic removal. At Green Haven, on the other hand, testing positive for drugs does not automatically lead to removal; the decision to remove the participant is made at a disciplinary hearing. At Shawangunk, there were no removals for poor performance from 2005 through 2009.

Participants in the treatment programs we visited expressed anxiety about high removal rates. At many programs, participants felt that they could be removed from the program solely because a staff member did not like them or if they did not properly make their beds. These sentiments were often validated through our observations and conversations with treatment staff, especially at facilities with extremely high removal rates.[191] Indeed, staff at Washington mentioned that repeated incidents of messy living areas could trigger a meeting with the program review committee. This consistently high anxiety level is unlikely to create a therapeutic environment.

11.5 RATES AND PATTERNS OF REMOVALS AT DOCS FACILITIES

Survey respondents commonly reported removals. In our survey of more than 1,100 inmates not currently in treatment, 22% said they had been removed from a substance abuse treatment program at their current facility, and 19% reported removal from a treatment program at another DOCS facility. Although many inmates reported having been removed from a DOCS substance abuse treatment program, certain facilities and programs had much higher removal rates than others. Facilities such as Five Points (58%), Washington (58%), Greene (48%) and Mid-State (41%) had significantly high removal rates for their ASAT programs. The removal rates at RSAT programs at Greene (48%) and Marcy (58%) were also alarmingly high.

[191] Removal rate represents how many of originally admitted participants are subject to unsatisfactory termination.

The CA was alarmed by the removal rate at Five Points: in 2007, more participants were removed (261) than graduated (176) from the program. A similar pattern was seen at Greene in 2008, when 160 participants completed the ASAT program and 204 were removed.

In stark contrast, relatively low removal rates were seen in 2008 at Wyoming (13%), Taconic (14%), Wende (15%), Eastern (21%) and Franklin (21%). In 2008, 105 women completed the Taconic ASAT program and only 18 were removed.

Removal rates did not correlate with overall program satisfaction, either positively or negatively. For instance, removal rates at Franklin were relatively low (21%), although its overall program satisfaction was one of the lowest, with only 19% of treatment participants reporting it was *very true* that they were satisfied with their treatment.

Table 11-1 Total Graduation and Removal Numbers for Facilities Visited

Prison	Total Graduations (by year)			*Removals (by year)**		
Albion	**2006**	**2007**	**2008**	**2006**	**2007**	**2008**
	0	0	13	N/A	N/A	0
Arthur Kill	**2005**	**2006**	**2007**	**2005**	**2006**	**2007**
2007	N/A	11	10	N/A	1	1
SNU/ ASAT	30	66	7	5	16	3
CASAT	N/A	2	5	N/A	2	2
MICA						
Arthur Kill	**2007**	**2008**	**2009**	**2007**	**2008**	**2009**
2009	81	86	43	20 (10,5,5)	18 (9,6,3)	7 (5,1,1)
CASAT	0	43	26	0	6 (3,1,2)	5 (2,1,2)
ASAT	4	7	4	14 (5,1,5)	9 (6,1,2)	4 (1,2,2)
MICA	10	14	2	1 (0,0,1)	2 (1,0,1)	1 (0,0,1)
SNU ASAT						
Bare Hill	**2006**	**2007**	**2008**	**2006**	**2007**	**2008**
	360	396	153	119 (72, 11, N/A)	109 (72, 22, N/A)	68 (42, 14, N/A)
Cayuga	**2006**	**2007**	**2008**	**2006**	**2007**	**2008**
	150	149	83	111 (50, 24, N/A)	98 (52, 18, N/A)	48 (15, 10, N/A)
Eastern	**2005**	**2006**	**2007**	**2005**	**2006**	**2007**
ASAT and SDU	20	106	39	5 (N/A)	26 (N/A)	13 (N/A)
Five Points	**2006**	**2007**	**2008**	**2006**	**2007**	**2008**
	166	176	77	175 (76, 58, 41)	261 (113, 60, 88)	222 (75, 51, 96)
Franklin	N/A	N/A	N/A	N/A	N/A	N/A
Gouverneur	N/A	N/A	N/A	N/A	N/A	N/A
Gowanda	**2006**	**2007**	**2008**	**2006**	**2007**	**2008**
ASAT	92	163	148	49 (24, 3, 22)	90 (28, 27, 35)	108 (36, 22, 50)
DWI	293	424	394	9 (8, 9, 39)	6 (26, 6, 31)	12 (21, 12, 28)
Green Haven	**2004**	**2005**	**2006**	**2004**	**2005**	**2006**
ASAT	138	126	34	126	152	41

* Removals are designated by: total number of removals (number of disciplinary removals, number of program performance removals, number of administrative removals)

Table 11-1 Total Graduation and Removal Numbers for Facilities Visited (continued)

Prison	Total Graduations (by year)			*Removals (by year)**		
Greene ASAT RSAT	**2006** 230 31	**2007** 271 122	**2008** 160 100	**2006** 213 (81,17,115) 30 (17, 3, 10)	**2007** 218 (100, 25, 93) 134 (67, 13, 54)	**2008** 204 (105,25, 74) 77 (33, 13, 31)
Hale Creek	**2006** 710	**2007** 849	**2008** 662	**2006** 65 (58,7,0)	**2007** 49 (35, 14,0)	**2008** 42 (29, 12,1)
Lakeview Shock	**2005** Males 1027 Females 147	**2006** Males 908 Females 182	**2007** Males 607 Females 141	**2005** Males 117 (90,17, N/A) Females 19 (17, 2, N/A)	**2006** Males 146(127, 19, N/A) Females 25 (22, 3, N/A)	**2007** Males 141 (132, 9, N/A) Females 9 (5, 4, N/A)
Marcy CASAT ASAT RSAT	**2005** 285 187 0	**2006** N/A 192 395	**2007** N/A 189 392	**2005** 37 (N/A, N/A, 113) 105 (N/A, N/A, 12) 37 (N/A, N/A, 9)	**2006** N/A 112 (N/A, N/A, 13 215 (N/A, N/A, 21)	**2007** N/A 115 (N/A, N/A, 11) 212 (N/A, N/A, 24)
Mid-State	**2007** 247	**2008** 251	**2009** 62	**2007** 71 (N/A, N/A, 83)	**2008** 64 (N/A, N/A, 69)	**2009** 15 (N/A, N/A, 21)
Oneida	**2005** 122	**2006** 184	**2007** 10	**2005** 50 (N/A)	**2006** 102 (N/A)	**2007** 4 (N/A)
Shawangunk	**2007** 62	**2008** 27	**2009** 18	**2007** 22 (10, 0, 12)	**2008** 21 (11, 0, 10)	**2009** 4 (3, 0, 1)
Sing Sing	**2007** 136	**2008** 97	**2009** 33	**2007** 278 (30, 42, 203)	**2008** 224 (30, 19, 174)	**2009** 35 (9, 5, 41)
Taconic ASAT CASAT	**2006** 51 86	**2007** 63 107	**2008** 105 111	**2006** 5 (8, N/A, N/A) 4 (N/A, 4, N/A)	**2007** 9 (9, N/A, N/A) 5 (N/A, 5, N/A)	**2008** 18 (18, N/A, N/A) 10 (N/A, 10, N/A)
Washington	**2007** 185	**2008** 195	**2009** 47	**2007** 389 (10, 73, 91)	**2008** 483 (12, 59, 225)	**2009** 149 (4, 23, 59)
Wende	**2006** 70	**2007** 73	**2008** 81	**2006** 14 (6, 4, 4)	**2007** 15 (7, 3, 5)	**2008** 16 (8, 5, 3)
Willard DTC	N/A	N/A	N/A	N/A	N/A	N/A
Wyoming ASAT CASAT	**2005** 262 127	**2006** 331 114	**2007** 55 51	**2005** 43 (N/A) 8 (N/A)	**2006** 36(N/A) 7 (N/A)	**2007** 9 (N/A) 6 (N/A)

* Removals are designated by: total number of removals (number of disciplinary removals, number of program performance removals, number of administrative removals)

Removal rates for specialized programs, such as CASAT and DWI, were lower than those in the ASAT and RSAT programs. The highest removal rates at a CASAT program were at Marcy (34%) and Arthur Kill 2009 (17%), while the lowest were at Taconic (6%), Hale Creek (7%) and Wyoming (7%). The DWI program at Gowanda had a 13% removal rate; the Albion DWI

program had only a 3% removal rate. The staff-to-participant ratio was often lower in these specialized programs, so that treatment participants may have received slightly more individual attention. As discussed in **Section 8, Treatment Programming and Materials**, the increase in individualized treatment and smaller group size allow treatment staff to work more closely and effectively with participants who need more intensive treatment, accounting for the lower removal numbers.

Examination of individual facility removals that were due to program performance or discipline reveals another important pattern. We observed several programs with low numbers of overall removals but a high percentage of removals due to disciplinary actions. For example, Hale Creek CASAT (79% of removals were due to discipline), Lakeview Female (84%), Lakeview Male (88%), Franklin (94%) and Taconic (100%) had the highest percentage of overall removals on disciplinary grounds. At these facilities, an extremely low percentage of overall removals resulted from poor program performance. This may indicate that treatment staff worked effectively with program participants to assist them if they were struggling within the program and that removals, when they did occur, resulted from disciplinary issues outside the treatment program's purview. Disciplinary removals represented the highest category of removals from the facilities we visited, with the average percentage of individuals removed for disciplinary reasons between 35 and 50%. Some specialty programs, however, had particularly low disciplinary removals; for example, the Arthur Kill SNU ASAT rate was only 17%.

Wende had the highest percentage of program performance removals at 31% of all removals, whereas Shawangunk (0%) and Franklin (6%) had the lowest. Program performance removals, though significant, ranked after both disciplinary and administrative removals in terms of frequency.

At facilities with high numbers of program performance removals, we saw lower program satisfaction among participants, and inmates' perception of treatment staff was lower. For example, 29% of the treatment participants surveyed at Wende (the facility with the highest percentage of program performance removals) reported that it was *mostly* or *very true* that the treatment staff was sincere in wanting to help them, compared with 67% at Shawangunk, the facility with the fewest program performance removals. Similarly, 33% of respondents from Wende stated it was *mostly* or *very true* that they were satisfied with their treatment as opposed to 61% from Shawangunk.

Administrative removals, though not related to behavior or performance, represent the second most common reason for removal systemwide. They were the highest at Washington (65%) and Mid-State ASAT (53%), as well as in the specialized programs at Arthur Kill SNU ASAT (83%), Mid-State ICP ASAT (69%) and Taconic CASAT (100%).

Treatment is most effective when delivered in a manner that allows participants to engage and build trust with staff and peers while they acquire the skills and attitudes that support a drug-free lifestyle.[192] This is especially critical in the TC model utilized by DOCS, where the community itself is the therapy. Transfers and removals are disruptive to this process for the individual as

[192] Fletcher and Chandler, *Principles of Drug Abuse Treatment for Criminal Justice Populations: A Research-Based Guide*.

well as the rest of the community. Furthermore, a substantial body of research shows that treatment of less than 90 days is ineffective, so these interruptions waste the inmates' time and the State's rapidly dwindling resources.

11.6 STRATEGIES FOR RESPONDING TO POOR PROGRAM PERFORMANCE AND NONCOMPLIANCE

The CA commends the DOCS treatment programs we visited that worked creatively and collaboratively with participants to help them remain in the program, responding to noncompliance with nonpunitive therapeutic interventions whenever appropriate.

Our concern in this area is threefold: (1) the lack of formal written policies and procedures in some facilities regarding removals; (2) the extreme variations in removal processes among facilities; and (3) the puzzlingly high rates of removals at some facilities.

The lack of formal policies and procedures can be addressed by sharing of "best practices" within DOCS. Some facilities we visited have detailed removal processes in place that have functioned well. If other facilities adopt these, it would reduce the stress on inmates and staff resulting from ambiguity in procedures. Consistency among facilities would also allow inmates who are transferred to familiarize themselves with, and settle into, new programs.

As for the high rates of removals, staff and management have access to many tools and strategies that are strongly grounded in practice as well as research, many of them customized for criminal justice settings. We urge DOCS to explore these and integrate them as appropriate into ASAT policies, supported by training for staff and management. As discussed in **Section 8**, **Treatment Programming and Materials**, most of the facilities we visited would benefit from a focused effort in this area.

A primary strategy that is extensively used to increase retention in all settings is motivational enhancement, an approach to treatment that helps participants resolve ambivalence about recovery and treatment rather than punishing them for expressing mixed feelings.[193] It can also help them identify and cope with inmates' self-defeating styles of relating to professional helpers, which may be strongly entrenched in individuals who have cycled through the treatment and justice systems many times—in other words, "learning how to be helped."[194]

The Texas Institute for Behavioral Research at Texas Christian University has developed and widely tested a program for motional enhancement in criminal justice settings.[195] This manualized program is in the National Registry of Evidence-based Programs and Practices maintained by the Substance Abuse and Mental Health Services Administration, part of the U.S. Department of Health and Human Services. TCU has an extensive array of evidence-based,

[193] Peters, Wexler, and Center for Substance Abuse Treatment (U.S.), *Substance Abuse Treatment for Adults in the Criminal Justice System: Treatment Improvement Protocol (TIP) Series 44 -- SAMHSA/CSAT Treatment Improvement Protocols -- NCBI Bookshelf*.
[194] White et al., "It's time to stop kicking people out of addiction treatment."
[195] Bartholomew, Dansereau, and Simpson, "Getting motivated to change: A collection of materials for leading motivation groups with substance abuse clients in criminal justice setting."

practice-tested materials available for all phases of treatment, much of it customized for criminal justice settings and all of it available for download and use at no charge (http://www.ibr.tcu.edu).

To reduce removals on both "performance" and disciplinary grounds, the Center for Substance Abuse Treatment (CSAT) strongly recommends an emphasis on relapse prevention programming that is matched to inmate needs: those with higher-severity substance abuse, who may be at risk of acting out or violating program rules, should be placed in more intensive, highly structured relapse prevention programming, with individual counseling and small-group work.[196]

Other strategies for reducing removals include:

a. Increase inmate participation in setting treatment goals and treatment planning.
b. Increase options for treatment matching, even if only internally, such as with higher-intensity groups.
c. Review assessment and treatment planning processes to maximize their accuracy and thus their utility to treatment.
d. Minimize "rules" that can set up unnecessary and unproductive conflicts, shifting the focus from control as much as possible, given the limitations of the prison setting.
e. Increase emphasis on peer guidance, such as matching senior inmates with newcomers to help familiarize them with culture and unspoken rules—shifting to "it has been our experience that…" from "thou shalt not."
f. Continue to assess changes in clinical status on an ongoing basis, rather than relegating assessment to intake only, promoting early intervention before relapse or other acting-out.
g. Use medication-assisted therapy when appropriate to address cravings and impulses that can lead to relapse.
h. Increase clinical supervision to help treatment staff avoid burnout and cope with countertransference—the counselor's emotional reaction to the participant, which can be affected by the counselor's own recovery process or family history.

Many more are available from both clinicians and researchers. The systems and tools provided by the Texas Institute of Behavioral Research at TCU are especially well regarded and often recommended.

The feature shared by these tools is that they are all actions to be taken *by the program* in collaboration with the participant. They allow the community to do its work as the core of the treatment, so participants develop genuine interpersonal, pro-social skills that will serve them well after completing treatment, both in the facility and after release.

The unfortunate truth is that the most challenging treatment participants are often those who most need the treatment in order to build a drug-free lifestyle. Programs best serve public health and public safety when they provide this population with effective treatment, with the requisite demands for high levels of skill, nuanced treatment strategies, and great patience on the part of the facility and the system.

[196] Gorski and Kelley, *Counselor's Manual for Relapse Prevention with Chemically Dependent Criminal Offenders*.

12. DRUG USE AND TESTING IN DOCS FACILITIES

FINDINGS

The frequency of positive tests for illicit substances varies significantly among the DOCS facilities we visited.

Inmates who test positive for illicit substances are frequently sent to the Special Housing Unit (SHU), where little to no substance abuse treatment is offered.

DISCUSSION

12.1 INTRODUCTION

Drug possession, use, and trade in correctional facilities pose both safety and health risks. Sale of drugs inside a prison may have a range of negative consequences, including strengthening prison gangs and increasing both inmate-on-inmate violence and inmate-on-staff assaults.[197] Furthermore, drug use inside prisons can pose a serious risk to the health of the drug user and increase the risk of transmitting infections such as HIV and hepatitis C.[198]

Correctional facilities across the country have devised a variety of drug-use-reduction strategies, some of which have proven extremely effective. For example, from 1995 to 1998, Pennsylvania implemented a strategy that resulted in a 41% reduction in drug finds, a 57% decrease in inmate-on-staff assault, and a 70% decrease in inmate-on-inmate violence.[199] Central to these strategies is drug testing such as random urinalysis. Throughout this project, we asked executive and treatment staff, as well as inmates, about their perceptions of drug use inside the facilities; DOCS drug-testing policies and procedures; and the impact of drug use on prison life.

12.2 DRUG USE AND POSSESSION WITHIN DOCS

Table 12-1 shows misbehavior reports issued in 2008 for drug use and possession in the DOCS facilities we visited. These data were provided by the DOCS Central Office in response to a CA request under the State Freedom of Information Law (FOIL). To facilitate comparison among facilities with differing populations, we calculated a rated number of disciplinary actions per 100 inmates. The information reveals significant variations in terms of misbehavior reports issued for drug use and possession from facility to facility. Some maximum-security facilities, such as Five Points, Sing Sing and Wende, had higher rates of both use and possession, while other maximum-security facilities, such as Green Haven and Eastern, showed lower rates. Shawangunk, another maximum-security facility, had low rates of drug possession, but some of

[197] Prendergast et al., "Reducing Substance Use in Prison," 84; 265.
[198] Strang et al., "Persistence of drug use during imprisonment."
[199] Prendergast et al., "Reducing Substance Use in Prison," 84; 265.

Table 12-1: Disciplinary Actions for Drug Possession and Use by Facility, 2008*

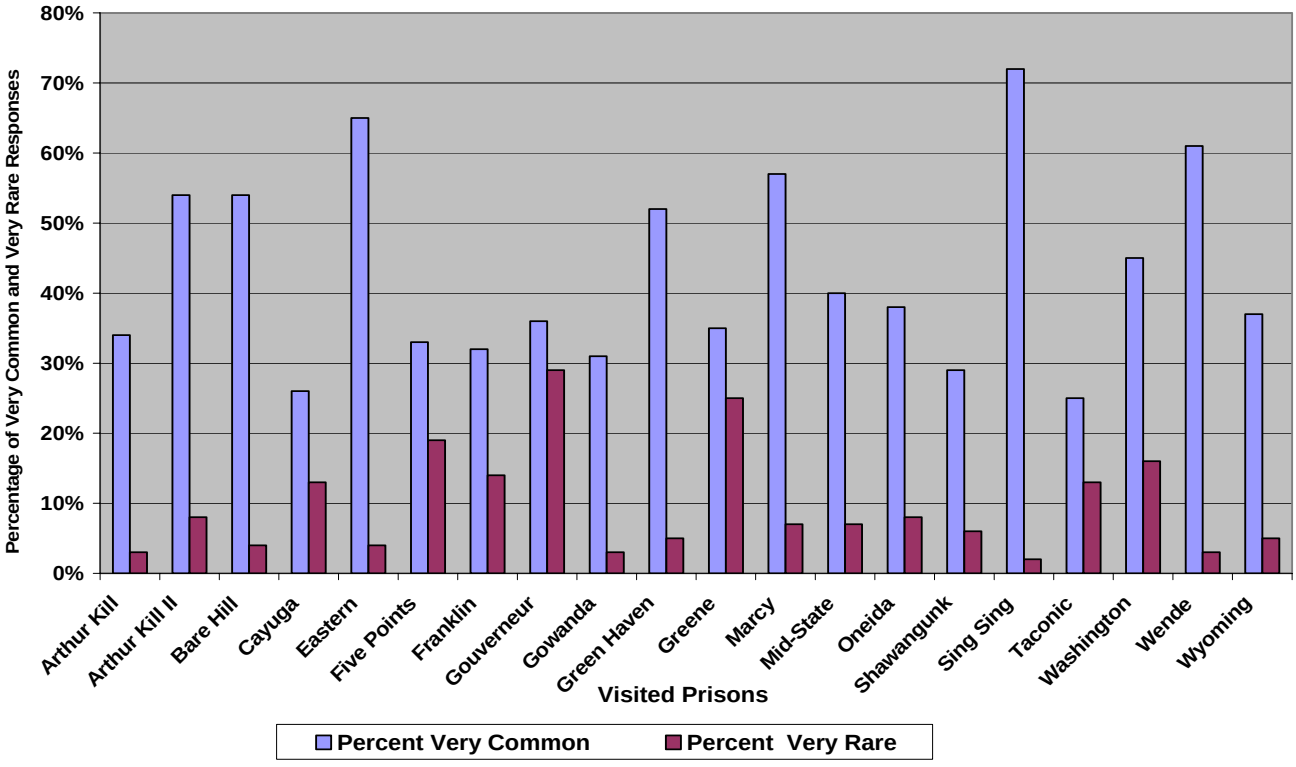
Prison (total population at time of visit)	Drug Possession Reports	Rate of Drug Possession (per 100 inmates)	Drug Use Reports	*Rate of Drug Use (per 100 inmates)*
Albion (1052)	4	0.41	1	*0.10*
Arthur Kill (964)	10	1.04	39	*4.06*
Bare Hill (1691)	14	0.84	51	*3.06*
Cayuga (1015)	6	0.71	9	*1.06*
Eastern (1009)	19	1.90	46	*4.60*
Five Points (1386)	36	2.63	87	*6.36*
Franklin	9	0.54	26	*1.55*
Gouverneur (1012)	4	0.48	30	*3.57*
Gowanda (1625)	15	0.89	17	*1.01*
Green Haven (2139)	27	1.32	48	*2.34*
Greene (1754)	22	1.46	22	*1.46*
Hale Creek (459)	0	0	2	*0.43*
Lakeview Shock (496)	0	0	0	*0*
Marcy (1093)	24	2.16	36	*3.24*
Mid-State (1434)	9	0.70	20	*1.56*
Oneida (1173)	19	1.72	31	*2.81*
Shawangunk (547)	3	0.56	70	*12.96*
Sing Sing (1730)	36	2.03	142	*8.00*
Taconic (320)	0	0	1	*0.30*
Washington (868)	9	0.97	23	*2.48*
Wende (914)	20	2.27	84	*9.51*
Willard DTC	0	0	1	*0.13*
Wyoming (1684)	*21*	*1.26*	*135*	*8.09*

* Data relates to the time of the CA visit

the highest rates of drug use. Similar trends were seen in the medium-security facilities, with Wyoming at the highest end of drug use and Gowanda at the lowest. Dedicated treatment facilities, such as Lakeview Shock, Willard DTC and Hale Creek, had low numbers of both drug use and possession. It is unclear whether these data indicate low levels of drug use/possession in the facility or low levels of detection and enforcement.

As discussed in detail in **Section 3.3.1** on project methodology, the CA surveyed inmates not currently in treatment as well as those in treatment. Only the nontreatment surveys asked about drug use and trafficking by inmates at the prison and whether this activity was a significant source of violence there. The use of contraband drugs by individuals was common, according to our survey results and inmate impressions, with 42% of individuals from all facilities stating that contraband drug use was *very common* and 31% reporting it as *somewhat common*. Only 14% of inmates said drug use in their prison was *very rare* or did not happen at all. According to our survey, drug use was most common at Eastern, Green Haven, Marcy, Sing Sing, and Wende. Sing Sing had the highest perceived drug use, with 73% of individuals reporting it as *very common.* **Chart 12-1** illustrates survey responses for this question from all facilities, distinguishing between survey respondents who reported contraband drug use as *very common* and those who reported it as *very rare*.

Chart 12-1 Contraband Drug Use (Non-program Survey Q71)



We are concerned that a facility such as Eastern, which had relatively few misbehavior reports for drug use or possession, had a high number of inmates (65%) reporting drug use as *very common*. Similarly, inmates did not view drug use as a serious problem at Shawangunk (29%),

but this facility had the highest reported rate of infractions for drug use among all the facilities system-wide.

Though these data are based on inmate perceptions of drug use and do not translate into an objective standard, they do indicate that at many facilities, misbehavior reports for drug use or possession, as well as staff impressions, may not always accurately represent actual prison drug use. There is not a clear correlation between inmate perception of drug use inside correctional facilities and the disciplinary data as provided by the Department.

The survey also asked inmates for their perceptions of how much, if at all, staff were involved in drug trafficking. Twelve percent of respondents reported that staff were involved *a lot* in trafficking in their prison, and 15% thought staff were involved *somewhat*. Even though over half (52%) of respondents thought staff were *not at all* involved, we are concerned that staff involvement in drug possession and sales appears to be a serious problem in some facilities. Surveys from Green Haven, Marcy, and Sing Sing reported the highest numbers for staff involvement. In these facilities, inmates perceived staff as involved *a lot* or *somewhat* in drug trafficking (50%, 36%, and 55%, respectively).

Correctional officials and inmates agree that drug use and sale in correctional facilities can result in higher levels of violence for inmates and staff. Seventeen percent of inmates we surveyed believed drugs contributed *a lot* to violence, and 23% said they contributed *somewhat*. The remaining 60% said they contributed *a little* or *not at all*. The ratios differed slightly among facilities, with more individuals from Green Haven, Marcy, and Sing Sing noting that drugs contributed *a lot* to violence (31, 39 and 28%, respectively). Sing Sing stood out, with only 36% of respondents believing that drugs contributed *very little* or *not at all* to violence (compared with the DOCS-wide average of 60%). If individuals entering prison are accurately identified with current or recent substance abuse and appropriately treated, the treatment and management of substance users in prisons could be strengthened and safety risks greatly reduced.[200]

12.3 DOCS DIRECTIVE ON DRUG TESTING

DOCS Directive 4937 on "Urinalysis Testing" outlines the drug testing procedures for all facilities. It lists nine situations when an inmate should be tested, although correctional staff emphasized only a few of these situations in our meetings with them. Most staff commented that urine tests are done either when an inmate's name comes up in a randomly generated list from Central Office, or when an inmate is suspected for some reason of using drugs.

According to the directive, there are three main types of testing: routine, suspicion, and random. Routine testing procedures are applied in special situations, such as when inmates return from family reunion programs or work release in the community. Suspicion-based testing can be provoked by several conditions, including: (1) the inmate is alleged to have been involved in a case of violent misconduct; (2) the inmate is found to be in possession of suspected illicit substances or associated paraphernalia; (3) the inmate is alleged to be under the influence of an illicit substance; or (4) the inmate is observed to be in possession of illegal substances and correctional staff are unable to obtain a sample of the suspected illegal substance. Random

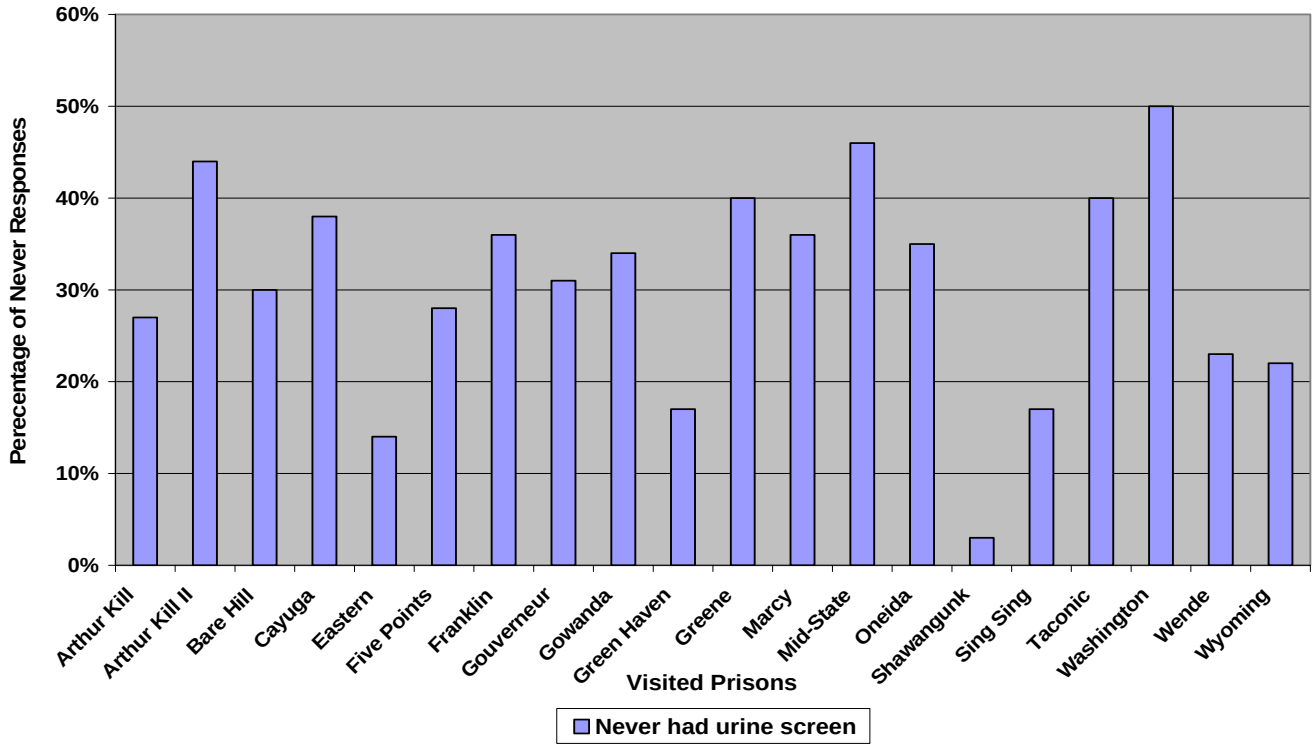
[200] Strang et al., "Persistence of drug use during imprisonment."

urinalysis occurs regularly, and is done as part of one of three actions: (1) a random facilitywide test; (2) a random test for inmates who have tested positive at some time during the previous two years; or (3) a random test for an identifiable program area, unit of the facility, or "identifiable group of inmates." These types of tests can be initiated by a watch commander or higher authority, but "shall not be used for the purpose of harassing or intimidating any inmate."[201]

In practice, drug testing appears to differ widely across facilities, with some facilities suggesting they use random testing much less than others. Most individuals (69%) we surveyed had undergone at least one drug screening during their current sentence, and 50% had undergone more than one screening. Of those who were screened, more than three-quarters (79%) tested negative. Of those who tested positive, 13% tested positive once, and 8% tested positive more than once. Only 41% of all tests, regardless of the results, were random, which correlates with staff reports from many facilities that they emphasize suspicion-based testing more than random testing.

Chart 12-2 illustrates the variations among facilities with regard to drug testing. It is clear that at some facilities, a considerable number of individuals have never been tested for drug use.

Chart 12-2 Individuals Never Tested for Drug Use (Non-program Survey Q27)



All facilities responded harshly to positive test results, almost always resulting in a SHU sentence.[202] According to our surveys, 87% of individuals with a positive urine test were

[201] State of New York Department of Correctional Services, "Urinalysis Testing (Directive 4937)," 1.
[202] SHU or Special Housing Units are areas for disciplinary confinement and consist of 23 hours of lockdown.

disciplined, and 86% received an SHU sentence. Of the individuals disciplined for drugs or alcohol, about half (54%) of them were disciplined only once, 23% were disciplined twice and 23% had been disciplined three or more times. The last segment of the population is of greatest concern.

12.4 IMPACT OF SHU SENTENCES FOR DRUG USE AND POSSESSION

The CA understands the impact drug use has on prison safety for inmates and staff, and the need for a disciplinary response. We are concerned, however, that inmates with the most severe substance abuse—and thus most in need of treatment—are apt to acquire multiple SHU sentences, where they cannot obtain treatment for that disorder. According to our survey, over 72% of individuals sent to the SHU for drug use remained there for three months or longer. The median SHU sentence for this population is five months. Only 14% of individuals in the SHU for drug use or possession received any kind of substance abuse treatment during their SHU sentence, though 70% of these individuals had been in substance abuse treatment programs at other facilities during their incarceration. Research shows that individuals with the greatest severity of substance abuse also have the greatest motivation.[203] The SHU, then, presents an excellent opportunity to provide effective treatment and enhance the safety of all in the facility. At a minimum, they should be offered the SHU Pre-Treatment Workbook while serving their SHU sentence.

> *"I've been incarcerated in NYS DOCS since 1998 and I've been dealing with a marijuana addiction for the duration of my incarceration. Just recently I was given 12 months SHU, 24 months loss of good time and a host of other penalties for testing positive for marijuana use. This is my 11th such drug conviction. I've done almost my entire prison sentence in SHU and keeplock due to my struggle with this addiction. With all due respect, if the last ten disciplinary sanctions didn't help me to kick the habit, then I obviously need some type of treatment and I should be given such treatment."*
>
> *Anonymous Inmate (Orleans, C.F.)*

Finally, we are concerned that treatment program participants who test positive for drug use are almost always removed from the program and not immediately returned to the program once their disciplinary sanction is completed. As mentioned in **Section 11, Treatment Program Completions and Removals**, a cardinal DOCS rule mandates that any inmate with a SHU sentence of 30 days or more is to be removed from his/her treatment program. Based on our survey, only 3.4% of individuals with positive urine samples receive fewer than four weeks in the SHU. This would imply that the vast majority of people sent to SHU (~95%) for a positive drug test are subsequently removed from their substance abuse treatment program. While we understand that drug use in prison is a serious issue and often requires some type of disciplinary action, this exclusive reliance on a punitive strategy is counterproductive. We recommend that DOCS explores alternative policies for this population, including reducing the duration of the disciplinary sanction for inmates who test positive for drugs and then prioritizing those inmates for intensive treatment as soon as they are released from the SHU.

[203] Hiller et al., "Problem Severity and Motivation for Treatment in Incarcerated Substance Abusers," 28-41.

Human Rights Watch released a report entitled *Barred from Treatment: Punishment of Drug Users in New York State Prisons* in March 2009.[204] This report argues against a punitive response for substance users that includes the denial of treatment for individuals found to have used drugs in prisons. One key recommendation of the report is the use of medication-assisted therapy for individuals with opioid dependence. Studies have shown that individuals with opioid dependence have a significantly more challenging time remaining abstinent in prison if not provided appropriate and effective treatment. It is our view that the evidence-based medication-assisted therapy could not only provide the necessary treatment to a population in considerable need, but could also simultaneously contribute to a decrease in drug trafficking and increase in prison safety. We are encouraged that OASAS has included a recommendation in its December 2009 DOCS Addiction Services Report to explore the use of medication-assisted therapy in DOCS treatment programs, and we urge DOCS to collaborate with OASAS on a pilot project in 2010–2011 fiscal year.

[204] Human Rights Watch, "Barred from Treatment."

13. CLINICAL CASE RECORDS

FINDINGS

Forms utilized by CASAT programs gathered and presented more comprehensive information than those used by ASAT programs.

DOCS forms and procedures as found in the ASAT Manual do not encourage collaboration between inmate and counselor in the development of critical treatment elements such as treatment and discharge plans.

DOCS case files did not include information that was collected from the substance abuse screening instruments at reception. This information is important because based on these instruments, the inmate was designated as "needing substance abuse treatment."

Clinical records were often not individualized and did not present a holistic or comprehensive view of the individual, his/her experiences or history.

No clear process exists for clinical supervisors to regularly review and ensure the quality and content of treatment records.

DISCUSSION

13.1 INTRODUCTION

Timely, clear, complete clinical records are critical to every type and dimension of health care treatment, from the dentist's office to open-heart surgery to psychodynamic therapy. Sound record-keeping policies and practices perform critical functions that cannot be addressed any other way, so they are indispensable to effective treatment.

The primary function of case records in substance abuse treatment is to support provision of the highest quality of care in several ways. First, documentation is critical to continuity of care within the prison system, such as prisons and jails, especially in settings that are often understaffed, have high staff turnover or treat transient populations. Documentation provides an excellent source for supervision as well as feedback from peers. Sound clinical records can also provide invaluable insight and supporting material to community-based aftercare providers who will serve inmates after their release to the community.[205]

Clinical documentation serves additional purposes from the perspective of management and administration. Case files and other records can provide critical back-up and detailed information for reviews related to licensing, accountability and risk management. For direct-service staff and supervisors, clinical records are a way to document job performance and compliance with credentialing requirements. Well-maintained records can provide data for

[205] *Addiction Counseling Competencies: The Knowledge, Skills, and Attitudes of Professional Practice*. Technical Assistance Publication (TAP) Series 21. 2008.

important research and help facility and agency management make a case for increased resources.[206]

Just as important for today's substance abuse counselors, case files can serve as a guide through the treatment process. The field of substance abuse treatment is advancing every day as new scientific findings are tested and transformed into clinical practice. Counselors are continually urged to use evidence-based practices about which they receive little or no training. They can use curricula to do this in the group setting, and need similar support and guidance when working with individual treatment participants, not just in individual counseling sessions but in the planning and review that happens between sessions. The case file can help provide guidance for those processes, encouraging consistency and quality.[207] Treatment records thus ensure that individuals engaged in treatment are receiving appropriate, quality and adequate care.[208]

The CA reviewed 78 treatment records from 14 DOCS correctional facilities, using an instrument that drew on a review of the scholarly literature in the area and input from clinicians and experts such as the Project's Advisory Committee. We also sought to identify standards for record keeping that are utilized by other jurisdictions and by community-based treatment providers.

Each DOCS facility creates its own forms and record-keeping system, usually using or adapting those in the ASAT Program Operations Manual. Thus, a major aim of our review was to identify best practices that could be shared around the DOCS system. We also sought to determine whether the records we obtained complied with the standards set by DOCS, both in terms of the forms that were used by individual facilities and how they were maintained by staff.

Although this report notes some differences among facilities, we were unable to conduct a comprehensive comparison of facility records, given the limited number of records we received from each facility. As detailed in this report, inconsistency was a dominant theme in the CA's review of DOCS substance abuse treatment. Improving clinical case records holds great promise as a powerful tool to address this deficiency.

13.2 STANDARDS AND PRACTICES

The key to useful case records is connection: each component relates to all the others, telling the same story from different perspectives at different points in time.[209] The "arc" of treatment starts before admission, with screening and assessment. Data collected during assessment provide the foundation for treatment planning. Movement toward the goals and objectives set out in the treatment plan is documented and assessed in progress notes. Refinement and adjustment of the treatment plan, documented in reviews and updates, reflect needs and strengths that emerge as the treatment process unfolds. Services are documented, as well as the client's

[206] Yates, "Measuring and improving cost, cost-effectiveness, and cost-benefit for substance abuse treatment programs."
[207] Dansereau, Joe, and Simpson, "Node-link mapping."
[208] Harris et al., "Are Clinical Records Really That Important?."
[209] Baird, *The Internship, Practicum, and Field Placement Handbook*.

response to services and staff impressions and insight. Throughout the process, starting at admission, all this information is considered in the development of a final discharge plan.

These principles are reflected in the standards that have been set by several highly regarded sources. A guide to addiction counseling competencies from the Substance Abuse and Mental Health Services Administration (SAMHSA), part of the Center for Substance Abuse Treatment (U.S. Department of Health and Human Services), devotes an entire section to the knowledge, skills and attitudes that contribute to effective client record management.[210] For its work in accrediting health care providers, JCAHO, the Joint Commission on Accreditation of Healthcare Organizations, has developed its own standards for clinical records in behavioral health care.[211] As in most states, treatment providers licensed by the New York State Office of Alcoholism and Substance Abuse Services (OASAS) must meet detailed, comprehensive requirements regarding case records.[212]

All these regulations and guidelines have several common threads to identify quality. These became the foundation of our record review—case records must be complete, legible, timely, accurate and authenticated (clearly signed/initialed). Data for treatment records should be gathered using questions that are appropriate for the patient and sensitive to his/her age, developmental level, culture, gender and communication needs. All sources we consulted emphasized that case records must be organized in a manner that facilitates access and review. They should be continually monitored and audited, both to maintain the quality of the records over time and to identify situations that require increased supervision or other interventions.

13.3 DOCS FORMS AND INSTRUCTIONS

The DOCS Alcohol and Substance Abuse Treatment (ASAT) Program Operations Manual sets out standards for case files and include some forms. Although it is not specified in the ASAT Manual, our review of treatment records seemed to suggest that each facility is free to create its own forms. This would comport with the DOCS policy that facilities are free to "define the primary and, if available, secondary treatment strategy in operation at the facility."[213] In fact, some non-ASAT programs utilized ASAT forms.

There appeared to be wide inconsistency in the forms used by facilities and the manner in which they were used, with most forms in treatment records being specific to certain programs such as ASAT. Although differentiation is helpful, and even necessary in some areas (e.g., program rules and regulations), many forms would benefit from standardization. This is especially true with respect to the intake form used for initial assessment for the treatment program, which is one of the forms that varied most among programs and facilities.

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[210] *Addiction Counseling Competencies: The Knowledge, Skills, and Attitudes of Professional Practice*. Technical Assistance Publication (TAP) Series 21. 2008.
[211] The Joint Commission on Accreditation of Healthcare Organizations, *Behavioral Health Care Accreditation Program, 2009 Chapter: Record of Care, Treatment, and Services*.
[212] OASAS, "Operating Regulations Part 819.5."
[213] State of New York Department of Correctional Services, *Alcohol and Substance Abuse Treatment (ASAT) Program Operations Manual*, 6.

13.3.1 Intake (Assessment)

Assessment is "an ongoing process through which the counselor collaborates with the client and others to gather and interpret information necessary for planning treatment and evaluating client progress."[214] The goal of assessment is to determine the nature and extent of an individual's drug problems, establish whether problems exist in other areas that may affect recovery and enable the formulation of an appropriate treatment plan.[215]

The data collected for assessment typically include basic demographic information such as name, date of birth, sex and preferred language. Assessment should also address physical and mental health, cognitive and behavioral functioning, educational and vocational status and history, spirituality, legal history, housing and parenting. A detailed history of substance use should include: current level of use; type of substance(s) used; quantity, frequency and duration of use of each; age at first use for each; difficulties related to health, mental health, legal issues, and social interactions resulting from substance use, as well as the impact of these difficulties; and substance-related treatment history, including outcomes and duration of periods of abstinence.[216] The professional conducting the assessment should include his or her impressions of the client's mental status and readiness for treatment, among other factors.[217]

In the DOCS records we reviewed, assessment on admission to treatment was conducted using the form "ASAT Intake." DOCS does not provide treatment staff with copies of the screening that was administered when the inmate entered the DOCS system and which led to the designation as "in need of substance abuse treatment." This initial treatment assessment document could be very helpful to treatment program staff. The ASAT Manual specifically states that staff "should not spend excessive time in screening activities." Providing the screening information from reception would help them achieve that goal. See **Section 5, Screening, Assessment, and Designation as In Need of Treatment,** for a complete discussion of DOCS screening and assessment practices.

No intake forms in the treatment records we reviewed provided basic demographic information such as date of birth, age, gender, race, ethnicity or marital status. Although DOCS retains much of this information electronically, it was not clear whether this data is available to staff who utilize the case file to guide and document treatment.

The intake forms in DOCS treatment records present background information through short (often one sentence or one word) responses to open- and closed-ended questions. Although these forms ask about the inmate's *reported* medical problems and mental health history, they do not record any relevant medical care, psychiatric diagnosis, mental health treatment, or family

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[214] *Addiction Counseling Competencies: The Knowledge, Skills, and Attitudes of Professional Practice*. Technical Assistance Publication (TAP) Series 21. 2008.
[215] Fletcher and Chandler, *Principles of Drug Abuse Treatment for Criminal Justice Populations: A Research-Based Guide*.
[216] *Addiction Counseling Competencies: The Knowledge, Skills, and Attitudes of Professional Practice*. Technical Assistance Publication (TAP) Series 21. 2008.
[217] Peters, Wexler, and Center for Substance Abuse Treatment (U.S.), *Substance Abuse Treatment for Adults in the Criminal Justice System: Treatment Improvement Protocol (TIP) Series 44 -- SAMHSA/CSAT Treatment Improvement Protocols -- NCBI Bookshelf*.

medical history. Furthermore, the forms ask about criminal history, but not legal history; educational history, but not current educational or vocational activities; and family relationships, but not personal ones. Finally, some intake forms, such as the CASAT intake form, provide a specific and structured format to capture information about each family member's alcohol and drug use history. The ASAT form, however, merely provides a blank space to note "family drug history," often resulting in vague or incomplete responses (e.g., the name of a family member without the corresponding history of substance abuse).

Most of the intake forms we observed are generally not structured in a way that is conducive to gathering comprehensive and clear information. The ASAT intake form, for example, asks "Has the person been sober/drug free and experienced relapse, or has person never attained recovery?" followed by a blank space. A clear understanding of the information that is sought here could be helpful to treatment staff. However, if read literally, the question asks for a "yes" or "no" answer. There is no prompt for details about the duration and dates of any periods of relapse/abstinence (see **Example 13-1**). Common responses to this question included "Yes," "Relapse," "Has been sober for X years" or simply a date. Consequently, the information provided by treatment staff about past substance abuse programs was often vague or incomplete.

The same form provides a spot for "primary drug" (followed by a blank line) and "secondary drug." Two items down is a line for "reported frequency and quantity of drug used during highest drug use period" without differentiating between primary and secondary substances. The form does not solicit information about the duration of drug use—while it asks for age of onset, it does not ask for date of last use (see **Example 13-2**). Most often, staff entered "daily" or "a couple of times a month," with several writing in a dollar amount.

Example 13-1 ASAT question regarding relapse/abstinence and past treatment

- Has person been sober/drug free and experienced relapse, or has person never attained recovery?
  _____

Example 13-2 ASAT question regarding frequency and quantity of drug use

- Reported frequency and quantity of drug use during highest drug period:
  _____

More important, where the form *does* include appropriate prompts, such as the question regarding current relationships with family members, most responses did not adequately provide the requested information. Instead, they listed only a family relationship (e.g., "brother") or relationship qualifier (e.g., "better now"), neither of which is useful in understanding current and potential support systems (see **Examples 13-3** and **13-4**).

Intake forms that specifically request information about family relationships include more comprehensive information. For example, some intake forms at Gouverneur Correctional Facility prompt counselors to check "good," "bad," or "deceased," to describe relationships with mother, father, brothers and sisters.

Example 13-3 Standard ASAT question regarding family member relationships

- Current family relationships (parents, siblings, significant others, children):
  _____

Example 13-4 Gouverneur C.F. question regarding family member relationships

- What is your current relationship with your parents, brothers, and sisters?

Mother	__Good	__Bad	__Deceased
Father	__Good	__Bad	__Deceased
Brothers	__Good	__Bad	__Deceased
Sisters	__Good	__Bad	__Deceased

This same pattern is apparent with respect to questions about treatment history. The ASAT form, for example, asks for treatment history (see **Example 13-5**) in very general and unstructured terms (i.e., as an open-ended prompt that provided a single blank line for a response). Perhaps as a result, many answers to this question were vague (e.g., "yes" or "ASAT"), providing no further information about prior treatment episodes such as date(s), duration, modality and outcome.

In contrast, the CASAT intake form specifically asks the evaluator to mark, check, or fill in the answers to a series of structured questions about treatment history that inquire about and differentiate between treatment episodes prior to and during incarceration, the treatment modality for each, duration of treatment, and outcome of each episode (e.g., treatment complete) (**Example 13-6**).

In general, the CASAT treatment records provide much more comprehensive information about treatment history. This suggests that the commonly used ASAT intake form could generate more helpful information if it were structured differently, and that current staff members have not been trained to use the ASAT forms.

Example 13-5 ASAT question regarding substance abuse treatment history

- Reported substance abuse treatment history (A.S.A.T., Inpatient, Outpatient, Methadone, etc.):

  _____

Example 13-6 CASAT question regarding substance abuse treatment history

Prior to this incarceration		While incarcerated (this offense)		Completed
TYPE	MONTHS	TYPE	MONTHS	□ yes □ no
Outpatient	_____	Residential ASAT	_____	□ yes □ no
Residential	_____	Non Residential	_____	□ yes □ no
AA/NA	_____	AA/NA	_____	□ yes □ no
_____	_____	_____	_____	□ yes □ no
(other)		(other)		

13.3.2 Treatment Plan

Treatment planning creates a road map for the client's recovery that flows directly from the assessment. As with most other clinical documents, there are many different formats for treatment plans. Standard practice calls for treatment goals and objectives to be agreed upon, realistic, explicit, measurable and individualized.[218] The ASAT Manual provides a form titled "ASAT Treatment Plan Initial Planning Session" and states that "program staff are responsible for . . . providing each participant with an individualized treatment plan and periodic evaluation

[218] Wiger, *The Clinical Documentation Sourcebook*.

of strengths and weaknesses in achieving program goals and objectives."[219] It is important to note that effective treatment planning is widely considered to require collaboration between the counselor and client.[220] The directions provided in the ASAT Manual for treatment planning quoted above, however, do not encourage this collaboration; neither do the initial treatment plan form or the treatment plan update form.

The treatment plan forms (both the initial and the update) omit critical information. The most commonly used treatment plan form, designed for ASAT initial planning sessions, requires the identification of short- and long-term goals, but does not explicitly ask for clear, measurable criteria pertaining to the goals or a specified timeline for monitoring and evaluating progress towards goals.

The ASAT program is structured around nine competencies that inmates are required to master in order to graduate from the program. The initial planning session form includes a numerical scale for staff to assess inmate understanding and skills in each competency area. However, it does not provide a space for the staff to explain the scores or how they were derived.

Individualization is widely regarded as indispensable to effective treatment planning. The format described above, however, encourages use of generic and generalizable goals (e.g., "maintain abstinence"). It does not encourage the evaluator to refer back to the initial assessment, which would support defining goals appropriate for the individual.

In fact, at some facilities, such as Arthur Kill and Taconic, three of the four comments sections referring to short-term and long-term goals had clearly been completed in advance, with standardized responses, and the forms photocopied. For example, every participant was provided with the goals "learn and abide by all ASAT group and facility rules" and "learn how chemical dependency affects all areas of life." "Complete ASAT" was also commonly entered as a goal or an "agreed-upon means to achieve" a goal, despite the fact that "attending," "completing" or "participating" in a program are widely considered unacceptable "goals" for attending, completing or participating in the program.

Examples of short-term goals in the records we reviewed included: "Accomplish GED," "Work on open communication in group" or "Work on managing self-anger feelings." Long-term goals included: "Make amends with family," "Establish a sober support network" or "Increase spirituality." Staff could likely benefit from training in formulating appropriate goals and objectives. The initial treatment plan form also includes a question about the "agreed upon means to achieve short and long term goals" followed by three lines to be completed by staff. Responses to this question were often vague and rarely individualized (e.g., "participate in ASAT sessions" or "Journal").

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[219] State of New York Department of Correctional Services, *Alcohol and Substance Abuse Treatment (ASAT) Program Operations Manual.*

[220] Zuckerman, E. *Clinician's Thesaurus, 6th Edition: The Guide to Conducting Interviews and Writing Psychological Reports*. Sixth Edition. The Guilford Press, 2005.

Staff should be prompted to note throughout the record, where applicable, other prison programs and services in which the treatment participant is enrolled (e.g., educational and vocational programs). Although substance abuse treatment staff are not responsible for identifying or operating these programs, noting the individual's participation results in more holistic and comprehensive recordkeeping.

13.3.3 Treatment Plan Updates

Treatment plans should be regularly assessed and adjusted as needed to ensure that goals and objectives remain practical and relevant to the individual's shifting conditions during treatment.

The ASAT Manual calls for two forms of update and evaluation. It provides that "the treatment plan will be updated after two months with subsequent updates *if necessary* using the Update of Initial Treatment Plan" form.[221] This requirement provides inadequate guidance to staff about when an update is "necessary" and results in considerable variation. Also included is a form titled "Monthly Evaluation by ASAT Staff Member."

The treatment plan update forms do not require the documentation or identification of specific skills that the inmate has acquired, although the first item of the form asks for a description of "participant progress in addressing ASAT program competency areas." The CASAT treatment plan update form specifically requests a review of short-term and long-term goals and provides separate opportunities for redefining both. The ASAT form, however, requires evaluation of the individual's progress in achieving only short-term goals, not long-term ones, and conversely provides an opportunity to revise only long-term goals, not short-term ones (**Examples 13-7** and **13-8**). Staff members *may* evaluate long-term goals as well, but the language in the prompt suggests it is not necessary. Perhaps as a result, in many of the records we reviewed this area was left blank or filled with "N/A."

Furthermore, questions on the treatment plan update forms regarding goal revisions or redefinitions do not require that they be expressed in measurable behavioral terms that clearly communicate what is expected of the inmate, nor do the forms include clear evaluation criteria and a specified timeline for monitoring/evaluating progress towards these goals. Instead, responses were commonly vague, such as "maintain long-term recovery plan" (without defining such a plan or referencing a previously stated one), "continue to work towards goals" or "complete competencies."

Finally, the treatment plan update form appears to serve as the only documentation of updates or adjustments to treatment plans, which is not sufficient to document any revisions that may be needed over time. Short-term goals, in particular, may change over several months (adjusted, deleted or added), yet there is no additional place to indicate and explain changes. The ASAT Program Operations Manual states that all treatment plans are to be updated two months after the

[221] "The treatment plan will be updated after two months with subsequent updates if necessary using the Update of Initial Treatment Plan." (State of New York Department of Correctional Services, *Alcohol and Substance Abuse Treatment (ASAT) Program Operations Manual*, 29.).

completion of the initial treatment plan if necessary, but some treatment records did not meet even this minimum requirement. Alternatively, a few records included more than one update, exceeding the expected standard.

Example 13-7 CASAT treatment plan update questions

- Review of former short-term goals:
  _____
- Review of former long-term goals:
  _____
- Redefinition of problem areas:
  _____
- Redefinition of short-term goals:
  _____
- Redefinition of long-term goals:
  _____
- New procedure:
  _____

Example 13-8 ASAT treatment plan update questions

- Staff feedback and comments regarding participant progress in addressing A.S.A.T. program competency areas:
  _____
- Evaluate participant progress in achieving short-term goals:
  _____
- Evaluate and revise, if necessary, long-term goals:
  _____
- Define participant's strengths and weakness in addressing program goals:
  _____
- If necessary, list and define program expectations and participant responsibilities:
  _____
- Agreed-upon new procedure:
  _____

13.3.4 Monthly Evaluations

Monthly evaluations present an opportunity to evaluate treatment progress using the same indicators each month. These forms were fairly consistent in format among facilities and were by far the most common form found in the files.

In our review, however, we found that these forms provide little information about how the individual was faring in treatment. It was unclear, for example, whether the monthly evaluations are intended to measure progress solely in that particular month, or to be cumulative. Many of the scores remained identical from month to month and were rarely accompanied by written comments to contextualize their interpretation. These scores also failed to give a sense of what the inmate had accomplished or needed to improve. When an area of weakness was identified by

a low rating, it was rarely addressed or expanded on in the comments section or elsewhere on the form.

We recommend, therefore, that the forms be revised so that staff comments accompany checkmarks for each indicator—for example, by creating a space next to each indicator with instructions to provide an example of the behavior that prompted the rating and to specify how the inmate can improve in that area, especially in areas with low scores.

Additionally, we were surprised that competency levels were estimated during the initial treatment planning session but not again until time of discharge. With the exception of Wende, the items measured in the monthly evaluation were completely different from the competencies rated at intake. (**Example 13-9 and 13-10**) (They were also different from the items rated on other forms in the ASAT Manual, evaluations by "dorm officer/work supervisor" and "academic teacher/vocational instructor," which were not included in the case files we reviewed.) This illustrates that monthly evaluations and progress notes are often completely disconnected from each other, the individual's needs and strengths, the evaluation criteria used at intake (the competencies) and treatment planning. Furthermore, the ratings for the treatment planning session are on a five-point scale, while the ASAT Manual and the discharge form contains a seven-point scale, making it difficult to compare progress at these different points.

Using the monthly evaluations to measure progress in the nine competencies would provide consistency throughout treatment and help monitor progress between intake and discharge. Adding the competencies to the monthly evaluation form, however, would require significant review and staff training; although Wende's monthly evaluation form includes an additional column for competencies, entries were often incomplete or unclear about how individuals were evaluated or what the scores meant.

The comments section at the bottom of the monthly evaluation form does not explicitly require that notes relate directly to the inmate's treatment plan, which would help ensure that comments were more specific, individualized and integrated. Consequently, many staff comments in this space were limited to "doing OK" and similar nonspecific comments or assessments. There was rarely a discussion of the individual's progress in treatment or ideas to adjust treatment interventions to reflect change.

At some facilities, such as Arthur Kill, several treatment records included very similar comments on each monthly evaluation, such as "Inmate continues to demonstrate positive attitude towards CASAT program," with no additional information or details.

Finally, the forms for the monthly evaluations we examined did not include a space for inmate or staff signatures, which are important to ensure accountability, encourage inmate buy-in and facilitate professional review.

Example 13-9 Competency areas evaluated on "Treatment Plan Initial Treatment Planning Session" form (Ranked on a 5-point scale, with 1 = very limited and 5 = exceptional)

- Drug use/abuse and consequences
- Dynamics of self and others
- Dynamics of criminal thinking
- Decision making and communication skills
- The process of addiction
- The thinking and actions associated with recovery
- The many problems associated with alcoholism/addiction
- Relapse prevention and how it works
- How to maintain a drug-free lifestyle

Example 13-10 Criteria used in monthly evaluations (Checked as "above average," "satisfactory" or "unsatisfactory")

- Level of understanding of didactic material
- Level of engagement
- Personal insight into addiction/recovery
- Accept criticism
- Speaks positively
- Supportive of peers and staff
- Makes realistic comments regarding addiction/recovery
- Sets goals—Takes steps to accomplish goals
- Displays appropriate group behavior
- Follows group/facility rules and instructions

13.3.5 Progress Notes

If the treatment plan is the road map to recovery, then progress notes are the reports of movement on the map. There are many formats for progress notes, with several points emerging as common to most. One widely used structure uses the acronym "SOAP" to guide the counselor in covering all the bases in the notes: the counselor's Subjective reaction to the session; Objective information on progress and significant events; Analysis of the implications of the subjective and objective material (especially how the session relates to treatment goals); and Plans for activities, tasks or assignments until the next session.[222] OASAS regulations require that progress notes provide "a chronology of the resident's progress related to the goals established in the treatment/service plan and be sufficient to delineate the course and results of treatment/services. The progress notes shall indicate the resident's participation in all significant services that are provided."[223] OASAS further requires that progress notes must be written, signed and dated by the responsible clinical staff member at least once a week.

Progress notes in DOCS treatment records were inconsistent within and among programs. Many records contained no progress notes. The progress notes that were present varied widely in content and form. This presents a clear opportunity for improvement through standardization. Because many DOCS treatment staff have experience at other treatment facilities, this may be relatively easy to accomplish.

[222] Cameron and turtle-song, "Learning to write case notes using the SOAP format," 286-292.
[223] OASAS, "Operating Regulations Part 819.5."

The forms in the records we reviewed provide little guidance or structure for progress notes, and are often limited to just a column for dates and blank lines. This likely contributes to the wide variations we observed.

Some progress notes we reviewed included only one or two entries. Others did not record any substantive information at all and instead acted as a log for completion of treatment forms; for example, "4/08: intake completed"; "5/08: monthly evaluation." Others incorporated a qualitative assessment of interactions, such as "12/08: fourth eval; adjusting well with staff and peers, needs aftercare plan before next evaluation."

Shawangunk Correctional Facility was among those with the most comprehensive progress notes, insofar as they provided additional information about the individual's attitude and engagement in treatment. Facilities with treatment records that contained no progress notes included Cayuga and Gouverneur. At some facilities, such as Albion and Taconic, some case files included progress notes while others did not. This serves as another illustration of some of the inconsistencies we observed both within and among facilities.

Progress notes were often entered irregularly, sometimes with months between notes. If there is no individual contact with a treatment participant for an extended time, it would be appropriate to enter a brief note as to the reason. We believe that the OASAS standard of a weekly entry would be appropriate.

To ensure that progress notes are both substantive and useful, we recommend that they be reviewed by a supervisor on a regular basis. Few of the records we reviewed had any indication of such review, which may be attributable to the absence of a format requiring such review. More importantly, there was no protocol for supervisory review of treatment records.

13.3.6 Discharge Plan

A discharge plan provides the bridge from residential (or prison-based) treatment to the community. The discharge plan is not identical to the discharge *form*. An effective discharge plan is more than a document—it is a relapse prevention plan, a reminder of support systems and a network of connections and referrals.[224] A strong, detailed discharge plan is especially important for those who have been disconnected from their communities for some time, as most inmates have.[225] In community-based programs, the discharge plan can serve as a valuable resource for providers of continuing care and aftercare.

OASAS regulations for community-based treatment programs require that discharge planning commence as soon as the client is admitted, that it be conducted in collaboration with the client and continue throughout treatment.[226] OASAS further requires that discharge plans include a relapse prevention plan and a specific plan for continuing care, complete with referrals and initial appointments. Finally, OASAS requires that discharge plans be reviewed by a clinical

[224] Baron et al., "Best Practices Manual for Discharge Planning: Mental Health & Substance Abuse Facilities, Hospitals, Foster Care, Prison and Jails."
[225] Rose, Clear, and Ryder, "Drugs, incarceration and neighborhood life."
[226] OASAS, "Operating Regulations Part 819.5."

supervisor before the client is discharged. A discharge *summary* provides an overview of a treatment participant's progress in treatment: the starting point; challenges and how they were overcome; and recommendations for sustaining abstinence and continuing recovery.

The ASAT "Evaluation, Referral and Discharge Form" (**Example 13-11**) serves as the discharge form for most treatment records we reviewed. The ASAT Manual states that "when a participant is discharged under one of the categories specified above (satisfactory, unsatisfactory, or administrative) the ASAT Evaluation/Discharge Form will be completed." See **Section 11, Treatment Program Completions and Removals,** for a complete discussion of DOCS treatment completions and removals.

The standard discharge form used in ASAT programs consists primarily of a grid where staff are asked to rate the treatment participant's "status and progress in achieving stages of recovery" in each of the nine competency areas. The recovery stages are defined in the ASAT Manual and include "the information stage," "the body of knowledge stage" and "the actualization stage." However, a staff person without the ASAT Manual in hand would be hard-pressed to complete the form accurately, since there were no prompts or directions. Thus, while some staff merely checked an appropriate box indicating status, others initialed it, while still others entered a date. The form does not include a space for a discharge plan or a discharge summary, nor does it ask for suggestions for the inmate's continuing recovery or possible areas of improvement.

The standard form, as included in the ASAT Manual, contains several lines for comments, but the accompanying directions suggest that explanations are necessary only when the inmate receives an unsatisfactory discharge. Even in the cases of unsatisfactory removals, however, the form often provided limited "explanation" and little if any information about the reasons for the discharge (tickets, testing positive for illicit substances, etc.), circumstances precipitating the incident/behavior or how/when substance abuse treatment services or support would be available following the inmate's removal from the program.

With regard to discharge planning, the discharge form does not designate a space to list referrals or recommendations to community-based services, such as continuing substance abuse treatment, housing or employment. Some facilities and programs, such as Taconic's CASAT program, use another form to supplement or replace the standard ASAT discharge form, that provides the "Phase II/Community Reintegration and Continuity of Care Plan." This form includes several items that are missing in the standard ASAT discharge form and could be easily incorporated, including staff recommendations for treatment, employment and residence upon release.

Example 13-11 Sample Discharge Form

NAME: [redacted] MONTH/YEAR: [redacted]

DIN #: [redacted] EVALUATOR: [redacted]

Attachment F
ASAT Staff Indicate Progress By Initials and Date

ASAT PROGRAM
EVALUATION, REFERRAL and DISCHARGE FORM

Status and Progress in Achieving Stages of Recovery

Competency Needs	Information Stage	Body of Knowledge Stage	Discovery/ Assessment Stage	Conceptual Stage	Understanding Stage	Internalization Stage	Actualization Stage
Drug Use/Abuse & Consequences							
Understanding Self & Others							
Understanding Criminal Thinking							
Decision Making & Communication Skills							
Process of Addiction							
Process of Recovery							
Alcoholism/ Addiction & Problems							
Process of Relapse Prevention							
Maintaining Drug-Free Lifestyle							

COMMENTS: Has done well in program. He has a good understanding of his issues but needs to stay focused on recovery & support

If Discharge, please indicate type and explain if not satisfactory.
Satisfactory ✓ Unsatisfactory _____ Administrative _____

cc: Guidance Unit Folder
Parole

13.3.7 Other Forms and Documents

Additional documents in treatment records we reviewed included program rules and regulations, inmate counseling notifications, treatment program materials (e.g., homework or in-class assignments and exercises, and self-assessments), program checklists, authorizations for release of records, counselor referral forms and inmate correspondence. Greene Correctional Facility records often included a graded "Final Exam." This form of post-test could provide a much-needed objective measure of progress in treatment, supplementing (not replacing) staff impressions and others standards.

The inmate assignments and extremely few self-assessments we saw enhanced the understanding of an inmate's participation in treatment and stage of recovery. Given that treatment participants' input is not captured elsewhere in DOCS treatment records, these documents provide rare opportunities for reviewers to gain insight into the inmate's perspective. These demonstrate the value of treatment participant input into creating and maintaining a meaningful case record that provides a comprehensive picture to anyone reviewing the chart, whether an outside reviewer, clinical supervisor or counselor new to the facility.

Most case files included program guidelines or rules, as well as treatment "contracts" (consent for treatment). These varied considerably from facility to facility and some did not include a place for the inmate's signature. In most of the treatment contracts, the language was stilted and legalistic.

13.4 GENERAL FINDINGS AND DISCUSSION

The treatment records we reviewed significantly lacked critical detail and substantive information. Forms often contained vague and incomplete responses (including items left blank or answered in one or two words). When complete responses were provided, they were often based on deficits rather than focused on solutions. The majority of the records we reviewed did not provide the quality or quantity of information that would allow current and future staff to track an inmate's progress in treatment. The manner in which the forms were utilized, as well as the way they were completed, created a lack of individualization and a pattern of generic treatment goals and updates, resulting in records that did not convey a helpful sense of the individual's background, needs and progress in treatment.

DOCS treatment records diverged considerably from current standards in the field by a complete absence of documents related to any treatment other than the current episode. This leaves treatment staff at a considerable disadvantage, and would seem unnecessary, at least with regard to previous treatment in DOCS facilities.

There was minimal to no continuity or integration among the elements of the treatment records, from assessment through treatment planning, progress notes and discharge. An inmate's problems and weaknesses identified at intake, for example, were rarely addressed in the initial treatment plan, treatment plan update, monthly evaluations or progress notes. Also, the files included little or no mention of other services or programs in which the inmate was involved, suggesting that either the treatment program staff were unaware of these programs and services

or that they knew of them and did not see the need to document them. References to elements of the therapeutic community (DOCS's dominant treatment modality), such as hierarchy status, sanctions (pull-ups, thinking reports, etc.) and presentations were also noticeably absent from most treatment record content.

With regard to the organization of the records, several were completely missing standard documents. This was particularly the case with missing monthly evaluations. Other files had multiple versions of the same document (e.g., both ASAT and CASAT intake forms, each filled out differently, or two initial treatment plans). Some records contained several undated forms. Nearly *every* form lacked signature by a clinical supervisor, suggesting a lack of oversight and review.

There was significant variation among staff and facilities with regard to both the forms themselves and how they were completed and used. For example, the program participation guidelines in case records at the Wende Correctional Facility were clearer and more concise than those at Taconic. The intake forms for CASAT and for Gouverneur Correctional Facility asked more-focused questions about history of substance abuse and treatment than the standard ASAT intake form. Several records at Five Points Correctional Facility used the treatment plan update forms more than once, which is good practice but rarely done at other facilities.

Records at Wende were missing some important documents, such as initial treatment plans. Most Wende records contained identical answers under "agreed-upon means to achieve short- and long-term goals." No facilities appeared to have a model case file that laid out the elements considered essential for a complete file at that particular facility. This is a "best practice" standard in the community that all facilities should emulate, which could address many of the issues identified in this report.

As for clinical staff, some wrote several sentences in the comments section of each monthly evaluation, whereas others left the monthly evaluations section completely blank. Revising the forms and providing appropriate training would help clinicians comply with requirements and tap the full extent of their experience and skills. Regular review by a qualified clinical supervisor would also help to address these concerns.

We recommend that OASAS work with DOCS treatment staff to design forms that are concise, intuitive and comprehensive, and that build upon and relate to one another. This is integral to ensuring that the goals and needs of the treatment participant that were identified at intake to the program are tracked and updated throughout the program and that progress with the competencies and in addressing stated short- and long-term goals are clearly documented. In addition, these forms and the instructions for completing them should better promote and encourage inmate participation in the treatment and discharge planning process, which reflects widely accepted practice in the field. Items included in the more comprehensive CASAT forms can assist in providing language and design to improve the ASAT forms.

In addition, we strongly recommend that staff be prompted to note throughout the record, where applicable, other prison programs and services in which the treatment participant is enrolled

(e.g., educational and vocational programs) in order to present a more holistic view of the individual and his/her needs.

DOCS should consider including in each clinical record a fact sheet (or "cheat sheet") containing demographics such as age, marital status, etc., that are probably in the central DOCS database but would be useful for treatment staff to have readily available.

Finally, it is also important that the program contracts and other forms be revised to ensure the language is accessible to those with all literacy levels.

14. OVERSIGHT AND SUPERVISION OF DOCS SUBSTANCE ABUSE TREATMENT PROGRAMS

FINDINGS

Limited formal protocols and procedures are in place for facility management oversight of DOCS substance abuse treatment programs. The little oversight that does take place is often provided by prison staff with limited qualifications.

The DOCS Office of Substance Abuse Treatment Services (OSATS) visits programs once or twice a year. The resulting reports are not standardized and corrective plans are not required.

Many facilities do not provide clinical supervision on a regular basis for direct-service treatment program staff.

There has been minimal outside monitoring of DOCS substance abuse treatment programs, with the exception of Willard Drug Treatment Campus and Edgecombe Correctional Facility.

DISCUSSION

14.1 INTRODUCTION

Program monitoring is an integral component of effective programs. It allows for strengths and weaknesses within a program to be identified, holds staff and administrators accountable for program quality and serves as the foundation upon which future program changes are built.[227] Monitoring can be conducted on various levels: individually, as part of clinical supervision; programmatically, as part of review and supervision by program staff; and on a systemwide organizational level through site visits, outcomes monitoring and other methods. Additionally, most substance abuse treatment programs in the community are evaluated regularly by an outside agency to ensure they are providing consistent quality of care services and are holding to state- or nationwide community standards.

The Substance Abuse Treatment Project looked at three types of oversight and supervision of DOCS substance abuse treatment programs: clinical, administrative, and institutional. *Clinical* supervision focuses on improving the effectiveness and counseling skills of the supervised staff by attending to their personal and professional needs as they affect the treatment participant. With *administrative* supervision, facility supervisors and managers seek to encourage compliance with policies and procedures of the program and the institution, helping the supervisee function as part of the organization. *Institutional* supervision is provided by outside

[227] Peters, Wexler, and Center for Substance Abuse Treatment (U.S.), *Substance Abuse Treatment for Adults in the Criminal Justice System: Treatment Improvement Protocol (TIP) Series 44 -- SAMHSA/CSAT Treatment Improvement Protocols -- NCBI Bookshelf*.

licensing and government entities to ensure that regulatory standards are maintained. In most settings, supervisors must balance clinical and administrative supervisory tasks.

14.2 CLINICAL SUPERVISION, GENERALLY

Clinical supervision is an ongoing interactive process involving direct-service staff and more-experienced clinical staff, which aims to constantly improve the quality of client care.[228] In substance abuse treatment, clinical supervision is the primary method of ensuring quality of care. Good clinical supervision mitigates staff burnout, enhances workforce retention, reduces turnover, and improves and maintains morale.[229] Clinical supervision helps counselors transform their training and education into practical skills and is widely acknowledged as an essential part of all clinical programs. In addition, appropriate clinical supervision can help staff members achieve and maintain credentials or licenses, further contributing to workforce retention.

One-on-one discussions are the primary model of interaction between supervisors and counselors, with group clinical supervision second. A recent study of clinical supervision nationally found that the primary tools of supervision include observing individual counseling sessions; observing group counseling sessions; reviewing case notes; reviewing audio/video tapes; and listening to case reviews/presentations by counselors.[230] The clinical supervisor carrying a caseload is also common, and letting the student "watch" the supervisor work can be a very effective teaching strategy.[231]

In community-based programs, if a supervisor oversees the work of one to five counselors, supervision tasks typically require two to three hours per week. This entails relying on group clinical supervision and direct observation through audio- or videotaping or live supervision. Supervisors might need to provide additional time for close supervision of trainees, interns or counselors needing specific attention.[232]

14.3 CLINICAL SUPERVISION IN DOCS SUBSTANCE ABUSE TREATMENT PROGRAMS

The ASAT Manual specifies that treatment teams are to comprise one correction counselor (CC) and two program assistants (PAs). Facilities with more than two teams qualify for the addition of an ASAT supervising correction counselor (ASAT SCC). If there is no ASAT SCC position, as in the majority of programs we visited, a general SCC is responsible for providing supervision to the CC and other treatment staff. The SCC is the main link to the deputy superintendent of programs (DSP), who in turn reports to the facility superintendent and the executive team about treatment program issues as appropriate. See **Section 7, Staffing**, for job descriptions, qualifications, and other details of staffing patterns.

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[228] U.S. Department of Health and Human Services, *Clinical Supervision and Professional Development of the Substance Abuse Counselor*, 5.
[229] Powell and Brodsky, *Clinical supervision in alcohol and drug abuse counseling*.
[230] Eby et al., "Motivational bases of affective organizational commitment," 463-483.
[231] Powell and Brodsky, *Clinical supervision in alcohol and drug abuse counseling*, 16.
[232] U.S. Department of Health and Human Services, *Clinical Supervision and Professional Development of the Substance Abuse Counselor*, 82; Washington State Division of Alcohol and Substance Abuse, "Clinical Supervisor Skill Standard."

We did not observe any formal clinical supervision on our visits, nor was any such supervision frequently reported to us in our interviews of staff or management. OSATS does not have written policies requiring the provision of routine clinical supervision. If more formal and consistent supervision were established for treatment staff, it is a concern that very few treatment staff members currently meet the qualifications for a clinical supervisor outlined by OASAS. The absence of routine clinical supervision can impact the effectiveness of treatment services, create an unsupportive environment for treatment staff, contribute to a lack of accountability for treatment staff and result in inconsistent treatment programs.

In most DOCS treatment programs the CC supervises the PAs, but as mentioned above, regular time is not set aside for formal case reviews or other forms of clinical supervision. Similarly, SCCs provide only administrative supervision to CCs. With the limited number of experienced clinicians in management or supervision, a CC who encounters a crisis or other challenging clinical situation would be unable to obtain clinical support. The same holds true for the DSP.

At some facilities we visited, treatment staff reported frequent contact with the DOCS OSATS for help with questions and challenges. However, these seemed to be primarily logistical issues rather than clinical questions.

As DOCS collaborates with OASAS to monitor and improve treatment in the State's prisons, phasing in a well-planned system for clinical supervision (by trained, experienced staff) will be invaluable. It is noteworthy that OASAS has adopted a detailed clinical "supervision vision statement" that highlights the invaluable role of clinical supervision in effective treatment and in moving the field forward.[233] Furthermore, OASAS regulations for chemical dependence residential services require clinical supervision on a routine basis by a "qualified health professional" with a minimum of three years of both administrative and clinical experience in a residential substance abuse treatment program.[234] Similar requirements are in place for outpatient programs.

Throughout our study, the CA observed significant variations from program to program, and at times within a program from session to session. This lack of standardization was evident from clinical content, program structure and staff quality. Regular clinical supervision could address these issues, holding treatment staff accountable for service quality and effectiveness while providing them with support and skills to do so. In addition, clinical supervision may help increase treatment staff's satisfaction and thus reduce the high staff turnover common in DOCS substance abuse treatment programs.

In order to ensure treatment staff are effectively carrying out their responsibilities, accurately keeping documentation and running engaging and appropriate treatment sessions, processes need to be established to monitor their work. OASAS guidelines for community-based residential treatment programs require a clinical supervisor to sign off on the initial comprehensive client assessment, treatment plan and discharge plan. When reviewing treatment records of inmates in DOCS treatment programs, the discharge plan is the only document we observed that required a

[233] U.S. Department of Health and Human Services, *Clinical Supervision and Professional Development of the Substance Abuse Counselor*, 135.
[234] OASAS, "Operating Regulations Part 819.7."

supervisor's signature. This lack of oversight and supervision likely contributes to the many incomplete and inadequate intake documents and treatment plans we found in inmates' records.

DOCS has made substantial strides in reorienting its institutional culture from a staff-dominated 12-step-based model to the participant-centered TC model. Clinical supervision will be a critical tool in continuing and expanding these shifts, helping staff focus on strengths, support and engagement in conditions that are often frustrating and stressful.[235] A wide variety of tools and supports are available to help with this process, many of them at low or no cost.[236]

14.4 TREATMENT PARTICIPANT PERCEPTIONS OF THEIR TREATMENT

Research has shown that substance abuse treatment program effectiveness decreases as participant ownership diminishes.[237] Similarly, measuring participants' satisfaction is an important element of program monitoring and has been shown to be predictive of both program completion and, more importantly, reduction in relapse.[238] Asking for feedback from program participants can increase their sense of ownership of the program, provide a mechanism for monitoring program effectiveness, and assist the program to better respond to the needs of the population.

The Multimodality Quality Assurance Scales (MQA) survey sought participants' assessment of their satisfaction with their treatment and several components of the treatment program. **Section 7**, **Staffing** and **Section 8**, **Treatment Programming and Materials**, detail the results of the survey respondents' answers. Overall, these data reflected mixed reviews of the programs, ranging from high levels of satisfaction at certain programs to very low levels at other institutions. For example, concerning staffing, overall 58% of survey respondents felt it was *mostly* or *very true* that they were satisfied with the counseling process, but the percentages ranged from a low of 31% at Bare Hill to a high of 96% at the Lakeview Female program. If such data were routinely sought from all programs, it would be invaluable to the Department in assessing their programs and determining where additional supervision and training are needed.

The MQA survey also sought program participants' assessment of their program attachment and ownership. Specifically, it asked on a four-point scale from *not true* to *very true* whether the program participant felt "an attachment and ownership in the program" (see MQA Q17(c), **Appendix B**). Thirty-nine percent of the survey respondents replied that it was *not true* that they had such attachment/ownership and only approximately one-third (36%) responded that it was *mostly* or *very true* that they felt such ownership. **Chart 14-1** illustrates the responses of *mostly* or *very true* for each prison and the assessment of all respondents listed under the last column labeled *Total*.

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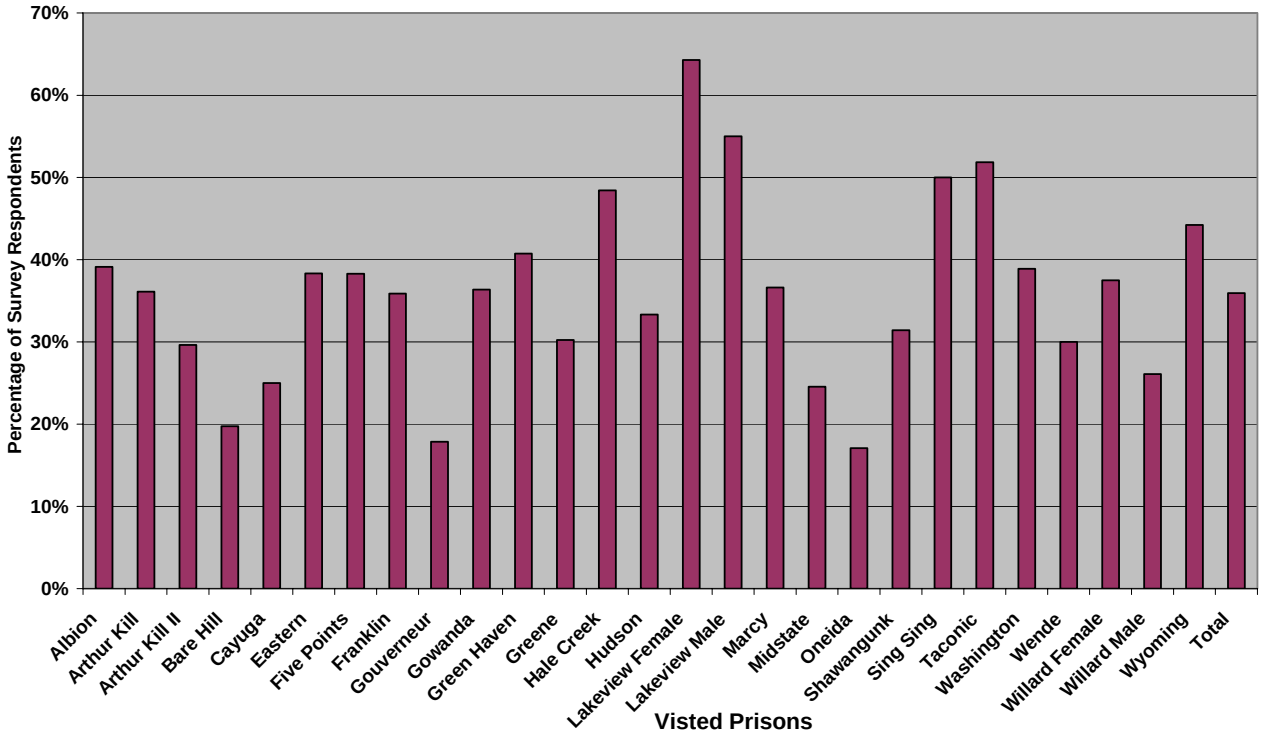
[235] White, Schwartz, and Philadelphia Department of Behavioral Health and Mental Retardation Services, *The Role of Clinical Supervision in Recovery-oriented Systems of Behavioral Healthcare*.
[236] U.S. Department of Health and Human Services, "Competencies for Substance Abuse Treatment Clinical Supervisors"; U.S. Department of Health and Human Services, *Clinical Supervision and Professional Development of the Substance Abuse Counselor*.
[237] Wanberg and Milkman, *Criminal conduct & substance abuse treatment*.
[238] Melnick, Hawke, and Wexler, "Client Perceptions Of Prison-Based Therapeutic Community Drug Treatment Programs," 124-25.

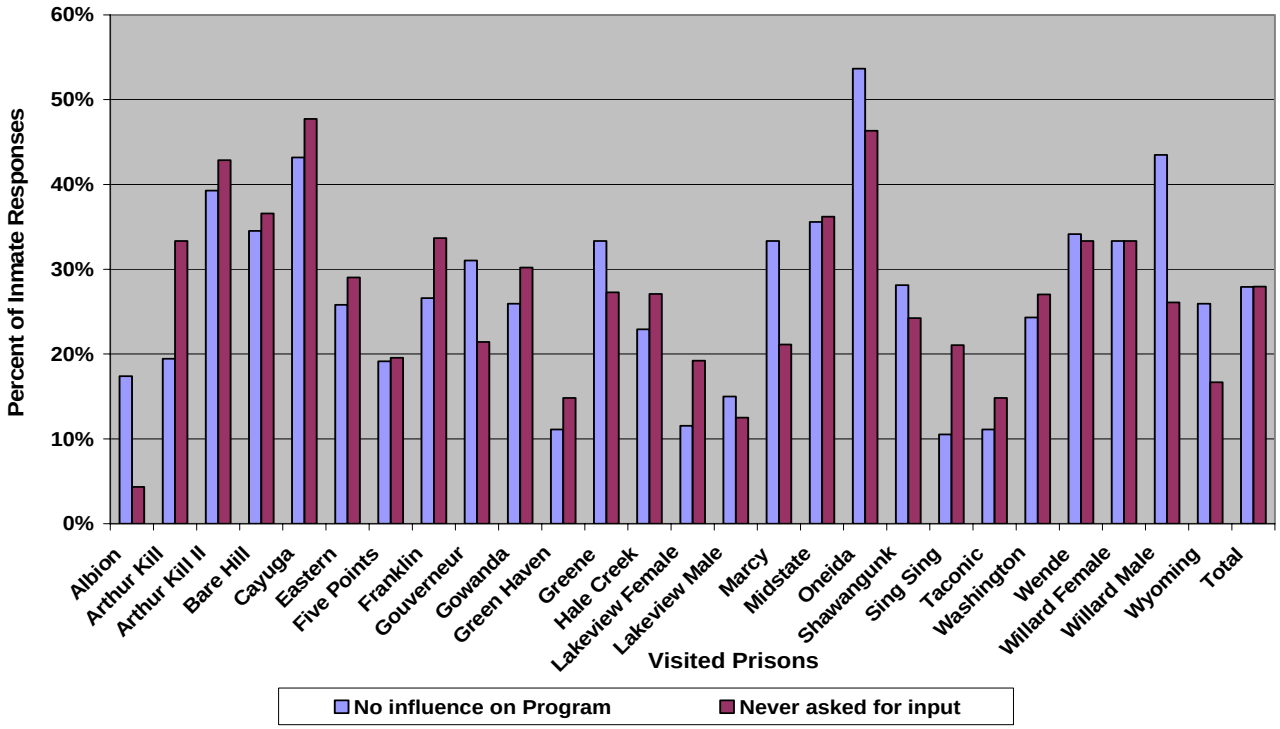
Chart 14-1 Survey Respondents' Assessment of Attachment and Ownership in Program as Mostly or Very True (MQA Q17c)



We are very concerned that nearly two-thirds of the survey respondents did not express significant attachment to their treatment program. Moreover, at certain facilities (Bare Hill, Gouverneur and Oneida) less than 20% of the respondents felt substantial attachment. If the prisons had a mechanism to gauge program participants' assessment of their program, it would be more likely that such levels of dissatisfaction would be revealed both to supervisory officials at the facility and OSATS, and some corrective action could be taken to improve program engagement.

Related to the concept of a participant's attachment to and ownership in his/her treatment program is the participant's ability to have some influence on what is occurring and the staff's receptivity to his/her opinions and suggestions. The results of the MQA survey demonstrate that many program participants did not believe that staff sought their input, nor did they feel that they had much influence on what happened within the program. Sixty-one percent of the individuals we surveyed reported that they have *no* or *very little influence* as to what happens in the program. Only 12% of survey respondents reported having a *great deal* of influence. Along with perceptions of influence, surveyed individuals were asked about how much input they are asked to give about the program by treatment staff. According to 48% of these individuals, treatment staff *rarely* or *never* ask them for their opinions or suggestions regarding treatment issues. Twenty-nine percent of respondents reported that they are asked to provide input often. **Chart 14-2** illustrates the perceptions of inmates who believe they had no influence in the program and were never asked for input into their substance abuse treatment programs.

Chart 14-2 Survey Respondents' Assessment of Their Input into and Influence on Their Treatment Program (MQA Q8 & Q9)



As with the other measurements of participants' evaluation of their treatment program, there was a high degree of variability of perceived influence and input among treatment programs.[239] The willingness of staff to seek input from their program participants is another indication of how well they are engaging the inmates in their program. Such information should be sought in a program monitoring effort to identify how to improve motivation and engagement, and thereby enhance program outcomes.

14.5 MONITORING BY DOCS

Every DOCS substance abuse treatment program is required to submit monthly reports to OSATS. These reports primarily consist of statistical information, including waiting list, screenings, admissions, caseloads, graduations and removals. The ASAT Manual indicates that these reports should describe program accomplishments, staff issues or any other needs or changes in the program, but the reports contain little qualitative or descriptive information. It is unclear what happens to these reports or how they are used by OSATS. Facility staff did not frequently report receiving any feedback from these monthly reports. Additionally, the ASAT Manual requires each program to develop a weekly schedule of its activities, indicating the name

[239] The facilities with the highest percentage of inmates saying they have *no influence* in their treatment program include Oneida (54%), Willard Male (44%), Cayuga (43%), Arthur Kill (39%), Mid-State (36%) and Bare Hill (35%). The facilities with the highest rates of inmates who had *never* been asked for their opinions or suggestions about the treatment programs were Cayuga (48%), Oneida (46%), Arthur Kill (38%), Bare Hill (37%) and Mid-State (34%).

of the session, facilitator and the time/location. The schedule is to be posted in the group room. We observed that some programs do not generate these schedules, and some programs responded to our FOIL request stating that such a schedule does not exist. We also observed that many of the site visit reports issued by Central Office include posting of the schedule as one of their recommendations. Though many programs we visited did have accurate and up-to-date program schedules, these inconsistencies from program to program could be addressed through more comprehensive and consistent monitoring.

OASAS guidelines require that community-based residential substance abuse treatment programs submit an annual report to facilitate monitoring the effectiveness and efficiency of the programs (**Appendix E**). These standards currently do not apply to DOCS treatment programs with the exceptions of Willard DTC and Edgecombe C.F. Both the CASAT program and the Lakeview Shock program are required by legislative mandate to produce an annual report providing an overview of program activities and charting any changes or trends in the population or programming.[240] These annual reports include some outcome data. It is our understanding that no other DOCS substance abuse treatment program produces similar reports. OASAS guidelines also require community-based residential substance abuse treatment programs to develop and implement utilization review and quality improvement plans. These help to guarantee program integrity and ensure that services are appropriate and effective, and create an important mechanism for future program improvement. OSATS does not require programs to develop these plans, and we did not observe them in any treatment program.

14.6 DOCS CENTRAL OFFICE SITE VISITS

DOCS substance abuse treatment programs are administered under the supervision of the DOCS Office of Substance Abuse Treatment Services, which visits each program once or twice every year. During these visits, OSATS staff meet with the facility treatment staff and executive team, and tour the program and housing areas. Areas reviewed during these visits include program capacity, staffing patterns, staff involvement, review of treatment records, adherence to treatment guidelines and TC procedures, aftercare and caseload overview. Some visits, but not all, include observation of a treatment session. A written site visit report incorporates findings and recommendations and is forwarded to the facility's superintendent.

The structure of reports issued before 2009 follow a roughly standardized model, as the categorized sections of information remain somewhat consistent through reports. However, a sampling of site visit reports from facilities we observed indicates significant variation in the content and length of these reports.[241] Some reports were extremely brief and general, while others included detailed information. The amount of detail included in the reports varied according to who was conducting the site visits. Some monitors appear concerned with the quality of the programs, while other reports reflect little critical analysis and review. Time constraints often resulted in the omission of review of important areas, such as evaluations of treatment records or observations about terminations/completions. Under the subdivision for review of treatment records, reports often simply stated that the records' contents were "in

[240] NYS Department of Correctional Services, *The Nineteenth Annual Shock Legislative Report*; NYS Department of Correctional Services, *The Comprehensive Alcohol and Substance Abuse Treatment Program: 2008*.
[241] Site visit reports requested by the CA and provided by DOCS as a result to a FOIL request dated May 12, 2009.

compliance" with ASAT standards. When a more thorough review was completed, the reports listed the contents of the treatment records; some even referenced specific inmate's files.

Most discrepancies found in treatment records dealt with missing contents, such as treatment plan updates (TPUs) and aftercare planning. Central Office also often recommended that TPUs and aftercare planning be made more "inmate-specific." While such recommendations could be easily followed up on during the next visit, the reports did not indicate who was responsible for enacting any changes and therefore did not provide a clear mechanism of accountability. Reporting on other program components, such as terminations and completions, often simply stated that the completions were "in compliance," or that the "removals are appropriate." There was no numerical data concerning the number of inmates being removed from, or completing, the program in any of the site reports. However, suggestions regarding the removal section often included the creation of a treatment plan review committee, an implementation that would improve the quality of ASAT. A section of the site visit report refers to "Security/Program Interaction." In some reports, this section contained details about correction officers who had completed training on the TC modality, while most reports stated only, "positive and supportive." Recommendations often lacked details or failed to assign responsibility for corrective actions.

Many reports—though not all—included a follow-up of the previous report's recommendations. They sometimes noted that the schedule was now being posted in an easily accessible program area, or that treatment records had begun including inmate-specific aftercare planning, but such follow-ups failed to include a more detailed inquiry into the process by which such changes were enacted. They only revealed how closely the program was adhering to structural ASAT guidelines, but did not detail the steps taken to arrive at the improved procedures. During our meetings with executive staff at each facility, we inquired about recent recommendations given by Central Office. They reported that recommendations ranged from extremely broad, such as "create more hierarchy" and "incorporate more TC into your overall structure," to more specific suggestions, such as changing a policy to allow photos in cubicles. Central Office's site visit reports that we received in response to our FOIL request support the facilities' claims that recommendations range from broad to specific. It became clear through the type of recommendations made that most facilities needed assistance complying with therapeutic community guidelines, and the reports were mainly concerned with checking that all areas of the program appear to be in adherence. The result was that timelines and corrective plans were not provided, and little was revealed about the quality of the programs. However, not all recommendations appeared vague or insufficient. For example, the recommendation issued in a February 2, 2007 report at Cayuga urged that "there should be high level of consistency in F-block residential ASAT." The monitor noted that the two modules of the program were being run in different manners, and that consistent treatment across both modules would strengthen the efficiency of the program. While we were pleased to find such details being noted by Central Office, it was disappointing to discover that the next report, issued April 3, 2008 simply noted "all recommendations completed" and did not provide more detailed follow-up on the important issue of program consistency.

In addition to finding many recommendations lacking in specificity, we were unable to determine what happens to the information in the site visit reports, and whether facilities are held

accountable for deficits or for developing and implementing corrective plans. Several staff members we interviewed struggled to recall recent recommendations by Central Office, suggesting that the impact of these visits varies greatly from facility to facility. Furthermore, it seems that the written report is shared with program staff only at the discretion of the facility's executive team.

The CA was concerned to hear in early 2010 about proposals to revise the site visit policy due to budget constraints. Previously, OSATS representatives visited a facility with the sole purpose of evaluating the substance abuse treatment program. The proposed—and currently implemented—changes call for annual site visits by a small team of individuals from DOCS Central Office who would evaluate *all* DOCS programs at the facility, including substance abuse treatment programs, educational programs, vocational programs, etc. The site visitors would be "generalists," with no requirement for the special training and expertise needed to accurately and productively evaluate clinical programs. We believe that this change would unacceptably reduce both the time and expertise invested in reviewing substance abuse treatment programs. Such concerns are supported by the contents of site reports issued in 2009 that were provided to the CA. Consistent with DOCS's description of the new review process for all prison programs by Central Office staff, the review of ASAT programs in these 2009 reports was included as a small section in a review of all programs. These reports strayed from the standardized model of their predecessors, forfeiting a great deal of substantive content. Unlike most previous reports, which noted the date of the previous visit, program capacity and staffing patterns, most of the new-format reports lacked this crucial information. The paragraph-long descriptions of the treatment program presented in most of these new reports contained little evaluative narrative and failed to reflect an effort to identify program strengths and weaknesses or provide guidance on how to improve the treatment provided. To address this concern, OSATS has stated that if problems are identified on a visit, the office would send staff to conduct a comprehensive evaluation. Though we appreciate this step, we remain concerned that generalist site visit teams may be unqualified to make even preliminary identifications of problems with substance abuse treatment programming.

Along with quality site visits, it is important that DOCS Central Office maintain open communication with staff at facilities. Some staff lauded OSATS for its helpful and timely advice, while others reported that clear communication was lacking. It may be that the executive teams at some facilities have easier access to DOCS Central Office than do PAs or CCs.

14.7 OASAS OVERSIGHT

Before April 2009, the only external oversight of DOCS substance abuse treatment services was provided at Willard Drug Treatment Campus and Edgecombe Correctional Facility, both of which are certified by the New York State Office of Alcoholism and Substance Abuse Services (OASAS). Though OASAS certifies all substance abuse treatment programs in the community, it has historically played no role in monitoring DOCS programs. This changed in early April 2009, with reform of the Rockefeller drug laws, which now require OASAS to monitor care and treatment of inmates in New York State prisons, develop guidelines for prison-based substance abuse treatment programs, and produce a yearly report on these programs.[242] OASAS has now

[242] *A156-B Budget Chapter 56*.

designed and started to implement a plan to develop initial recommendations to comply with the legislative mandates, and released its first report in December 2009.

Treatment staff we spoke with held disparate views about the new OASAS role with DOCS treatment programs. Many expressed concern that additional, unnecessary paperwork could detract from clinical time. There was also fear that OASAS would impose standards that ASAT programs would struggle to meet due to inadequate resources. Much of this results from DOCS treatment staff concerns that OASAS management and staff are unfamiliar with the culture and constraints of the prison setting and might make unreasonable demands. On the other hand, others anticipated that OASAS involvement could bring additional training and resources, which would be welcome additions.

The CA looks forward to the new role OASAS will play in monitoring DOCS substance abuse treatment programs. We encourage OASAS to establish detailed reviewing instruments and clear protocols regarding their visits to DOCS facilities, and urge OASAS to meet confidentially with treatment staff and participants, and to review case records and observe group counseling and educational sessions. We are concerned that OASAS may not have adequate staff and appropriate resources for this substantial task. The extreme variability among programs that we observed means that OASAS cannot assume that any programs are representative of others, requiring site visits to a wide selection of programs. We encourage the State legislature and executive to address this issue and provide OASAS with the necessary staffing and other resources needed to accomplish this new role.

It is beyond the scope of this report to offer guidance for DOCS and OASAS as they address the organizational and cultural shifts that are likely to result from the addition of OASAS oversight and the changes we recommend. A special 2009 issue of the journal *Drug and Alcohol Dependence*[243] looks at some of these complex issues using data from the National Criminal Justice Treatment Practices survey. A great deal of other material has been developed in the last several years to help with organizational and programmatic change in substance abuse treatment programming, both in and outside prisons.

14.8 OASAS UPDATE

The Correctional Association provided both OASAS and DOCS with an opportunity to review a draft of ***Treatment Behind Bars: Substance Abuse Treatment in New York Prisons, 2007-2010*** and share any additional information, clarifications or comments with staff. Though DOCS declined to meet and discuss the report, CA staff was able to meet with an OASAS representative on October 6, 2010. This meeting allowed CA staff to better understand some of the steps that have been initiated by DOCS and OASAS to enhance New York's prison substance abuse treatment programs. We were pleased to note that several of the CA's observations and findings were on the radar of both agencies, and that there appeared to be a shared objective to improve various areas in DOCS treatment programs including, screening and assessment, supervision and aftercare planning. The meeting with OASAS also provided the CA with limited information about the agency's future plans with regard to DOCS' treatment programs.

[243] "Drug and Alcohol Dependence."

The CA was pleased to learn that OASAS, in response to a DOCS request, is evaluating DOCS's screening process for determining substance abuse treatment needs and is considering recommending new screening and assessment instruments. The CA's report clearly lays out the shortfalls of the current screening process and recommends the use of matching individuals to appropriate levels of treatment based upon treatment needs. Again, we were happy to learn from OASAS that the idea of developing several levels of care within the DOCS system was under consideration, and we urge DOCS and OASAS to move forward with this concept. Quality screening instruments clearly contribute to the effectiveness of the process, but the way these instruments are administered also impacts the outcome. We understand that DOCS and OASAS plan to train staff in motivational interviewing techniques to be better able to solicit more comprehensive information while simultaneously enhancing the individual's motivation for treatment; we commend both agencies for this effort.

In addition to the increased training in motivational interviewing techniques, OASAS appeared interested in exploring the idea of establishing best practice training centers in the future for DOCS treatment staff. The CA strongly supports this idea as a way to ensure all treatment staff receive appropriate and consistent training and to reduce some of the many variations in quality across programs we observed. We are slightly concerned that OASAS appears to have no current plans to address what we believe to be a vague and somewhat ineffective curriculum, and encourage them to consider closely evaluating the curriculum in the future.

OASAS has recently certified five DOCS substance abuse treatment programs and has plans to attempt to visit all of the treatment programs within the next four years. We are also under the impression that the regulations produced by OASAS contain a minimum level of requirements from DOCS' treatment programs, but a gold standard initiative will be established as a reward system to encourage treatment staff and programs to go above and beyond the regulations. The CA's report specifically discusses the substance abuse treatment services offered to individuals with mental illness and outlines several shortcomings. OASAS will not currently focus on treatment services for such special populations, but is committed to assessing this area in the future.

In December 2010, OASAS released its second annual report on NYS DOCS Addiction Services. The annual report included new draft operational guidelines for DOCS treatment programs that have been introduced to five pilot facilities. We were pleased with the inclusion in the guidelines specific requirements for enhanced program oversight, clinical supervision, documentation and staff training. Though the new guidelines discussed the development of more comprehensive assessments for individuals entering DOCS treatment programs, we were very concerned with the complete absence from the report of any steps OASAS would be recommending DOCS to take to address the overall screening process for individuals entering DOCS custody. During reception processing, individuals are first identified as needing treatment, and we concluded during our study that the lack of comprehensive assessments prior to treatment enrollment resulted in inadequate evaluation of treatment needs and inappropriate program assignment for some participants.. Additionally, the recent OASAS report omitted any mention of matching individuals to varying levels of care or formalizing a removal policy for individuals in the treatment programs, both areas we strongly encourage OASAS and DOCS to address. As with any guidelines, the success lies with the implementation and we urge OASAS

to offer training and continued guidance to DOCS treatment staff to ensure appropriate implementation.

It was clear from our meeting with OASAS that many positive steps to address the quality of DOCS treatment programs are being considered, though formal policies have not yet been established. We hope to see these ideas move towards full implementation in the coming years. One area where it appears the state agencies have taken concrete actions to improve treatment for individuals incarcerated in New York prisons is with regard to aftercare and reentry. The New York's Transition from Prison to the Community (NYTPC) Model has been developed to serve as what the agencies describe as an ideal reentry system for New York State, though it has yet to be implemented. We believe the model will first be piloted and understand that it will require long-term commitment from various agencies to fully operationalize.

As the result of a FOIL request, the CA has had access to some preliminary documents describing NYTPC and is pleased to see a focus on increased assessments, client-centered approach, evidence-based programming and monitoring and evaluation of programs in order to monitor success. The NYTPC calls for individuals involved in the criminal justice system to develop a Transitional Accountability Plan (TAP), which would begin with probation conducting an initial risk and needs assessment. This assessment will then be passed to DOCS who will conduct further periodic assessments to allow them to appropriately prioritize programming and treatment resources. The TAP will be developed with input from the individual and will be continuously updated. In addition, the NYTPC calls for DOCS staff (and Parole staff) to be trained in motivational interviewing techniques and that DOCS programs be evidence-based and more closely monitored and evaluated. Once an individual has been released from prison, the TAP will be provided to Parole who will also conduct further risk and needs assessments and will continue to support the goals outlined in the plan. Supervision levels will be determined based on risk, and resources will be targeted to those most in need. The NYTPC also calls for Parole to use a system of graduated responses based on the risk and needs assessment to respond to parole violators. This new model relies heavily on effective collaborations and calls for the Office of Mental Health (OMH), OASAS, and other human service providers to work collaboratively in order to facilitate prompt access to public benefits and other basic needs for individuals being released back to their communities.

We thank OASAS for their review of the CA's report and look forward to working together to improve substance abuse treatment services for this often overlooked population.

15. AFTERCARE, CONTINUING CARE AND REENTRY SUPPORT

FINDINGS

Most treatment programs make little effort to develop specific in-prison and post-release aftercare recommendations for program graduates.

Discharge planning is minimal, and many of the Department staff responsible for this task lack the expertise and resources to execute it effectively. The treatment staff who have worked with the inmates for a minimum of six months and are in the best position to assess an individual's readiness for, and make recommendations to, appropriate community-based treatment programs are not charged with the responsibility of developing a detailed discharge plan. In practice at most facilities, the treatment staff provide little to no support or assistance to inmates who have graduated prison-based substance abuse treatment and are being released.

DISCUSSION

15.1 AFTERCARE AND REENTRY, GENERALLY

Continuing care, both inside prison and post-release, plays a major role in reducing relapse and recidivism after the conclusion of primary treatment, according to a well-established consensus of researchers, experts and clinicians. This is especially true for those returning to the community from prison, as they face major shifts in their environment that may challenge their recovery—reduced structure, increased decision-making, and potential relapse triggers they have not faced in years. Continuing care is also critical for those who complete residential treatment in prison and return to the general population, with its lack of emphasis on recovery, possible access to drugs, and increased stressors.[244]

There is increasing evidence that the prison-based component of treatment may serve primarily as an orientation or transitional phase to the community-based component. Inmates participating in prison treatment only (i.e., without aftercare) often have long-term post-treatment outcomes similar to those receiving no treatment at all.[245]

[244] Belenko, "Assessing released inmates for substance-abuse-related service needs," 94-113; Soyez and Broekaert, "How do substance abusers and their significant others experience the re-entry phase of therapeutic community treatment," 211-220; Wexler et al., "The Amity Prison TC Evaluation," 147-167; WEXLER et al., "Three-Year Reincarceration Outcomes for Amity In-Prison Therapeutic Community and Aftercare in California," 321-336; Inciardi, Martin, and Butzin, "Five-year outcomes of therapeutic community treatment of drug-involved offenders after release from prison," 88-107; Knight, Simpson, and Hiller, "Three-year reincarceration outcomes for in-prison therapeutic community treatment in Texas," 337-351; "Three-year outcomes of therapeutic community treatment for drug-involved offenders in Delaware," 294-320; Butzin, Martin, and Inciardi, "Treatment during transition from prison to community and subsequent illicit drug use," 351-358.

[245] Lowe, Wexler, and Peters, *The RJ Donovan in-prison and community substance abuse program*.

Participation in treatment during the critical transition from prison to community has been shown to be particularly effective, such as a therapeutic community for inmates in work release or similar programming.[246] These benefits are seen even for reentering inmates with an extensive criminal history, low rates of marital bonds and substantial unemployment.[247]

Thus, there is growing consensus that the most effective strategy for inmates with substance abuse problems is a seamless continuum with three elements: an in-prison therapeutic community (TC); a transitional TC during work release or similar programming; and, when appropriate to the individual's needs and resources, lower-intensity care that can include outpatient counseling and group therapy.[248] In this final phase, individuals should be encouraged to continue their connections with the transitional TC, returning for "refresher" or reinforcement sessions, attending groups and seeing their counselors on a regular basis.[249]

This multistage model has been operating in the Delaware correctional system since the mid-1990s. Positive outcomes have been identified for former inmates at 18 months, 42 months, and 60 months after release.[250] Significantly, both the 18- and 42-month follow-up studies reflect a lack of substantial long-term effects for in-prison treatment alone.[251] The DOCS CASAT program also provides a similar continuum of services beginning with a six-month intensive residential treatment program, followed by work release with outpatient treatment and enrollment in community-based treatment services after release. Men who completed all three phases of CASAT had a 22% recidivism rate and women a 21% rate after a three-year post-release follow-up, compared with 41% of men and 31% of women who did not participate in the three phase program.[252]

Many people with substance abuse, including those returning to the community from incarceration, have a panoply of additional problems and needs: psychiatric, medical, employment, family and social. Identifying and addressing these needs is critical to the maintenance of a drug- and crime-free lifestyle, considerably expanding the definition of "continuing care." In order to prevent the often piecemeal variety of services frequently available for inmates returning to their communities, there is currently a movement toward a recovery-oriented integrated system (ROIS). This approach allows for coordination between treatment, correction and social services to better meet both the reentry and recovery needs of individuals returning from prison. All agencies and individuals within this system will have a

[246] Butzin, Martin, and Inciardi, "Evaluating component effects of a prison-based treatment continuum," 63-69.
[247] Butzin, Martin, and Inciardi, "Treatment during transition from prison to community and subsequent illicit drug use," 351-358.
[248] Taxman, "Reducing recidivism through a seamless system of care."
[249] Inciardi, Martin, and Butzin, "Five-year outcomes of therapeutic community treatment of drug-involved offenders after release from prison," 88-107.
[250] Ibid.
[251] Martin, Butzin, and Inciardi, "Assessment of a multistage therapeutic community for drug-involved offenders.," 109-116; Martin et al., "Three-year outcomes of therapeutic community treatment for drug-involved offenders in Delaware," 294-320.
[252] DOCS *Comprehensive Alcohol and Substance Abuse Treatment Program Legislative Report, 2008*. http://www.docs.state.ny.us/Research/Reports/2009/CASAT_Report_2008.pdf

common vernacular, established procedures for communication and uniform assessment tools for referrals and tracking progress.[253]

It should be noted, however, that some researchers point out that it is extremely challenging to study community-based treatment for individuals under criminal justice supervision because of the difficulty of disentangling the effects of the supervision from those of the treatment.[254] A related consideration is that in the field of substance abuse treatment, "aftercare" is defined as lower-intensity treatment (e.g., outpatient) that follows an initial episode of higher-intensity treatment (e.g., inpatient or residential). In the criminal justice literature, "aftercare" often refers to any *post-release* treatment. Most research on care after prison, however, looks at services provided in transitional TCs—often called "halfway houses"—which are intensive.[255]

15.2 DOCS TRANSITIONAL SERVICES

Despite the well-established benefits of referral to transitional and post-release care for substance abuse, the CA found that the systems and staff at DOCS facilities are not structured to make the necessary referrals and connections. Staff at some facilities, such as Lakeview, appear to better able assist participants with reentry, and suggested their programs are more effective because they place a strong focus on "going home." In addition, the Lakeview Shock program also requires that all individuals who have completed a shock program be transferred to the Division of Parole supervision program, which consists of more intense supervision and smaller caseloads. Shock inmates returning to New York City are also enrolled in an "After Shock" parole program that provides specialized employment, vocational and relapse prevention services.

Inmates are often released from DOCS facilities without active Medicaid coverage, rendering them unable to enroll in most community-based treatment programs. The Department is making some effort to address this extremely important issue; the CA looks forward to its continued progress.

The main effort by DOCS to facilitate reentry is Transitional Services (TS), a three-phase program that aims to orient inmates to life in prison and help them prepare for return to the community.[256] Phase I, the orientation/introductory phase, is provided to every inmate entering the State correctional system and generally lasts from one to two weeks. As described by DOCS, Phase II (the core phase) assists inmates in "developing the basic skills necessary to live a productive, crime free life in society." Most Phase II programs are half-day group sessions run by inmate facilitators during a two- to three-month period. There is no standard time for when this program is offered to inmates, but most participants are enrolled during the middle to latter half of their sentences. Not every prison conducts Phase II programming, and many inmates do not participate in the program as it is not widely available. Phase III, the transitional phase, is "the final preparation for community reentry," according to DOCS. It lasts for up to three

[253] De Leon, "Therapeutic Community Treatment in Correctional Settings: Towards a Recovery-Oriented Integrated System (ROIS)."
[254] Pelissier and Cadigan, "Interagency Priorities at the Crossroads."
[255] Ibid.
[256] NYS Department of Correctional Services, "Program Services - Transitional Services Program."

months, and includes activities such as résumé preparation and mock interviewing. According to DOCS policies, every inmate should be enrolled in Phase III shortly before release.

Phase III is the most critical for successful reentry. During this time, inmates can contact community-based organizations in order to identify resources such as housing and employment. Individuals not participating in Transitional Services may write to the TS staff to request information or assistance with identifying appropriate community-based programs. The extent of assistance provided varies among facilities, depending on available resources and facility policies about the services they will provide general population inmates not enrolled in Phase III of Transitional Services.

> *Much of the information that they have is outdated, and what resources they do have, are underfunded and understaffed, many of them having moved away a long time ago. I never found these services to be helpful at all simply because most of them only exist on paper, and are not actual contacts with people who are in positions to really offer a helping hand.*
>
> Anonymous Inmate (Oneida C.F.)

The TS program is supervised by a full-time transitional services counselor, but in most prisons the program is led by inmates with counselors supervising all three phases of the program and at times offering individual assistance. In some facilities, we observed an array of up-to-date resources, sometimes—though rarely—maintained with computer assistance. One resource is *Connections: A guide for formerly incarcerated people to information sources in New York City*, published by the New York Public Library's Correctional Services Program; it includes a job-search guide as well as a directory.[257] The volume is regularly updated and published annually online as well as in print. Though it is provided free of charge to correctional facilities and community-based organizations that serve formerly incarcerated people, several of the DOCS facilities we visited had editions that were out of date.

Of the 1,186 surveys received from current treatment participants, 16% stated that they were currently participating in TS Phase III. Twenty-nine percent of the 1,162 respondents not in treatment stated that they were currently or previously enrolled in TS Phase III. Of these survey respondents currently or previously enrolled in Phase III, 38% reported that they had not received services or assistance in identifying and connecting with community-based substance abuse treatment programs, while 62% stated they did receive such assistance. More than half (58%) of these survey respondents stated that the TS staff were *not at all* or *only slightly* helpful, even though 48% of the survey respondents expressed being *moderately*, *considerably* or *extremely* interested in entering substance abuse treatment after release.

15.3 CONNECTING WITH OUTSIDE SERVICE PROVIDERS

At most of the facilities we visited, inmates received little assistance from DOCS staff in contacting community-based organizations to request post-release support. However, Transitional Services and treatment staff at some facilities (such as Bare Hill, Greene, Hale Creek and Marcy) stated they made calls to outside treatment providers on behalf of inmates. Inmates reported that they often wrote to service providers on their own, rarely receiving a

[257] The New York Public Library, "Correctional Services Program | The New York Public Library."

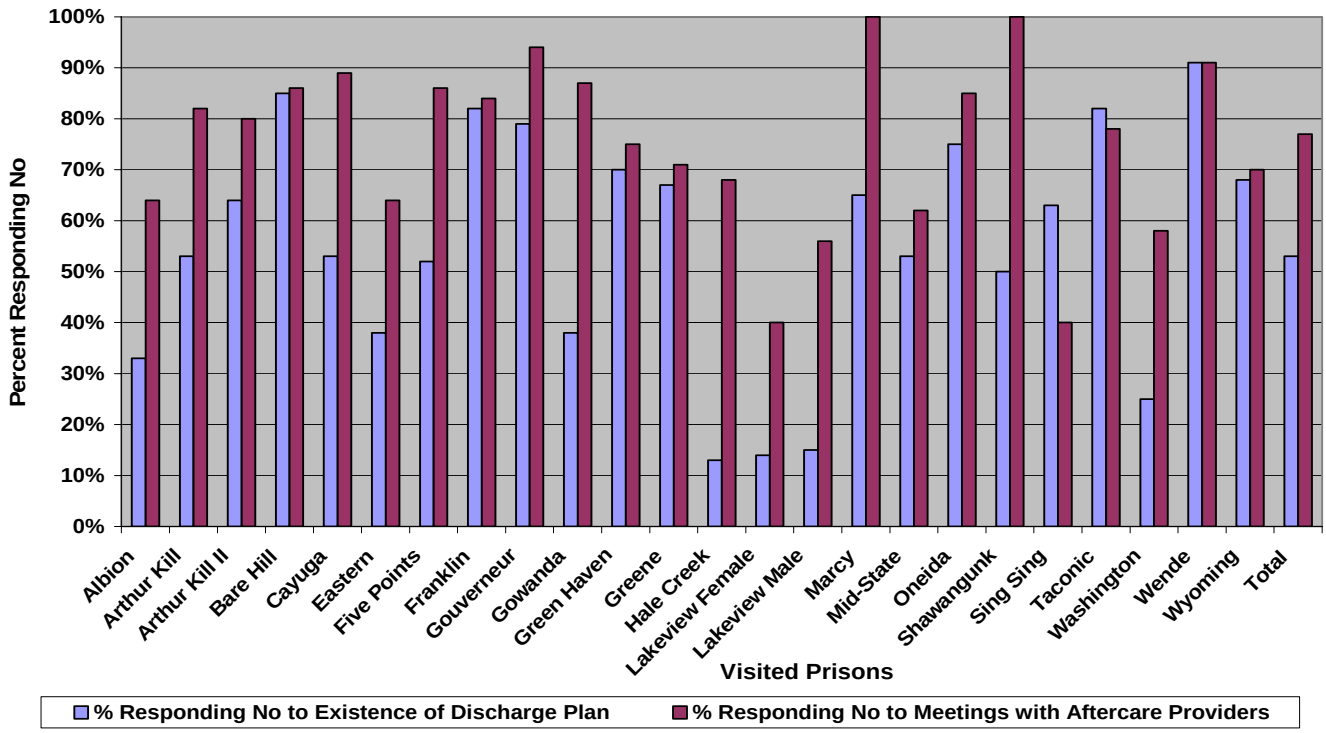
response. Inmates may receive a more positive response from community-based treatment programs if prison-based clinical staff initiated and were more involved in the referral process.

Seventy-seven percent of survey respondents who had been in the treatment program for longer than 90 days said there were no meetings between aftercare providers and participants while they were in the program. As with other features of DOCS programming discussed throughout this report, considerable variation existed among programs. A significant percentage of treatment participants responding to our survey at several prisons reported no such meetings, including those at Marcy (100% of survey respondents), Shawangunk (100%), Gouverneur (94%), Wende (91%) and Cayuga (89%). Survey respondents at other facilities, however, described meeting with outside providers at least once during their treatment, including participants at Sing Sing (60% of respondents), Lakeview Female (60%), Lakeview Male (44%), Washington (42%) and Mid-State (39%).

With regard to discharge planning, 53% of surveyed treatment participants who had been in the program for more than 90 days stated that there was no discharge plan for inmates on completing the program. However, the ASAT Manual[258]calls for completion of the "ASAT Evaluation/Discharge Form" when an inmate is discharged from treatment for any reason.[259] This response by program participants indicated that the discharge planning process was limited to completion of the form, and that participants were rarely involved in discharge planning in any meaningful way. A higher percentage of treatment participants who had been in the program for longer than 90 days reported that there was no discharge plan for inmates upon completion of the program, including respondents at Wende (91% of respondents), Bare Hill (85%), Taconic (82%), Franklin (82%) and Gouverneur (79%). In contrast, a substantial percentage of survey respondents from other treatment programs said that a discharge plan was completed for each individual before completing the program, including those from Hale Creek (87% of survey respondents), Lakeview Female (86%), Lakeview Male (85%), Washington (75%) and Albion (67%). Similarly, at Willard DTC, 88% of treatment participants who had been in the program more than 60 days (Willard DTC is a 90-day program) reported that a discharge plan was in place for every inmate completing the program. See **Chart 15-1** for detailed information from all facilities we visited.

[258] State of New York Department of Correctional Services, *Alcohol and Substance Abuse Treatment (ASAT) Program Operations Manual*, sec. VIII. E. 36.
[259] The form included in the ASAT Manual as Attachment E is titled "ASAT Program Evaluation, Referral and Discharge Form."

Chart 15-1 Survey Respondents' Assessment of Aftercare Planning (MQA Q5 & Q6)



15.4 DOCS IN-PRISON AFTERCARE

> *"I am satisfied with the 6 month ASAT program, although I wish there was a follow-up program."*
>
> *Anonymous Inmate (Five Points, C.F.)*

Inmates under DOCS custody are prioritized for admission to substance abuse treatment based on proximity to their release date. Nonetheless, for a variety of reasons, inmates may face considerable time in prison after completing treatment. Whether they have six months, one year or five years remaining on their sentence, moving from a residential therapeutic community back to the prison's general population is a major transition that can test newly acquired skills and attitudes without the support that was readily available from the program. In treatment, inmates are encouraged to share openly about their histories and emotions, giving and receiving peer support, while survival in the general population can require a guarded, impersonal manner.

In most of the facilities visited for the Substance Abuse Treatment Project, treatment staff consistently and enthusiastically expressed the desire for continuing care programming and services inside the prison, such as a dedicated aftercare dorm. Although staff would not conduct treatment sessions in this area, treatment graduates could maintain a therapeutic community with community meetings and other TC components. Treatment staff also believed that graduates of in-prison treatment could benefit significantly from checking in with counselors periodically to update their relapse prevention plans and refresh the skills they acquired in treatment. We were

pleased to discover an aftercare dorm for substance abuse treatment graduates at Mid-State Correctional Facility, and encourage the Department to expand these dorms to other facilities.

The CA recommends that DOCS explore providing formalized continuing care for inmates who complete treatment and are awaiting release.

15.5 12-STEP PROGRAMS IN PRISON

Historically, substance abuse treatment in New York's prisons (as in most other settings) was based on the 12 steps of Alcoholics Anonymous (AA).[260] In 1996, however, New York State's highest court found in favor of an inmate who contended that 12-step programs are religious in nature, so that DOCS requirements that he participate in the program violated his First Amendment rights.[261] Since then, federal courts in New York and around the country have held similarly, so that several jurisdictions have been forced to eliminate their reliance on the 12-steps for their clinical programming.

In New York, DOCS developed the ASAT manual and chose the therapeutic community (TC) to replace the 12-step approach as its preferred modality, and commenced the process of converting its treatment programs to this model. This process continues today, with varying degrees of progress. See **Section 8, Treatment Programming and Materials**, for more information on this transition and its consequences for inmates and staff.

Twelve-step meetings continue in DOCS facilities, however, as approved voluntary programs after program hours. The meetings are organized and led by inmates or by members of local 12-step groups and vary in size and frequency of sessions among facilities. Twelve-step literature, such as books and pamphlets, are sometimes provided at no charge by local groups in the area or national offices. The DOCS facilities provide space, but no other resources, including staff or any other supervision or observation.

These programs serve an essential function in New York's prisons. DOCS prioritizes inmates for treatment based upon proximity to release, so many individuals may spend years in prison before entering a treatment program. Inmates entering the prison system with substance abuse problems are thus at risk for continued substance abuse or relapse. These independent programs, managed and run by volunteers, thus provide the only recovery support for inmates awaiting treatment. Similarly, after individuals graduate from in-prison treatment, the 12-step programs offer the only opportunity for inmates to maintain their recovery with support and assistance from their peers.

In most facilities, volunteers from local 12-step groups are required to conduct the meetings. Many of New York's prisons are in extremely remote locations, however, far from population centers that can support an adequate corps of volunteers.

Generally, the prisons we visited reported that it is more difficult to recruit NA volunteers than AA volunteers. This reflects the historically slower growth of Narcotics Anonymous in New

[260] White, *Slaying the Dragon*, 163 ff.
[261] *Griffin v. Coughlin*.

York State, which is commonly attributed to fears that the Rockefeller drug laws would consider NA meetings as illegal fraternizing with fellow addicts.[262] Furthermore, many NA members may be forbidden to enter DOCS facilities as conditions of parole or other restrictions. DOCS reported that as of March 3, 2009, there were 342 individuals listed as outside volunteers for AA meetings in prison, compared with only 51 volunteers for NA.

Thirty-three percent of respondents to our survey for individuals not currently in treatment reported participating in a voluntary substance abuse program such as AA or NA. Of these, 55% stated they were satisfied with the program.

As previously mentioned, participation in and frequency of AA and NA meetings differed among facilities. At Gowanda, Cayuga, and Green Haven, meetings were held the most frequently and had the highest attendance, while those at Five Points, Wende and Wyoming had lower participation rates. Some facilities reported that they no longer hosted AA or NA meetings because of construction or lack of space (Eastern); lack of volunteers (Shawangunk); low attendance (NA at Albion); or lack of inmates with "the right credentials" (Gouverneur). Arthur Kill was the only facility where a Spanish-speaking group (AA) met regularly. Inmates at facilities such as Franklin, Hale Creek and Wende were able to run their own programs when volunteers were not available. As of March 2009, the Department listed 57 facilities with AA meetings and 15 facilities with NA meetings.

Even after release, 12-step groups and meetings may be the primary support for former inmates as they await admission to treatment programs and long after they complete formal treatment—at no charge. Thus, although DOCS treatment programs must take care to clarify that participation in 12-step groups is not required, inmates should be educated about the programs: how they work, what they offer and how to locate meetings. They should also be educated about alternative peer support groups, such as SMART Recovery, Rational Recovery, SOS and others that are available in the returning inmate's community.

We found, however, that some prison treatment programs did not provide this education, nor did they encourage inmates to attend the meetings in the facilities to become familiar with them. Twenty-four percent of all the treatment participants we surveyed reported that discussion and explanation of the 12-step programs were not an important part of their program. As with all our findings, a tremendous amount of variation existed from facility to facility. See **Chart 15-2**.

[262] White, *Slaying the Dragon*, 239.

Chart 15-2 Survey Respondents' Assessment of Whether 12-Step Program Goals Were Explained (MQA Q15(a))

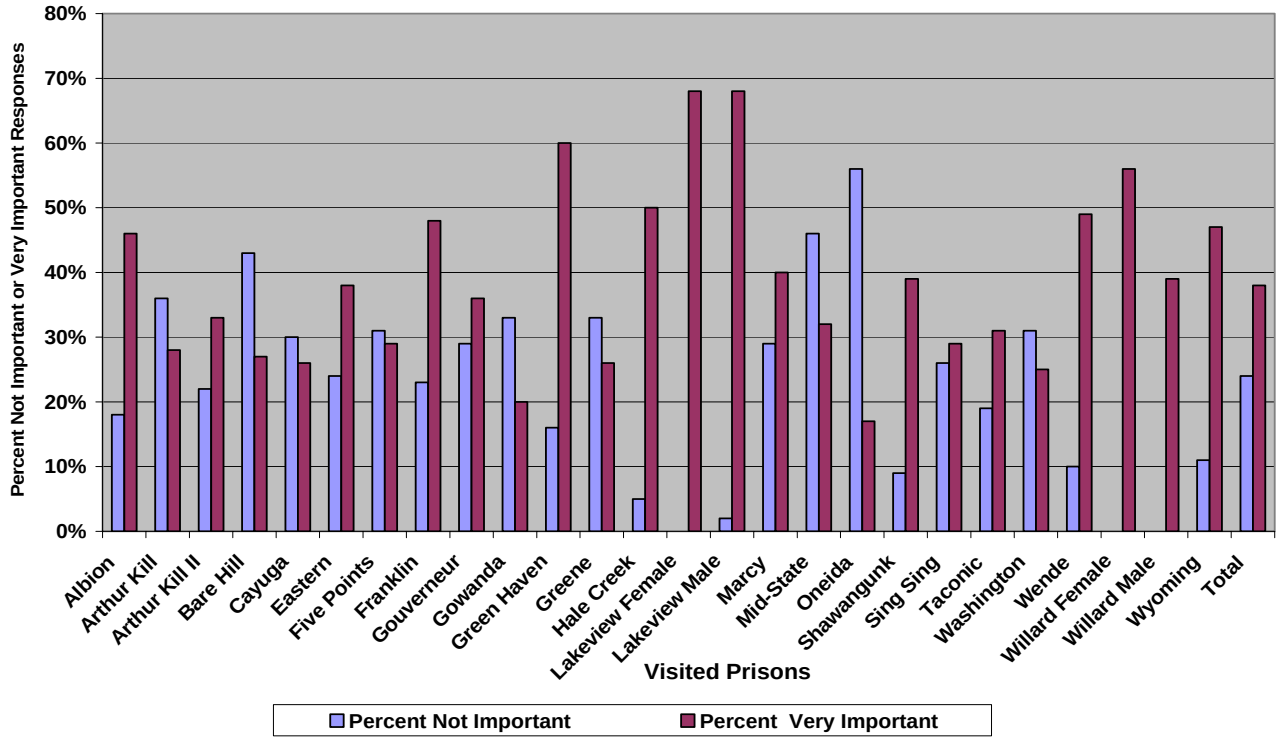


Chart 15-2 illustrates that familiarity with the 12-step programs appears to be an integral component of treatment in some facilities, such as Lakeview Male/Female (where 68% reported it was *very important*), Green Haven (60%), Willard DTC Female (56%) and Hale Creek (50%). The 12-step approach was considerably less prominent in programs at Oneida (56% reported it was *not important*), Mid-State (46%), Bare Hill (43%), Arthur Kill 2009 (36%) and Gowanda (33%). Treatment participants were also asked whether explanation of how to work the 12 steps was an important part of their treatment. Similar to the data presented above, 25% of survey respondents reported that it was not an important part of their program, with comparable variation among facilities.

15.6 DOCS SUPPORT FOR POST-RELEASE SERVICES

An average length of stay in DOCS substance abuse treatment is six months, providing ample opportunity for treatment staff to become familiar with the needs and strengths of program participants. Staff are thus well positioned to help inmates plan their reentry and reintegration into the community, especially their continuing treatment for substance use problems. For the most part, however, current procedures do not take advantage of this rich resource.

When an inmate is discharged from a substance abuse treatment program, DOCS treatment staff complete the "ASAT Program: Evaluation, Referral and Discharge Form." This one-page document includes neither recommendations for further treatment (if any) nor a summary of individual needs. The form features a confusing grid that lists "Status and Progress in Achieving

Stages of Recovery" on one axis and the nine competency areas of ASAT on the other. The staff person completing the form is instructed to initial or date the grid to reflect the inmate's progress. The bottom of the form includes a space to check off if the discharge is satisfactory, unsatisfactory or administrative. See **Section 11, Treatment Program Completions and Removals** for more information. If "not satisfactory," an explanation is required in the area marked "comments." Otherwise, no narrative or clinical comments of any kind are requested. Some facilities have modified the form to add lines for signatures of the staff and participant, though these do not appear in the template provided by the ASAT Manual.

The CA reviewed hundreds of DOCS substance abuse treatment case records after obtaining the necessary consent from treatment participants. We found that these forms contained limited substantive information about the program participant.[263] In most of the records we reviewed, any "comments" stated that the individual had completed the program. Notwithstanding the form's title, no referrals were mentioned. In addition, though treatment staff reported that inmates developed relapse prevention plans as part of their treatment program, these plans were not evident in most treatment records, nor were other clinical documents. Staff from the DOCS Office of Substance Abuse Treatment Services frequently made similar observations about the lack of specificity in the records during their prison site visits, as discussed in **Section 14, Oversight and Supervision of DOCS Substance Abuse Treatment Programs**.

As Willard DTC is only a 90-day program, we analyzed the responses to the aftercare/discharge questions for individuals who had been enrolled in the Willard program for more than 60 days. Seventy-eight percent of men and 100% of women reported no meetings with aftercare providers, and 11% of men and 20% of women reported no discharge plan.

One of the keys to effective reentry planning is the existence of a variety of services to help ensure continuity of care. Discharge plans and meetings with aftercare providers are both integral components necessary to ensure this successful reentry. The considerable number of treatment participants reporting no such services is of concern, but equally alarming is the amount of variation within a single program concerning the full scope of reentry services provided. Few program participants reported both having discharge plans and meeting with aftercare providers. Rather, some programs, such as Hale Creek, Lakeview Male, and Willard DTC Male/Female, had a high number of participants who described having the more general discharge plans described above in place, but no meetings with aftercare providers.

At in-prison Parole Board hearings, community-based substance abuse treatment is sometimes made a condition of parole. Usually, however, parole officers in the community have the discretion to determine the treatment modality and length of stay for the parolees they supervise. Thus, according to staff and current and former inmates we interviewed, some inmates conduct extensive research to identify and contact community-based programs, only to be ordered to another program by their parole officers

[263] For more information about the discharge forms and case records, see Section 13, Treatment Records.

15.7 COLLABORATING WITH PAROLE

Most DOCS treatment staff reported that their relationships with the Parole staff in their facilities were minimal or nonexistent. DOCS treatment staff rarely collaborated with parole officers to plan an inmate's transition to the community. Treatment staff with whom we spoke did not feel that Parole staff were interested in their diagnostic impressions. As treatment staff are in the best position to make a recommendation and inform Parole of an individual's needs, we encourage better and more consistent coordination among treatment staff, transitional service staff and Parole.

In addition, we recommend that DOCS Office of Substance Abuse Treatment Services develop a comprehensive discharge planning system, including a final assessment tool and specific recommendations for post-release treatment, if any. We strongly recommend that DOCS and the Division of Parole utilize standardized instruments to facilitate cross-disciplinary cooperation and communication, including involvement of Transitional Services.[264] We suggest that DOCS draw on the extensive array of such instruments that have already been developed, validated and implemented widely, all designed specifically for prison-based substance abuse treatment. These include the tools, manuals, workbooks and instruments developed by the Texas Institute of Behavioral Health at TCU[265] and the Inmate Pre-release Assessment (IPASS) for Reentry Planning.[266] Considering the gaps, variations, inconsistencies and errors that we observed in case records, policies and procedures, we believe that adapting and implementing these and other practices will improve productivity, program integrity and morale.

A key to successful planning for post-release support is collaboration among all service providers. The CA was therefore pleased to learn that DOCS is collaborating with the Division of Parole to develop the Transitional Accountability Plan (TAP). This document will attempt to identify and track the needs and resources available to each inmate, incorporating components such as housing, substance abuse, mental health and employment. All treatment staff will be trained in how to use the form and the plan effectively. DOCS reported that the TAP will be piloted during 2010.

Work on the TAP will begin at the onset of each inmate's incarceration. It will be a live document that will be updated and amended throughout the individual's incarceration to reflect progress in treatment and changes in health, family and other areas. Parole and other agencies will have access to the information in the document when the inmate is released. It is our understanding that a version of this document will be passed to community-based organizations serving the former inmate after addressing confidentiality concerns by redacting or removing material such as pre-sentence reports.

We strongly encourage DOCS and Parole to formalize the plans for managing this system through the reentry process and beyond. Studies show that management by a single individual, acting as a kind of case manager, is critical to successful discharge and reentry planning.[267]

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[264] Belenko, "Assessing released inmates for substance-abuse-related service needs," 94-113.
[265] "IBR -- Projects -- Criminal Justice Projects."
[266] Farabee et al., "The inmate prerelease assessment for reentry planning," 1188-1197.
[267] Field, *Continuity of Offender Treatment for Substance Use Disorders from Institution to Community*.

One aspect that appears to set this plan apart from previous attempts at enhanced discharge planning is that DOCS is describing TAP as the inmate's plan and is focusing on incorporating more information on the inmate's interests and needs. All staff working on the TAP will be trained in motivational interviewing, a counseling technique that can enhance the inmate's buy-in and commitment to the plan.

DOCS has also reported that it is piloting new assessment instruments that are gender informed and more comprehensive than the current tools. The CA looks forward to the implementation of these much-needed additions and enhancements and, again, we suggest that DOCS explore the many tools that have been developed and implemented in the field. We look forward to observing the impact this new document has on an inmate's experience with the reentry process.

15.8 POST-RELEASE SUPPORT

In Phase Two of the Substance Abuse Treatment Project, the CA interviewed several people who were formerly incarcerated and had completed DOCS prison-based treatment programs. Almost all reported that any connections they made with community-based treatment while incarcerated were the results of their own efforts. When asked what they found most helpful in their reentry process, most spoke of assistance received from other inmates who were familiar with programs. Many of these formerly incarcerated individuals described facing challenges with housing and being released to shelters where crime and drug use were rampant. They stated that the stress associated with being released without housing, employment or support services made it very difficult to focus on maintaining their recovery. As discussed in **Section 15.2, DOCS Transitional Services**, many reported that they did not have active Medicaid coverage at the time of their release, so they could not be admitted to a community-based treatment program.

We also convened several small focus groups on these issues. The focus group participants reported that their parole officers often directed them to substance abuse treatment programs without considering the parolee's needs, resources, previous treatment and or contacts they made with community agencies during their incarceration. They added that parole officers were often unwilling or unable to offer the supportive services necessary for successful reentry.

16. SPECIAL POPULATIONS

Findings

Gender appropriate topics and materials for substance abuse treatment programs in DOCS facilities housing women varied significantly.

Inmates with both substance abuse problems and mental health needs do not consistently receive appropriate substance abuse treatment.

Overview

The current general substance abuse treatment programs employed by DOCS could be enhanced to better meet the needs of all individuals identified as in need of substance abuse treatment. The needs of special populations, such as women and individuals with mental health issues, warrant more specific treatment services requiring special attention and accommodation. Of the 58,378 inmates in New York State on January 1, 2010, a total of 2,480 were women and 8,600 were reportedly on the OMH caseload as of January 2008.[268] Consequently, this section of the report is dedicated to identifying the specialized needs of these two subpopulations under DOCS custody, describing the current services available for these populations and recommending appropriate and effective substance abuse treatment components the Department could employ to improve these services.

16.1 SUBSTANCE ABUSE TREATMENT SERVICES FOR WOMEN

In New York State, a greater percentage of female inmates than male inmates are identified as in need of substance abuse treatment (88% compared to 82% in 2007) and committed for drug-related offenses (30% compared to 19% in 2009).[269] The proportion of women identified as "substance users" among the total female inmate population has steadily increased over time (from 81% in 1998 to 88% in 2007). While this may be attributed in large part to DOCS' evolving methods of identifying inmates in need of substance abuse treatment, as discussed in **Section 4, Population Designated as In Need of Treatment**, the large percentage of female inmates in NYS with substance abuse treatment needs is also reflective of a national increase of women in the criminal justice system throughout the United States who report having used illicit substances. Unfortunately, the expanding rate of incarcerated women entering substance abuse treatment throughout the United States has not been met with a similar increase in gender-specific treatment designs in correctional settings, and nearly all standardized national prison treatment modalities remain "male dominated in content and structure."[270]

Several studies have shown that female inmates who use substances have needs that differ from their male counterparts and merit the development of specialized treatment programs. Female

[268] NYS Department of Correctional Services, *Under Custody Report: Profile of Inmate Population Under Custody on January 1, 2009*.
[269] NYS Department of Correctional Services, *Identified Substance Abusers 2007*; NYS Department of Correctional Services, *Under Custody Report: Profile of Inmate Population Under Custody on January 1, 2009*.
[270] Baletka and Shearer, "Assessing Program Needs of Female Offenders Who Abuse Substances."

inmates in need of substance abuse treatment, for example, are more likely than males to have severe patterns and histories of drug abuse, as measured by their greater frequency of use, higher rates of polydrug use and stronger preference for "harder drugs" such as crack, heroin, and cocaine.[271] The high frequency of use among this population is likely facilitated by many female inmates' relationships with substance-using friends, family members and intimate partners, as incarcerated women identified as in need of substance abuse treatment are more likely than males to have been raised in households with active substance use. Incarcerated women in need of substance abuse treatment are also nearly seven times more likely than men to have been married to a substance abuser.[272] This act of maintaining and developing relationships with substance-using individuals ultimately hinders female inmates' recovery from addiction and should be adequately addressed by substance abuse treatment programs.

The underlying reasons contributing to the general substance abuse of women in correctional settings also varies from that of men. Women, for example, are more likely than men to abuse substances as a coping mechanism to alleviate emotional pain, stress or trauma correlated with psychological, physical and sexual abuse.[273] Not only are women who commit criminal offenses and abuse substances seven times more likely than men to report physical or sexual childhood abuse, but they also experience higher rates of lifetime depression, suicidal behavior and psychiatric disorders than their male counterparts.[274] To best meet the needs of female inmates with substance abuse histories, it is therefore recommended that correctional treatment programs offer individual therapy on a regular (preferably weekly) basis, provided by mental health professionals who are familiar with, and sensitive to, the large extent to which trauma and psychological distress contribute to women's motivation for using substances. [275]

Although group therapy is an effective treatment method for men in correctional settings, several questions have been raised about the effectiveness of group therapy for women identified as in need of substance abuse treatment.[276] It may be helpful, therefore, to readjust the time allotted for group therapy in substance abuse treatment programs to allow for the provision of more individual sessions with female inmates. In "Assessing Program Needs of Female Offenders Who Abuse Substances," Baletka and Shearer also note the importance of limiting the use of confrontational models in substance abuse treatment programs, as confrontational approaches are unintentionally perceived as threatening to women survivors of abuse and consequently inhibit

[271] Langan and Pelissier, "Gender differences among prisoners in drug treatment"; Hall et al., "Treating drug-abusing women prisoners"; Peters et al., "Treatment of substance-abusing jail inmates: Examination of gender differences"; NYS Department of Correctional Services, *Identified Substance Abusers 2007*; Kassebaum et al., "Substance abuse treatment for women offenders."
[272] Langan and Pelissier, "Gender differences among prisoners in drug treatment"; Baletka and Shearer, "Assessing Program Needs of Female Offenders Who Abuse Substances"; Kassebaum et al., "Substance abuse treatment for women offenders."
[273] Langan and Pelissier, "Gender differences among prisoners in drug treatment"; Baletka and Shearer, "Assessing Program Needs of Female Offenders Who Abuse Substances"; Kassebaum et al., "Substance abuse treatment for women offenders"; Peters et al., "Treatment of substance-abusing jail inmates: Examination of gender differences."
[274] Hall et al., "Treating drug-abusing women prisoners"; Langan and Pelissier, "Gender differences among prisoners in drug treatment."
[275] Farkas and Hrouda, "Co-occurring disorders among female jail detainees."
[276] Kelly and Kropp, "The Association of Program-Related Variables to Length of Sobriety: A Pilot Study of Chemically Dependent Women"; Ramsey, "GENESIS: A Therapeutic Community Model for Incarcerated Female Drug Offenders"; Baletka and Shearer, "Assessing Program Needs of Female Offenders Who Abuse Substances."

them in the process of identifying and addressing the underlying causes of their addiction. Similarly, treatment approaches that emphasize the harm that substance abuse has on users and their families have been found to have an adverse effect on women who exhibit feelings of guilt, self-blame and low self-esteem, despite their typical effectiveness in programs for men.[277]

Incarcerated women in need of substance abuse treatment are also confronted with more difficulties than men with regard to employment opportunities, housing stability and educational attainment. Female inmates in need of substance abuse treatment, for example, are less likely than men to have completed high school or obtained a GED, thus exacerbating the employment obstacles they already encounter as a result of having fewer marketable skills/trades, less work experience overall and lower earnings than men when employed. A holistic approach to treatment that involves the coordination of other services and programs within the prison, as well as linkages to resources in the discharge planning and reentry process, would therefore be helpful.[278] Such coordination could be facilitated by an accurate assessment of all the needs of female inmates in substance abuse treatment programs during the initial screening process.

Apart from vocational and educational preparation, parenting training has also been identified as a highly effective treatment component for women in correctional settings, both because they tend to be the primary caretakers of their children and recognize its importance, and also because substance abuse is so heavily correlated with substantiated cases of child abuse and neglect.[279] Nationally, eight out of every 10 women entering the criminal justice system are parents, and approximately two-thirds of all women in prison have children who are under the age of 18.[280] For many incarcerated women, losing custody of their children as a result of their incarceration may heighten the guilt and self-blame they already feel and motivate them to participate in treatment. As a result, parenting training that focuses on the relationship between substance abuse and family relationships could be particularly helpful for women identified as in need of substance abuse treatment. SAMSHA recommends that programs working with females who commit offenses use initial screening and assessment instruments that incorporate information related to parenting and the individual's custody of children to capture information that is relevant to women. Although very few women-focused instruments exist, some (such as TCUDS II), have been reported to have "good reliability with both genders," while others (TWEAK) having been specifically designed for women.[281]

Finally, treatment-seeking female inmates, particularly those who report intravenous drug-use, are more susceptible to sexual and reproductive health risks than males, as they are more likely to engage in high-risk sex with other partners, share needles and exchange sex for money or drugs. These behaviors, in turn, result in a heightened chance of contracting a Sexually Transmitted Infection (STI), which, if untreated, can lead to significant health complications such as cervical cancer, infertility, pelvic inflammatory disease (PID) and increased rates of HIV

[277] Baletka and Shearer, "Assessing Program Needs of Female Offenders Who Abuse Substances."
[278] Langan and Pelissier, "Gender differences among prisoners in drug treatment"; Alemagno, "Women in jail."
[279] Baletka and Shearer, "Assessing Program Needs of Female Offenders Who Abuse Substances."
[280] Kassebaum et al., "Substance abuse treatment for women offenders."
[281] Peters, Wexler, and Center for Substance Abuse Treatment (U.S.), *Substance Abuse Treatment for Adults in the Criminal Justice System: Treatment Improvement Protocol (TIP) Series 44 -- SAMHSA/CSAT Treatment Improvement Protocols -- NCBI Bookshelf*, 38; Kassebaum et al., "Substance abuse treatment for women offenders." TWEAK is an acronym for Tolerance, Worried, Eye-opener, Amnesia, and K/Cut down on alcohol consumption.

transmission.[282] It is important, therefore, that correctional substance abuse treatment programs for women include a safe-sex education component encompassing HIV education and prevention to help offset and minimize the risks that women encounter in these areas.

As part of our Substance Abuse Treatment Project, the Correctional Association visited a number of substance abuse treatment programs, two of which were exclusively women's facilities (Albion and Taconic) and two of which offered women's substance abuse treatment programs (Lakeview and Willard Drug Treatment Campus) in facilities treating both men and women in separate programs. At first glance, the data we collected from both male and female inmates in substance abuse treatment programs suggested that women had higher satisfaction rates across a number of treatment components, as well as higher levels of overall engagement. For example, women (25%) strongly agreed that the people in the program were trying to do what was best for them more often than men (12%). Similarly, women (39%) felt that staff believed in them at higher levels than men (16%). Finally, women rated both their participation in (88%) and commitment to (82%) the program more positively than men (69% and 62%, respectively). Though seemingly more positive, women also reported experiencing slightly greater hesitation about participating in treatment when compared to men, with 53% of female respondents and 44% of male respondents stating that treatment program participants were mostly or very afraid to speak up for fear of ridicule or retaliation.

However, upon observing inmate responses on a facility-by-facility basis, we noticed significant variability in satisfaction and engagement levels among different women facilities. Taconic and Lakeview were two facilities that had higher rates of satisfaction and engagement in a number of areas and consequently influenced the higher satisfaction and engagement levels reported by women as a whole. As an example of this variation, (56%) of Taconic inmates reported that it was *mostly* or *very true* that the people in their program were "trying to do what's best" for them, but only 26% of Albion inmates reported feeling the same way. The low percentage of women from Albion who responded positively to this particular prompt was even less than the 27% of the total male respondents who also reported that it was *mostly* or *very true* that their programs were acting in their best interests. Similarly, when asked about their engagement levels, 64% of Lakeview female inmates reported feeling that it was *mostly* or *very true* that they feel an attachment to and ownership of their program, a percentage that was significantly more than that of Albion inmates (39%), who had more positive responses than male inmates overall (35%).

When visiting Taconic, we were pleased to find that the substance abuse treatment program staff members were making a number of efforts to incorporate gender-specific treatment components into their curriculum, such as discussions regarding the impact of substance abuse on the female reproductive system and a "Wellness Day" for ASAT and CASAT program participants. ASAT staff also appeared sensitive to the fact that the current ASAT and CASAT curriculum did not adequately address the extensive trauma, especially domestic violence, that many of their program participants had experienced. To supplement the DOCS ASAT curriculum outlined in the ASAT Program Operations Manual, ASAT staff reported using spirituality, stress management and self-assessment planning exercises from SAMHSA and Hazelden materials. The effort to incorporate more gender-specific material into the program at Taconic likely influenced some of the high satisfaction and engagement rates reported, and we encourage the

[282] Baletka and Shearer, "Assessing Program Needs of Female Offenders Who Abuse Substances."

Department to develop a women-centered curriculum for all DOCS treatment programs serving women.

16.2 TREATMENT SERVICES FOR INMATES WITH CO-OCCURRING DISORDERS

Individuals with co-occurring mental and substance use disorders represent another significant sector of the prison population with specialized treatment needs. Nation-wide, it is estimated that co-occurring mental and substance use disorders (COD) are more prevalent among individuals involved in the criminal justice system than in the general population, with approximately 75% of inmates in state prisons in need of substance abuse treatment identified as also having a mental health condition.[283] While it is currently unclear how many inmates in New York State are actually dually-diagnosed with both substance abuse and mental health disorders, it is surely greater than the approximately 4% of treatment beds currently designated for inmates with co-occurring disorders in NYS DOCS correctional facilities. An accurate determination of the real need of treatment beds and programs, however, would require an adequate assessment of the prevalence of co-occurring mental and substance use disorders in the New York State inmate population, though a 2007 Office of Mental Health (OMH) report estimates that 30.2% of 8,400 DOCS inmates on the OMH caseload have a primary or secondary diagnosis of substance abuse.[284]

16.2.1 Community Treatment Standards for Individuals with Co-Occurring Mental and Substance Use Disorders

Nationally, the Substance Abuse and Mental Health Services Administration (SAMSHA) states that the identification of one disorder (either mental health or substance use) should automatically trigger a screening for the other type of disorder given the high rates of co-occurring disorders among individuals involved in the criminal justice system. [285] In the assessment process, SAMSHA further suggests that a skilled evaluator conduct a joint, rather than separate, assessment of mental health and substance use disorders and examine the interaction between symptoms of both to determine whether the individual's mental health condition is present independent of his/her substance use, whether it is contingent on that person's use of a controlled substance or whether the individual's substance use is merely mimicking symptoms of a mental disorder.[286] It is also possible that mental health conditions previously masked by an inmate's use emerge only after he/she attains abstinence, or that an individual experiences heightened depression or anxiety in the early stages of recovery as a result of his/her withdrawal. For these reasons, mental health assessments of individuals identified as in need of substance abuse treatment should occur regularly throughout the treatment process, not just during the initial screening period.

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[283] Rothbard et al., "Effectiveness of a jail-based treatment program for individuals with co-occurring disorders"; Taxman et al., "COD services in community correctional settings."
[284] NYS Office of Mental Health, Central New York Psychiatric Center, "CNYPC Patient Demographic and Diagnostic Profile - Year 2007."
[285] Peters, Wexler, and Center for Substance Abuse Treatment (U.S.), *Substance Abuse Treatment for Adults in the Criminal Justice System: Treatment Improvement Protocol (TIP) Series 44 -- SAMHSA/CSAT Treatment Improvement Protocols -- NCBI Bookshelf.*
[286] Ibid.

There are numerous tools and instruments that can be used during the screening and assessment process to determine the severity of an individual's mental health and substance abuse issues. Several commonly used screening instruments that focus on both substance use *and* mental disorders include the Addiction Severity Index (ASI), the Global Appraisal of Needs (GAIN) – Short Screener and the Mini International Neuropsychiatric Interview (MINI). These instruments were reviewed by a joint Co-Occurring Center for Excellence (COCE)/Co-Occurring State Incentive Grants (COSIG) Workgroup and found to be reliable, internally consistent and valid.[287] Although the actual criteria for determining whether an individual has a co-occurring disorder varies considerably and encompasses multiple substance-related and mental health diagnoses, the National Association of State Mental Health Program Directors (NASMHPD) and National Association of State Alcohol and Drug Abuse Directors (NASADAD) developed a conceptual framework that classifies individuals into four quadrants based on the relative severity of their substance abuse and mental disorders: (I) less severe mental disorder/less severe substance disorder, (II) more severe mental disorder/less severe substance disorder, (III) less severe mental disorder/more severe substance disorder, and (IV) more severe mental disorder/more severe substance disorder.[288] Each quadrant in the model corresponds to an appropriate level of care, ranging from primary care settings or intermediate outpatient settings for either mental health or substance use programs to intensive, comprehensive and highly integrated programs that address both mental health and substance abuse issues.[289]

In describing the treatment needs of inmates with co-occurring mental and substance use disorders (hereafter referred to as COD), it is important to emphasize that individuals with dual-diagnoses are *not* a homogenous group and have many different mental health and substance use needs that will inevitably influence the effectiveness of any given treatment modality or approach. Some variation among inmates with COD may be attributed to gender differences between males and females in need of substance abuse treatment (e.g., women are more likely than men to be diagnosed with PTSD or depression).[290] Although there is substantial literature that indicates the usefulness of targeted interventions for specific populations (e.g., Dialectical Cognitive-Behavioral Therapy has been found to be particularly effective in treating dually-diagnosed individuals with borderline personality disorder, while *Seeking Safety* has shown promise among dually-diagnosed women suffering from PTSD),[291] it is beyond the scope of this section to make diagnosis-specific recommendations for treatment. Instead, we will speak broadly of the general treatment needs and possible treatment approaches for individuals with co-occurring disorders.

Individuals with COD have been referred to generally as "a particularly vulnerable subgroup with complex service and treatment needs"[292] that merit special attention in the provision of substance abuse treatment programs. As a whole, they are less likely to receive both mental

[287] SAMHSA's Co-Occuring Center for Excellence (COCE), "Screening: Technical Assistance (TA) Report for the Co-Occuring State Incentive Grants (COSIGSs)."
[288] SAMHSA's Co-Occuring Center for Excellence (COCE), "Definitions and Terms Relating to Co-Occuring Disorders Overview Paper 1."
[289] SAMHSA's Co-Occuring Center for Excellence (COCE), "Overarching Principles to Address the Needs of Persons With Co-Occurring Disorders Overview Paper 3."
[290] Farkas and Hrouda, "Co-occurring disorders among female jail detainees."
[291] Taxman et al., "COD services in community correctional settings."
[292] Tsai et al., "Integrated dual disorders treatment."

health and substance abuse treatment and more likely to have poorer outcomes in treatment (including low engagement levels and early termination) when they receive care in only mental health or substance use. Without treatment in both areas, individuals with COD are at a greater risk of relapse, suicide, HIV infection, unemployment and poor interpersonal relationships than the general population.[293] Dually-diagnosed individuals involved in the criminal justice system are also particularly susceptible to incarceration or re-incarceration, similar to the way that individuals with co-occurring disorders who are not involved in the criminal justice system are vulnerable to hospitalization or re-hospitalization in the absence of treatment.[294] Studies have additionally shown that individuals with co-occurring disorders who have committed offenses are at greater risk of acting violently than individuals with mental health disorders alone, with the rate of violent acts increasing proportionate to substance use, thus emphasizing the importance of providing concurrent substance abuse treatment.[295]

Some components of traditional substance abuse treatment programs (e.g., intense encounters) are not conducive to the recovery of individuals with serious mental disorders and may contribute to some of the previously referenced poor treatment outcomes (e.g., low engagement, early termination, etc.) observed among individuals with dual-diagnoses. Confrontational services and the rigidity of many traditional substance abuse treatment services, for example, have been found to be overly harsh or impose too many undue restrictions for individuals with mental health diagnoses and can lead to decompensation in some cases.[296]

Instead, treatment programs that appropriately implement a modified therapeutic community (MTC) approach have been found to be useful in correctional settings for individuals with co-occurring disorders, in part because they can provide increased flexibility of programming and a decreased intensity of interpersonal interactions.[297] When paired with an integrated aftercare component, the modified therapeutic community model has been shown to produce significantly better outcomes as compared to a comparison group on measures of re-incarceration[298] and substance use.[299] Additionally, there exists a substantial evidence base for Integrated Dual Disorder Treatment (IDDT) as community-based treatment for individuals with serious mental disorders co-occurring with substance use disorders.

In general, there is a clinical consensus that integrated mental health and substance abuse treatment provides effective ways to produce optimal outcomes for individuals with co-occurring disorders (See, for example SAMHSA TIP 42). *Integrated treatment* refers broadly to any mechanism by which treatment interventions for co-occurring disorders are combined within the context of a primary treatment relationship or service setting. Integrated treatment is a means of actively combining interventions intended to address substance use and mental disorders in order

[293] Hawkins, "A Tale of Two Systems"; Taxman et al., "COD services in community correctional settings."
[294] Cropsey et al., "Specialized prisons and services"; Taxman et al., "COD services in community correctional settings."
[295] Cropsey et al., "Specialized prisons and services."
[296] DiNitto, Webb, and Rubin, "The effectiveness of an integrated treatment approach for clients with dual diagnoses."
[297] Sacks, Sacks, and Stommel, "Modified TC for MICA Inmates in Correctional Settings: A Program Description."
[298] Sacks et al., "Modified TC for MICA offenders."
[299] Sullivan et al., "Modified Therapeutic Community Treatment for Offenders with MICA Disorders."

to treat both disorders, related problems and the whole person more effectively.[300] The settings in which integrated services can be delivered vary from a single provider who identifies and treats an individual's substance abuse and mental health needs through direct contact, to several programs or teams of providers who collaborate to deliver mental health and substance abuse services. Integrated services should be offered to individuals with co-occurring disorders during the screening, assessment, treatment planning, treatment delivery and continuing care phases of any given program. Individuals with co-occurring disorders who receive integrated care in the community are not only more likely to be engaged in their treatment and adhere to their treatment plan, but are also more likely to attend/complete their program and have better post-treatment outcomes.[301]

16.2.2 DOCS Programs for Individuals with Co-Occurring Mental and Substance Use Disorders

The Office of Mental Health (OMH) provides all mental health treatment services in New York State prisons and each correctional facility is assigned an OMH level from 1 to 6, with OMH level 1 facilities housing individuals with the most intensive mental health treatment needs and OMH level 6 facilities having no mental health treatment programs or staff on site. Fourteen of the OMH level 1 correctional facilities in New York State operate a residential Intermediate Care Program (ICP) for individuals with mental health disorders who are unable to manage in the general prison population. Most of these ICP units offer a variety of program and treatment services including substance abuse treatment programs run by DOCS, and were previously referred to as ICP ASAT programs (the name has recently been changed to ICP IDDT). Individuals housed in the ICP may be required to participate in an ICP IDDT program if identified as having a co-occurring substance use disorder.

In addition to treatment programs in the ICP, individuals with co-occurring mental and substance use disorders may receive some level of substance abuse treatment in the Behavioral Housing Unit (BHU) or Special Treatment Program (STP), both programs for individuals in disciplinary housing with mental health disorders. (See **Section 16.2.4**) We commend both DOCS and OMH for the strong commitment they have made to providing adequate mental health services for individuals residing in the ICP and disciplinary housing units, and have observed that many inmates in these units report higher rates of satisfaction and feelings of safety and support than their counterparts in general population.

With more than 8,600 inmates on the DOCS OMH caseload and only 589 residing in ICP units, the majority of individuals with co-occurring mental and substance use disorders are housed in general population (GP) and only three DOCS facilities operate ASAT programs for general population COD inmates, previously referred to as MICA ASAT and now named IDDT GP.

As of August 2009, DOCS reported that IDDT programs (e.g., programs for ICP, STP, BHU, and general population inmates) had a combined capacity of 379 inmates (**Table 16-1**). As

[300] Sacks, Ries, and Center for Substance Abuse Treatment (U.S.), *Substance Abuse Treatment for Persons with Co-Occurring Disorders: Treatment Improvement Protocol (TIP) Series 42 -- SAMHSA/CSAT Treatment Improvement Protocols -- NCBI Bookshelf*.
[301] Rothbard et al., "Effectiveness of a jail-based treatment program for individuals with co-occurring disorders."

previously discussed, these substance abuse treatment programs are offered to individuals with co-occurring mental and substance use disorders in disciplinary, residential mental health and general population settings.[302]

TABLE 16-1 Substance Abuse Treatment Programs in DOCS Special Housing Units

Program and Prisons Offered		Unit Capacity	Unit Census July 2009	SA Program Capacity
IDDT ICP				
	Albion	38	19	17
	Attica	78	73	17
	Auburn	50	49	17
	Clinton	60	60	17
	Elmira	56	57	9
	Fishkill	24	23	9
	Five Points	22	21	10
	Great Meadow	102	66	17
	Mid-State	20	20	10
	Sing Sing	64	62	17
	Wende	38	32	17
	TOTAL	552	589	157
IDDT GP				
	Mid-State	1,187	1,116	42
	Arthur Kill	969	911	17
	Bedford Hills	856	717	50
	TOTAL	3,012	2,744	109
STP ASAT				
	Five Points STP	50	46	7
BHU ASAT				
	Great Meadow (cell study only)	38	39	38
	Sullivan	64	23	60
	TOTAL	102	62	98

Although the DOCS' Intermediate Care Program (ICP) manual outlines the admissions criteria for the ICP housing unit, it does not present the criteria used to select which ICP inmates are eligible for substance abuse programming while housed in the ICP unit. During a visit to Downstate Reception Facility in November 2009, Correctional Association staff members inquired about the substance abuse and mental health screening process for all inmates entering DOCS custody, but were unable to ascertain the instruments used to make this assessment, the

[302] In addition to these programs, DOCS offers a Special Needs Unit ASAT program for inmates with developmental disabilities. These operate in at least two facilities and offer twenty treatment slots. These programs are not covered in this report because PVP did not observe or gather specific data from these programs during the course of the study.

point at which the decision is made to place an individual into any specialized treatment programs for individuals with co-occurring mental and substance use disorders nor the individual or agency (DOCS or OMH) responsible for making the determination. Though we believe OMH may be conducting their own evaluation and diagnosis of substance abuse, our best estimate is that DOCS is responsible for identifying and placing inmates into these specialized substance abuse treatment programs. It is evident that inmates in New York State prisons do not undergo a joint mental health and substance abuse screening process, but rather, are assessed for mental health conditions separately from being screened for substance abuse. As mental health and corrections counselors conduct separate screenings with inmates, it is unclear if there is any process for communicating information between the two groups.

16.2.3 Treatment for Inmates with Co-occurring Disorders in Residential Mental Health Programs

The ICP IDDT program, offered at 11 facilities, only serves individuals identified by OMH as having an Axis I and/or Axis II DSM-IV[303] mental health diagnosis. Of the various substance abuse treatment programs offered to inmates with mental health issues, the ICP IDDT programs are by far the most integrated and appropriate for individuals with co-occurring disorders. ICP IDDT programs involve collaboration between OMH staff and substance abuse corrections counselors and do not use confrontational models, hierarchy, pushups/pull-ups, or impose strict time limits for program completion. Additionally, OMH provides inmates with mental health conditions in specialized substance abuse treatment programs with additional discharge planning services. Though DOCS has reported that an updated IDDT program curriculum is used for these programs, the CA has been unable to access a copy and is therefore unable to comment on how comprehensive or effective the program content is.

The 11 ICP IDDT programs have a capacity to serve 157 participants among the total ICP population that can reach a maximum of 781 patients if all units are at full capacity. Most of the ICP IDDT programs we visited were not filled to capacity, and these facilities reported no waiting list for the program, suggesting that the needs of most co-occurring ICP inmates were being met at these prisons.

16.2.4 Treatment for Inmates with Co-occurring Disorders in Disciplinary Confinement

Modified ASAT programs are offered to Behavioral Health Unit (BHU)[304] inmates at Great Meadow and Sullivan Correctional Facilities, and to Specialized Treatment Program (STP)[305] inmates housed in the Special Housing Unit (SHU) at Five Points. The substance abuse treatment offered to inmates in the above disciplinary settings is extremely limited and primarily consists of a cell-study program guided by a substance abuse treatment-readiness workbook,

[303] As detailed in the Diagnostic and Statistical Manual (DSM), Fourth Edition, Axis I diagnoses includes clinical syndromes such as depression, schizophrenia and bipolar whereas Axis II diagnosis refer to both developmental and personality disorders.
[304] The BHU is a DOCS residential program for inmates with mental illness or serious behavior problems who are serving lengthy disciplinary sentences.
[305] The STP is a DOCS program for SHU inmates with mental illness that offers five hours per week of group counseling.

with the exception of Sullivan's BHU ASAT program.[306] This workbook is solely focused on substance use and does not clearly address the mental health needs of this population.

With approximately 5,000 disciplinary confinement (SHU) beds in the system and a population of 4,350 inmates housed in these units as of 2009, there is a need to develop treatment programs for disciplinary inmates who are not allowed to participate in the general population treatment programs while they are in the SHU. The CA has visited many disciplinary units, and the percentage of these inmates suffering from mental health problems is even greater than the 14% of the entire prison population on the OMH caseload. For example, at some disciplinary units we have visited, 20% to 50% of the disciplinary inmates are actively receiving mental health care. Similarly, many of the disciplinary inmates also have substance abuse problems, including some of whom have been disciplined for using drugs in the prison. The only treatment program for disciplinary inmates involving regular sessions with a treatment staff occurs at Sullivan's BHU program, a 60-bed program for disciplinary inmates with serious mental health problems. The remainder of DOCS disciplinary inmates either have no access to any substance abuse treatment services or can use the treatment-readiness workbook. A more comprehensive program and support system is needed, especially for SHU inmates (who often have intense substance abuse and mental health needs).

16.2.5 Treatment for Inmates with Co-occurring Disorders in General Population

Given that residential substance abuse treatment options for individuals with co-occurring mental and substance use disorders are offered at only a limited number of facilities and only serve individuals with serious mental illness, the majority of inmates with more moderate mental health needs are placed in regular, non-IDDT substance abuse treatment programs. Anecdotally, treatment staff in general population substance abuse treatment programs have informed the CA on our visits that addressing the mental health issues of these inmates is one of the greatest challenges they face in their substance abuse treatment programs. There are only two male (Arthur Kill, capacity of 17 and Mid-State, capacity of 42) and one female (Bedford Hills, capacity of 50) prisons that have specialized IDDT programs for general population inmates.

The general population IDDT programs at these three facilities have a combined capacity for only 109 participants, an amount clearly insufficient to meet the needs of the inmate population with co-occurring disorders residing in general population. With 8,600 DOCS inmates on the OMH caseload in 2009, including estimates of 2,360 to 3,000 DOCS inmates with serious mental illness, the Department has an extremely large population of individuals who require significant mental health services. The total capacity of the Department's residential mental health programs for non-disciplinary inmates with serious mental illness is approximately 1,030 beds, well below the number of inmates with serious mental illness. Consequently, 1,300 to 2,000 inmates with serious mental illness live in general population, and many of these individuals have substance abuse histories, given the Department's estimate that 83% of all inmates are identified substance abusers. DOCS' 109 general population IDDT program slots cannot meet this need and most inmates with serious mental illness in general population are

[306] Sullivan Correctional Facility is an exception, as it is the only place where substance abuse treatment programs offered to inmates in the BHU can be applied towards merit time eligibility. However, the Correctional Association did not visit Sullivan C.F. as part of our study.

either assigned to a regular substance treatment program or prohibited from participating in the many prisons substance abuse treatment programs for general population inmates that do not accept individuals with serious mental illness. One barrier that exists to expanding IDDT programs in general population is the need for greater coordination between OMH and DOCS. The Office of Mental Health operates independently from DOCS and has their own staff and budget to provide mental health services for inmates in New York State prisons. In order to run effective IDDT programs in general population, certain OMH resources (e.g., staff) are required. As DOCS does not control these limited resources, they would have to work intensively with OMH to identify available resources and programs for COD inmates in general population.

Whereas the specialized DOCS IDDT substance abuse treatment programs in general population have been reportedly designed to be adjusted to meet the needs of inmates with co-occurring mental and substance use disorders,[307] inmates with mental health conditions who participate in general population substance abuse treatment programs, not general population IDDT, do not receive the same level of integrated treatment (e.g., trained OMH staff or a curriculum specifically designed for individuals with dual diagnoses). It is well documented that COD individuals involved in the criminal justice system who are placed in general substance abuse treatment programs forgo many benefits of integrated care identified by experts, including reduced substance use and improved abstinence, improved mental health symptoms (including fewer suicidal thoughts), and reduced rates of hospitalization, re-incarceration and arrest.[308] Individuals with COD in general population in New York prisons should be provided with more opportunities and programs for integrated treatment services as well as a program facilitated by qualified, mental health and substance abuse counselors or program assistants.

Furthermore, dually-diagnosed participants in general population IDDT programs often lack an extensive aftercare component critical to their success and recovery. A reoccurring theme among inmates in IDDT general population programs at Arthur Kill Correctional Facility was that they received inadequate discharge planning services or none at all. One inmate survey respondent stated that he "had to contact other treatment agencies myself" and had "no help from staff for outpatient counseling." Yet discharge planning in correctional settings, which can be even more challenging for dually-diagnosed inmates than for inmates with mental health needs, remains an essential element in adequately preparing inmates with co-occurring disorders for their return to the community.[309] Some jail-based programs have adopted an integrated approach to service coordination and community referrals, including a treatment team comprised of corrections counselors, community treatment providers, forensic case managers and probation officers (where applicable) that communicates regularly with a re-entry liaison to plan a dually-diagnosed inmate's transition back into the community.[310]

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[307] The IDDT programs in general population reportedly utilize the previously mentioned newly updated IDDT curriculum/manual that we have been unable to assess.

[308] Rothbard et al., "Effectiveness of a jail-based treatment program for individuals with co-occurring disorders"; Drake, O'Neal, and Wallach, "A systematic review of psychosocial research on psychosocial interventions for people with co-occurring severe mental and substance use disorders"; Smith, Sawyer, and Way, "Central New York psychiatric center"; Sacks, Ries, and Center for Substance Abuse Treatment (U.S.), *Substance Abuse Treatment for Persons with Co-Occurring Disorders: Treatment Improvement Protocol (TIP) Series 42 -- SAMHSA/CSAT Treatment Improvement Protocols -- NCBI Bookshelf*.

[309] Smith, Sawyer, and Way, "Central New York psychiatric center."

[310] Rothbard et al., "Effectiveness of a jail-based treatment program for individuals with co-occurring disorders."

16.2.6 Survey Participants Assessment of IDDT Services

Over the course of the project, the Correctional Association visited four IDDT programs (both ICP/IDDT and GP/IDDT) with a combined capacity of 103 inmates. We sent out 70 surveys to treatment participants in these programs and received 26 surveys in return: Arthur Kill (11), Mid-State (11), Sing Sing (3), and Wende (1). In addition, we were able to conduct short interviews with IDDT treatment participants during the visit.

While we realize that the project does not have sufficient data to conduct a significant quantitative analysis, many inmate comments and survey responses still merit consideration. Several inmates in IDDT programs who communicated with the CA reported feeling dissatisfied and disengaged with their treatment due to their lack of involvement in their own treatment process. Some participants noted that they either did not have a treatment plan or were not consulted in the development of their treatment plan, and felt as though their goals were pre-established by program staff rather than by their personal treatment needs and objectives. Alternately, inmates in ICP/IDDT programs, administered by both OMH and DOCS staff, reported that staff were more engaged and provided more individual attention to inmates than general population substance abuse treatment program staff. The ICP/IDDT survey participants also expressed greater satisfaction with their treatment program and had more positive assessments of the effectiveness of communication within their program than the responses from general population treatment program participants.

Regardless of the treatment setting (residential, disciplinary, or general population), we recommend that staff members implementing substance abuse treatment programs are required to undergo and provided with considerable mental health training. Staff members operating the specialized IDDT substance abuse treatment programs, whether in the ICP or general population, in particular should be mental health professionals cross-trained in both substance abuse and mental health practices.

17. MODEL PROGRAMS

In order to effectively and accurately make recommendations for improving substance abuse treatment services in New York State prisons, we researched best-practice models already in place throughout the United States. These prison-based substance abuse treatment programs helped us to understand the components necessary for prison-based treatment programs to be effective. Many of the research articles we reviewed during our literature were for studies and outcomes that were slightly out of date. After consultation with our advisory committee, we identified the main vendor companies providing prison-based treatment services and enquired about their most stable and effective programs. We spoke with representatives from WestCare Foundation Inc., Community Education Centers, Inc. (CEC) and Gateway Foundation Inc. and were provided various recommendations, some of which were included in our literature search. The following is a brief description of the programs for which we were able to have one- to two-hour telephone interviews, as well as three programs in New Jersey that we visited in person. The summaries below are based on the descriptions provided to us by the various programs, and are not a result of any assessment done by the Correctional Association of New York.

17.1 SHERIDAN CORRECTIONAL CENTER: SHERIDAN, ILLINOIS

The Sheridan program is one of the largest prison-based treatment programs in the country and is run by WestCare. The treatment program at Sheridan began in 2004 as a result of extensive work by the governor's office, Illinois Department of Corrections, treatment providers and other experts to create a program based on best practices that would effectively serve both the inmate population and community at large. It currently has 950 treatment beds and 430 beds for pre-treatment programming. Sheridan utilizes a therapeutic community model integrating education, job preparation, counseling, clinical reentry management services and community reintegration. Treatment staff employ what they describe as "enhanced best practice cognitive- behavioral programming," a specialized Young Adult Aggression Management component, and integrate 12-step programming. As a TC program, Sheridan employs a hierarchy that allows individuals to work their way up into positions of greater leadership. In addition, individuals at Sheridan take part in a daily, 30-minute morning meeting.

Participants at Sheridan cannot be mandated into the program. If they refuse to participate or withdraw from the program, they must complete their sentence at a regular correctional facility. The program at Sheridan lasts from nine to 24 months, though the average participant will complete it in 11 months. The completion rate for the Sheridan program is 80%, and no individuals are removed from the program for poor program performance. Individuals not performing well are given more specialized treatment, and staff work closely to monitor and assist them to succeed. Individuals can be removed for disciplinary or administrative reasons, though prior to this point, a process is established that requires all individuals facing removal to attend a meeting with DOC officers and treatment staff. Though Sheridan is an extremely large program, the staff-to-participant ratio is 1:20. Treatment staff are at the facility until 7:00 p.m. Monday through Friday, and a limited number treatment staff are present during the weekend hours.

Fifty percent of all treatment staff were certified drug counselors at the time of our interview, though the remaining staff were all in the process of obtaining their certification. Illinois law requires that an individual can only work as a substance abuse counselor for two years before getting certified. Treatment staff are given one full day per month of training, and the program focuses on providing clinical supervision. The individuals with whom we spoke believe that one of the many reasons that Sheridan is successful is that the warden and assistant warden both have substance abuse training and experience. In addition, the program employs many recovering staff and formerly incarcerated individuals who, they believe, are better able to connect with the participants.

Individuals at Sheridan are programmed into group sessions in the morning or afternoon. When they are not participating in these groups, they are attending vocational or educational training, employment readiness programming or reentry case management. Prior to launching the program, the individuals involved in creating the Sheridan program performed a labor market analysis to get a better understanding of in-demand jobs. As a result, the vocational programs offered at Sheridan directly relate to opportunities in the community. Sheridan has focused on working closely with community members and groups in order to ensure a positive transition after release. Community-based organizations come to the prison and speak with treatment participants; in addition, post-release case management services are offered as well as housing assistance. By working closely with an array of outside organizations, treatment staff report being able to make recommendations based on an individual's level of care need and other risk factors, and can help participants connect to vocational and aftercare treatment services.

Participants at Sheridan are provided a minimum of one hour per month of individual counseling. The program is licensed by the Illinois Department of Alcohol and Substance Abuse (DASA). An outside researcher from Loyola University has been involved in conducting ongoing evaluations of the program's effectiveness. He has found that, after controlling for the influence of age, race, education level, marital status, number of children, committing county, gang membership, conviction offense, felony crime class, total prior arrests, prior arrests for drug law violations and violent crimes, time served in prison and prior prison sentences, Sheridan graduates had a 20% lower likelihood of being reincarcerated than the statistically similar comparison group. Furthermore, the likelihood of reincarceration for those Sheridan graduates who complete aftercare is 52% lower than the comparison group.[311] In addition, treatment records are regularly reviewed by clinical supervisors and they report that problems are addressed immediately.

17.2 OZARK CORRECTIONAL CENTER: FORDLAND, MISSOURI

The 650-bed dedicated treatment facility, operated by Gateway Foundation Inc. Corrections Division, is a therapeutic community program lasting approximately 12 months and running 24 hours per day, seven days per week. The program is divided into three phases. Phase I is the "orientation" phase, lasting three to three and a half weeks in length with a participant population of between 75 and 85 men. This phase consists of a tightly structured schedule, beginning at 6:30 a.m. and ending at 9:30 p.m., made up of small groups, classes, community meetings,

[311] Olson, Rozhon, and Powers, "Enhancing prisoner reentry through access to prison-based and post-incarceration aftercare treatment."

encounter sessions and recreation and hygiene time. Phase II is referred to as the "intensive treatment" phase and generally runs for five to six months with a participant population of between 270 and 280 men. During this phase, individuals participate in a half day of treatment programming and a half day of working in the facility. Phase III, the "relapse prevention/ reentry" phase, lasts approximately five months and has a participant population of about 320 men. During this phase, participants attend fewer classes than in Phase II; they may have full-time jobs during the day and attend treatment groups at night. In addition to the three phases described above, Ozark Correction Center (OCC) also operates a Phase IV program for chronic offenders where the focus is on DWI education and advanced relapse prevention.

OCC has 31 treatment staff comprised of 15 "counselor 1" positions (individuals not required to be certified), nine "counselor 2" positions (staff certified or qualified), and three "counselor 3" positions (staff certified with advanced degree). In addition, there are two clinical supervisors, one clinical director and one program director. Only the certified/qualified counselors facilitate the small group sessions and conduct individual counseling, while the remaining counselors offer support, monitoring and educational lecturing. Though the facility is contractually obligated to provide 20 hours of training per year, they usually offer more than 40 hours per year of training focused on the core competency areas and working with dual diagnosis individuals. Security staff tend to be supportive of the treatment and may participate by writing pull-ups and push-ups, staffing and selecting members for the hierarchy structure. TC training for security staff was a past requirement, but since many of the current security staff have been at the facility for some time, the majority have received some type of TC training. OCC staff are also all exposed to reality therapy training.

The Missouri Department of Correction staff determines eligibility and exclusion for the OCC program. In order to be eligible, individuals must have four years or more on their sentence and a history of chronic substance use.[312] The program accepts individuals with co-occurring disorders, but not individuals who need protective custody. Individuals with co-occurring disorders work closely with mental health staff who will have joint meetings with treatment staff on a monthly basis. These individuals participate in regular programming and receive any additional mental health support on an individual basis. Also, chronic/repeat offenders who have received more than a two-year prison sentence and are court mandated to treatment can be sent to the facility. Currently, many of the decisions made at the diagnostic center are based more on security risk than on the severity of an individual's substance abuse problem, though individuals from OCC and MDOC are working with Texas Christian University (TCU) to develop a treatment matching protocol. If an individual decides to decline to participate in the program at OCC, he must serve the remainder of his sentence in another facility. If an individual has received a longer sentence from a judge but graduates from the OCC treatment program before his sentence is complete, a judge will make a final decision as to whether or not to grant that individual early release. If early release is given, the individual will be placed on probation for the remainder of his sentence.

Though the program uses the TC model as the primary treatment modality, it also relies heavily on cognitive-behavioral therapy, motivational interviewing and the 12-step program. Treatment

[312] The term "chronic" as applied at Ozark Correctional Center is a generic identifier for offenders who have been sentenced to two years of treatment for DWI-specific charges.

participants are required to attend AA/NA groups two to three times per week. Every day begins with a morning meeting lasting 30 minutes and concludes with an encounter or confrontation group, followed by a "wrap-up" session that allows the day to end in a more positive and motivational manner. There is a full hierarchy in place, though some modifications have been made to the exact role of the inmate within that structure. In addition to the encounter groups that run five nights a week for 45 minutes per session, the program utilizes a therapeutic peer review (TPR) to address specific participant behavior. The TPR group, comprising senior hierarchy members, meets up to three times per day, and sessions primarily involve the use of pull-ups and push-ups. An individual who has been directed to report to the TPR panel at the evening meeting will report at the designated time and either admit or deny the actions stated on the pull-up. If the individual denies the behavior, he will be required to provide three witnesses on his behalf and an investigation will ensue. If the behavior is admitted, the individual must follow the TPR script, listen to the panel members without offering an explanation or defense and conclude by saying "Thank you for your responsible concern."

Ozark Correctional Center uses Gateway's curriculum for their didactic classes, as well as the Change Companies' Relapse Prevention and Reentry Programs curriculum. Though the basic curriculum is provided to all treatment staff, it is left to individual staff members to decide on how they want to present the information. Small groups consist of around 12 individuals and the larger classes have approximately 25 participants. Most of the material is presented by counselors or, at times, inmate facilitators, but only Phase III participants may play the facilitator role. In addition to the various groups, classes and meetings offered, treatment participants are provided one hour of individual counseling per month. Crisis counseling is offered any time, according to need. Individuals in Phase I may attend school if such programming is required and individuals in Phase II or III may either attend school or work when not in groups; vocational classes are not available. DOC classification staff also participate and teach classes such as life skills, anger management and a "dad's class." Gateway and DOCS staff have also initiated a collaborative effort and co-facilitate a "pathway to change" class for treatment participants.

As a part of discharge planning, treatment staff will complete a case evaluation for each participant, which is then sent to parole or probation. The inmate and counselor will work together to develop an aftercare plan, including a list of specific aftercare providers. Though the treatment staff work closely with the participants to prepare for their release, they do not have any real input in the final decision about which community-based program the individual will be referred to. These decisions are made by individuals in parole or probation field offices, with whom treatment staff have little to no contact.

At the time of our phone call in the fall of 2009, OCC reported in the past seven months a 4.8% removal rate for disciplinary reasons, 11.2% removal rate for program performance reasons and 1.2% for administrative reasons. The program has established a program review committee (PRC), which evaluates every discharge, though the warden has final review. Disciplinary discharge tends to result from a violation of one of the cardinal rules, and most often is initiated by classification or security staff. Individuals removed for program performance have usually been through various stages (e.g. peer interventions, treatment interventions, learning experiences, behavior contracts, etc.) prior to removal. Before meeting with the PRC, another DOC committee called the "offender management team" will meet first and try to come up with

a problem-solving activity for the individual. This team is composed of DOC staff, classification staff, treatment staff and peer leaders. The PRC may recommend program extension or restart rather than program removal.

The program at OCC has in place various levels of monitoring and supervision. Clinical supervision is provided in a few different ways. The certified counselor 2s and 3s mentor noncertified staff, and counselor 3s facilitate team meetings four times per week to discuss cases or clinical problems. The counselor supervisor provides supervision to all counselor 3s, and one-on-one clinical supervision is provided monthly to all treatment staff, though individual supervision can occur more frequently depending on need. In addition, OCC must meet the Missouri Department of Mental Health standards for running a substance abuse treatment program and receive an annual audit from the department. The program is also monitored by a division of DOC that conducts monthly and quarterly oversight. There is an annual audit in place, monthly reporting of quality assurance and other outcomes, as well as quarterly site visits by DOC. Gateway also utilizes its own audit instrument to assess the program's effectiveness. The quality assurance plan at OCC requires counselor supervisors to review a portion of treatment records each month, and to audit all treatment records at the end of each phase and at 10 months. Clinical and program directors will also audit a percentage of treatment records each month.

Ozark Correctional Center believes the program's effectiveness lies in its focus on model fidelity. In addition, staff reported a very positive relationship with DOC, resulting in a great deal of cooperation. They credit aspects of this positive relationship to the amount of substance abuse treatment experience and training within the DOC administration.

17.3 ESTELLE UNIT: HUNTSVILLE, TEXAS

This special needs unit located in Huntsville, Texas serves up to 212 men with disabilities ranging from mild psychological issues, to schizophrenia, to chronic conditions managed by medication. The unit is operated by Gateway Foundation Inc. Corrections Division and uses a therapeutic community model, including a structured hierarchy and the use of pull-ups and push-ups, as well as cognitive-behavioral therapy (CBT). Estelle has no separate curriculum geared specifically for individuals with co-occurring disorders. Most of the participants in the Estelle program are mandated to treatment by the court, and the majority of participants are probationers. Individuals go through a diagnostics screening and must meet certain criteria, including having some type of co-occurring disorder, having pled guilty or having deferred adjudication. Prior to arriving at Estelle, most individuals will have spent three to six months in county jail before going to diagnostics and being screened for the program. A second assessment is done 30 days after arrival at Estelle, though it is rare that at this point someone is deemed inappropriate for the program. Participation in the program at Estelle is voluntary, and an individual can choose between participating in the program or serving regular prison time.

The Estelle program runs for approximately nine months, though individuals can be legally held for up to one year. The program is divided into three phases: orientation (Phase I); chemical dependency education (Phase II); and relapse prevention (Phase III). The orientation phase of the program allows individuals to learn the protocols and regulations of the unit, utilizing CBT

and REBT (rational emotive behavior therapy) curricula and thinking reports. During this phase, treatment participants are assigned an inmate orientation liaison and a big brother. Phase I lasts between 35 and 45 days and has about 50 participants. Individuals attend classes seven days a week, consisting of mostly didactic work. The chemical dependency education phase of the program is both formal and informal. It is a much more interactive phase, with more written assignments, thinking reports and continuing CBT treatment. In addition, participants learn and complete journaling and mapping exercises from Texas Christian University. This phase lasts about four months. In Phase III the emphasis is placed on creating a transition from the treatment environment to the outside community. This phase lasts four months, and inmates work with staff to identify appropriate community referrals and to develop both a comprehensive continuum of care and relapse prevention plan.

In order to move through the various phases, participants must complete an exit exam to measure their progress. Approximately 20 to 23 hours of indirect group time per week is facilitated by inmate hierarchy members, and staff co-facilitates all direct service groups (20 to 26 hours per week). Only six hours of all group time is phase specific. During the remaining time of weekly programming, all participants, regardless of phase, attend the same groups. There is also a reentry program, which is utilized as a fast track for individuals who had previously completed the program and relapsed. This program lasts for five months. On the weekends, trainings are held where the whole community comes together to participate. In addition to the scheduled treatment groups, the Estelle unit offers GED, life skills, anger management, leadership training and physical education.

Monthly individual counseling is required for 50 minutes, though often treatment staff will see individuals more frequently as a result of their special needs. Mental health components of the program are provided separately and are overseen by a PhD-level member of the treatment team. Large groups run between 35 and 50 participants, though often they are divided up to work in smaller groups.

At the Estelle Unit there is one counselor for every 16 participants. The treatment staff consists of a program director, two clinical supervisors, one transitional coordinator, one counselor 3, five counselor 2s and four counselor interns. All counselors have received specific mental health training and must be licensed substance abuse treatment counselors. Some of the treatment staff at Estelle are themselves recovering substance users, which both treatment staff and participants report as very helpful. Gateway provides continuing education for all treatment staff and mental health training is provided on a yearly basis. Thirty days of training is provided to all new hires, in addition to the 90 days of required TC correctional training. Sixty hours of biannual training is offered to all treatment staff on different subject areas, dependent on emerging needs. Treatment staff describe security staff as “seasoned” and “very pro-treatment.” Security staff are able to attend TC trainings, but it is not a requirement. All security staff working on the unit are handpicked; they do not participate directly in the treatment of individuals. They must report all behavior to treatment staff and cannot assign learning experiences or participate in community meetings.

Approximately 90 to 95% of all treatment participants complete the program. The Estelle Unit uses a system of alternative programming (AP), which functions as a graduated sanctions process

with peers holding each other accountable. Therapeutic counseling is also provided for individuals who may be struggling in the program. Individuals who continue to be challenged may be removed and sent to another behavioral unit, though in 90% of cases, treatment staff agree to allow the individual to return. Any individual who tests positive in a drug test is automatically removed from the program.

All treatment participants at Estelle are released into aftercare programs or transitional care facilities providing 90 days of transitional services. Treatment staff prepare a discharge packet using an addiction severity index to help identify problem areas or needs. Any arising behavioral issues or specific ongoing needs are described in the discharge packet, which includes specific recommendations for the type of treatment needed in the community.

Every few weeks, treatment staff meetings are held with the University of Texas medical branch, which provides mental health services in Texas prisons. Each clinical supervisor is in charge of a treatment team and will hold monthly meetings with the team as a whole, as well as with individual staff members. The Estelle Unit uses a quality improvement plan, and uses only recognized, evidence-based curricula approved by the Texas Department of Criminal Justice's Rehabilitations Program Division. The Texas Department of Criminal Justice (TDCJ) conducts yearly audits of the program and Gateway utilizes its own internal audits to measure program effectiveness.

17.4 INDIAN CREEK CORRECTIONAL CENTER: CHESAPEAKE, VIRGINIA

This Virginia DOC run facility contracted CEC to operate a 984-bed dedicated treatment program lasting between 12 and 28 months (average stay is 15.5 months). All participants in the program must have a maladaptive pattern of substance use noted by one or more of the following: interferes with responsibilities, interferes with safety, causes legal problems or causes social and interpersonal problems. Individuals convicted of predatory sex offenses are not eligible to enroll in the program, and all treatment participants must have more than 18 and not more than 28 months until their expected release. All inmates entering Virginia DOC are reviewed by Central Classification Services and are screened using the ASI and Texas Christian University Client Evaluation of Self and Treatment (TCU CEST) instruments. Individuals determined to be in need of the Indian Creek Correctional Center/CEC program will first spend 30 days in the program's screening unit to determine if they are appropriate candidates (only 5% of individuals are determined to be ineligible at this time). Although the facility does not currently match individuals to programs according to level of need, the program is attempting to develop a treatment matching approach. At present, the facility has operationalized a more intensive training unit for individuals in need of greater services (less than 5% of overall population). Consequently, this measure has increased the ability to lower hostility while increasing motivation. Inmates are then successfully integrated (approximately 60% of the 5% mentioned above) into the multiphase treatment program.

The program at Indian Creek is divided into four phases. Individuals begin in the Screening, Evaluation and Assessment Unit (SEA) before moving into Phase I. SEA individuals are grouped together throughout the day and do not participate in any outside jobs or activities. SEA individuals are eligible to move on to Phase I when they demonstrate an understanding of the TC

approach. SEA runs for approximately 14 to 30 days. In Phase I of the program, they are oriented through a variety of interactive skills training where they learn to practice skills, challenge each other and role play. Phase II is the largest phase and runs for approximately six to nine months with around 500 participants. During this phase, individuals participate in half-day group sessions and spend the remainder of the day at other activities. This phase utilizes a curriculum based on their stage of change and is comprised of more than 58 different topic/interactive groups. Phase III treatment participants are able to get higher-paying jobs within the facility and are allowed to enroll in certain Department of Corrections education classes and enterprise classes, such as forklift training and vocational courses (e.g. carpentry, small engine repair, upholstery, etc.). A different set of topic/interactive skills training groups are covered in this phase, and individuals begin to participate in offender seminars. Treatment participants can co-facilitate groups with treatment staff during this phase. Phase III is a minimum of six months in length and generally consists of 150 to 200 participants. Phase IV is the reentry phase, which individuals can only participate in when they have six months or less remaining on their sentence. Group sessions in this phase are initiated by counselors, with some peer facilitation by treatment participants.

Indian Creek uses a TC approach closely integrating CBT and motivational enhancement elements into their program. In addition, the program utilizes the TCU/IBR[313] curriculum for high hostility, criminal thinking and low motivation as identified by the TCU/IBR CEST and Criminal Thinking Scales. Community or development meetings are held every morning and afternoon for 30 minutes on each unit, whereas encounter sessions or therapeutic awareness are conducted on a weekly basis. Treatment staff estimate that approximately 2,000 awareness slips or written push-ups are issued each month and that eight times per month, peer awareness panels, made up of four inmates from the cadre, are held. The peer awareness panels allow participants' peers to address any arising behavioral problems and facilitate the signing of behavioral agreements. A structured hierarchy is in place at Indian Creek Correctional Center, and every individual in the facility plays a role in the hierarchy. Monthly individual counseling is provided for all treatment participants for 15 to 45 minutes and focuses on reviewing an individual's progress and other arising needs. Treatment staff describe the individual counseling as an open dialogue. If individuals require more immediate staff attention, they can complete a communication form requesting additional individual counseling.

Treatment participants spend about 30% of their time working in large groups of approximately 40 participants and 70% in small groups comprised of between 12 and 15 participants. Groups usually run for 50 minutes followed by a 15-minute break and then another 50-minute session, which allows treatment staff to cover two topic areas. After Phase I, in addition to the group sessions, individuals can participate in other classes, such as GED, small engine repair, carpentry and special needs. Participants with mental health problems are accepted into the program at Indian Creek if treatment staff believe they are manageable and may benefit from the treatment structure. If these individuals are on any psychotropic medication, they will have continuous contact with the clinical psychologist. The psychologist will work with all treatment staff to support individuals with mental health problems and enters his/her notes in the computer-based data system. This allows for all treatment staff to be informed about an individual's current mental status.

[313] Substance abuse curriculum developed by the Texas Christian University's Institute of Behavioral Research.

The treatment staff is made up of a master's level program director (licensed), a master's level clinical operations coordinator (licensed), six clinical supervisors (certified counselors; a majority are master's level), thirty counselors (certified), three transition specialists, a data entry worker and an administrative assistant. According to DOC policy, any counselor who does not have certification when beginning employment has two years from his/her start date to receive it. There is approximately one member of the treatment staff for every 30 participants. Indian Creek Correctional Center has its own on-site 40-hour block of training that it offers once a quarter to assist individuals in getting their certification. Treatment staff get an additional 40 hours of off-site training per year. All security staff in the facility have completed TC training as well as community building training, as required by DOC for all staff including administrative.

In Phase IV's Reentry Unit, treatment participants spend time writing résumés and discussing housing, employment and other key reentry areas with more than 25 to 30 outside stakeholders who come in to do presentations and answer questions. There are also smaller reentry preparation groups that require each individual to create a 12-page reentry document. Representatives from Probation come to the program on a monthly basis to answer questions and help prepare an individual for his release. Every individual leaving the program has a reentry discharge plan sent out to Probation two weeks prior to his release, including a two-page document with a reentry summary and description of what treatment the individual completed and how he progressed in treatment. The state also requires every inmate to have home plans in place prior to release, completed by the institutional correction counselors. Transition specialists, counselors and clinical supervisors working in Phase IV all have received specific training about reentry. Treatment staff estimate that 20% of individuals completing the program will move on to community-based treatment programs (both mandatorily and voluntarily), with 15 to 20% of these moving into residential programs.

Indian Creek staff reported a 16% removal rate for disciplinary/program noncompliance reasons, a 1% removal rate for medical/psychological reasons and a less than 1% removal rate for institutional infractions. If an individual is moved to the more intensive training unit three times, he has to appear before the joint clinical assessment team to determine whether he should be removed from the program. This team includes a nurse, doctor, psychologist and treatment staff. The program has increased using more learning experiences (LE), which has greatly reduced the removals and disciplinary responses to problem behavior. The new policy requires security staff to complete the top part of the LE form describing the behavior, but allows treatment staff to decide on the appropriate response.

In addition to directly observing group sessions, clinical supervisors utilize observation rooms to watch counselors facilitating groups. Once a supervisor has completed an observation, he/she completes an observation facilitation form, which is used to provide feedback to the counselor. Every treatment staff member undergoes quarterly evaluations based on his/her performance and individualized supervision plan. New staff at Indian Creek Correctional Center are given orientation packets and are unable to facilitate any groups alone until their orientation checklists have been signed off by a supervisor. Supervisors prepare an evaluation every 30 days during the first three months of employment for all new staff. Team meetings are also held on a regular basis to allow staff to present difficult cases or arising challenges. The program director conducts monthly town hall meetings with counselors only.

The program at Indian Creek Correctional Center is monitored by Virginia DOC, which conducts monthly site visits. Every week, the facility executive team performs a weekly inspection of some of the units and generates a weekly report. They evaluate areas such as cleanliness, TC elements, groups, hierarchy board and other essential program functions. The weekly reports go out to the entire institution, and by the end of the month, all units have been visited and the executive team awards flags to the top three units. These scores represent overall sanitation, number of disciplinary charges, attendance and how many individuals have graduated to a new phase. The top three units receive certain privileges, and the treatment team believes this system has helped to increase both staff and participant motivation. The program at Indian Creek produces an annual report detailing program outcomes and specifying areas in need of improvement. The computer data system, CADMUS, used by the facility allows all staff to enter their notes and results of any assessment tools directly into the computer. This information is accessible to all staff and allows counselors to better keep track of an individual's progress. It also has greatly helped the facility track data and outcomes for their own internal review process.

17.5 CEC PENN PAVILION: NEW BRIGHTON, PENNSYLVANIA

CEC Penn Pavilion, or the Community Recovery Academy, is a halfway house providing comprehensive substance abuse treatment to reduce chronic recidivism. The structure, content and methods utilized in the program are informed by empirically proven methods of effective programming and continuous evaluation of program effectiveness. Penn Pavilion has 45 inpatient beds and 30 outpatient slots. Approximately half of the participants in the program have previously completed a prison-based substance abuse treatment program. Individuals who have received a street referral complete a 45-day inpatient program whereas State Intermediate Punishment (SIP) individuals complete 60 days of inpatient and Back on Track (BOTO) individuals complete 90 days. The SIP program provides a sentencing option for individuals who have substance abuse issues, whose offense was motivated by these issues or is a less serious offense, or who would have received a sentence of 30 months or more. Most individuals qualifying for SIP are people with multiple DUIs and their sentence will include six months in prison followed by 60 days of community corrections and outpatient treatment. Back on Track individuals are generally parolees who have experienced difficulties under parole supervision and have committed multiple violations. A portion of their BOTO program is received in the correctional institution and the remaining 90 days in community corrections. The program provides an alternative to remaining in the state correctional facility.

Individuals are screened into the program at the prison level and must have a history of substance abuse and/or crimes related to drug use. Residents are all assessed utilizing the Texas Christian University Drug Screen II (TCU-DSII), Salient Factor Score, Criminal Sentiments Survey-Modified (CSS-M) and Level of Services Inventory-Revised (LSI-R) to ensure appropriate placement in available programming. The CSS-M is also used as a post test instrument at the conclusion of treatment. In addition to these instruments, the Hostile Interpretations Questionnaire (HIQ) is also administered as a pretest instrument for residents entering the Violence Prevention Program. The classification committee designates individuals for inpatient or outpatient programming, and will identify all individuals with mental health problems for appropriate program placement. All residents must have a demonstrated maladaptive pattern of substance use noted by one or more of the following: interferes with responsibilities; interferes

with safety; causes legal problems; or causes social and interpersonal problems. The program does not accept any individuals convicted of a sex offense or arson, and will not admit anyone convicted of a severely violent act. Participants are given the right to decline the program, but if they choose to do so, they must return to DOC custody.

The inpatient program runs from 8:00 a.m. to 4:00 p.m. and begins with work details followed by medication and a morning meeting. Groups are held in the morning and afternoon for one and a half hours per session. The outpatient program is comprised of weekly one-hour individual sessions and two-hour group sessions. Penn Pavilion uses a modified TC model, including pull-ups and push-ups, but does not employ a structure hierarchy for the participants. The program also uses the TCU/IBR curriculum for high hostility, criminal thinking and low motivation for treatment. This curriculum is used with all residents in the inpatient and outpatient treatment programs, but is varied, both in time and content, based on the resident's individual treatment plan. AA/NA groups are offered every Friday. In addition to the treatment group sessions, additional groups are offered, including: batterers intervention, violence prevention, victim awareness, transitional services, life skills and thinking for change.

The treatment staff at the program comprise a center director (licensed), chief of programs (licensed), and lead counselor, all of whom are required to have a master's degree, and a facility compliance manager and a bachelor's level counselor. The team has recently been cut back and the current staff-to-participant ratio for the inpatient program is 1:8 and for the outpatient program is 1:30. Treatment staff are required to attend 25 hours of specific substance abuse training by the Bureau of Drug and Alcohol Programs (BDAP). CEC requires a total of 58 hours of annual training, though they report staff getting up to 100 hours of training per year. Security staff also receive substance abuse training in order to better understand the treatment approach and experiences of the individuals in the programs.

Much of the reentry planning activities occur in individual meetings and group sessions, and focuses on preparing individuals to find employment, interviewing techniques, résumé preparation and obtaining necessary documents. The local community-based employment office for Career Links visits the program and works closely with community businesses to assist individuals in finding employment opportunities. While in the program, participants will prepare a home plan and begin saving money. From the money they earn during work release or other jobs, 40% is set aside for housing, 10% to cover court costs, 20% goes back to the state and 10% is placed in their savings account. The local housing authority directly assists individuals find placements in the community, and treatment staff have also developed close working relationships with the housing authority, supportive housing programs, local rental agents and social security offices. Counselors take on a case management role in helping individuals prepare for their release, and all participants must have an aftercare plan in place before leaving, including having identified community treatment providers. Treatment staff at Penn Pavilion have also developed close ties with other community-based organizations that can offer assistance, such as Goodwill, Salvation Army, Big Brothers, Department of Transportation, Family Services, Professional Outfitters of New Brighton, the Veterans Administration (VA) and Gateway Rehab.

Treatment participants having difficulty in the program are first approached at the counselor level and any inappropriate behavior is properly documented. The next step is to develop a behavioral plan, and if the problem persists, the individual attends a conference with the treatment team. If the behavior still continues after this conference, another conference is held with the treatment team, staff from the Pennsylvania Board of Probation and Parole (PBPP) and DOC staff. Penn Pavilion reports a 3% removal rate for disciplinary or program noncompliance reasons.

The chief of programs provides clinical supervision, including both weekly individual and group supervision. He/she will also review treatment files with the counselors and address any problem areas. All files are subject to monthly file review, and no treatment file can be closed until it has been reviewed. The program is audited twice per year by DOC, including additional file reviews and review of policies and procedures. The treatment staff meet regularly at treatment team meetings, and a utilization review plan is in place to ensure the effectiveness of the program. Penn Pavilion is ACA-accredited and receives an ACA audit every three years. In addition, the Department of Health (DOH) conducts yearly site visits and publishes a report on its findings.

17.6 NORTHERN STATE PRISON: NEWARK, NEW JERSEY

Though Northern State Prison in Newark, New Jersey is a maximum security prison, it also has a minimum security annex housing a substance abuse treatment program run by Gateway Foundation Inc. Corrections Division. This 192-bed capacity treatment program uses a modified therapeutic community approach, while also integrating many cognitive-behavioral elements. The program at Northern State provides a structured schedule with seven days a week of programming. Participants are up at 7:00 a.m. and have various activities scheduled until approximately 7:00 p.m. Following their morning wake-up, individuals participate in a 30-minute morning meeting and then attend various group sessions ranging from encounter, didactic, cognitive restructuring or peer groups. Following lunch, participants attend additional group sessions, and after 3:00 p.m., they perform their TC work assignments. Dinner is followed with a meeting to recap what was learned during the day and to begin to prepare for the day to come. A small number of participants attend education programs in the morning or afternoon.

Similar to other TC programs, the program is divided into three phases: orientation (lasting 60 to 90 days), primary treatment (four to six months) and reentry/transition (three to six months). The average total time spent in the program ranges from 12 to 13 months, though treatment length is determined by progress, not by a set time limit. Apart from having to fulfill the eligibility requirements to qualify for a minimum security facility, individuals must have at most 40 months left until their release. Treatment staff reported that it is very rare for an individual to complete the program and then return to general population, as most people transition on to area assessment centers. Individuals who have been convicted of a sex offense or arson are unable to participate in the treatment program, and screening for the program is conducted by DOC at a classification/reception facility using the ASI instrument.

In addition to community meetings and encounter groups, the participants are part of a structured hierarchy. The elders in the hierarchy have additional responsibilities, including facilitating one

group per week, monitoring the housing coordinators and meeting regularly with clinical staff. Treatment participants frequently facilitate peer seminars to discuss various topics, and pull-ups and push-ups are used throughout the program. Some hierarchy members, along with treatment staff, constitute a treatment progress review (TPR) committee, which meets with individuals exhibiting problematic behaviors. A meeting with the TPR automatically occurs if an individual has received two pull-ups from their peers. All treatment participants are required to meet with their counselors once per month for a minimum of 30 minutes for individual counseling.

The treatment staff at Northern State is composed of seven counselors and two supervisors. Though not all counselors are certified substance abuse counselors, they are all in the process of working toward their certification. All new staff are told during the hiring process that they must attain their certification within two years of beginning employment, and staff are required to write a detailed educational plan proposing how they will achieve this certification. At least two members of the treatment team are formerly incarcerated and bring significant insight and experience into the program. The security staff are not integrated into the treatment program and function in a more independent fashion.

Every treatment participant completes a monthly self-assessment covering 14 different areas. Treatment staff complete similar assessments on participants every 60 days, and then meet with participants to compare results and discuss any discrepancies. Prior to completing a phase, participants will also retake the TCU screening instrument so their progress, or lack thereof, can be properly documented. Participants work on their reentry plan with their counselors individually. The program at Northern State has recently joined a project developing a recovery-oriented integrated system (ROIS), which could greatly impact and increase the effectiveness of their reentry and aftercare planning. This system encourages all stakeholders, from community-based organizations, social service providers, Parole/Probation, prison staff and the courts to the treatment participant, family and community, to work in collaboration to ensure the most effective reentry process for the individual. New Jersey DOC is responsible for monitoring the program and conducts monthly site visits and yearly audits. Gateway gives DOC monthly reports including performance measures and also does their own internal audits to monitor program effectiveness and outcomes.

17.7 TALBOT HALL: NEWARK, NEW JERSEY

This 500-bed assessment center run by CEC is designed to provide services to individuals with substance abuse treatment needs and those without a substance problem, though approximately 70% of all residents have substance abuse issues, and facility staff estimate that 50% to 60% of all residents have more serious substance abuse treatment needs. Individuals incarcerated in New Jersey prisons apply to participate in this voluntary program when they are within 18 months of their first parole eligibility. Individuals accepted into Talbot Hall will participate in the program for 60 to 70 days before moving on to a halfway house.

Fifty to 60 new residents arrive each week at Talbot Hall and, after being cleared by medical staff, move to the assessment center at the facility. At this time, treatment staff conduct a comprehensive assessment looking at level of risk, mental health needs, substance abuse needs (using the TCU CEST instrument), personality tests and a test to determine work-related IQ. In

addition, staff check work readiness, complete a bio-psychosocial assessment and ask questions regarding the individual's outside support systems. At the conclusion of the assessment, treatment staff will determine whether an individual requires intensive, moderate or minimum treatment. Staff will report all of their findings to the resident, who is then given an opportunity to respond or voice objections.

Following the assessment process, the resident will complete 10 days of orientation on his assigned unit and must pass a test in order to transition to the next phase and begin to participate in wider programming. The day at Talbot Hall is very structured, beginning at 8:00 a.m. and running until 10:00 p.m. All residents participate in a 50-minute didactic session in the main lecture hall and are then placed in smaller groups during the day to discuss the information presented during the lecture. Any residents requiring extra attention are assigned a big brother from the unit to support them. House meetings are held every morning and evening, and resident seminars occur regularly on the weekends. Talbot Hall also has an additional relapse track, separated from the other units, for 20 to 40 individuals who may have relapsed at the halfway house and need more intensive substance abuse treatment services.

Daily programming also includes GED and computer classes, as well as anger management and parenting groups. Alcoholics Anonymous, Narcotics Anonymous and Gamblers Anonymous are held at the facility, and some individuals may be required to attend these programs as part of their treatment plans. Talbot Hall has an active family program and encourages family members to become oriented with the program curriculum during visits. The program at Talbot Hall uses an eight-week curriculum developed by CEC and based on the Federal Bureau of Prisons treatment programs. Though a modified TC with community meetings, pull-ups, push-ups and a structured hierarchy, the program also utilizes a strengths-based approach and a great deal of REBT therapy.

Generally, all residents will move on to a halfway house prior to being released, but staff at Talbot Hall still work with individuals to create résumés and prepare financial aid package applications for community colleges. CEC has developed an alumni association for any resident who has completed a CEC program anywhere in the country. This association is a resource that assists with housing, referrals, employment and volunteer work. They have monthly alumni association meetings and will help every individual create an action plan and set up appointments on the outside with various organizations or businesses. Alumni association staff are always on call and can be called at any time of crisis for support or advice after an individual's release. This service provides a great continuity of care for individuals as they begin their transition back to their communities.

The treatment staff at Talbot Hall consists of seven senior counselors, five unit counselors, two unit supervisors and one unit manager. Treatment staff are scheduled seven days a week, 24 hours a day. CEC provides their own certified alcohol and drug counselor (CADC) training, therefore all staff who are not certified counselors can work toward certification. New treatment staff attend seven days of training prior to beginning at Talbot Hall, followed by five days of on-the-job training. All established employees participate in 40 hours of training annually, though clinical staff also have specific clinical training offered twice per month. Individual counseling is offered to all residents every 14 days for 30 to 40 minutes. Treatment staff utilize a

computerized system that allows staff to communicate with each other and keep informed on the progress of every resident.

Facility staff reported 56 disciplinary removals against 2,600 successful graduations. Residents may receive merits or demerits on a daily basis. Every time a merit or demerit is issued, the resident appears before the clinical intervention committee. If the resident has received a merit, he may earn certain privileges. Demerits may lead to extra assignments, such as thinking reports or essays. In addition to the clinical intervention committee, each unit has a peer intervention committee (PIC) that meets with residents to discuss any problematic behaviors. If an individual appears to refuse to take responsibility for his behavior, he will be required to attend a responsibility group meeting four days per week for one week. At the end of the week, the senior counselor decides whether to allow the individual to exit the group or retake the course. The formal removals process begins with a case conference if an individual has received various demerits, or following a significant incident. The next step in the process is for the individual to be asked to sign a 30-day manager's contract. The final step is an administrative review, at which point treatment staff decide whether to remove the individual from the program.

Senior treatment staff will observe sessions of other counselors on a regular basis and offer feedback. Case conference meetings are also held on a weekly basis to discuss difficult cases. Treatment charts, individual counseling notes and treatment plans are also regularly audited. Staff at Talbot Hall conduct peer review research to track the program's outcomes and have found a considerable reduction in recidivism for individuals who have completed both the program at Talbot Hall and the halfway house. The Office of Community Programs visits the program weekly to address any issues, and reviews charts on an annual basis. Treatment staff produce monthly reports and the treatment leadership committee (TLC) from Central Office conducts internal audits of the program. Talbot Hall also has a quality management committee that meets on a monthly basis to assess staff performance, program quality and resident morale. In addition to the above monitoring, the state sends in contract monitors to inspect the program, and ACA conducts a major inspection every three years.

17.8 TULLY HOUSE: NEWARK, NEW JERSEY

Tully House is a 315-bed halfway house run by CEC, located in Newark, New Jersey. Most of the individuals transferred to Tully House come from two area assessment centers and are often the hardest-to-place individuals. The typical stay for most residents is between six and nine months. Tully House accepts adult offenders, excluding those convicted of arson and/or a sex offense, who are within 18 months of parole eligibility. All new residents are screened using the TABE (Test for Adult Basic Education) test.

The three-phase program at Tully House begins with an intensive supervision phase lasting from three to four months and consisting of two hours of morning lectures and two hours of afternoon activities every day. Prior to beginning Phase I and within 24 hours of arrival at Tully House, individuals are each assigned a big brother and must complete a 10- to 15-day orientation period from which they must test out to transition to the next phase. During Phase I, an individual does not participate in any programming in the community. Once he moves into Phase II and completes a two-week blackout period during which time he has no contact with individuals

outside the facility, he is eligible to exit the facility, but only on escorted trips. When an individual is ready to move on from Phase II, he submits a request slip to his counselor to be allowed to participate in the six-week intensive Pre-Phase III period, also referred to as a "job readiness program." Weekly case conferences are made up of a panel of five individuals, including residents, to determine which individuals are ready to move into this phase. Every resident applying for entry into Phase III must fulfill certain requirements. They must have a relapse and criminality plan in place, a résumé, birth certificate and Social Security card. In addition, these individuals must have acquired a pair of dress pants, shoes, shirts and a tie. Once Pre-Phase III is completed, an individual can move on to Phase III, in which participants are involved in more active community work or school, while attending a daily one-hour lecture, five days per week.

In addition to the above programming, Tully House has a specialized domestic violence program consisting of a 10-week intensive curriculum with approximately 145 participants. The other specialty of the facility is substance abuse treatment. For most individuals the day begins at 9:15 a.m. and runs until 10:00 p.m. A separate relapse prevention curriculum for 45 minutes, five days per week, lasting three months, is also a requirement for all residents. Every resident who is not participating in work release must complete approximately 120 to 130 treatment hours, compared with 40 hours for those in work release. The majority of the residents at Tully House end up participating in vocational school, college or work, though work release is becoming increasingly difficult to find. Tully House also offers a six- to 12-week parenting course, AA/NA groups, criminality groups, GED services and a family services program. The AA/NA meetings and criminality group are held seven days per week and high-risk residents must attend one group or the other.

The program at Tully House is a modified TC that uses traditional TC aspects, such as a structured hierarchy, community meetings and pull-ups and push-ups. In addition, the treatment staff utilize CBT and REBT treatment approaches and focus on offering praises and merits rather than criticism. Role playing is a large part of the program and helps to prepare the residents for transitioning back to the community. All of the substance abuse treatment curriculum used at Tully House is based on the treatment programs at the Federal Bureau of Prisons.

The treatment staff rely on the use of MSW graduate students, and at the time of our visit, had seven such students who were the primary providers of individual counseling. The staff view the reentry process as a wstep-down process and make sure that every resident has completed the three phases prior to their release. Treatment staff assist eligible individuals with SSI disability applications and VA payment applications. They also help residents enroll in vocational or school programs prior to be being paroled.

All residents at Tully House are given monthly evaluations and individuals may lose certain privileges for behavior such as cursing or smoking in the bathroom. Staff estimate that 10 to 15% of all removals are for program failures such as positive urine tests.

17.9 NEW YORK STATE DOCS

While reviewing several substance abuse treatment programs throughout the country, it was evident that it would be difficult to find a program that uniquely fits the population and organization of New York DOCS. All of the programs presented above—and, it appears, the most successful prison-based substance abuse treatment programs—are provided by outside vendor companies, whereas in New York, substance abuse treatment programs are run by the Department of Correctional Services. Though outside vendors have provided treatment services in New York prisons in the past, we have not been able to include a significant sample of data from treatment participants in programs run by outside providers to enable us to draw any definitive conclusions. It is unclear why DOCS decided to end their contracts with previous outside treatment providers who performed treatment services in New York State prisons, like Stay'n Out and Phoenix House, when they had proven and documented success rates. Based on our various interviews of model programs, it is clear that outside providers likely possess a greater level of clinical expertise and experience, and are better positioned to take advantage of various outside resources.

After conversations with a wide range of programs, ranging from dedicated prison-based treatment programs to community corrections to halfway houses, a few components of effective programs became more apparent, and their distinction from substance abuse treatment programs offered in New York State prisons more clear.

Most of the above programs have formal individual counseling requirements exceeding what is offered in New York. They also appeared to have more detailed and structured curricula allowing individuals to move through phases as their treatment progresses. The staff at the facilities we reached out to also appeared to have a greater percentage of certified and/or licensed staff and more strict requirements for gaining certification while employed. The training offered to staff also appeared more comprehensive and specific to substance abuse treatment and issues. The five in-prison TC programs (excluding halfway houses and community treatment) had programs ranging from nine to 28 months, considerably longer than the NYS ASAT program. In addition, many of the programs we interviewed had more aftercare treatment programs available as well as more coordinated and supportive reentry support. Finally and most clearly different, these programs all seemed to have more formal internal and external monitoring processes in place, including quality assurance plans, more frequent audits and treatment record reviews, as well as more intensive clinical supervision.

18. RECOMMENDATIONS

Screening/Assessment

A. Develop and implement a more comprehensive, standardized assessment process and instrument that enables the guidance/reception staff to distinguish between type and severity of need for substance abuse treatment, as well as criminal risk, and to distinguish between substance use, substance abuse and substance dependence. The initial screening completed at DOCS reception facilities indicates that a specific problem with substance use might exist, but is insufficient in its ability to identify an inmate's level of need and an appropriate program placement. The addition of a more comprehensive assessment tool for use on individuals who screened positive (1) under the MAST or SSI tests, (2) as a result of reviewing the pre-sentence reports, or (3) during interviews with correction staff, would reduce the number of individuals being inappropriately placed into treatment programs. This would ensure that individuals were being placed into the programs that most accurately reflect their level of need, make the best use of limited staffing and financial resources and be most effective in reducing risk of relapse and recidivism due to drug use. DOCS should also investigate the use of alternative, well-regarded screening instruments such as AUDIT,[314] ADS[315] and TCUDS.[316]

B. Develop written guidelines for identifying who should be designated as in need of substance abuse treatment. These should take into account and clearly define the severity of the substance abuse problem, the risk of relapse and the risk for future criminal behavior. Without a clear definition of what constitutes substance abuse and a need for treatment, there will consistently be tremendous variation among treatment participants and their levels of substance abuse severity. Formal definitions and guidelines will allow for greater consistency in the screening process, as well as needed guidance for all correction staff involved in making this determination.

C. Require staff conducting any further assessments regarding substance use to be trained to administer the standardized assessment instrument. Decisions regarding appropriate placements for substance abuse treatment programs are more effective when done by trained professional staff. A degree of understanding about the different levels of severity regarding substance abuse, the type of prison-based programs available and the program that best suits individual's needs can reduce inappropriate referrals and increase treatment effectiveness. Specialized training covering basic counseling techniques, essential mental health terms, relationship building and reflective listening should be offered to counselors administering screening and assessment instruments.

D. Develop clear policies and procedures, in coordination with the Office of Mental of Mental Health (OMH), for identifying individuals in need of treatment programs for co-occurring disorders or special needs. OMH staff should work in coordination with

[314] Babor et al., "The Alcohol Use Disorders Identification Test: Guidelines for Use in Primary Care."
[315] Allen and Columbus, "Alcohol Dependence Scale (ADS)."
[316] "IBR -- Projects -- TCU Drug Screen Evaluation."

counselors assessing inmates for substance abuse treatment, sharing mental health information as needed and collaborating when necessary to make an appropriate recommendation for substance abuse treatment services for individuals with mental health problems or those with special needs.

E. Require treatment staff to conduct a reassessment for individuals entering a treatment program as circumstances may have changed from the time an individual enters DOCS to when he/she begins a treatment program. Since DOCS treatment programs are offered near the end of an inmate's sentence, many individuals do not begin treatment until they have spent a significant amount of time in prison. During this time their level of need, severity and risk may have changed, and individuals should be reassessed to ensure they are placed into appropriate programs.

F. Develop a variety of treatment and educational programs for individuals with varying needs and match individuals who have been identified as needing substance abuse treatment to appropriate programs based on their individual needs and severity of substance abuse. Matching programs to individual needs greatly increases the chance that an individual will be successful in his/her treatment placement. Treatment matching after determining appropriate level of care requires that a continuum of services be available, ranging in levels of intensity, length, treatment modality and location (residential or outpatient). In order to create a successful therapeutic environment, inmates with similar type and severity of substance abuse issues should be placed together to maximize the effectiveness of their treatment and make best use of the treatment staff resources. Correctional facilities in Colorado and Maine have had success with treatment matching and these programs could serve as models for a similar approach in New York State.

G. Allow for prioritization of substance abuse treatment programs according to need and severity of substance abuse problem for inmates demonstrating circumstances such as active substance dependence when entering prison and drug use inside prison. The current policy of prioritizing individuals for treatment based on proximity to release is not appropriate for every inmate. Inmates with a significant need for substance abuse treatment at admission to DOCS, or who repeatedly receive disciplinary sanctions for drug use inside of prison, should be prioritized for substance abuse treatment services regardless of the length of their prison sentence. DOCS should explore the creation of a completely voluntary substance abuse treatment program for individuals entering the prison system who feel they need treatment services more urgently. This option should also be available for inmates who receive a misbehavior report for use or possession of drugs while incarcerated. We agree with the Substance Abuse and Mental Health Services Administration (SAMHSA) that inmates with significant substance abuse needs and high recidivism risk should be prioritized for initial placement into a substance abuse treatment program.

Treatment Program, Processes, Content and Structure

H. Standardize program content and material using evidence-based, up-to-date workbooks, handouts and videos. The DOCS Office of Substance Abuse Treatment

Services should provide a more detailed curriculum for treatment programs, including handouts and videos to be used in the program. We encourage treatment staff with community-based treatment experience to introduce relevant materials they believe would add value to the program, but such materials should be reviewed by OSATS staff during their routine monitoring of the programs to ensure the appropriateness of such materials, and to identify useful materials that could be distributed to all treatment programs. Centralization of materials and program content can assist in making certain that materials and content are up-to-date and inclusive of new evidence-based practices and approaches.

I. Provide a more detailed curriculum for each treatment modality and type of program, clearly indicating where modification by facilities and programs is permissible. Ensure that curricula consist of clinical services as well as drug education, and focus on learning and practicing new skills, rather than only discussions. With such a large number of DOCS correctional facilities offering substance abuse treatment programs and a treatment staff consisting of individuals with various training and experiences, it is challenging to provide standardized, consistently effective treatment services without detailed, comprehensive curricula. Not only should the curricula provide more specific guidance to treatment staff, but they should also include handouts and activity suggestions for each topic, ensuring that regardless of where an inmate receives treatment services, they are effective and consistent with DOCS and community standards.

J. Develop alternative ways to individualize treatment for individuals with varying degrees of substance abuse severity and motivation. Some variation with treatment program participants is expected, even if the Department were to institute a more comprehensive assessment and treatment matching policy. In order to appropriately address every individual's needs, DOCS Office of Substance Abuse Treatment Services should develop formal methods for addressing them. This could include increased individual counseling or the creation of subgroups within programs for individuals with low motivation or who are close to completing the program and ready to focus more intensely on reentry and relapse prevention planning.

K. Decrease large group session size and increase frequency of small group session use. Large group sessions are conducive to didactic instruction, but do not create an appropriate environment for open communication, sharing and discussion. Group sizes should be limited in order to ensure best clinical effectiveness, and groups should routinely break into smaller groups that can facilitate greater interaction, dialogue and support among peers.

L. Improve fidelity to therapeutic community and cognitive-behavioral principles. Efforts should be taken to ensure that key elements of therapeutic communities and the cognitive-behavioral approach are more fully integrated into the program. These efforts include increased focus on role playing and skills development, as well as use of incentives and privileges in the community.

M. Increase frequency and length of individual counseling sessions. Individual counseling in a setting with such a diverse population and large group sessions allows inmates to address more sensitive issues that they might be hesitant to disclose in a group setting.

Additionally, individual counseling sessions facilitate the creation of therapeutic relationships between inmates and treatment staff and provide the opportunity for treatment staff to more directly attend to an individual's unique needs and circumstances. Individual counseling sessions in DOCS substance abuse treatment programs should be offered in accordance with OASAS and ACA standards for community- and prison-based programs, and an increased amount and frequency of individual counseling should be formalized and built into treatment staff's schedules. Treatment participants should receive the type and frequency of individual counseling that reflects the severity of their substance abuse and motivation. It is also essential that treatment staff ensure the confidentiality of such individual sessions and accurately document their duration and content.

Program Climate

N. Create more incentives to encourage inmates to participate in substance abuse treatment programs and decrease coercive elements of the program. Mechanisms and policies should be developed that assist inmates in being able to complete the treatment program. Treatment staff should be encouraged to look at incidents of rule infraction as a learning opportunity rather than justification for an individual's removal from the program. Individuals who are positively contributing to and progressing through the program should be provided certain privileges to encourage and empower individuals toward success.

Reentry/Aftercare

O. Increase aftercare services available in prison for inmates completing programs and returning to general population, including possibly an aftercare dorm. Research has shown that aftercare in the community is essential to prevent relapse and recidivism. Many inmates participating in prison-based treatment program will not be returning immediately to the community, and for these inmates, the availability of aftercare programs within prison is essential. Returning to general population from an intensive residential therapeutic community can produce substantial stress and lead to a return to habitual and survival tendencies, and thus contribute to relapse. Though AA and NA support programs are available in many prisons, we found that many inmates were not encouraged to participate and did not engage in these programs. Many treatment staff also expressed a desire to have a process that would enable them to check in with graduates of the program about their relapse prevention plans and any challenges they are facing. The creation of an aftercare dorm for inmates completing residential substance abuse treatment programs, more formal and diverse aftercare services and continuity of services from treatment staff are important elements to reducing recidivism and relapse, as well as adding an incentive for inmates to complete the program.

P. Develop a more comprehensive, coordinated and integrated discharge planning policy, including recommendations from treatment staff on the types of programs that would best suit individuals' substance abuse treatment needs in the community. Widespread research has shown that the provision of aftercare services and some continuum of treatment support greatly reduce incidents of recidivism and relapse. Treatment staff have worked with individuals in their program for months and are in the best position to make an

informed recommendation as to what services are most appropriate upon completion of the program and when the individual is released to the community. In order to promote successful reentry from prison for individuals graduating from prison-based substance abuse treatment programs, there must be a prison-based reentry-oriented integrated process that includes input from, and coordination with, treatment staff, Parole and community-based organizations. A comprehensive discharge plan should be created that includes specific recommendations for the type and length of treatment program or services that would most benefit the individual, as well as important information about his/her medical, psychiatric, employment, family and social needs. In addition, every individual leaving prison should be provided with documentation from the treatment staff outlining the treatment services he/she received while incarcerated. This information would enable community-based treatment staff to provide a more effective and appropriate continuity of services.

Q. Information about 12-steps and other alternative, free recovery support services should be explained during DOCS substance abuse treatment programs. As a result of past litigation, 12-steps can no longer be used as a treatment modality in DOCS treatment programs, but that does not prohibit treatment staff from fully explaining the program and its structure to treatment participants. Often 12-steps or similar alternative programming are the most readily available and affordable option for many individuals being released from State prison. A familiarity with the program can assist individuals in their recovery process and provide some continuity of care in the reentry process.

R. Enhance relationships with Parole and Transitional Services staff in order to further collaborate on discharge and reentry planning. Phase III Transitional Services staff are tasked with assisting inmates with reentry. In addition, Parole makes important decisions regarding a formerly incarcerated individual's treatment services in the community. Historically these decisions have been reached with little or no discussion with prison treatment staff and counselors. We were pleased to learn that Parole and DOCS have been working together to create a Transitional Accountability Plan (TAP), a discharge planning document created as soon as an individual enters the DOCS system that is passed to Parole as he/she is released. DOCS staff reported that TAP will be piloted soon, and we encourage DOCS and Parole to continue to work together in a more formalized way in order to ensure that inmates being released from State prisons are provided appropriate and effective continuity of care for substance abuse treatment.

Staffing

S. Require initial and ongoing training on the therapeutic community (TC) treatment approach for all correction officers (CO) working in TC substance abuse treatment program housing units or in treatment programs, including relief officers. The TC model is based upon a concept of creating a 24-hour-a-day, 7-days-a-week treatment environment where the community takes the role of therapeutic agent. Correction officers are assigned to TC dorms and are present during community meetings and group sessions. Consequently, they become members of the therapeutic community and are the only staff support available when the treatment staff leave the prison for the evening and on weekends. A large part of the effectiveness of the TC model is that learning and modeling

behavior takes place not only within the formal group sessions, but in all activities throughout the morning, afternoon and night. The general training given to COs focuses on maintaining security and discipline, rather than in supporting individuals in their recovery process. Requiring TC training for all COs working in, or with, substance abuse treatment programs will assist the inmates and treatment staff in ensuring a more effective and consistent treatment environment.

T. Increase substance abuse treatment staffing numbers. State policy makers should take action to ensure that authorized DOCS treatment staff positions are promptly filled. Staff-to-treatment-participant ratios should be in accordance with OASAS community regulations.

U. Increase qualifications and skills necessary for treatment staff. Treatment staff should meet the necessary requirements and qualifications as outlined by OASAS.

V. Provide more comprehensive and frequent training for treatment staff covering topics such as evidence-based counseling approaches used in substance abuse treatment, working within the criminal justice setting and working with special populations. Though some of the treatment staff with whom we spoke were highly trained and knowledgeable in their field, many would greatly benefit from increased training on new approaches and theories in the field. With increased training, staff could develop new counseling and treatment participant engagement strategies and learn more information on working with specific populations such as individuals with special needs, mental health needs and sex offenders. The Department should develop additional training sessions and encourage greater participation in training by providing monetary support, approved absences and other incentives to enhance the skills of the treatment staff. Training for all DOCS substance abuse treatment programs should be offered by a consistent set of trainers able to inspect treatment plans and observe programs in order to best identify needed areas for training. We encourage the Department to explore the creation of a "model training program" where all new staff can receive training prior to placement at a permanent facility.

Clinical Case Records

W. Work with the Office of Substance Abuse Services (OASAS) to design new treatment record forms that are concise, individualized, intuitive and comprehensive. OASAS has the expertise and experience to assist DOCS in developing forms that more effectively capture the information necessary to offer the highest quality of services to treatment participants. They may also be able to offer training or assistance in developing training for treatment staff on completing these forms in a manner that is both individualized and concrete. DOCS should take advantage of the existing resources and work with OASAS towards improving these forms.

X. Promote better inmate participation in the treatment and discharge planning process. Treatment staff should be encouraged to involve treatment participants in developing their treatment and discharge plans in order to increase ownership and investment in the program and their recovery. This collaboration should be documented in the treatment records, and

should be viewed as an important learning experience for the participant and an opportunity to engage them in important therapeutic conversations.

Y. Develop formal process for regular review of treatment records by a clinical supervisor. Without a process in place to ensure accountability, the most comprehensive forms can become ineffective. Proper auditing and supervision of treatment records and their content not only provides this accountability, but allows treatment staff to develop their professional skills while increasing the quality of services beings offered to treatment participants.

Monitoring/Oversight

Z. Develop and implement written policies and procedures on how individual facilities and DOCS Office of Substance Abuse Treatment Services provide clinical supervision and oversight to treatment staff. All individual treatment plans and records should be regularly monitored by a clinical supervisor. Clinical supervision should be provided to all treatment staff by a qualified clinical supervisor in accordance with OASAS community standards. If a qualified clinical supervisor is not available at the prison, DOCS should employ a consultant to offer clinical supervision to treatment staff two to four times per month. In order to ensure staff accountability, procedures should be formally developed to monitor staff performance, including the use of participant satisfaction surveys; performance should be documented and include specific necessary steps for improvement.

AA. Develop written policies and procedures for OASAS oversight and evaluation of DOCS substance abuse treatment programs. To mitigate the significant variation we observed among programs, formal policies requiring quality assurance and utilization review plans should be established. In addition, documents should be developed for monitoring purposes to comprehensively rate treatment plans and records, program sessions and participant satisfaction and to track outcomes. Monitoring documents should also address participant placement in treatment and aftercare, response to participant's special needs and integration of mental health and medical services where necessary.

Special Populations

BB. Increase collaboration with the Office of Mental Health (OMH) in providing support and expertise in substance abuse treatment programs serving inmates with mental health issues. Though we applaud the Department's efforts to increase the number of substance abuse treatment programs for inmates with mental health needs, we are concerned by the lack of mental health training and expertise of many of the treatment staff. Group treatment sessions can often trigger an emotional situation that would require mental health intervention. OMH staff should frequently participate in treatment sessions of the IDDT programs for both general population inmates and individuals in residential mental health programs. Weekly treatment meetings should be scheduled with OMH staff and treatment staff working in those programs to address the special needs of this population, including specific discharge planning needs.

CC. Increase the number of Integrated Dual Diagnosed Treatment Programs available in general population. DOCS and OMH have been able to collaboratively develop what appears to be generally successful integrated treatment programs for individuals with co-occurring mental health and substance abuse problems (COD) housed in both disciplinary and residential mental health programs. Thousands of inmates with mental health disorders, many of them seriously mentally ill, reside in general population and therefore, DOCS and OMH should perform a comprehensive assessment of the treatment needs of general population COD inmates and then significantly increase the number of general population IDDT programs beyond the three current general population IDDT programs to meet those identified needs.

DD. Increase the number of resources available for limited English speakers and the number of bi-lingual treatment staff. Conduct a needs assessment for limited English speakers in need of substance abuse treatment and determine if a Spanish-language substance abuse treatment program should be piloted at one facility. Treatment staff should be able to provide limited English speakers with information and materials in their native language. All materials and information made available to the group should also be available to limited English speakers whose treatment services should not be reduced simply because of their inability to speak English. Prison administrators should make a strong effort to recruit more bilingual treatment staff, offering pay differentials where necessary. The Department should explore the possibility of creating at least one Spanish-only treatment program, to allow individuals with limited English skills to participate more fully in their recovery. In addition, if inmate translators are to be used, they should be used as a paid position of adequately trained individuals who are not currently in treatment.

EE. Incorporate gender-appropriate topics and curriculum into the substance abuse treatment programs offered in prisons that house women. Gender-specific programs should address issues of maintaining and developing healthy relationships, trauma, parenting and health education. The Department should explore the use of gender-specific screening and assessment instruments such as TCUDS II or TWEAK.[317]

Program Removals

FF. Standardize the removals process for all prison-based substance abuse treatment programs and develop program retention committees at all treatment programs with the aim of working creatively with individuals to engage them in treatment and decrease the number of inmates being removed from the program. Substance abuse and dependence are chronic, reoccurring conditions of which relapse, acting out, noncompliance and multiple experiences with treatment programs are extremely typical and expected. Many inmates resist being forced into treatment and may act out in various ways, and it is up to treatment staff of such programs to find ways to engage these participants in the recovery process. Too often we observed inmates being removed from programs for minor infractions, and staff not committed to working with inmates who are disengaged or

[317] Peters, Wexler, and Center for Substance Abuse Treatment (U.S.), *Substance Abuse Treatment for Adults in the Criminal Justice System: Treatment Improvement Protocol (TIP) Series 44 -- SAMHSA/CSAT Treatment Improvement Protocols -- NCBI Bookshelf*, 38.

resistant to treatment. Every substance abuse treatment program in DOCS should develop program retention committees, whose policies should be targeted at working resourcefully with individuals who demonstrate problems in the program, and using removals as a very last resort.

Drug Use and Testing

GG. Institute less punitive responses to drug usage inside the prison and develop appropriate programs for this population. We recognize that drug use inside prisons can impact the safety of inmates and staff and must be regarded seriously. Individuals testing positive for drug use inside the prisons are often the inmates most in need of intensive treatment services. Disciplinary responses for these individuals should be reduced, not eliminated, and efforts should be made to guarantee that individuals placed in disciplinary housing as a result of a positive urine test are offered some sort of treatment preparation or services during this confinement. In addition, once a disciplinary sentence is completed, these individuals should be prioritized for intensive substance abuse treatment services.

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GLOSSARY

Administrative Removal: When an inmate is transferred to another facility as a result of a transfer request, change in security classification or need for services not offered at the current facility, such as medical or mental health care.

Alcohol and Substance Abuse Treatment (ASAT): A six-month substance abuse treatment program operated in most medium- and maximum-security DOCS facilities, totaling 56 prisons, that aims to provide education and counseling through a competency-based curriculum consisting of nine subject areas.

American Correctional Association Standards (ACA): The ACA, a private correctional association, provides services that include the development and promulgation of new standards, revision of existing standards, coordination of the accreditation process for all correctional components of the criminal justice system, semi-annual accreditation hearings and technical assistance to correctional agencies and training for consultants who are involved in the accreditation process.

ASAT Manual: The DOCS ASAT Manual outlines the basic structure, process and curriculum of the treatment program.

Comprehensive Alcohol and Substance Abuse Treatment (CASAT): A residential intensive three-phase substance abuse treatment program offered at four correctional facilities: Arthur Kill, Hale Creek, Taconic and Wyoming.

CASAT Phase 1: The first phase of this treatment program is comprised of a six-month residential treatment program, based on the ASAT curriculum.

CASAT Phase 2: Second phase focuses on community reintegration and involves participants in work release and treatment programs in a prison or community-based treatment program prior to parole supervision. The program is designed to occur within four to 18 months of an inmate's earliest release date.

CASAT Phase 3: Phase three includes aftercare for participants who have been released on parole and are enrolled in community-based treatment.

Central New York Psychiatric Center (CNYPC): This Office of Mental Health (OMH) center located in Marcy, NY consists of a 226 bed maximum security inpatient facility which provides comprehensive mental health service to persons incarcerated in the New York State and county correctional system. OMH staff at CNYPC also coordinate and monitor mental health services provided in all state prisons.

Cognitive Behavior Therapy (CBT): A psychotherapeutic approach that aims to address problems concerning dysfunctional emotions, behaviors and cognitions through a goal-oriented, systematic procedure that emphasizes the substitution of desirable thinking patterns for maladaptive ones.

Credentialed Alcoholism and Substance Abuse Counselors (CASAC): A credentialing system administered by the New York State Office of Alcoholism and Substance Abuse Services (OASAS). CASAC standards require that candidates complete a minimum of 6,000 hours (approximately three years) of supervised, full-time-equivalent experience in "an approved work setting" (usually an OASAS-licensed treatment program, though exceptions can be granted). Counselors who have fulfilled a substantial portion of the credentialing requirements are designated CASAC-T (CASAC Trainee).

Criminal Justice Drug Abuse Treatment Studies (CJDATS): A multisite, cooperative research program that aims to explore the complex issues related to the treatment of individuals involved with the criminal justice system who have substance use disorders.

Department of Correctional Services (DOCS): The New York State Department of Correctional Services is responsible for the confinement and habilitation of approximately 59,000 inmates held at 67 state correctional facilities plus the 916-bed Willard Drug Treatment Campus.

Deputy Supervisor of Programs (DSP): He/she is responsible for all facility programs, and reports to the facility superintendent and the executive team about treatment program issues.

Diagnostic and Statistical Manual of Mental Disorder (DSM): The standard classification of mental disorders used by mental health professionals in the United States. It is intended to be applicable in a wide array of contexts and used by clinicians and researchers of many different orientations (e.g., biological, psychodynamic, cognitive, behavioral, interpersonal, family/systems).

Dual Diagnosis/ Co-occurring Disorders (COD): Individuals diagnosed with both mental health and substance abuse disorders.

Earned Eligibility Program (EEP): The goal of the Earned Eligibility Program is to increase the rate of safe releases for inmates who have demonstrated an overall pattern of progress in prescribed programs while serving their required minimum sentence. Prior to an inmate's initial Parole Board hearing, the Earned Eligibility Program provides for a review of treatment and disciplinary records to determine whether the case is certifiable and whether an Earned Eligibility Certificate should be issued or denied. Evaluation results are provided to the Parole Board to be used in deciding whether to release the inmate or to deny parole. This program of standards and review is available to inmates serving indeterminate sentences with minimum sentences of eight years or less.

Four-point Likert scale: A psychometric scale commonly used in questionnaires, and is the most widely used scale in survey research. When responding to a Likert questionnaire item, respondents specify their level of agreement to a statement such as whether the statement is *not true, somewhat true, mostly true* or *very true*.

Good Time: Good time is credit for time served on good behavior, and it is used to reduce sentence length. Inmates earn good time by participating in certain vocational and educational programs.

Guidance System (KGNC): Identifies inmates who have a need for substance abuse treatment based on interviews and evaluations conducted by facility program counselors.

Hierarchy: System used in Therapeutic Community programs in which every individual is assigned a role in the hierarchy structure. Individuals move up through the hierarchy as they demonstrate improvements in attitudes and behavior as well as clinical progress. An increase in privileges and responsibilities is common as individuals progress through the structure.

Inmate Payroll System (KIPY): A system used to record inmate pay for work or other prison-related activities. This system has been used to screen and document inmates who are actively participating in substance abuse treatment programs, in order to identify all individuals who have already been designated as in need of treatment.

Integrated Dual Diagnosed Treatment (IDDT): The IDDT programs combine the ASAT competencies with a specialized treatment curriculum tailored to meet the individual needs of participants with mental health problems. The program length is a minimum of nine months, with generally one half-day module, five days per week.

Intermediate Care Program (ICP): An ICP is a segregated supportive living/treatment program that provides 24-hour "care and custody" for inmates with serious and persistent mental illness. ICPs are jointly operated by DOCS and the New York State Office of Mental Health (OMH), which has statutory responsibility for providing a continuum of mental health services to inmates in DOCS care.

Mentally Ill, Chemically Addicted (MICA): A type of ASAT program for individuals who suffer from mental illness as well as substance abuse; recently these programs have been renamed IDDT.

Michigan Alcohol Screening Test (MAST): A self-administered paper-and-pencil screening test that comprises 25 items regarding social, vocational, family and other problems resulting from alcohol use. DOCS considers a MAST score above 4 to be indicative of alcohol abuse and of the need for substance abuse treatment.

Modified Therapeutic Community: Modified version of the therapeutic community (TC) model which increasingly integrates aspects of other approaches, such as cognitive-behavioral treatment and social learning techniques, and adjusts program aspects in response to the setting.

Multimodality Quality Assurance Scales (MQA) Participant Survey: An instrument developed by the National Development and Research Institutes, Inc., (NDRI) to evaluate participant assessment of substance abuse treatment programs. The MQA was developed to study the modified prison-based treatment programs that often employ multiple treatment modalities.

Office of Alcoholism and Substance Abuse Services (OASAS): The New York State agency that licenses drug treatment programs in New York.

Office of Mental Health (OMH): New York State's primary agency for the regulation and oversight of mental health care services, which has a statutory responsibility for providing a continuum of mental health services to inmates.

Office of Substance Abuse Treatment Services (OSATS): Within DOCS, the office responsible for providing and monitoring substance abuse treatment programs in state prisons.

Program Assistant (PA): Core staff members in the Alcohol and Substance Abuse Treatment (ASAT) program generally responsible for the majority of the frontline work, including group session facilitation, individual counseling and monthly evaluations. At a typical ASAT facility, two PAs are supervised by one ASAT correction counselor.

Program Retention Committee/Program Review Committee (PRC): A type of oversight committee in some prison substance abuse treatment programs responsible for assessing treatment participants' program performance. The PRC can recommend removal from a treatment program or other therapeutic interventions to improve program performance. The PRC generally strives to work resourcefully with individuals who demonstrate problems in a given program and use removals as a very last resort.

Push-ups/Pull-ups: Within a therapeutic community (TC), a pull-up is a verbal reprimand given by participants or staff to a participant who is seen as inappropriately handling emotions, behaviors or tasks. Push-ups, in contrast, are positive acknowledgements of self or other participants. Some facilities referred to these as "regressions" and "progressions."

Residential Substance Abuse Treatment (RSAT): A federally funded substance abuse treatment program, established by the Violent Crime Control and Law Enforcement Act of 1994, that requires treatment participants to be housed together. RSAT uses the same curriculum as the ASAT program.

Rockefeller Drug Law Reforms: Legislation passed in April 2009 that among many things, requires the Office of Alcoholism and Substance Abuse Services (OASAS) to monitor prison-based substance abuse treatment programs, develop guidelines for the operation of these programs and release an annual report assessing the effectiveness of such programs.

Supervising Correction Counselor, ASAT (SCC): Senior staff members in the Alcohol and Substance Abuse Treatment (ASAT) program. These staff members generally supervise larger treatment programs, and are required to have had some experience (minimum of one year) in a prison-based substance abuse treatment program and one year as a Correction Counselor (CC).

Shock Incarceration Programs: An intensive, voluntary, boot camp–style treatment program that emphasizes substance abuse treatment, military-style discipline, physical labor and fitness, a variety of life skills and education in a Therapeutic Community (TC) setting.

Simple Screening Instrument for Alcohol and other Drug Use (SSI-AOD): A standardized self-report screening instrument used by DOCS during the reception process to identify individuals as in need of substance abuse treatment.

Special Housing Unit (SHU): Disciplinary confinement area where inmates are sent for violating prison rules, including infractions related to substance use, and are kept on daily 23-hour lockdown.

Special Needs Unit (SNU): Housing area for inmates who are developmentally disabled.

Therapeutic Community (TC): Substance abuse treatment model that is highly structured and hierarchical. It views substance abuse as a problem of the whole person and focuses its treatment approach on the entire individual. TC programs are commonly used in the prison setting.

Transitional Services (TS): A three-phase program, run by DOCS and staffed by counselors and inmates, that aims to orient inmates to life in prison and help them prepare for return to the community.

TS Phase I: The orientation/introductory phase provided to every inmate entering the New York State correctional system and generally lasting from one to two weeks.
TS Phase II: The core phase, which consists of half-day group sessions run by inmate facilitators during a two- to three-month period and helps inmates to develop basic life skills.
TS Phase III: The transitional phase, which lasts up to three months, includes activities related to job preparedness such as résumé preparation and mock interviewing, and enrolls inmates shortly before their release date.

Treatment Improvement Protocol (TIP): One of a series of best practice documents for substance abuse treatment put together by the Center for Substance Abuse Treatment (CSAT) under the auspices of the federal government's Substance Abuse and Mental Health Services Administration (SAMHSA).

Unsatisfactory Completion: Removal from an ASAT program because of disruptive behavior or other program performance issues.

Work Release: As a part of certain inmates' transition back to the community, part-time release for specifically sanctioned employment.

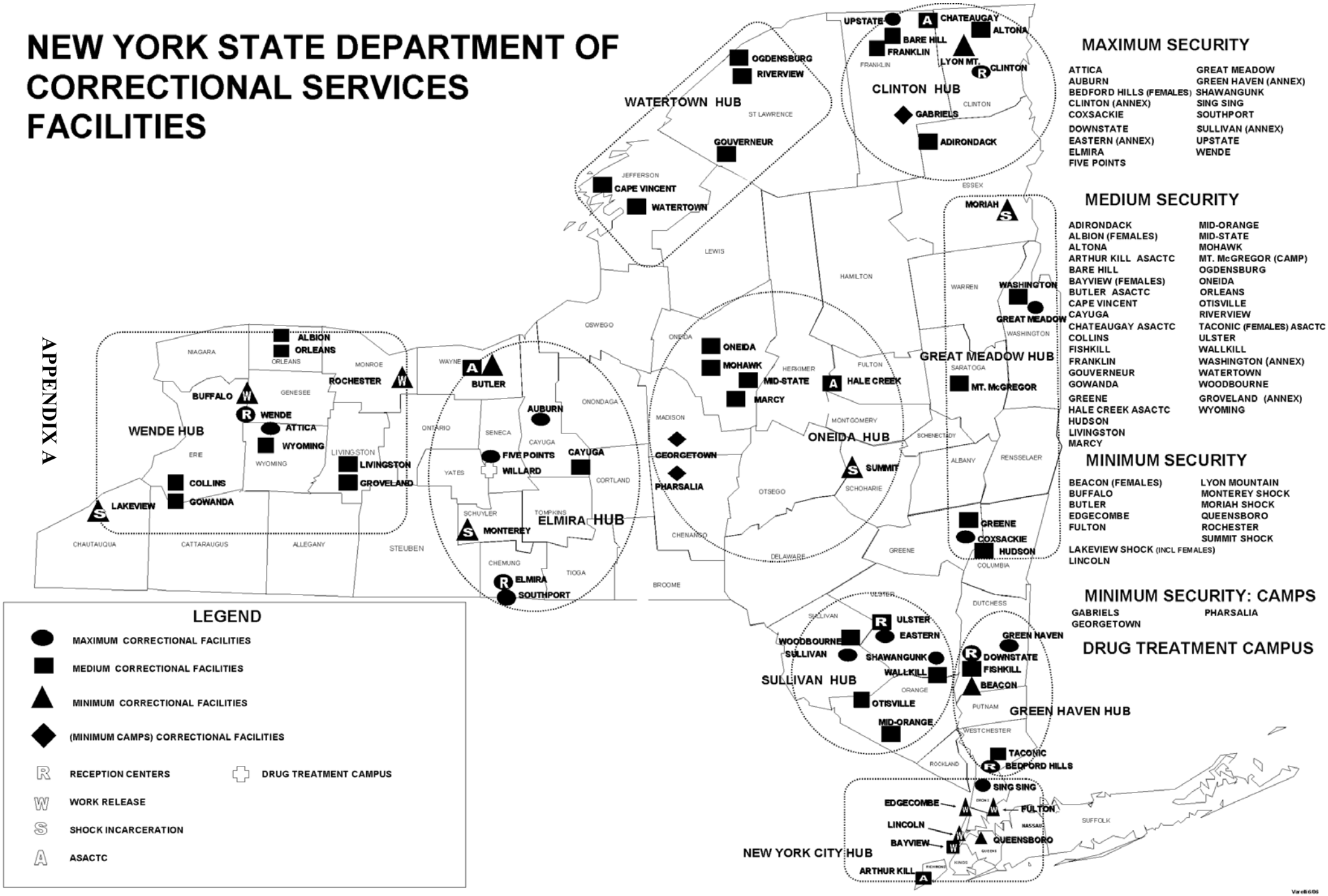
Treatment Behind Bars: Substance Abuse Treatment in New York Prisons, 2007–2010

APPENDIX

APPENDIX A

NEW YORK STATE DEPARTMENT OF CORRECTIONAL SERVICES FACILITIES

APPENDIX A



MAXIMUM SECURITY

ATTICA
AUBURN
BEDFORD HILLS (FEMALES)
CLINTON (ANNEX)
COXSACKIE
DOWNSTATE
EASTERN (ANNEX)
ELMIRA
FIVE POINTS
GREAT MEADOW
GREEN HAVEN (ANNEX)
SHAWANGUNK
SING SING
SOUTHPORT
SULLIVAN (ANNEX)
UPSTATE
WENDE

MEDIUM SECURITY

ADIRONDACK
ALBION (FEMALES)
ALTONA
ARTHUR KILL ASACTC
BARE HILL
BAYVIEW (FEMALES)
BUTLER ASACTC
CAPE VINCENT
CAYUGA
CHATEAUGAY ASACTC
COLLINS
FISHKILL
FRANKLIN
GOUVERNEUR
GOWANDA
GREENE
HALE CREEK ASACTC
HUDSON
LIVINGSTON
MARCY
MID-ORANGE
MID-STATE
MOHAWK
MT. McGREGOR (CAMP)
OGDENSBURG
ONEIDA
ORLEANS
OTISVILLE
RIVERVIEW
TACONIC (FEMALES) ASACTC
ULSTER
WALLKILL
WASHINGTON (ANNEX)
WATERTOWN
WOODBOURNE
GROVELAND (ANNEX)
WYOMING

MINIMUM SECURITY

BEACON (FEMALES)
BUFFALO
BUTLER
EDGECOMBE
FULTON
LAKEVIEW SHOCK (INCL FEMALES)
LINCOLN
LYON MOUNTAIN
MONTEREY SHOCK
MORIAH SHOCK
QUEENSBORO
ROCHESTER
SUMMIT SHOCK

MINIMUM SECURITY: CAMPS

GABRIELS
GEORGETOWN
PHARSALIA

DRUG TREATMENT CAMPUS

LEGEND

- MAXIMUM CORRECTIONAL FACILITIES
- MEDIUM CORRECTIONAL FACILITIES
- MINIMUM CORRECTIONAL FACILITIES
- (MINIMUM CAMPS) CORRECTIONAL FACILITIES
- R — RECEPTION CENTERS
- DRUG TREATMENT CAMPUS
- W — WORK RELEASE
- S — SHOCK INCARCERATION
- A — ASACTC

APPENDIX B

MULTIMODALITY QUALITY ASSURANCE SCALES (MQA) © PARTICIPANT SURVEY

PRISON SUBSTANCE ABUSE TREATMENT PROGRAMS

Prison Visiting Project
Correctional Association of NY

Gerald Melnick, Ph.D.
Frank Pearson, Ph.D
National Development and Research Institutes, Inc.
71 West 23rd Street, 8th Floor,
New York, NY 10010

MULTIMODALITY QUALITY ASSURANCE SCALES (MQA)

GUIDE TO THE MQA FOR PROGRAM PARTICIPANTS

PURPOSE: We ask that you complete the following questionnaire concerning your substance abuse treatment program. Our goal is to improve the quality of substance abuse treatment. The purpose of this questionnaire is to learn what is happening in substance abuse treatment programs throughout the state. We want to find out exactly what programs are doing and how satisfied people are with the services. The questions that you answer, and other questions that we are asking the administration and staff, will help us provide feedback on how to improve the substance abuse treatment programs.

CONFIDENTIALITY: Your answers to the questionnaire are confidential. The research is being conducted by Correctional Association of New York (CA) with the assistance from the National Development & Research Institutes, Inc. (NDRI), both not-for-profit organizations that conduct research in substance abuse treatment and prison issues. The CA and NDRI are separate from the treatment program and the Department of Correctional Services (DOCS). All of the information is grouped together at CA and only the grouped information is available to people outside the CA and NDRI. All questionnaires are destroyed after the information is entered into the CA database.

COMPLETENESS: Missing information makes any results questionable. **Therefore, we hope you will answer each of the questions.**

QUESTIONS: If you have any questions (or if you have any comments), please feel free to contact: Jack Beck from the CA at (212) 254-5700, or by mail: Jack Beck, Director, Prison Visiting Project, Correctional Association of NY, 2090 Adam Clayton Powell Blvd, New York, New York 10027.

SURVEY INSTRUCTIONS:

1. Use “9” if you don’t know the answer to a question.
2. You may check more than one response for items describing facts about the program.

NOTE: Please do not skip over any items unless you decide you do not wish to answer the question! Completeness is very important for us to understand your opinion of the program!

Name of Program

Name of Facility

Today's Date

- -

Month - Day - Year

ID Number (CA Staff will fill in)

Housing Area

Program

Counselor/PA Name

Gender: Male Female

Race/Ethnicity:

White and Hispanic/Latino ☐ African-American and Hispanic/Latino ☐ Latino ☐ African-American ☐

White ☐ Asian/Pacific Islander ☐ Native American ☐ Other ☐ (explain)_____

I have been in this program for: 1-30 days ☐ 31-60 days ☐ 61-90 days ☐ More than 90 days ☐

I have been in this prison for: Years: _____ Months: _____

My earliest possible release date is: _____

PLEASE ANSWER THE FOLLOWING QUESTIONS TO THE BEST OF YOUR KNOWLEDGE.

1. Have you been in another prison substance abuse treatment program during your current incarceration?

YES ☐ *if YES*, how many: _____ NO ☐

If YES, identify the most recent prison where you were in a substance abuse treatment program: _____,

the date you started the program:_____ and whether you successfully completed it: YES ☐ NO ☐

If you did not complete the program, why did you leave the program early?

Removed for a ticket 0 Removed for not participating 1

Transferred to another facility 2 Withdrew from Program 3 Other 5 (explain)_____

2. Were you ever in a substance abuse treatment program before your current incarceration?

YES ☐ NO ☐

3. Using the following scale, rate the area of the building where your substance abuse treatment program is conducted on the qualities listed below:

	Very Poor 0	**Inadequate 1**	**Adequate 2**	**Very Good 3**
a. Lighting	0	1	2	3
b. Ventilation	0	1	2	3
c. State of repair	0	1	2	3
d. Cleanliness/odor	0	1	2	3
e. General quality	0	1	2	3

TREATMENT AND DISCHARGE PLANNING IN SUBSTANCE ABUSE TREATMENT PROGRAM

4. **Do inmates participate in updating their treatment plan?** YES ☐ NO ☐ DON'T KNOW ☐

5. **Is there a discharge plan for inmates upon completing this substance abuse treatment program?**
   YES ☐ NO ☐ DON'T KNOW ☐

6. **Are there meetings between aftercare providers and participants while participants are still in your substance abuse treatment program?**

No	☐
Yes: Once	☐
Yes: More than once	☐
Don't know	☐

IF YES, what percent of your fellow participants scheduled to be discharged meet with an aftercare provider? ☐☐☐ % DON'T KNOW ☐

HOW WOULD YOU RATE YOUR SATISFACTION WITH THE TREATMENT PLAN IN YOUR SUBSTANCE ABUSE TREATMENT PROGRAM: (Please Check One)

0	1	2	3	9
Very Dissatisfied	Somewhat Dissatisfied	Somewhat Satisfied	Very Satisfied	Unknown I have no information about this

IF 0 or 1,explain:_____

HOW WOULD YOU RATE YOUR SATISFACTION WITH THE DISCHARGE PLANNING IN YOUR SUBSTANCE ABUSE TREATMENT PROGRAM? (Please Check One)

0	1	2	3	9
Very Dissatisfied	Somewhat Dissatisfied	Somewhat Satisfied	Very Satisfied	Unknown I have no information about this

IF 0 or 1,explain:_____

7. **Are you in Transitional Services Phase III?** YES NO

   If YES, have you received discharge planning for your substance abuse treatment needs from the Transitional Services program? YES NO

8. **How often does the substance abuse treatment staff ask for your opinions and suggestions? (Check One)**

0	1	2	3
Never	**Rarely**	**Sometimes**	**Often**

9. In general, how much influence do you feel you have on what actually happens in the substance abuse treatment program? (Check One)

0	1	2	3
None	**Very Little**	**Moderate Amount**	**Great Deal**

SAFETY OF PROGRAM PARTICIPANTS

10. How often, if ever, do physical confrontations between inmates occur in your substance abuse program?

0	1	2	3
Never	**Rarely**	**Sometimes**	**Often**

HOW SATISFIED ARE YOU WITH YOUR SAFETY IN YOUR SUBSTANCE ABUSE PROGRAM? (Please Check One)

0	1	2	3	9
Very Dissatisfied	Somewhat Dissatisfied	Somewhat Satisfied	Very Satisfied	Unknown I have no information about this

IF 0 or 1, explain: _____

LIST OF SERVICES

Indicate whether you are currently enrolled in any of the following educational or vocational programs or if you have already completed them at this prison or at another prison.

Program	Currently Enrolled	Completed at this Prison	Completed at other Prison
a. G.E.D. classes	☐	☐	☐
b. Other basic educational classes (ABE, ESL, etc.)	☐	☐	☐
c. Vocational training	☐	☐	☐
d. Other (specify)_____	☐	☐	☐

HOW SATISFIED ARE YOU WITH THE EDUCATIONAL AND VOCATIONAL PROGRAMS AT THIS PRISON?: (Please Check One)

0	1	2	3	9
Very Dissatisfied	Somewhat Dissatisfied	Somewhat Satisfied	Very Satisfied	Unknown I have no information about this

IF 0 or 1, explain : _____

11. Have you received the following SOCIAL SKILLS training in your current substance abuse treatment program and/or in another program at this prison?

SOCIAL SKILLS	In this Program	In Another Program at this prison
a. Communication skills	☐	☐
b. Personal hygiene skills	☐	☐
c. Parenting skills	☐	☐
d. Leisure time activities skills	☐	☐
e. Stress management	☐	☐
f. Anger management	☐	☐
g. Money management	☐	☐
h. Other (specify)_____	☐	☐

HOW WOULD YOU RATE YOUR SATISFACTION WITH THE SOCIAL SKILLS TRAINING AT THIS PRISON, LISTED ABOVE IN QUESTION 11?**:** (Please Check One)

☐ 0	☐ 1	☐ 2	☐ 3	☐ 9
Very Dissatisfied	Somewhat Dissatisfied	Somewhat Satisfied	Very Satisfied	Unknown I have no information about this

IF 0 or 1, explain : _____

12. Have you received the following SERVICES in your current substance abuse treatment program and/or in another program at this prison?

SERVICE	This Program	Another Program at this prison
a. Vocational assessment (finding out what job skills you have)	☐	☐
b. Job placement	☐	☐
c. Family planning and/or sex education	☐	☐
d. Basic health education	☐	☐
e. Substance abuse education	☐	☐
f. AIDS prevention	☐	☐
g. Location of housing	☐	☐
h. Assistance with government benefits or entitlements	☐	☐
i. Legal assistance	☐	☐
j. Other (specify)_____	☐	☐

HOW WOULD YOU RATE YOUR SATISFACTION WITH THE SERVICES AT THIS PRISON, LISTED ABOVE IN QUESTION 12: (Please Check One)

☐ 0	☐ 1	☐ 2	☐ 3	☐ 9
Very Dissatisfied	Somewhat Dissatisfied	Somewhat Satisfied	Very Satisfied	Unknown I have no information about this

IF 0 or 1, explain: _____

TREATMENT TECHNIQUES

13. How important is each of these to your substance abuse treatment program?

MENU A	**Not Important 0**	**Somewhat Important 1**	**Mostly Important 2**	**Very Important 3**
a. Staff members confront unacceptable behavior outside of individual and group counseling	☐ 0	☐ 1	☐ 2	☐ 3
b. Participants frequently help each other	☐ 0	☐ 1	☐ 2	☐ 3
c. Participants who violate the program norms receive a penalty or punishment	☐ 0	☐ 1	☐ 2	☐ 3
d. Work is used as part of the therapeutic program	☐ 0	☐ 1	☐ 2	☐ 3
e. DOCS substance abuse treatment staff serve as role models for the participants	☐ 0	☐ 1	☐ 2	☐ 3
f. Inmate substance abuse treatment staff serve as role models for the participants	☐ 0	☐ 1	☐ 2	☐ 3
g. Senior participants serve as role models for newer participants	☐ 0	☐ 1	☐ 2	☐ 3
h. The program involves increasing privileges as participants advance	☐ 0	☐ 1	☐ 2	☐ 3

HOW SATISFIED ARE YOU WITH THE PROGRAM TECHNIQUES LISTED ABOVE IN MENU "A"? (Please Check One)

☐ 0	☐ 1	☐ 2	☐ 3	☐ 9
Very Dissatisfied	Somewhat Dissatisfied	Somewhat Satisfied	Very Satisfied	Unknown I have no information about this

IF 0 or 1, explain : _____

14. How important is each of these to your substance abuse treatment program?

MENU B	**Not Important 0**	**Somewhat Important 1**	**Mostly Important 2**	**Very Important 3**
a. Helps participants to identify "trigger" situations for taking drugs	☐ 0	☐ 1	☐ 2	☐ 3
b. Encourages participants to find pleasure in other things besides drugs or alcohol	☐	☐	☐	☐
c. Encourages participants to communicate with others in an assertive, but polite way	☐ 0	☐ 1	☐ 2	☐ 3
d. Emphasizes problem solving techniques to deal with frustration	☐	☐	☐	☐
e. Helps participants to recognize errors in thinking	☐ 0	☐ 1	☐ 2	☐ 3

HOW SATISFIED ARE YOU WITH THE PROGRAM TECHNIQUES LISTED ABOVE IN MENU "B"**?**
(Please Check One)

☐ 0	☐ 1	☐ 2	☐ 3	☐ 9
Very Dissatisfied	Somewhat Dissatisfied	Somewhat Satisfied	Very Satisfied	Unknown I have no information about this

IF 0 or 1, explain : _____

15. How important is each of these to your substance abuse treatment program?

MENU C	**Not Important 0**	**Somewhat Important 1**	**Mostly Important 2**	**Very Important 3**
a. The goals of the 12-Step program are discussed and explained	☐ 0	☐ 1	☐ 2	☐ 3
b. How to work the 12-Steps is explained	☐ 0	☐ 1	☐ 2	☐ 3
c. The reasons why the 12-Steps succeed are explained	☐ 0	☐ 1	☐ 2	☐ 3
d. Discusses the nature of the "sponsoring relationship"	☐ 0	☐ 1	☐ 2	☐ 3
e. Discusses the barriers to affiliation with the 12-Step program	☐ 0	☐ 1	☐ 2	☐ 3

HOW SATISFIED ARE YOU WITH THE PROGRAM TECHNIQUES LISTED ABOVE IN MENU "C"**?**
(Please Check One)

☐ 0	☐ 1	☐ 2	☐ 3	☐ 9
Very Dissatisfied	Somewhat Dissatisfied	Somewhat Satisfied	Very Satisfied	Unknown I have no information about this

IF 0 or 1, explain : _____

16. Please respond to the following statements in terms of how you feel about the substance abuse treatment program.

	Not True 0	Somewhat True 1	Mostly True 2	Very True 3
a. I really feel like a part of something	☐	☐	☐	☐
b. I feel that people in this program are interested in helping me	☐	☐	☐	☐
c. I think that the people in the program are trying to do what is best for me	☐	☐	☐	☐
d. I think that the program is well organized (runs smoothly)	☐	☐	☐	☐
e. I think that the staff believes in me	☐	☐	☐	☐

17. Please respond to the following statements in terms of your involvement in the substance abuse treatment process:

	Not True 0	Somewhat True 1	Mostly True 2	Very True 3
a. I understand and accept the program rules, philosophy and structure	☐	☐	☐	☐
b. I enthusiastically participate in program activities	☐	☐	☐	☐
c. I feel an attachment and ownership in the program	☐	☐	☐	☐
d. My behavior and attitude set a good example for other members of the program	☐	☐	☐	☐

HOW WOULD YOU RATE YOUR SATISFACTION WITH YOUR OWN INVOLVEMENT IN YOUR SUBSTANCE ABUSE TREATMENT PROGRAM? (Please Check One)

☐ 0	☐ 1	☐ 2	☐ 3	☐ 9
Very Dissatisfied	Somewhat Dissatisfied	Somewhat Satisfied	Very Satisfied	Unknown I have no information about this

IF 0 or 1, explain : _____

18. Please respond to the following statements in terms of your relationship with the substance abuse treatment program:

	Not True 0	Somewhat True 1	Mostly True 2	Very True 3
a. The substance abuse treatment staff supports my goals	0	1	2	3
b. The substance abuse treatment staff is sincere in wanting to help me	0	1	2	3
c. I work well with my substance abuse treatment staff	0	1	2	3
d. I am satisfied with my treatment	0	1	2	3
e. This treatment meets or exceeds my expectations	0	1	2	3

HOW WOULD YOU RATE YOUR SATISFACTION WITH THE COUNSELING PROCESS IN YOUR SUBSTANCE ABUSE TREATMENT PROGRAM? (Please Check One)

0	1	2	3	9
Very Dissatisfied	Somewhat Dissatisfied	Somewhat Satisfied	Very Satisfied	Unknown I have no information about this

IF 0 or 1, explain : _____

19. Please respond to the following statements in terms of your commitment to treatment:

	Not True 0	Somewhat True 1	Mostly True 2	Very True 3
a. I feel good about my progress working on my problems	0	1	2	3
b. I feel that I am working on my problems	0	1	2	3
c. I am attempting to change	0	1	2	3
d. Although not always successful, I am at least doing something about my problem	0	1	2	3
e. I accept responsibility for my problems	0	1	2	3

HOW WOULD YOU RATE YOUR SATISFACTION WITH YOU COMMITMENT TO YOUR SUBSTANCE ABUSE TREATMENT? (Please Check One)

0	1	2	3	9
Very Dissatisfied	Somewhat Dissatisfied	Somewhat Satisfied	Very Satisfied	Unknown I have no information about this

IF 0 or 1, explain : _____

COMMUNICATION SCALE

20. Using the scale below, please rate how strongly you agree with each of the following statements about participant communication at this substance abuse treatment program:

	Not True 0	Somewhat True 1	Mostly True 2	Very True 3
a. We have open and frank discussions about our differences	0	1	2	3
b. Disagreements are generally resolved fairly	0	1	2	3
c. The participants are divided into small groups or cliques that do not communicate well	0	1	2	3
d. We actively seek out a variety of opinions	0	1	2	3
e. Most viewpoints are given serious consideration	0	1	2	3
f. People are afraid to talk for fear of being made fun of	0	1	2	3
g. We are not afraid to disagree with other participants	0	1	2	3
h. We learn a lot from considering each others' opinions	0	1	2	3
i. Individuals who disagree with the majority are likely to have a hard time	0	1	2	3

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Name

DIN #

ID Number (CA Staff will fill in)

Reminder: All of your responses to the questions are important, so please check through the questionnaire to see that no questions have been skipped.

APPENDIX C

Name: _____ **Facility:** _____**DIN:** _____
Date: _____ **Housing Area:** _____Cell/dorm/SHU

Correctional Association Inmate Survey About Substance Abuse Needs
TO BE USED FOR INMATES OUTSIDE OF SATx PROGRAM AREA

This is a survey from the Correctional Association of NY, an independent, non-profit organization that visits New York State prisons. We are not part of DOCS, and we have legislative authority to monitor prison conditions. During our visits to your prison and in correspondence with inmates there, we attempt to gather as much information as possible to obtain an accurate picture about conditions within New York State prisons. We will use the information we gather to write a report which we will send to NYS legislators, the Superintendent, the Commissioner of DOCS, inmates (including the ILC), and members of the public. We also do follow-up advocacy aimed at improving the conditions at the prisons that we visit.

We are currently investigating how the Department treats inmates with a substance abuse problem. We will use this information to develop suggestions on how to improve substance abuse treatment.

The survey asks questions about your experiences in DOCS and activities prior to your incarceration. We will not share your answers with anyone outside our organization. We are gathering surveys from about 100 inmates at the prison, so our report will be based on many inmates' experiences and will not specifically reveal what you told us. You don't have to answer any question you don't want to, and if you don't know the answer to a question, just say "I don't know." Also, you can stop the survey at any time. There is no penalty for not participating in the survey. This survey will take about 20 minutes of your time.

No.	Question		Response
	GENERAL		
1	How long have you been in this facility?		**Estimate #_____ Months/Years** *(circle one)*
2	How long have you been in DOCS custody during your current bid?		**Estimate #_____ Months/Years** *(circle one)*
	PROGRAMS and SERVICES		
3	Do you have a job or are you in a program, such as school or a vocational or treatment program?	1 2	**Yes** **No** *(Go to #5)*
4	Describe you assignment: _____		
5	Are you currently on a waiting list for a program? Identify: _____	1 2	**Yes** **No** (Go to #7)
6	If so, how long have you been waiting for this program?	1 99	**Estimate # _____ Days/Weeks/Months** *(Circle one)* **N/A or Don't Know**
7	If you are currently in an **educational program** or if you have been in one in the past year, are you/were you satisfied with your educational program? Identify completed program: _____	1 2 3 4	**Yes** **Sometimes or Somewhat** **No** **N/A**
8	If you are currently in a **vocational program** or if you have been in one in the past year, are you/were you satisfied with your vocational program? Identify completed program: _____	1 2 3 4	**Yes** **Sometimes or Somewhat** **No** **N/A**

9	If you currently have a **job** or if you have had a job in the past year, are/were you satisfied with your job assignment? Identify completed program: _____	1 2 3 4	**Yes** **Sometimes or Somewhat** **No** **N/A**
10	Describe what you **like** or **dislike** about your current program or job: _____ _____ _____		
	EXPERIENCE WITH, NEED FOR, OR INTEREST IN SUBSTANCE ABUSE TREATMENT		
11	Are you or have you ever been in a substance abuse treatment program ***in this prison***?	1 2 3 4	**Yes, I am currently in program: _____** **Yes, but was removed /When:_____** **Yes, I completed the program: When: _____ Program: _____** **No** *(Go to #13)*
S1	If you are currently enrolled in a substance abuse treatment program ***in this prison*** and/or completed a substance abuse treatment program ***in this prison***, may we send you an additional survey about your experiences in the program?	1 2	**Yes** **No**
12	Are/were you satisfied with your substance abuse treatment program at this prison?	1 2 3 4	**Yes** **Sometimes or Somewhat** **No** **N/A**
13	Are you interested in enrolling in a substance abuse treatment program before you are released or once you return to the community?	1 2	**Yes** **No**
14	How important is it for you to get drug treatment while you are incarcerated?	1 2 3 4 5	**Not at all** **Slightly** **Moderately** **Considerably** **Extremely**
15	Are you on a waiting list for a substance abuse treatment program at this prison? If yes, how long have you been waiting for the program?	1 2	**Yes / How may:_____ Weeks/Months** **No**
16	Have you ever been in a substance abuse treatment program at another prisons?	1 2	**Yes** **No** *(if No, go to # 22)*
17	How many substance abuse treatment programs have you been enrolled in during this incarceration?		**Number of treatment programs: _____**
18	What was the most recent substance abuse treatment program; what prison were you in; and when did you receive this treatment?		**Program Name:_____** **Prison _____** **When _____**
19	Did you complete this program?	1 2	**Yes** *(Go to # 22)* **No**

20	If you did not complete this program, why did you leave the program early?	1 2 3 4 5 6	**Removed for a ticket** **Removed for not participating** **Transferred to another facility** **Released** **Withdrew from program** **Other**
21	Please Explain why you did not complete this treatment program: _____ _____ _____ _____		
22	Were you ever on a waiting list for a substance abuse treatment program at another prison? If yes, which prison were you in when you were most recently on a list and how long were you on the list?	1 2	**Yes / How may:_____ Weeks/Months** **No** **Prison: _____**
	DOCS SCREENING FOR SUBSTANCE ABUSE PROBLEMS		
23	Have you ever been told during intake to DOCS, or at any time during your incarceration, that you should enroll in a substance abuse treatment program?	1 2	**Yes** **No** *(Go to #25)*
24	Who informed you that you should enroll in a substance abuse treatment program; what prison were you in; and when did this occur?		**Person Who Told You: _____** **Prison: _____** **When: _____**
25	During your admission process to DOCS at the reception facility, were you asked questions about your experiences with drugs and alcohol?	1 2	**Yes** **No** *(Go to #27)*
26	During your admission process did you report abuse of any of drugs and/or alcohol?	1 2 3 4	**No substance abuse** **Alcohol abuse only** **Drug abuse only** **Drug and alcohol abuse**
	DRUG TESTING BY DOCS		
27	How many times, if any, have you had your urine screened by DOCS for drugs during this incarceration? If more than once, indicate how many times.	1 2 3	**Never** *(Go to #31)* **Once** **More than once, # of Times _____**
28	How many, if any, of these samples were found to be positive? If more than one, indicate the number.	1 2 3	**None** **One** **More than one, # of positive results ____**
29	Were any of these drug tests **NOT** a random test ordered by DOCS' Central Office?	1 2	**Yes** **No**
30	When did you have your most recent drug test in DOCS; what prison were you in; and what were the results of the test, including the identified substance?		**When: _____** **Prison: _____** **Results of test: Negative Positive** (circle one) **Substance Identified: _____**

	DISCIPLINARY ACTIONS DUE TO DRUG POSSESSION OR USE		
31	Have you ever been disciplined during you current incarceration for having or using drugs or alcohol?	1 2	**Yes** **No** *(Go to #40)*
32	How many times have you been disciplined for having or using drugs or alcohol?	1 2 3 4	**Once** **Two times** **Three to five times** **More than five times, # of times: ____**
33	What prison were you in when you were most recently disciplined for this conduct, when did this happen and what was your disciplinary sanction?		**Prison: _____** **When: _____** **Disciplinary Sanction: _____**
34	How much total time have you spent in SHU or keeplock during your current incarceration due to disciplinary sanctions for having or using drugs or alcohol?	1 2	**No SHU time** **How may:_____ Weeks/Months in SHU and/or Keeplock**
35	Explain what substances you have been disciplined for using while incarcerated: _____ _____		
36	Did you receive any substance abuse treatment, including a cell study program, while you were in SHU or keeplock?	1 2	**Yes** **No** *(Go to #40)*
37	What prison were you in when you participated in this SHU/keeplock treatment program and when did you receive this treatment?		**Prison _____** **When _____**
38	Please describe what treatment you received: _____ _____		
39	Were you satisfied with the substance abuse program you received while in SHU or keeplock?	1 2 3	**Yes** **Sometimes or Somewhat** **No**
	VOLUNTEER AND OTHER SUBSTANCE ABUSE TREATMENT PROGRAMS		
40	Have you participated in any voluntary substance abuse treatment programs such as Narcotics Anonymous or Alcoholics Anonymous during this incarceration?	1 2	**Yes** **No** *(Go to #43)*
41	Identify the most recent program; what prison you were in at the time; and when you were in this program?		**Program Name:_____** **Prison _____** **When _____**
42	Were you satisfied with this volunteer substance abuse program you received while in DOCS?	1 2 3	**Yes** **Sometimes or Somewhat** **No**
43	Explain any other experiences you had with substance abuse treatment during this incarceration that you have not already indicated above: _____ _____		

	SUBSTANCE USE (DRUGS OR ALCOHOL) PRIOR TO BEING INCARCERATED		
	THE FOLLOWING QUESTIONS REFER ONLY TO YOUR USE OF DRUGS OR ALCOHOL DURING THE TWELVE MONTHS BEFORE YOU WERE INCARCERATED AND NOT TO YOUR ACTIVITIES IN PRISON.		
44	Did you use larger amounts of drugs or alcohol or use them for a longer time than you had planned or intended?	1 2	**Yes** **No**
45	Did you try to cut down on your drug or alcohol use but were unable to do it?	1 2	**Yes** **No**
46	Did you spend a lot of time getting drugs or alcohol, using them, or recovering from their use?	1 2	**Yes** **No**
47	Did you get so high or sick from drugs or alcohol that it kept you from doing work, going to school or caring for children?	1 2	**Yes** **No**
48	Did you get so high or sick from drugs or alcohol that it caused an accident or put you or others in danger?	1 2	**Yes** **No**
49	Did you spend less time at work, school or with friends so that you could use drugs or alcohol?	1 2	**Yes** **No**
50	Did your drug or alcohol use cause emotional or psychological problems?	1 2	**Yes** **No**
51	Did your drug or alcohol use cause problems with family, friends, work or police?	1 2	**Yes** **No**
52	Did your drug or alcohol use cause physical health or medical problems?	1 2	**Yes** **No**
53	Did you increase the amount of a drug or alcohol you were taking so that you could get the same effects as before?	1 2	**Yes** **No**
54	Did you ever keep taking a drug or alcohol to avoid withdrawal or keep from getting sick?	1 2	**Yes** **No**
55	Did you ever inject drugs with a needle?	1 2	**Yes** **No**
56	How serious do you think your drug or alcohol problems are?	1 2 3 4 5	**Not at all** **Slightly** **Moderately** **Considerably** **Extremely**

57	How often did you use each type of drug during the 12 months before this incarcertion? ***(Mark with an X)***		**Never** / **Only a few times** / **1-3 times a month** / **1-5 times a week** / **About every day**
	a. Alcohol		____ ____ ____ ____ ____
	b. Marijuana/Hashish		____ ____ ____ ____ ____
	c. Hallucinogens/LSD/Psychedelics/PCP/ mushrooms/Peyote		____ ____ ____ ____ ____
	d. Crack/Freebase		____ ____ ____ ____ ____
	e. Heroine and Cocaine (mixed together as speedball)		____ ____ ____ ____ ____
	f. Cocaine (by itself)		____ ____ ____ ____ ____
	g. Heroine (by itself)		____ ____ ____ ____ ____
	h. Street Methadone (non-prescription)		____ ____ ____ ____ ____
	i. Other Opiates/Opium/Morphine/Dermerol		____ ____ ____ ____ ____
	j. Methamphetamine/Speed/Ice (Uppers)		____ ____ ____ ____ ____
	k. Tranquilizers/Barbituarates/Sedatives		____ ____ ____ ____ ____
	l. Other (specify) _____		____ ____ ____ ____ ____
	TRANSITIONAL SERVICES/DISCHARGE PLANNING		
58	What is your earliest possible release date?		**Date:** _____
59	How interested are you in participating in a substance abuse treatment program after you are released?	1 2 3 4 5	**Not at all** **Slightly** **Moderately** **Considerably** **Extremely**
60	Has any department employee or prison volunteer assisted you to prepare for accessing a community-based substance abuse treatment program when you are released?	1 2	**Yes** **No**
61	Who assisted you; what job were they performing; what prison were you in; and when did you receive this assistance?		**Person:** _____ **Person's Job:** _____ **Prison** _____ **When** _____
62	How helpful was this person in assisting you in your efforts to identify a community-based substance abuse treatment program?	1 2 3 4 5	**Not at all** **Slightly** **Moderately** **Considerably** **Extremely**

	PHASE III TRANSITIONAL SERVICES		
63	Are you now, or have you been during this incarceration, enrolled in Phase III of Transitional Services?	1 2	**Yes** **No** *(Go to #68)*
64	What prison were you in when you were in Phase III of Transitional Services and when did this occur?		**Prison** _____ **When** _____
65	Did Transitional Services provide you with any help or materials about community-based substance abuse treatment programs?	1 2	**Yes** **No**
66	Describe what assistance or materials were provided: _____ _____ _____		
67	How helpful has the staff of Transitional Services been in your efforts to identify a community-based substance abuse treatment program?	1 2 3 4 5	**Not at all** **Slightly** **Moderately** **Considerably** **Extremely**
	COMMUNITY-BASED SUBSTANCE ABUSE TREATMENT PROGRAMS CONTACTED		
68	Have you had any contact with a community-based substance abuse treatment program during this incarceration?	1 2	**Yes** **No**
69	What program have you contacted; who did you contact at that program and when did you have this contact?		**Program Name:** **Name of Contact:** _____ **When:** _____
70	Identify any other treatment programs with whom you have been in contact: _____		
	GENERAL DRUG USE IN PRISON		
71	How common is contraband drug use by inmates at this prison?	1 2 3 4 5 6	**Very Common** **Somewhat Common** **Somewhat Rare** **Very Rare** **None** **Don't Know**
72	Compared to other prisons you've been in, how would you compare the level of drug use by inmates here as compared to drug use at other facilities?	1 2 3 4 5 6	**Much More** **Somewhat More** **Average or About the Same** **Somewhat Less** **Much Less** **Don't know**
73	How much, if at all, is drug use and drug trafficking by inmates a significant source of the violence in the prison?	1 2 3 4	**A Lot** **Somewhat** **Very Little** **Not at All**

74	How much, if at all, are staff involved in drug trafficking in this prison?	1 2 3 4	**A Lot** **Somewhat** **Very Little** **Not at All**
	FUTURE CONTACT		
75	Would you agree to speak with us in the legal visiting room or correspond with us further about the abuse situation at this prison?	1 2	**Yes** **No**

Our address is:

Prison Visiting Project, Correctional Association of New York
2090 Adam Clayton Powell Blvd, Ste 200
New York, NY 10027

Name _____
DIN _____
Survey ID _____ (CA Staff will fill in)

APPENDIX D

Definition of Substance Dependence and Substance Abuse

From the Diagnostic and Statistical Manual of Mental Disorders – 4th Edition (DSM-IV-TR, 2000)

Substance Dependence

Features

The essential feature of Substance Dependence is a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues use of the substance despite significant substance-related problems. There is a pattern of repeated self-administration that can result in tolerance, withdrawal, and compulsive drug-taking behavior. A diagnosis of Substance Dependence can be applied to every class of substances except caffeine. The symptoms of Dependence are similar across the various categories of substances, but for certain classes some symptoms are less salient, and in a few instances not all symptoms apply (e.g., withdrawal symptoms are not specified for Hallucinogen Dependence). Although not specifically listed as a criterion item, "craving" (a strong subjective drive to use the substance) is likely to be experienced by most (if not all) individuals with Substance Dependence. Dependence is defined as a cluster of three or more of the symptoms listed below occurring at any time in the same 12-month period.

Tolerance (Criterion 1) is the need for greatly increased amounts of the substance to achieve intoxication (or the desired effect) or a markedly diminished effect with continued use of the same amount of the substance. The degree to which tolerance develops varies greatly across substances. Furthermore, for a specific drug, varied degrees of tolerance may develop for its different central nervous system effects. For example, for opioids, tolerance to respiratory depression and tolerance to analgesia develop at different rates. Individuals with heavy use of opioids and stimulants can develop substantial (e.g., 10-fold) levels of tolerance, often to a dosage that would be lethal to a nonuser. Alcohol tolerance can also be pronounced, but is usually less extreme than for amphetamine. Many individuals who smoke cigarettes consume more than 20 cigarettes a day, an amount that would have produced symptoms of toxicity when they first started smoking. Individuals with heavy use of cannabis or phencyclidine (PCP) are generally not aware of having developed tolerance (although it has been demonstrated in animal studies and in some individuals). Tolerance may be difficult to determine by history alone when the substance used is illegal and perhaps mixed with various diluents or with other substances. In such situations, laboratory tests may be helpful (e.g., high blood levels of the substance coupled with little evidence of intoxication suggest that tolerance is likely). Tolerance must also be distinguished from individual variability in the initial sensitivity to the effects of particular substances. For example, some first-time drinkers show very little evidence of intoxication with three or four drinks, whereas others of similar weight and drinking histories have slurred speech and incoordination.

Withdrawal (Criterion 2a) is a maladaptive behavioral change, with physiological and cognitive concomitants, that occurs when blood or tissue concentrations of a substance decline in an individual who had maintained prolonged heavy use of the substance. After developing unpleasant withdrawal symptoms, the person is likely to take the substance to relieve or to avoid

those symptoms (Criterion 2b), typically using the substance throughout the day beginning soon after awakening. Withdrawal symptoms, which are generally the opposite of the acute effects of the substance, vary greatly across the classes of substances, and separate criteria sets for Withdrawal are provided for most of the classes. Marked and generally easily measured physiological signs of withdrawal are common with alcohol, opioids, and sedatives, hypnotics, and anxiolytics. Withdrawal signs and symptoms are often present, but may be less apparent, with stimulants such as amphetamines and cocaine, as well as with nicotine and cannabis. No significant withdrawal is seen even after repeated use of hallucinogens. Withdrawal from phencyclidine and related substances has not yet been described in humans (although it has been demonstrated in animals). Neither tolerance nor withdrawal is necessary or sufficient for a diagnosis of Substance Dependence. However, for most classes of substances, a past history of tolerance or withdrawal is associated with a more severe clinical course (i.e., an earlier onset of Dependence, higher levels of substance intake, and a greater number of substance-related problems). Some individuals (e.g., those with Cannabis Dependence) show a pattern of compulsive use without obvious signs of tolerance or withdrawal. Conversely, some general medical and postsurgical patients without Opioid Dependence may develop a tolerance to prescribed opioids and experience withdrawal symptoms without showing any signs of compulsive use. The specifiers With Physiological Dependence and Without Physiological Dependence are provided to indicate the resence or absence of tolerance or withdrawal.

The following items describe the pattern of compulsive substance use that is characteristic of Dependence. The individual may take the substance in larger amounts or over a longer period than was originally intended (e.g., continuing to drink until severely intoxicated despite having set a limit of only one drink) (Criterion 3). The individual may express a persistent desire to cut down or regulate substance use. Often, there have been many unsuccessful efforts to decrease or discontinue use (Criterion 4). The individual may spend a great deal of time obtaining the substance, using the substance, or recovering from its effects (Criterion 5). In some instances of Substance Dependence, virtually all of the person's daily activities revolve around the substance. Important social, occupational, or recreational activities may be given up or reduced because of substance use (Criterion 6). The individual may withdraw from family activities and hobbies in order to use the substance in private or to spend more time with substance-using friends. Despite recognizing the contributing role of the substance to a psychological or physical problem (e.g., severe depressive symptoms or damage to organ systems), the person continues to use the substance (Criterion 7). The key issue in evaluating this criterion is not the existence of the problem, but rather the individual's failure to abstain from using the substance despite having evidence of the difficulty it is causing.

Criteria for Substance Dependence

A maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by three (or more) of the following, occurring at any time in the same 12-month period:
(1) tolerance, as defined by either of the following:
(a) a need for markedly increased amounts of the substance to achieve intoxication or desired effect
(b) markedly diminished effect with continued use of the same amount of the substance

(2) withdrawal, as manifested by either of the following:
(a) the characteristic withdrawal syndrome for the substance (refer to Criteria A and B of the criteria sets for Withdrawal from the specific substances)
(b) the same (or a closely related) substance is taken to relieve or avoid withdrawal symptoms

(3) the substance is often taken in larger amounts or over a longer period than was intended
(4) there is a persistent desire or unsuccessful efforts to cut down or control substance use
(5) a great deal of time is spent in activities necessary to obtain the substance (e.g., visiting multiple doctors or driving long distances), use the substance (e.g., chain-smoking), or recover from its effects
(6) important social, occupational, or recreational activities are given up or reduced because of substance use
(7) the substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance (e.g., current cocaine use despite recognition of cocaine-induced depression, or continued drinking despite recognition that an ulcer was made worse by alcohol consumption)

Substance Abuse

Features

The essential feature of Substance Abuse is a maladaptive pattern of substance use manifested by recurrent and significant adverse consequences related to the repeated use of substances. In order for an Abuse criterion to be met, the substance-related problem must have occurred repeatedly during the same 12-month period or been persistent. There may be repeated failure to fulfill major role obligations, repeated use in situations in which it is physically hazardous, multiple legal problems, and recurrent social and interpersonal problems (Criterion A). Unlike the criteria for Substance Dependence, the criteria for Substance Abuse do not include tolerance, withdrawal, or a pattern of compulsive use and instead include only the harmful consequences of repeated use. A diagnosis of Substance Abuse is preempted by the diagnosis of Substance Dependence if the individual's pattern of substance use has ever met the criteria for Dependence for that class of substances (Criterion B). Although a diagnosis of Substance Abuse is more likely in individuals who have only recently started taking the substance, some individuals continue to have substance-related adverse social consequences over a long period of time without developing evidence of Substance Dependence. The category of Substance Abuse does not apply to caffeine and nicotine. The term *abuse* should be applied only to a pattern of substance use that meets the criteria for this disorder; the term should not be used as a synonym for "use," "misuse," or "hazardous use."

The individual may repeatedly demonstrate intoxication or other substance-related symptoms when expected to fulfill major role obligations at work, school, or home (Criterion A1). There may be repeated absences or poor work performance related to recurrent hangovers. A student might have substance-related absences, suspensions, or expulsions from school. While intoxicated, the individual may neglect children or household duties. The person may repeatedly be intoxicated in situations that are physically hazardous (e.g., while driving a car, operating machinery, or engaging in risky recreational behavior such as swimming or rock climbing) (Criterion A2). There may be recurrent substance-related legal problems (e.g., arrests for

disorderly conduct, assault and battery, driving under the influence) (Criterion A3). The person may continue to use the substance despite a history of undesirable persistent or recurrent social or interpersonal consequences (e.g., marital difficulties or divorce, verbal or physical fights) (Criterion A4).

Criteria for Substance Abuse

A. A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following, occurring within a 12-month period:
(1) recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home (e.g., repeated absences or poor work performance related to substance use; substance-related absences, suspensions, or expulsions from school; neglect of children or household)
(2) recurrent substance use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine when impaired by substance use)
(3) recurrent substance-related legal problems (e.g., arrests for substance-related disorderly conduct)
(4) continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g., arguments with spouse about consequences of intoxication, physical fights)

B. The symptoms have never met the criteria for Substance Dependence for this class of substance.

APPENDIX E

OASAS Regulations for Chemical Dependence Residential Services

The Office of Alcoholism and Substance Abuse Services (OASAS) is the state agency responsible for regulating and developing the state's system of chemical dependence agencies. OASAS not only directly operates twelve Addiction Treatment Centers in New York State, it also licenses and oversees approximately 1,300 community-based, substance abuse treatment programs. In addition to ensuring the quality of care of community treatment programs and making certain all community-based treatment programs are in compliance with state and national standards, OASAS also administers the credentialing of alcoholism and substance abuse counselors.

As recognized experts in the field of substance abuse treatment services, OASAS has developed operating regulations in order to standardize best practice across community agencies. Some of these regulations for chemical dependence residential services include group therapy sessions of no more than 12 individuals and a client/staff ratio of one to fifteen. Though OASAS supports the use of peer facilitation as a potentially important component of effective treatment programs, it requires these sessions to be directly supervised by a clinical staff member in attendance.

OASAS has also developed a *Level of Care for Alcohol and Drug Treatment Referral Protocol* (LOCADTR) in order to assure that all individuals found to be in need of substance abuse treatment services are able to be placed in the least restrictive, but most clinically appropriate, level of care available. Levels of care include crisis services, non-intensive outpatient services, intensive outpatient services and intensive residential programs. Individuals are matched into appropriate programs upon completion of a level of care determination by a clinical staff member. In addition to matching individuals to appropriate treatment services, OASAS regulations call for the completion of a comprehensive evaluation, which results in a determination of whether or not an individual has a diagnosis of alcohol-related or substance-related use disorder. This evaluation must be completed no later than 14 days following admission and must include substance use history, treatment history and a full psychosocial assessment covering areas such as medical, family, education and mental health. Though the completed comprehensive evaluation is conducted by a member of the clinical staff, it must be signed by a qualified health profession.

OASAS defines qualified health professional (QHP) as an individual who is in good standing with the appropriate licensing or certifying authority and has a minimum of one year of experience in the substance abuse treatment field. A QHP may be a current credentialed alcoholism and substance abuse counselor, a certified social worker or a licensed psychologist.[1] OASAS regulations require that a minimum of 25% of all clinical staff be qualified health professionals.

According to OASAS regulations, treatment plans should include specific goals for each problem identified, specific objectives to be achieved while in the treatment program that measure progress towards the above goals, schedules for the provision of services, and the diagnosis for which the individual is being treated. Similar to the comprehensive evaluation, the treatment plan must be approved and signed by the clinical staff's supervisor. Included in the treatment records are progress notes completed weekly by clinical staff, which should provide observations of an

[1] QHPs may also include certified nurse practitioners, licensed occupational therapists, physicians or physician assistants, registered professional nurses, certified rehabilitation counselors, AAMFT accredited family therapists or a therapeutic recreation therapist.

individual's progress towards their goals, as well as indicate an individual's engagement or participation in the program.

The regulations provided by OASAS offer significant instructions regarding discharge planning. The discharge plan should be developed in collaboration with the individual and must identify what, if any, continuing substance abuse or other treatment services are recommended, identify specific providers or community-based treatment organizations who provide these services, and give specific referrals and initial appointments in order to access these services. The discharge plan must also be reviewed by the clinical supervisor prior to an individual leaving the program. OASAS-certified residential chemical dependence programs must also establish and implement both a quality improvement plan, as well as a utilization review plan. Utilization review plans should monitor admissions, retention and discharge data and ensure that they are appropriate. Quality improvement plans should be designed to guarantee the program is operating based on professionally recognized standards of care, and self-evaluations should be completed quarterly. OASAS also recommends the use of peer reviews and client satisfaction surveys. An annual report must be completed, illustrating the effectiveness of the treatment programs, as well as areas for improvement.

OASAS also offers specific regulations regarding staffing. All clinical staff should receive regular training in substance abuse, individual/group therapy, communicable diseases, infectious control procedures, role of clinical supervision, and quality improvement. In addition, each program must have a designated clinical supervisor responsible for day-to-day operations and providing clinical supervision to clinical staff. This clinical supervisor must be a qualified health professional with a minimum of three years of administrative and clinical experience. OASAS stresses the importance that all clinical staff must be provided with appropriate clinical supervision and continuing training opportunities.

APPENDIX F

Appendix F: Summary of MQA Survey Responses by Prison

The following tables summarize survey responses for the Correctional Association MQA Survey (see Appendix B for an example of this survey). The tables include data from the 23 facilities visited, listed using the abbreviations designated below:

AL	Albion
AK I	Arthur Kill
AK II	Arthur Kill II
BH	Bare Hill
CY	Cayuga
EA	Eastern
FP	Five Points
FR	Franklin
GV	Gouverneur
GO	Gowanda
GH	Green Haven
GR	Greene
HC	Hale Creek
LVF	Lakeview Female
LVM	Lakeview Male
MA	Marcy
MS	Midstate
ON	Oneida
SH	Shawangunk
SS	Sing Sing
TA	Taconic
WA	Washington
WE	Wende
WIF	Willard DTC Female
WIM	Willard DTC Male
WY	Wyoming

Summary of MQA Survey Responses for Visited Prisons

Prison	Q6 Treatment Plan Satisfaction				Q6 Discharge Planning Satisfaction				Q10 Safety Satisfaction			
	Very Dissatisfied	Somewhat Dissatisfied	Somewhat Satisfied	Very Satisfied	Very Dissatisfied	Somewhat Dissatisfied	Somewhat Satisfied	Very Satisfied	Very Dissatisfied	Somewhat Dissatisfied	Somewhat Satisfied	Very Satisfied
AL	17.4%	13.0%	47.8%	21.7%	38.9%	5.6%	33.3%	22.2%	9.1%	18.2%	50.0%	22.7%
AK I	26.5%	5.9%	47.1%	20.6%	48.3%	10.3%	24.1%	17.2%	19.4%	8.3%	36.1%	36.1%
AK II	42.1%	10.5%	26.3%	21.1%	57.9%	5.3%	10.5%	26.3%	4.2%	20.8%	41.7%	33.3%
BH	43.6%	30.8%	21.8%	3.8%	70.1%	11.9%	13.4%	4.5%	21.5%	12.7%	50.6%	15.2%
CY	45.9%	13.5%	29.7%	8.1%	37.0%	29.6%	18.5%	14.8%	22.0%	17.1%	29.3%	31.7%
EA	13.2%	20.8%	39.6%	26.4%	31.0%	9.5%	38.1%	21.4%	9.7%	3.2%	35.5%	51.6%
FP	16.7%	22.2%	33.3%	27.8%	36.4%	13.6%	31.8%	18.2%	6.5%	8.7%	34.8%	50.0%
FR	36.3%	16.3%	33.8%	13.8%	54.7%	15.6%	14.1%	15.6%	13.3%	14.4%	33.3%	38.9%
GV	36.8%	15.8%	42.1%	5.3%	55.6%	22.2%	16.7%	5.6%	13.8%	10.3%	55.2%	20.7%
GO	19.2%	21.2%	44.2%	15.4%	34.0%	21.3%	38.3%	6.4%	16.0%	6.0%	32.0%	46.0%
GH	20.0%	20.0%	45.0%	15.0%	64.3%	7.1%	21.4%	7.1%	15.4%	15.4%	19.2%	50.0%
GR	36.1%	16.7%	36.1%	11.1%	33.3%	13.3%	46.7%	6.7%	14.6%	9.8%	39.0%	36.6%
HC	7.7%	9.0%	59.0%	23.1%	17.9%	16.1%	44.6%	21.4%	3.2%	6.5%	34.4%	54.8%
LVF	4.3%		56.5%	39.1%	9.1%		54.5%	36.4%		3.8%	15.4%	80.8%
LVM	2.7%	2.7%	45.9%	48.6%	20.7%	3.4%	48.3%	27.6%	7.7%		17.9%	74.4%
MA	34.4%	13.1%	32.8%	19.7%	48.9%	17.0%	27.7%	6.4%	10.0%	20.0%	47.1%	22.9%
MS	30.4%	17.4%	39.1%	13.0%	44.4%	13.9%	30.6%	11.1%	18.5%	16.7%	38.9%	25.9%
ON	58.3%	19.4%	11.1%	11.1%	42.1%	21.1%	26.3%	10.5%	27.0%	18.9%	37.8%	16.2%
SH	20.7%	10.3%	37.9%	31.0%	22.2%	14.8%	33.3%	29.6%	3.3%		43.3%	53.3%
SS	14.7%	17.6%	32.4%	35.3%	43.8%	6.3%	18.8%	31.3%	8.3%	2.8%	44.4%	44.4%
TA	17.4%	13.0%	56.5%	13.0%	35.7%	14.3%	32.1%	17.9%		3.7%	29.6%	66.7%
WA	35.5%	9.7%	38.7%	16.1%	54.5%	22.7%	18.2%	4.5%	29.4%	8.8%	44.1%	17.6%
WE	31.3%	15.6%	37.5%	15.6%	12.5%	25.0%	25.0%	37.5%	15.0%	2.5%	30.0%	52.5%
WIF		44.4%	33.3%	22.2%	16.7%	33.3%	38.9%	11.1%	11.1%	11.1%	22.2%	55.6%
WIM	23.8%	33.3%	33.3%	9.5%	34.9%	18.6%	27.9%	18.6%	21.7%	4.3%	56.5%	17.4%
WY	27.5%	11.8%	43.1%	17.6%	40.7%	15.1%	28.9%	15.3%	7.8%	13.7%	21.6%	56.9%
TOTAL	26.8%	16.0%	38.3%	18.7%	38.9%	5.6%	33.3%	22.2%	12.7%	10.2%	36.6%	40.4%

Summary of MQA Survey Responses for Visited Prisons

Prison	Q10 Edu./Voc. Programs Satisfaction				Q11 Social Skills Training Satisfaction				Q12 Services Satisfaction			
	Very Dissatisfied	Somewhat Dissatisfied	Somewhat Satisfied	Very Satisfied	Very Dissatisfied	Somewhat Dissatisfied	Somewhat Satisfied	Very Satisfied	Very Dissatisfied	Somewhat Dissatisfied	Somewhat Satisfied	Very Satisfied
AL	10.0%	5.0%	45.0%	40.0%	4.3%	4.3%	69.6%	17.4%	13.6%	18.2%	54.5%	13.6%
AK I	54.5%	18.2%	24.2%	3.0%	38.7%	6.5%	45.2%	9.7%	48.5%	9.1%	33.3%	9.1%
AK II	56.0%	20.0%	12.0%	12.0%	30.4%	21.7%	21.7%	26.1%	41.7%	12.5%	29.2%	16.7%
BH	41.8%	16.5%	25.3%	16.5%	44.7%	21.1%	28.9%	5.3%	60.5%	19.7%	18.4%	1.3%
CY	23.3%	9.3%	39.5%	27.9%	44.4%	19.4%	19.4%	16.7%	32.5%	30.0%	32.5%	5.0%
EA	26.1%	17.4%	32.6%	23.9%	31.4%	17.6%	25.5%	25.5%	19.3%	21.1%	49.1%	10.5%
FP	14.6%	12.2%	43.9%	26.8%	32.6%	7.0%	44.2%	16.3%	34.0%	17.0%	42.6%	6.4%
FR	19.2%	13.7%	31.5%	35.6%	38.7%	12.0%	30.7%	18.7%	47.1%	12.6%	34.5%	5.7%
GV	17.4%	21.7%	43.5%	17.4%	28.6%	23.8%	33.3%	14.3%	36.0%	20.0%	44.0%	
GO	23.3%	4.7%	48.8%	23.3%	30.4%	21.7%	43.5%	4.3%	38.0%	12.0%	44.0%	6.0%
GH	33.3%	16.7%	41.7%	8.3%	26.1%	17.4%	52.2%	4.3%	43.5%	13.0%	43.5%	
GR	27.8%	22.2%	11.1%	38.9%	35.1%	8.1%	43.2%	13.5%	31.8%	22.7%	38.6%	6.8%
HC	14.1%	10.9%	29.7%	45.3%	18.4%	10.5%	57.9%	13.2%	17.0%	20.5%	51.1%	11.4%
LVF	7.4%	3.7%	22.2%	66.7%	8.3%	8.3%	41.7%	41.7%	18.5%	7.4%	51.9%	22.2%
LVM	11.4%	5.7%	34.3%	48.6%	12.8%	5.1%	43.6%	38.5%	22.0%	2.4%	41.5%	34.1%
MA	13.7%	5.9%	37.3%	43.1%	29.6%	22.2%	31.5%	16.7%	29.2%	23.1%	43.1%	4.6%
MS	21.7%	19.6%	30.4%	28.3%	13.8%	12.1%	56.9%	17.2%	29.3%	31.0%	32.8%	6.9%
ON	12.5%	9.4%	50.0%	28.1%	35.1%	16.2%	37.8%	10.8%	33.3%	16.7%	33.3%	16.7%
SH	26.7%	20.0%	30.0%	23.3%	28.1%	6.3%	28.1%	37.5%	20.0%	36.7%	30.0%	13.3%
SS	19.4%	19.4%	19.4%	41.7%	14.3%	11.4%	34.3%	40.0%	29.7%	24.3%	24.3%	21.6%
TA	45.0%	5.0%	20.0%	30.0%	15.4%	3.8%	38.5%	42.3%	18.5%	25.9%	51.9%	3.7%
WA	20.0%	10.0%	40.0%	30.0%	31.0%	10.3%	48.3%	10.3%	33.3%	3.0%	51.5%	12.1%
WE	50.0%	26.5%	8.8%	14.7%	42.9%	3.6%	39.3%	14.3%	42.9%	14.3%	34.3%	8.6%
WIF	11.1%	11.1%	22.2%	55.6%	14.3%	28.6%	28.6%	28.6%	12.5%	50.0%	25.0%	12.5%
WIM	27.3%		45.5%	27.3%	36.4%	13.6%	40.9%	9.1%	26.1%	26.1%	47.8%	
WY	30.4%	10.9%	30.4%	28.3%	29.2%	10.4%	37.5%	22.9%	34.6%	13.5%	40.4%	11.5%
TOTAL	25.3%	13.2%	31.5%	29.9%	28.8%	13.2%	39.4%	18.5%	32.9%	18.6%	39.1%	9.5%

Summary of MQA Survey Responses for Visited Prisons

Prison	Q13 Menu A Techniques Satisfaction				Q14 Menu B Techniques Satisfaction				Q15 Menu C Techniques Satisfaction			
	Very Dissatisfied	Somewhat Dissatisfied	Somewhat Satisfied	Very Satisfied	Very Dissatisfied	Somewhat Dissatisfied	Somewhat Satisfied	Very Satisfied	Very Dissatisfied	Somewhat Dissatisfied	Somewhat Satisfied	Very Satisfied
AL	9.5%	14.3%	52.4%	23.8%	4.8%	4.8%	47.6%	42.9%	27.3%	13.6%	27.3%	31.8%
AK I	34.3%	14.3%	25.7%	25.7%	17.1%	8.6%	51.4%	22.9%	36.4%	12.1%	30.3%	21.2%
AK II	20.8%	12.5%	29.2%	37.5%	12.0%	16.0%	40.0%	32.0%	25.9%	18.5%	33.3%	22.2%
BH	34.6%	16.7%	35.9%	12.8%	29.1%	15.2%	26.6%	29.1%	49.4%	14.3%	24.7%	11.7%
CY	26.8%	22.0%	31.7%	19.5%	26.8%	4.9%	34.1%	34.1%	40.0%	14.3%	34.3%	11.4%
EA	8.2%	9.8%	47.5%	34.4%	4.8%	14.5%	27.4%	53.2%	25.0%	12.5%	41.1%	21.4%
FP	4.4%	8.9%	64.4%	22.2%	8.7%	4.3%	26.1%	60.9%	13.5%	13.5%	51.4%	21.6%
FR	25.3%	14.3%	33.0%	27.5%	28.0%	9.7%	29.0%	33.3%	45.3%	8.1%	25.6%	20.9%
GV	18.5%	18.5%	48.1%	14.8%	17.9%		35.7%	46.4%	25.0%	17.9%	32.1%	25.0%
GO	18.2%	5.5%	54.5%	21.8%	13.0%	9.3%	33.3%	44.4%	33.3%	18.5%	42.6%	5.6%
GH	23.1%	7.7%	38.5%	30.8%	3.7%	3.7%	37.0%	55.6%	18.5%	11.1%	37.0%	33.3%
GR	15.6%	13.3%	53.3%	17.8%	14.0%	7.0%	34.9%	41.9%	28.6%	16.7%	33.3%	21.4%
HC	7.5%	16.1%	57.0%	19.4%	4.3%	5.4%	26.1%	64.1%	11.1%	6.7%	43.3%	37.8%
LVF		7.1%	57.1%	35.7%	3.6%	10.7%	25.0%	60.7%	3.6%	7.1%	25.0%	64.3%
LVM	12.2%	2.4%	48.8%	36.6%	2.4%		24.4%	73.2%	2.4%	4.9%	39.0%	53.7%
MA	13.0%	21.7%	42.0%	23.2%	13.4%	9.0%	34.3%	43.3%	23.1%	15.4%	41.5%	20.0%
MS	24.1%	22.4%	43.1%	10.3%	13.6%	15.3%	42.4%	28.8%	37.0%	18.5%	24.1%	20.4%
ON	41.7%	27.8%	25.0%	5.6%	26.3%	15.8%	39.5%	18.4%	44.7%	15.8%	28.9%	10.5%
SH	17.6%	14.7%	29.4%	38.2%	14.3%	11.4%	17.1%	57.1%	9.4%	18.8%	28.1%	43.8%
SS	19.4%	8.3%	33.3%	38.9%	8.1%	10.8%	18.9%	62.2%	17.1%	20.0%	34.3%	28.6%
TA	14.8%	7.4%	44.4%	33.3%	11.5%	3.8%	26.9%	57.7%	32.0%	8.0%	20.0%	40.0%
WA	15.2%	12.1%	48.5%	24.2%	11.4%	17.1%	28.6%	42.9%	19.4%	12.9%	48.4%	19.4%
WE	29.7%	5.4%	37.8%	27.0%	12.8%	7.7%	20.5%	59.0%	28.9%	10.5%	18.4%	42.1%
WIF	22.2%	11.1%	22.2%	44.4%	22.2%	11.1%	11.1%	55.6%	25.0%	12.5%	37.5%	25.0%
WIM	30.4%	26.1%	43.5%		9.1%	22.7%	40.9%	27.3%	9.1%	18.2%	54.5%	18.2%
WY	18.9%	5.7%	45.3%	30.2%	5.7%	9.4%	26.4%	58.5%	20.4%	11.1%	33.3%	35.2%
TOTAL	19.3%	13.7%	43.1%	24.0%	13.7%	9.6%	30.7%	45.9%	26.7%	13.1%	34.1%	26.0%

Summary of MQA Survey Responses for Visited Prisons

Prison	Q17 Involvement Satisfaction				Q18 Counseling Process Satisfaction				Q19 Commitment Satisfaction			
	Very Dissatisfied	Somewhat Dissatisfied	Somewhat Satisfied	Very Satisfied	Very Dissatisfied	Somewhat Dissatisfied	Somewhat Satisfied	Very Satisfied	Very Dissatisfied	Somewhat Dissatisfied	Somewhat Satisfied	Very Satisfied
AL	4.3%		43.5%	52.2%	19.0%	4.8%	42.9%	33.3%	5.0%	5.0%	15.0%	75.0%
AK I	11.1%		52.8%	36.1%	28.6%		57.1%	14.3%	5.7%	5.7%	25.7%	62.9%
AK II		3.8%	46.2%	50.0%	29.2%	20.8%	20.8%	29.2%	7.7%	3.8%	19.2%	69.2%
BH	12.5%	12.5%	37.5%	37.5%	48.1%	21.0%	21.0%	9.9%	12.5%	10.0%	32.5%	45.0%
CY	4.7%	7.0%	39.5%	48.8%	47.6%	19.0%	19.0%	14.3%	2.4%	4.8%	35.7%	57.1%
EA	3.3%	8.2%	45.9%	42.6%	22.6%	17.7%	33.9%	25.8%	5.0%	5.0%	28.3%	61.7%
FP	8.5%	4.3%	48.9%	38.3%	23.3%	9.3%	39.5%	27.9%	4.7%	2.3%	25.6%	67.4%
FR	8.6%	11.8%	34.4%	45.2%	29.7%	20.9%	29.7%	19.8%	9.0%	5.6%	30.3%	55.1%
GV	3.8%	15.4%	38.5%	42.3%	36.0%	24.0%	32.0%	8.0%			21.4%	78.6%
GO	9.3%	5.6%	44.4%	40.7%	22.2%	16.7%	42.6%	18.5%	5.7%		39.6%	54.7%
GH		7.4%	33.3%	59.3%	29.6%	14.8%	37.0%	18.5%	4.0%	4.0%	16.0%	76.0%
GR	9.5%	9.5%	40.5%	40.5%	31.0%	11.9%	42.9%	14.3%	2.3%	4.7%	41.9%	51.2%
HC	2.1%	4.3%	52.1%	41.5%	6.3%	9.5%	50.5%	33.7%	3.2%	4.3%	25.5%	67.0%
LVF		3.6%	32.1%	64.3%	3.6%		46.4%	50.0%			18.5%	81.5%
LVM	10.3%		33.3%	56.4%	10.5%	5.3%	34.2%	50.0%			23.1%	76.9%
MA	5.7%	5.7%	35.7%	52.9%	30.9%	13.2%	30.9%	25.0%		1.4%	24.3%	74.3%
MS	8.9%	8.9%	48.2%	33.9%	21.4%	23.2%	42.9%	12.5%	5.4%	3.6%	35.7%	55.4%
ON	23.1%	20.5%	35.9%	20.5%	52.5%	15.0%	25.0%	7.5%	17.1%	2.4%	26.8%	53.7%
SH	14.3%	2.9%	31.4%	51.4%	17.1%	14.3%	28.6%	40.0%	6.1%	9.1%	21.2%	63.6%
SS	8.1%	8.1%	24.3%	59.5%	13.2%	13.2%	28.9%	44.7%		2.6%	15.8%	81.6%
TA		3.7%	37.0%	59.3%	15.4%	7.7%	26.9%	50.0%	3.8%		15.4%	80.8%
WA	11.4%		31.4%	57.1%	37.1%	5.7%	28.6%	28.6%	5.9%		20.6%	73.5%
WE	12.8%	12.8%	30.8%	43.6%	34.2%	15.8%	26.3%	23.7%	10.3%	2.6%	30.8%	56.4%
WIF	11.1%		22.2%	66.7%	14.3%	28.6%	14.3%	42.9%			11.1%	88.9%
WIM	21.7%	8.7%	56.5%	13.0%	31.8%	13.6%	45.5%	9.1%	13.6%		40.9%	45.5%
WY	12.0%	4.0%	26.0%	58.0%	21.6%	27.5%	27.5%	23.5%	11.3%	1.9%	30.2%	56.6%
TOTAL	8.3%	7.1%	39.4%	45.2%	26.5%	15.2%	33.7%	24.6%	5.8%	3.6%	27.6%	63.1%

Summary of MQA Survey Responses for Visited Prisons

Prison	Menu A (a): Staff Confronts Behavior				Menu A (b): Participants Help				Menu A (c): Violation Incurs Penalty			
	Not Important	Somewhat Important	Mostly Important	Very Important	Not Important	Somewhat Important	Mostly Important	Very Important	Not Important	Somewhat Important	Mostly Important	Very Important
AL	9.1%	13.6%	22.7%	54.5%	13.0%	13.0%	17.4%	56.5%	4.3%	21.7%	26.1%	47.8%
AK I	13.9%	19.4%	19.4%	47.2%	8.3%	25.0%	25.0%	41.7%	5.9%	11.8%	32.4%	50.0%
AK II	8.0%	28.0%	24.0%	40.0%	3.8%	19.2%	19.2%	57.7%	12.0%	28.0%	24.0%	36.0%
BH	24.1%	24.1%	15.2%	36.7%	13.4%	17.1%	23.2%	46.3%	12.3%	25.9%	18.5%	43.2%
CY	14.3%	23.8%	23.8%	38.1%	7.0%	18.6%	37.2%	37.2%	11.6%	30.2%	18.6%	39.5%
EA	1.7%	11.9%	27.1%	59.3%		18.0%	18.0%	63.9%		21.3%	19.7%	59.0%
FP	14.0%	34.9%	14.0%	37.2%	4.4%	13.3%	44.4%	37.8%	17.8%	33.3%	17.8%	31.1%
FR	14.3%	17.6%	12.1%	56.0%	7.6%	17.4%	19.6%	55.4%	9.7%	23.7%	16.1%	50.5%
GV	22.2%	18.5%	7.4%	51.9%	6.9%	34.5%	6.9%	51.7%	14.3%	32.1%	17.9%	35.7%
GO	19.6%	27.5%	25.5%	27.5%	9.4%	24.5%	34.0%	32.1%	11.8%	21.6%	31.4%	35.3%
GH	7.4%	14.8%	11.1%	66.7%	3.8%	7.7%	15.4%	73.1%	3.7%	29.6%	11.1%	55.6%
GR	15.6%	26.7%	15.6%	42.2%	6.7%	26.7%	31.1%	35.6%	11.4%	22.7%	22.7%	43.2%
HC	8.5%	17.0%	25.5%	48.9%	2.1%	18.1%	21.3%	58.5%	7.4%	12.8%	27.7%	52.1%
LVF	7.4%	18.5%	22.2%	51.9%	3.7%	11.1%	29.6%	55.6%	3.7%	22.2%	14.8%	59.3%
LVM	7.7%	28.2%	41.0%	23.1%	2.4%	14.6%	26.8%	56.1%	7.5%	12.5%	37.5%	42.5%
MA	14.3%	27.1%	25.7%	32.9%	9.7%	12.5%	36.1%	41.7%	9.9%	26.8%	25.4%	38.0%
MS	10.7%	37.5%	16.1%	35.7%	8.8%	28.1%	21.1%	42.1%	1.7%	24.1%	27.6%	46.6%
ON	20.0%	27.5%	17.5%	35.0%	17.1%	36.6%	26.8%	19.5%	7.3%		12.2%	80.5%
SH	18.2%	12.1%	9.1%	60.6%	8.8%	14.7%	17.6%	58.8%	8.8%	29.4%	14.7%	47.1%
SS	21.6%	18.9%	27.0%	32.4%	5.4%	13.5%	35.1%	45.9%	10.8%	27.0%	24.3%	37.8%
TA	3.7%	14.8%	14.8%	66.7%		22.2%	37.0%	40.7%	3.7%	22.2%	14.8%	59.3%
WA	20.0%	14.3%	17.1%	48.6%	8.3%	11.1%	27.8%	52.8%	17.1%	17.1%	22.9%	42.9%
WE	24.3%	24.3%	16.2%	35.1%	2.8%	27.8%	30.6%	38.9%	22.2%	25.0%	27.8%	25.0%
WIF		12.5%		87.5%		11.1%	22.2%	66.7%	11.1%	11.1%	22.2%	55.6%
WIM	13.0%	17.4%	43.5%	26.1%	4.3%	39.1%	21.7%	34.8%	4.3%	30.4%	34.8%	30.4%
WY	15.1%	15.1%	20.8%	49.1%	3.7%	9.3%	20.4%	66.7%	11.1%	27.8%	20.4%	40.7%
TOTAL	14.0%	21.7%	20.2%	44.0%	6.6%	19.1%	25.8%	48.5%	9.3%	22.6%	22.4%	45.7%

Summary of MQA Survey Responses for Visited Prisons

Prison	Menu A (d): Work is Incorporated				Menu A (e): Staff Are Role Models				Menu A (f): Inmates Are Role Models			
	Not Important	Somewhat Important	Mostly Important	Very Important	Not Important	Somewhat Important	Mostly Important	Very Important	Not Important	Somewhat Important	Mostly Important	Very Important
AL	8.7%	21.7%	26.1%	43.5%	8.7%	21.7%	21.7%	47.8%	9.1%	22.7%	18.2%	50.0%
AK I	14.3%	17.1%	28.6%	40.0%	22.9%	25.7%	8.6%	42.9%	16.7%	22.2%	22.2%	38.9%
AK II	16.0%	24.0%	20.0%	40.0%	16.0%	32.0%	20.0%	32.0%	15.4%	11.5%	23.1%	50.0%
BH	21.3%	23.8%	25.0%	30.0%	32.9%	14.6%	7.3%	45.1%	28.0%	13.4%	17.1%	41.5%
CY	14.0%	30.2%	14.0%	41.9%	27.9%	18.6%	14.0%	39.5%	25.6%	16.3%	18.6%	39.5%
EA	11.5%	18.0%	19.7%	50.8%	13.1%	11.5%	16.4%	59.0%	8.3%	15.0%	21.7%	55.0%
FP	26.1%	23.9%	19.6%	30.4%	26.7%	8.9%	13.3%	51.1%	15.9%	18.2%	13.6%	52.3%
FR	18.5%	15.2%	22.8%	43.5%	21.5%	12.9%	7.5%	58.1%	17.8%	10.0%	11.1%	61.1%
GV	10.3%	41.4%	3.4%	44.8%	31.0%	10.3%	20.7%	37.9%	14.8%	22.2%	25.9%	37.0%
GO	19.2%	28.8%	23.1%	28.8%	26.9%	23.1%	19.2%	30.8%	19.2%	23.1%	25.0%	32.7%
GH	7.7%	11.5%	15.4%	65.4%	7.4%	3.7%	14.8%	74.1%	7.4%	7.4%	3.7%	81.5%
GR	15.6%	26.7%	33.3%	24.4%	26.7%	17.8%	17.8%	37.8%	13.3%	28.9%	17.8%	40.0%
HC	7.4%	18.1%	24.5%	50.0%	14.9%	18.1%	23.4%	43.6%	7.4%	17.0%	26.6%	48.9%
LVF	11.1%	22.2%	22.2%	44.4%	10.7%	14.3%	42.9%	32.1%	7.7%	11.5%	38.5%	42.3%
LVM	12.5%	30.0%	10.0%	47.5%	17.5%	12.5%	20.0%	50.0%	15.0%	25.0%	22.5%	37.5%
MA	12.7%	19.7%	32.4%	35.2%	34.7%	13.9%	18.1%	33.3%	25.4%	18.3%	16.9%	39.4%
MS	12.1%	22.4%	22.4%	43.1%	22.4%	15.5%	19.0%	43.1%	14.0%	21.1%	24.6%	40.4%
ON	22.0%	14.6%	14.6%	48.8%	78.0%	14.6%	2.4%	4.9%			100.0%	
SH	21.2%	15.2%	21.2%	42.4%	9.1%	15.2%	15.2%	60.6%	11.8%	17.6%	11.8%	58.8%
SS	22.2%	33.3%	19.4%	25.0%	13.9%	13.9%	22.2%	50.0%	13.9%	16.7%	25.0%	44.4%
TA	14.8%	29.6%	14.8%	40.7%	3.7%	14.8%	25.9%	55.6%	3.7%	14.8%	22.2%	59.3%
WA	25.0%	13.9%	13.9%	47.2%	30.6%	16.7%	5.6%	47.2%	13.9%	8.3%	25.0%	52.8%
WE	25.7%	20.0%	28.6%	25.7%	23.7%	15.8%	15.8%	44.7%	21.1%	26.3%	15.8%	36.8%
WIF		12.5%	25.0%	62.5%	12.5%	12.5%	25.0%	50.0%		12.5%	37.5%	50.0%
WIM	8.7%	21.7%	26.1%	43.5%	13.0%	30.4%	13.0%	43.5%	13.0%	34.8%	13.0%	39.1%
WY	16.7%	16.7%	27.8%	38.9%	11.3%	24.5%	18.9%	45.3%	12.0%	18.0%	22.0%	48.0%
TOTAL	15.8%	21.7%	22.1%	40.4%	22.9%	16.3%	16.2%	44.6%	15.4%	17.7%	20.1%	46.8%

Summary of MQA Survey Responses for Visited Prisons

Prison	Menu A (g): Senior Role Models				Menu A (h): Increasing Privileges				Menu B (a): Identify "Triggers"			
	Not Important	Somewhat Important	Mostly Important	Very Important	Not Important	Somewhat Important	Mostly Important	Very Important	Not Important	Somewhat Important	Mostly Important	Very Important
AL		30.4%	26.1%	43.5%	14.3%	38.1%	9.5%	38.1%		9.1%	31.8%	59.1%
AK I	14.7%	20.6%	23.5%	41.2%	34.3%	28.6%	11.4%	25.7%	11.4%	14.3%	20.0%	54.3%
AK II	8.0%	16.0%	32.0%	44.0%	32.0%	12.0%	12.0%	44.0%		11.1%	18.5%	70.4%
BH	12.2%	18.3%	20.7%	48.8%	26.3%	12.5%	20.0%	41.3%	14.5%	12.0%	18.1%	55.4%
CY	18.6%	18.6%	16.3%	46.5%	18.6%	30.2%	23.3%	27.9%	9.1%	6.8%	20.5%	63.6%
EA		18.0%	16.4%	65.6%	24.6%	23.0%	21.3%	31.1%	1.6%	4.9%	19.7%	73.8%
FP	6.5%	13.0%	23.9%	56.5%	27.3%	11.4%	15.9%	45.5%	6.7%	8.9%	20.0%	64.4%
FR	9.7%	14.0%	15.1%	61.3%	23.9%	9.8%	8.7%	57.6%	12.0%	8.7%	21.7%	57.6%
GV	6.9%	24.1%	20.7%	48.3%	35.7%	14.3%	14.3%	35.7%	6.9%	13.8%	20.7%	58.6%
GO	11.5%	23.1%	34.6%	30.8%	25.5%	15.7%	17.6%	41.2%	7.5%	7.5%	22.6%	62.3%
GH		11.1%	14.8%	74.1%	18.5%	22.2%	7.4%	51.9%		3.7%	7.4%	88.9%
GR	13.6%	15.9%	27.3%	43.2%	20.0%	20.0%	33.3%	26.7%	4.5%	13.6%	22.7%	59.1%
HC	4.2%	16.8%	17.9%	61.1%	20.4%	19.4%	18.3%	41.9%	3.2%	2.1%	13.7%	81.1%
LVF	15.4%	7.7%	30.8%	46.2%	18.5%	11.1%	25.9%	44.4%	3.6%	3.6%	28.6%	64.3%
LVM	7.3%	17.1%	26.8%	48.8%	15.4%	15.4%	23.1%	46.2%	2.4%	4.9%	19.5%	73.2%
MA	18.1%	16.7%	22.2%	43.1%	33.8%	11.3%	14.1%	40.8%	2.9%	14.3%	24.3%	58.6%
MS	8.6%	12.1%	27.6%	51.7%	42.1%	10.5%	8.8%	38.6%	5.2%	13.8%	17.2%	63.8%
ON	17.1%	43.9%	19.5%	19.5%	82.9%	9.8%	7.3%		34.1%	31.7%	14.6%	19.5%
SH	15.2%	21.2%	9.1%	54.5%	38.2%	17.6%	8.8%	35.3%	2.9%	5.7%	14.3%	77.1%
SS	11.1%	16.7%	22.2%	50.0%	32.4%	21.6%	18.9%	27.0%	5.4%	8.1%	16.2%	70.3%
TA	7.4%	11.1%	22.2%	59.3%	11.1%	33.3%	18.5%	37.0%	3.8%	11.5%	3.8%	80.8%
WA	13.9%	2.8%	22.2%	61.1%	27.8%	8.3%	25.0%	38.9%	12.5%	9.4%	18.8%	59.4%
WE	10.8%	24.3%	32.4%	32.4%	30.6%	22.2%	16.7%	30.6%	2.6%	5.3%	23.7%	68.4%
WIF		25.0%	12.5%	62.5%	28.6%		14.3%	57.1%		11.1%		88.9%
WIM	8.7%	39.1%	13.0%	39.1%	21.7%	17.4%	30.4%	30.4%	8.7%	21.7%	8.7%	60.9%
WY	5.6%	11.1%	16.7%	66.7%	30.2%	11.3%	22.6%	35.8%	5.6%	7.4%	16.7%	70.4%
TOTAL	9.8%	17.9%	21.6%	50.8%	28.4%	16.6%	17.1%	37.9%	7.0%	9.7%	18.6%	64.6%

Summary of MQA Survey Responses for Visited Prisons

Prison	Menu B (b): Find Other Enjoyment				Menu B (c): Communicate Assertively				Menu B (d): Problem Solving Tech.			
	Not Important	Somewhat Important	Mostly Important	Very Important	Not Important	Somewhat Important	Mostly Important	Very Important	Not Important	Somewhat Important	Mostly Important	Very Important
AL		9.1%	31.8%	59.1%	4.5%	9.1%	18.2%	68.2%	4.5%	9.1%	18.2%	68.2%
AK I	11.4%	14.3%	20.0%	54.3%	11.4%	17.1%	17.1%	54.3%	11.4%	17.1%	17.1%	54.3%
AK II		11.1%	18.5%	70.4%		3.7%	18.5%	77.8%		3.7%	18.5%	77.8%
BH	14.5%	12.0%	18.1%	55.4%	15.5%	4.8%	16.7%	63.1%	15.5%	4.8%	16.7%	63.1%
CY	9.1%	6.8%	20.5%	63.6%	9.1%	4.5%	15.9%	70.5%	9.1%	4.5%	15.9%	70.5%
EA	1.6%	4.9%	19.7%	73.8%		3.2%	17.7%	79.0%		3.2%	17.7%	79.0%
FP	6.7%	8.9%	20.0%	64.4%	4.4%	6.7%	13.3%	75.6%	4.4%	6.7%	13.3%	75.6%
FR	12.0%	8.7%	21.7%	57.6%	10.0%	7.8%	14.4%	67.8%	10.0%	7.8%	14.4%	67.8%
GV	6.9%	13.8%	20.7%	58.6%	6.9%	6.9%	24.1%	62.1%	6.9%	6.9%	24.1%	62.1%
GO	7.5%	7.5%	22.6%	62.3%	3.7%	13.0%	27.8%	55.6%	3.7%	13.0%	27.8%	55.6%
GH		3.7%	7.4%	88.9%		11.1%	7.4%	81.5%		11.1%	7.4%	81.5%
GR	4.5%	13.6%	22.7%	59.1%	9.1%	11.4%	18.2%	61.4%	9.1%	11.4%	18.2%	61.4%
HC	3.2%	2.1%	13.7%	81.1%	4.2%	3.2%	11.6%	81.1%	4.2%	3.2%	11.6%	81.1%
LVF	3.6%	3.6%	28.6%	64.3%		3.7%	14.8%	81.5%		3.7%	14.8%	81.5%
LVM	2.4%	4.9%	19.5%	73.2%	2.4%	4.9%	12.2%	80.5%	2.4%	4.9%	12.2%	80.5%
MA	2.9%	14.3%	24.3%	58.6%	4.3%	17.1%	17.1%	61.4%	4.3%	17.1%	17.1%	61.4%
MS	5.2%	13.8%	17.2%	63.8%	5.3%	12.3%	17.5%	64.9%	5.3%	12.3%	17.5%	64.9%
ON	34.1%	31.7%	14.6%	19.5%	29.3%	36.6%	17.1%	17.1%	29.3%	36.6%	17.1%	17.1%
SH	2.9%	5.7%	14.3%	77.1%	5.7%	8.6%	2.9%	82.9%	5.7%	8.6%	2.9%	82.9%
SS	5.4%	8.1%	16.2%	70.3%	11.1%	2.8%	19.4%	66.7%	11.1%	2.8%	19.4%	66.7%
TA	3.8%	11.5%	3.8%	80.8%	7.4%	11.1%	3.7%	77.8%	7.4%	11.1%	3.7%	77.8%
WA	12.5%	9.4%	18.8%	59.4%	11.8%	5.9%	14.7%	67.6%	11.8%	5.9%	14.7%	67.6%
WE	2.6%	5.3%	23.7%	68.4%		5.4%	27.0%	67.6%		5.4%	27.0%	67.6%
WIF		11.1%		88.9%		11.1%	11.1%	77.8%		11.1%	11.1%	77.8%
WIM	8.7%	21.7%	8.7%	60.9%	4.3%	8.7%	26.1%	60.9%	4.3%	8.7%	26.1%	60.9%
WY	5.6%	7.4%	16.7%	70.4%	7.4%		13.0%	79.6%	7.4%		13.0%	79.6%
TOTAL	7.0%	9.7%	18.6%	64.6%	7.0%	8.5%	16.1%	68.3%	7.0%	8.5%	16.1%	68.3%

Summary of MQA Survey Responses for Visited Prisons

Prison	Menu B (e): Learn Errors in Thinking				Menu C (a): 12-Step Goals Explained				Menu C (b): How to Work 12-Steps			
	Not Important	Somewhat Important	Mostly Important	Very Important	Not Important	Somewhat Important	Mostly Important	Very Important	Not Important	Somewhat Important	Mostly Important	Very Important
AL		9.1%	18.2%	72.7%	18.2%	13.6%	22.7%	45.5%	18.2%	22.7%	13.6%	45.5%
AK I	11.1%	11.1%	25.0%	52.8%	36.1%	33.3%	2.8%	27.8%	38.9%	27.8%	8.3%	25.0%
AK II		14.8%	22.2%	63.0%	22.2%	37.0%	7.4%	33.3%	25.9%	29.6%	11.1%	33.3%
BH	16.9%	7.2%	20.5%	55.4%	43.2%	21.0%	8.6%	27.2%	43.2%	19.8%	9.9%	27.2%
CY	9.1%	4.5%	15.9%	70.5%	30.2%	30.2%	14.0%	25.6%	23.8%	26.2%	23.8%	26.2%
EA		5.0%	13.3%	81.7%	24.1%	24.1%	13.8%	37.9%	25.9%	24.1%	17.2%	32.8%
FP	2.2%	11.1%	17.8%	68.9%	31.0%	23.8%	16.7%	28.6%	34.1%	12.2%	22.0%	31.7%
FR	10.0%	6.7%	16.7%	66.7%	23.0%	11.5%	17.2%	48.3%	21.8%	16.1%	12.6%	49.4%
GV	10.3%	6.9%	10.3%	72.4%	28.6%	14.3%	21.4%	35.7%	24.1%	17.2%	20.7%	37.9%
GO	9.3%	11.1%	20.4%	59.3%	33.3%	31.4%	15.7%	19.6%	34.0%	36.0%	12.0%	18.0%
GH	3.7%	3.7%	3.7%	88.9%	16.0%	16.0%	8.0%	60.0%	16.0%	16.0%	4.0%	64.0%
GR	6.8%	18.2%	20.5%	54.5%	32.6%	18.6%	23.3%	25.6%	30.2%	25.6%	16.3%	27.9%
HC	2.1%	5.3%	12.6%	80.0%	5.4%	16.3%	28.3%	50.0%	7.6%	10.9%	28.3%	53.3%
LVF		3.6%	14.3%	82.1%		7.1%	25.0%	67.9%	3.6%	3.6%	25.0%	67.9%
LVM	2.4%	7.3%	19.5%	70.7%	2.4%	9.8%	19.5%	68.3%	2.4%	12.2%	14.6%	70.7%
MA	4.3%	20.3%	20.3%	55.1%	28.6%	15.7%	15.7%	40.0%	27.9%	17.6%	14.7%	39.7%
MS	6.9%	10.3%	20.7%	62.1%	45.6%	5.3%	17.5%	31.6%	46.4%	3.6%	14.3%	35.7%
ON	22.0%	29.3%	22.0%	26.8%	56.1%	19.5%	7.3%	17.1%	53.7%	22.0%	4.9%	19.5%
SH	2.9%	11.4%	8.6%	77.1%	9.1%	18.2%	33.3%	39.4%	9.1%	21.2%	27.3%	42.4%
SS	8.3%	8.3%	22.2%	61.1%	25.7%	28.6%	17.1%	28.6%	30.3%	24.2%	15.2%	30.3%
TA	7.7%	15.4%	11.5%	65.4%	19.2%	15.4%	34.6%	30.8%	19.2%	15.4%	30.8%	34.6%
WA	5.7%	17.1%	8.6%	68.6%	31.3%	34.4%	9.4%	25.0%	36.4%	18.2%	15.2%	30.3%
WE		15.8%	18.4%	65.8%	10.3%	15.4%	25.6%	48.7%	7.9%	15.8%	21.1%	55.3%
WIF			11.1%	88.9%		11.1%	33.3%	55.6%		11.1%	33.3%	55.6%
WIM	8.7%	13.0%	21.7%	56.5%		21.7%	39.1%	39.1%	4.3%	30.4%	30.4%	34.8%
WY	5.6%	3.7%	20.4%	70.4%	11.3%	18.9%	22.6%	47.2%	15.1%	18.9%	20.8%	45.3%
TOTAL	6.6%	10.3%	17.2%	65.9%	24.3%	19.3%	18.3%	38.1%	24.8%	18.7%	17.2%	39.2%

Summary of MQA Survey Responses for Visited Prisons

Prison	Menu C (c): 12-Step Success Explained				Menu C (d): Sponsoring Relationship				Menu C (e): Barriers to Affiliation			
	Not Important	Somewhat Important	Mostly Important	Very Important	Not Important	Somewhat Important	Mostly Important	Very Important	Not Important	Somewhat Important	Mostly Important	Very Important
AL	18.2%	18.2%	13.6%	50.0%	13.6%	18.2%	22.7%	45.5%	13.6%	18.2%	22.7%	45.5%
AK I	37.1%	28.6%	11.4%	22.9%	34.3%	22.9%	11.4%	31.4%	35.3%	23.5%	11.8%	29.4%
AK II	29.6%	25.9%	18.5%	25.9%	22.2%	22.2%	11.1%	44.4%	25.9%	25.9%	14.8%	33.3%
BH	46.3%	15.0%	11.3%	27.5%	33.3%	13.6%	16.0%	37.0%	42.5%	13.8%	13.8%	30.0%
CY	26.2%	26.2%	19.0%	28.6%	26.2%	16.7%	21.4%	35.7%	28.6%	26.2%	21.4%	23.8%
EA	26.3%	22.8%	15.8%	35.1%	15.5%	20.7%	17.2%	46.6%	28.1%	21.1%	15.8%	35.1%
FP	31.7%	14.6%	26.8%	26.8%	26.2%	21.4%	19.0%	33.3%	33.3%	9.5%	31.0%	26.2%
FR	24.1%	9.6%	15.7%	50.6%	18.6%	12.8%	19.8%	48.8%	23.3%	12.8%	16.3%	47.7%
GV	28.6%	10.7%	10.7%	50.0%	13.8%	20.7%	6.9%	58.6%	20.7%	17.2%	24.1%	37.9%
GO	30.6%	34.7%	18.4%	16.3%	26.5%	32.7%	14.3%	26.5%	28.0%	42.0%	12.0%	18.0%
GH	16.0%	12.0%	12.0%	60.0%	8.3%	12.5%	8.3%	70.8%	12.5%	12.5%	12.5%	62.5%
GR	31.0%	21.4%	19.0%	28.6%	27.9%	27.9%	14.0%	30.2%	32.6%	25.6%	16.3%	25.6%
HC	4.3%	9.8%	31.5%	53.3%	4.3%	12.0%	23.9%	59.8%	6.5%	10.9%	26.1%	56.5%
LVF		7.1%	28.6%	64.3%	3.6%	10.7%	25.0%	60.7%	3.6%	17.9%	25.0%	53.6%
LVM	2.4%	9.8%	22.0%	65.9%	9.8%	12.2%	19.5%	58.5%	4.9%	17.1%	24.4%	53.7%
MA	30.4%	15.9%	15.9%	37.7%	21.7%	17.4%	18.8%	42.0%	30.4%	18.8%	14.5%	36.2%
MS	48.2%	3.6%	12.5%	35.7%	30.4%	8.9%	26.8%	33.9%	48.2%	1.8%	19.6%	30.4%
ON	51.2%	29.3%	4.9%	14.6%	58.5%	26.8%	4.9%	9.8%	61.0%	17.1%	4.9%	17.1%
SH	9.1%	21.2%	15.2%	54.5%	9.1%	18.2%	15.2%	57.6%	12.1%	21.2%	15.2%	51.5%
SS	30.3%	27.3%	18.2%	24.2%	20.6%	26.5%	23.5%	29.4%	32.4%	26.5%	17.6%	23.5%
TA	19.2%	15.4%	26.9%	38.5%	15.4%	19.2%	26.9%	38.5%	19.2%	19.2%	26.9%	34.6%
WA	28.1%	21.9%	15.6%	34.4%	18.2%	21.2%	15.2%	45.5%	30.3%	21.2%	18.2%	30.3%
WE	10.5%	15.8%	13.2%	60.5%	15.8%	10.5%	21.1%	52.6%	17.9%	12.8%	20.5%	48.7%
WIF		22.2%	11.1%	66.7%		11.1%	22.2%	66.7%	11.1%	11.1%	22.2%	55.6%
WIM	4.3%	21.7%	34.8%	39.1%		21.7%	39.1%	39.1%		30.4%	34.8%	34.8%
WY	17.0%	20.8%	22.6%	39.6%	13.2%	18.9%	24.5%	43.4%	18.9%	20.8%	20.8%	39.6%
TOTAL	25.0%	17.6%	18.1%	39.3%	20.1%	17.9%	18.9%	43.2%	25.6%	18.2%	18.8%	37.4%

Summary of MQA Survey Responses for Visited Prisons

Prison	Q16(a) – Feel Part of Something				Q16(b) – Interested in Helping Me				Q16(c) – Do What is Best for Me			
	Not True	Somewhat True	Mostly True	Very True	Not True	Somewhat True	Mostly True	Very True	Not True	Somewhat True	Mostly True	Very True
AL	47.8%	21.7%	13.0%	17.4%	34.8%	43.5%	4.3%	17.4%	47.8%	26.1%	8.7%	17.4%
AK I	33.3%	25.0%	22.2%	19.4%	34.3%	48.6%	8.6%	8.6%	33.3%	44.4%	11.1%	11.1%
AK II	40.7%	25.9%	18.5%	14.8%	40.7%	29.6%	18.5%	11.1%	33.3%	37.0%	14.8%	14.8%
BH	64.6%	24.4%	8.5%	2.4%	67.5%	24.1%	6.0%	2.4%	74.7%	18.1%	6.0%	1.2%
CY	59.5%	26.2%	2.4%	11.9%	65.1%	16.3%	7.0%	11.6%	67.4%	16.3%	7.0%	9.3%
EA	27.9%	31.1%	19.7%	21.3%	29.5%	37.7%	19.7%	13.1%	37.1%	32.3%	21.0%	9.7%
FP	37.0%	17.4%	30.4%	15.2%	38.3%	29.8%	21.3%	10.6%	42.6%	29.8%	12.8%	14.9%
FR	45.2%	30.1%	11.8%	12.9%	50.5%	30.1%	8.6%	10.8%	61.1%	20.0%	10.5%	8.4%
GV	39.3%	53.6%	3.6%	3.6%	57.1%	39.3%	3.6%		64.3%	28.6%	7.1%	
GO	38.9%	31.5%	18.5%	11.1%	35.2%	37.0%	16.7%	11.1%	37.7%	34.0%	17.0%	11.3%
GH	29.6%	25.9%	11.1%	33.3%	18.5%	33.3%	29.6%	18.5%	25.9%	33.3%	11.1%	29.6%
GR	46.5%	34.9%	16.3%	2.3%	46.5%	37.2%	14.0%	2.3%	60.5%	25.6%	7.0%	7.0%
HC	20.8%	36.5%	22.9%	19.8%	16.7%	31.3%	32.3%	19.8%	19.8%	32.3%	29.2%	18.8%
LVF	14.3%	28.6%	32.1%	25.0%	7.1%	25.0%	32.1%	35.7%	10.7%	21.4%	28.6%	39.3%
LVM	17.5%	27.5%	25.0%	30.0%	17.5%	32.5%	20.0%	30.0%	17.9%	23.1%	35.9%	23.1%
MA	36.1%	31.9%	19.4%	12.5%	43.1%	30.6%	15.3%	11.1%	48.6%	19.4%	16.7%	15.3%
MS	48.3%	27.6%	12.1%	12.1%	34.5%	41.4%	13.8%	10.3%	43.9%	33.3%	12.3%	10.5%
ON	65.9%	14.6%	9.8%	9.8%	73.2%	12.2%	7.3%	7.3%	78.0%	12.2%	7.3%	2.4%
SH	34.3%	28.6%	14.3%	22.9%	25.7%	34.3%	14.3%	25.7%	31.4%	28.6%	14.3%	25.7%
SS	16.2%	35.1%	29.7%	18.9%	29.7%	18.9%	29.7%	21.6%	21.6%	27.0%	29.7%	21.6%
TA	14.8%	25.9%	22.2%	37.0%	3.7%	48.1%	14.8%	33.3%	3.7%	40.7%	29.6%	25.9%
WA	33.3%	33.3%	16.7%	16.7%	47.2%	27.8%	13.9%	11.1%	52.8%	30.6%	8.3%	8.3%
WE	48.7%	20.5%	17.9%	12.8%	52.5%	20.0%	20.0%	7.5%	59.0%	15.4%	12.8%	12.8%
WIF	44.4%	22.2%	11.1%	22.2%	11.1%	33.3%	11.1%	44.4%	11.1%	33.3%	11.1%	44.4%
WIM	43.5%	30.4%	13.0%	13.0%	21.7%	56.5%	8.7%	13.0%	39.1%	34.8%	17.4%	8.7%
WY	37.7%	22.6%	20.8%	18.9%	39.6%	22.6%	15.1%	22.6%	39.6%	32.1%	13.2%	15.1%
TOTAL	38.7%	28.6%	17.1%	15.6%	38.8%	31.2%	16.0%	14.0%	43.9%	27.0%	15.5%	13.5%

Summary of MQA Survey Responses for Visited Prisons

Prison	Q16(d) – Program is Well Organized				Q16(e) – Staff Believes in Me				Q17(a) – Understand and Accept Rules			
	Not True	Somewhat True	Mostly True	Very True	Not True	Somewhat True	Mostly True	Very True	Not True	Somewhat True	Mostly True	Very True
AL	47.8%	30.4%	8.7%	13.0%	34.8%	13.0%	26.1%	26.1%	13.0%	8.7%	34.8%	43.5%
AK I	48.6%	31.4%	8.6%	11.4%	36.1%	19.4%	16.7%	27.8%	2.8%	38.9%	16.7%	41.7%
AK II	51.9%	14.8%	22.2%	11.1%	33.3%	44.4%	3.7%	18.5%		11.1%	48.1%	40.7%
BH	75.9%	14.5%	7.2%	2.4%	70.7%	22.0%	4.9%	2.4%	13.4%	26.8%	28.0%	31.7%
CY	65.9%	20.5%	6.8%	6.8%	61.4%	9.1%	11.4%	18.2%	4.7%	41.9%	16.3%	37.2%
EA	33.9%	35.5%	16.1%	14.5%	29.5%	37.7%	21.3%	11.5%	3.3%	19.7%	31.1%	45.9%
FP	36.2%	21.3%	27.7%	14.9%	41.3%	21.7%	8.7%	28.3%	8.7%	26.1%	26.1%	39.1%
FR	61.3%	15.1%	9.7%	14.0%	40.9%	23.7%	16.1%	19.4%	9.7%	16.1%	23.7%	50.5%
GV	64.3%	35.7%			75.0%	17.9%	7.1%			28.6%	35.7%	35.7%
GO	48.1%	20.4%	24.1%	7.4%	43.4%	24.5%	18.9%	13.2%	10.9%	18.2%	32.7%	38.2%
GH	44.4%	37.0%	7.4%	11.1%	44.4%	29.6%	3.7%	22.2%		33.3%	33.3%	33.3%
GR	55.8%	32.6%	4.7%	7.0%	52.4%	28.6%	7.1%	11.9%	2.3%	16.3%	41.9%	39.5%
HC	31.3%	31.3%	21.9%	15.6%	22.9%	37.5%	19.8%	19.8%	3.2%	15.8%	30.5%	50.5%
LVF	17.9%	21.4%	32.1%	28.6%	21.4%	14.3%	21.4%	42.9%	3.6%	7.1%	14.3%	75.0%
LVM	23.1%	17.9%	33.3%	25.6%	35.0%	25.0%	17.5%	22.5%		15.0%	22.5%	62.5%
MA	43.1%	33.3%	9.7%	13.9%	44.4%	18.1%	29.2%	8.3%	5.6%	22.2%	31.9%	40.3%
MS	55.2%	34.5%	6.9%	3.4%	48.3%	29.3%	13.8%	8.6%	13.8%	15.5%	36.2%	34.5%
ON	70.0%	12.5%	10.0%	7.5%	73.2%	12.2%	4.9%	9.8%	19.5%	31.7%	19.5%	29.3%
SH	37.1%	28.6%	20.0%	14.3%	33.3%	27.3%	12.1%	27.3%	5.7%	14.3%	22.9%	57.1%
SS	24.3%	29.7%	29.7%	16.2%	28.9%	18.4%	15.8%	36.8%	2.8%	30.6%	22.2%	44.4%
TA	14.8%	44.4%	22.2%	18.5%	18.5%	18.5%	22.2%	40.7%		18.5%	22.2%	59.3%
WA	44.4%	30.6%	16.7%	8.3%	55.6%	13.9%	11.1%	19.4%	5.6%	11.1%	25.0%	58.3%
WE	62.5%	2.5%	27.5%	7.5%	55.0%	22.5%	12.5%	10.0%	10.0%	22.5%	32.5%	35.0%
WIF	44.4%	33.3%	11.1%	11.1%	22.2%	33.3%		44.4%		11.1%	11.1%	77.8%
WIM	47.8%	43.5%	4.3%	4.3%	54.5%	31.8%	9.1%	4.5%	4.3%	34.8%	21.7%	39.1%
WY	30.2%	41.5%	18.9%	9.4%	43.4%	15.1%	15.1%	26.4%	9.6%	23.1%	23.1%	44.2%
TOTAL	46.8%	26.4%	15.5%	11.3%	43.8%	23.8%	14.5%	17.8%	6.7%	21.5%	27.8%	44.0%

Summary of MQA Survey Responses for Visited Prisons

Prison	Q17(b) – Participate in Program				Q17(c) – Feel Attachment/Ownership				Q17(d) – Set a Good Example			
	Not True	Somewhat True	Mostly True	Very True	Not True	Somewhat True	Mostly True	Very True	Not True	Somewhat True	Mostly True	Very True
AL	8.7%	13.0%	34.8%	43.5%	43.5%	17.4%	17.4%	21.7%		34.8%	13.0%	52.2%
AK I	5.7%	25.7%	25.7%	42.9%	33.3%	30.6%	22.2%	13.9%	8.3%	19.4%	22.2%	50.0%
AK II		18.5%	40.7%	40.7%	37.0%	33.3%	18.5%	11.1%		11.1%	44.4%	44.4%
BH	11.0%	26.8%	32.9%	29.3%	61.7%	18.5%	14.8%	4.9%	15.7%	31.3%	28.9%	24.1%
CY	7.0%	27.9%	20.9%	44.2%	56.8%	18.2%	11.4%	13.6%	7.0%	20.9%	25.6%	46.5%
EA	3.3%	30.0%	26.7%	40.0%	35.0%	26.7%	20.0%	18.3%	5.0%	23.3%	33.3%	38.3%
FP	10.6%	19.1%	34.0%	36.2%	38.3%	23.4%	10.6%	27.7%	10.9%	30.4%	19.6%	39.1%
FR	9.6%	21.3%	30.9%	38.3%	41.3%	22.8%	12.0%	23.9%	3.2%	21.3%	27.7%	47.9%
GV	3.6%	35.7%	32.1%	28.6%	60.7%	21.4%	10.7%	7.1%	7.1%	32.1%	25.0%	35.7%
GO	9.1%	30.9%	25.5%	34.5%	30.9%	32.7%	20.0%	16.4%	7.3%	29.1%	30.9%	32.7%
GH	7.4%	18.5%	18.5%	55.6%	37.0%	22.2%	18.5%	22.2%	3.7%	14.8%	11.1%	70.4%
GR	4.7%	27.9%	27.9%	39.5%	37.2%	32.6%	16.3%	14.0%	4.7%	20.9%	37.2%	37.2%
HC	5.3%	13.7%	36.8%	44.2%	23.2%	28.4%	31.6%	16.8%	3.2%	13.7%	35.8%	47.4%
LVF	3.6%	3.6%	39.3%	53.6%	7.1%	28.6%	32.1%	32.1%	3.8%	15.4%	30.8%	50.0%
LVM	7.5%	10.0%	30.0%	52.5%	17.5%	27.5%	20.0%	35.0%	2.5%	20.0%	20.0%	57.5%
MA	5.6%	16.7%	31.9%	45.8%	38.0%	25.4%	19.7%	16.9%	5.6%	19.4%	29.2%	45.8%
MS	10.3%	22.4%	24.1%	43.1%	50.9%	24.6%	10.5%	14.0%	12.3%	12.3%	36.8%	38.6%
ON	19.5%	29.3%	29.3%	22.0%	56.1%	26.8%	7.3%	9.8%	12.5%	27.5%	25.0%	35.0%
SH	11.4%	22.9%	25.7%	40.0%	42.9%	25.7%	8.6%	22.9%	11.8%	32.4%	17.6%	38.2%
SS	5.6%	16.7%	38.9%	38.9%	27.8%	22.2%	33.3%	16.7%	8.3%	16.7%	36.1%	38.9%
TA		22.2%	25.9%	51.9%	14.8%	33.3%	14.8%	37.0%	3.7%	18.5%	25.9%	51.9%
WA	11.1%	8.3%	19.4%	61.1%	33.3%	27.8%	11.1%	27.8%	5.7%	22.9%	28.6%	42.9%
WE	22.5%	20.0%	35.0%	22.5%	55.0%	15.0%	17.5%	12.5%	15.0%	27.5%	25.0%	32.5%
WIF			44.4%	55.6%	25.0%	37.5%	12.5%	25.0%		33.3%	11.1%	55.6%
WIM	13.0%	34.8%	34.8%	17.4%	34.8%	39.1%	17.4%	8.7%	8.7%	39.1%	30.4%	21.7%
WY	5.8%	13.5%	38.5%	42.3%	34.6%	21.2%	32.7%	11.5%	5.8%	21.2%	34.6%	38.5%
TOTAL	8.1%	21.0%	30.7%	40.1%	38.6%	25.4%	18.2%	17.7%	7.0%	22.6%	28.7%	41.7%

Summary of MQA Survey Responses for Visited Prisons

Prison	Q18(a) – Staff Supports My Goals				Q18(b) – Staff is Sincere				Q18(c) – Work Well with Staff			
	Not True	Somewhat True	Mostly True	Very True	Not True	Somewhat True	Mostly True	Very True	Not True	Somewhat True	Mostly True	Very True
AL	19.0%	28.6%	23.8%	28.6%	19.0%	19.0%	33.3%	28.6%	10.0%	25.0%	25.0%	40.0%
AK I	30.6%	30.6%	22.2%	16.7%	33.3%	25.0%	25.0%	16.7%	22.9%	31.4%	11.4%	34.3%
AK II	34.6%	34.6%	26.9%	3.8%	30.8%	34.6%	19.2%	15.4%	18.5%	22.2%	37.0%	22.2%
BH	64.2%	23.5%	6.2%	6.2%	57.3%	30.5%	9.8%	2.4%	48.1%	28.4%	17.3%	6.2%
CY	52.3%	25.0%	13.6%	9.1%	58.1%	14.0%	11.6%	16.3%	38.6%	27.3%	11.4%	22.7%
EA	23.3%	38.3%	18.3%	20.0%	17.7%	40.3%	16.1%	25.8%	22.6%	33.9%	21.0%	22.6%
FP	43.2%	15.9%	9.1%	31.8%	34.1%	29.5%	9.1%	27.3%	22.7%	27.3%	20.5%	29.5%
FR	39.6%	26.4%	17.6%	16.5%	43.6%	22.3%	12.8%	21.3%	26.4%	25.3%	23.1%	25.3%
GV	51.7%	37.9%	3.4%	6.9%	58.6%	27.6%	6.9%	6.9%	20.7%	44.8%	10.3%	24.1%
GO	21.8%	40.0%	23.6%	14.5%	34.5%	30.9%	16.4%	18.2%	27.3%	27.3%	29.1%	16.4%
GH	22.2%	33.3%	14.8%	29.6%	18.5%	37.0%	14.8%	29.6%	11.1%	44.4%	11.1%	33.3%
GR	30.2%	48.8%	11.6%	9.3%	32.6%	34.9%	18.6%	14.0%	27.9%	25.6%	20.9%	25.6%
HC	10.4%	32.3%	34.4%	22.9%	15.8%	26.3%	28.4%	29.5%	9.6%	25.5%	28.7%	36.2%
LVF	3.6%	14.3%	46.4%	35.7%	3.6%	17.9%	32.1%	46.4%	3.6%	10.7%	42.9%	42.9%
LVM	10.5%	23.7%	21.1%	44.7%	15.4%	20.5%	23.1%	41.0%	7.7%	25.6%	20.5%	46.2%
MA	27.8%	26.4%	29.2%	16.7%	36.1%	23.6%	23.6%	16.7%	23.2%	21.7%	23.2%	31.9%
MS	38.6%	31.6%	17.5%	12.3%	28.1%	36.8%	19.3%	15.8%	26.3%	28.1%	28.1%	17.5%
ON	63.4%	22.0%	4.9%	9.8%	65.0%	20.0%	2.5%	12.5%	53.7%	22.0%	12.2%	12.2%
SH	25.7%	28.6%	14.3%	31.4%	8.8%	32.4%	23.5%	35.3%	5.7%	37.1%	20.0%	37.1%
SS	10.5%	28.9%	36.8%	23.7%	16.2%	18.9%	24.3%	40.5%	11.1%	22.2%	27.8%	38.9%
TA	7.7%	26.9%	23.1%	42.3%	11.5%	19.2%	15.4%	53.8%	15.4%	15.4%	7.7%	61.5%
WA	41.7%	25.0%	13.9%	19.4%	44.4%	22.2%	5.6%	27.8%	36.1%	22.2%	11.1%	30.6%
WE	47.5%	25.0%	10.0%	17.5%	47.5%	22.5%	10.0%	20.0%	25.0%	32.5%	17.5%	25.0%
WIF	11.1%	22.2%	22.2%	44.4%	11.1%	22.2%		66.7%	12.5%	12.5%	12.5%	62.5%
WIM	34.8%	47.8%	13.0%	4.3%	43.5%	34.8%	13.0%	8.7%	34.8%	39.1%	17.4%	8.7%
WY	23.5%	31.4%	17.6%	27.5%	30.8%	28.8%	11.5%	28.8%	18.9%	32.1%	18.9%	30.2%
TOTAL	32.0%	29.6%	19.2%	19.3%	33.2%	27.0%	16.8%	23.0%	23.9%	27.5%	21.1%	27.6%

Summary of MQA Survey Responses for Visited Prisons

Prison	Q18(d) – Satisfied with My Treatment				Q18(e) – Treatment Meets Expectation				Q19(a) – Feel Good About Progress			
	Not True	Somewhat True	Mostly True	Very True	Not True	Somewhat True	Mostly True	Very True	Not True	Somewhat True	Mostly True	Very True
AL	25.0%	20.0%	25.0%	30.0%	25.0%	40.0%	5.0%	30.0%	9.5%	9.5%	33.3%	47.6%
AK I	36.1%	22.2%	25.0%	16.7%	44.4%	30.6%	16.7%	8.3%	22.2%	16.7%	19.4%	41.7%
AK II	33.3%	25.9%	25.9%	14.8%	48.1%	22.2%	18.5%	11.1%	7.4%	11.1%	33.3%	48.1%
BH	63.0%	18.5%	12.3%	6.2%	70.7%	15.9%	12.2%	1.2%	19.5%	29.3%	15.9%	35.4%
CY	47.7%	25.0%	11.4%	15.9%	65.9%	13.6%	11.4%	9.1%	13.6%	20.5%	34.1%	31.8%
EA	30.6%	27.4%	19.4%	22.6%	38.7%	21.0%	25.8%	14.5%	6.5%	12.9%	33.9%	46.8%
FP	34.1%	15.9%	15.9%	34.1%	43.2%	20.5%	20.5%	15.9%	10.9%	8.7%	28.3%	52.2%
FR	53.3%	12.2%	18.9%	15.6%	56.0%	24.2%	7.7%	12.1%	14.0%	16.1%	24.7%	45.2%
GV	35.7%	28.6%	14.3%	21.4%	71.4%	17.9%	3.6%	7.1%		24.1%	27.6%	48.3%
GO	34.5%	25.5%	32.7%	7.3%	43.6%	29.1%	20.0%	7.3%	11.1%	16.7%	35.2%	37.0%
GH	30.8%	26.9%	19.2%	23.1%	40.7%	25.9%	18.5%	14.8%	3.7%	11.1%	18.5%	66.7%
GR	39.5%	27.9%	14.0%	18.6%	52.4%	23.8%	19.0%	4.8%	14.0%	20.9%	32.6%	32.6%
HC	13.7%	26.3%	29.5%	30.5%	20.8%	32.3%	24.0%	22.9%	7.3%	8.3%	32.3%	52.1%
LVF	3.6%	17.9%	35.7%	42.9%	7.1%	10.7%	39.3%	42.9%	3.6%	10.7%	21.4%	64.3%
LVM	10.3%	23.1%	25.6%	41.0%	15.4%	23.1%	28.2%	33.3%		15.4%	20.5%	64.1%
MA	28.2%	28.2%	23.9%	19.7%	43.1%	20.8%	15.3%	20.8%	5.6%	12.7%	33.8%	47.9%
MS	40.4%	22.8%	22.8%	14.0%	59.6%	19.3%	12.3%	8.8%	17.9%	21.4%	19.6%	41.1%
ON	61.0%	22.0%	7.3%	9.8%	70.7%	12.2%	9.8%	7.3%	31.7%	26.8%	14.6%	26.8%
SH	31.4%	14.3%	20.0%	34.3%	28.6%	28.6%	11.4%	31.4%	11.8%	11.8%	26.5%	50.0%
SS	16.2%	8.1%	45.9%	29.7%	24.3%	18.9%	32.4%	24.3%	2.7%	5.4%	29.7%	62.2%
TA	16.0%	16.0%	24.0%	44.0%	30.8%	15.4%	19.2%	34.6%		18.5%	29.6%	51.9%
WA	38.9%	25.0%	11.1%	25.0%	50.0%	19.4%	5.6%	25.0%	8.3%	13.9%	25.0%	52.8%
WE	48.8%	17.1%	17.1%	17.1%	55.0%	17.5%	17.5%	10.0%	23.1%	7.7%	23.1%	46.2%
WIF	33.3%		22.2%	44.4%	22.2%	22.2%	22.2%	33.3%	11.1%	22.2%	11.1%	55.6%
WIM	34.8%	47.8%	8.7%	8.7%	47.8%	47.8%		4.3%	4.3%	21.7%	39.1%	34.8%
WY	32.1%	18.9%	26.4%	22.6%	45.3%	20.8%	26.4%	7.5%	13.2%	15.1%	28.3%	43.4%
TOTAL	35.3%	21.9%	21.4%	21.5%	45.0%	22.5%	17.1%	15.3%	11.3%	15.8%	27.0%	46.0%

Summary of MQA Survey Responses for Visited Prisons

Prison	Q19(b) – Working on My Problems				Q19(c) – Attempting to Change				Q19(d) – Doing Something about Prob.			
	Not True	Somewhat True	Mostly True	Very True	Not True	Somewhat True	Mostly True	Very True	Not True	Somewhat True	Mostly True	Very True
AL	9.5%	9.5%	38.1%	42.9%	9.5%		9.5%	81.0%	9.5%	9.5%	14.3%	66.7%
AK I	22.9%	11.4%	17.1%	48.6%	2.8%	13.9%	13.9%	69.4%	2.8%	8.3%	27.8%	61.1%
AK II	7.4%	3.7%	33.3%	55.6%	3.7%	3.7%	29.6%	63.0%	3.7%	11.1%	18.5%	66.7%
BH	13.4%	24.4%	19.5%	42.7%	7.4%	12.3%	22.2%	58.0%	4.9%	13.4%	24.4%	57.3%
CY	9.1%	13.6%	40.9%	36.4%	2.3%	6.8%	27.3%	63.6%	4.5%	11.4%	22.7%	61.4%
EA	3.2%	19.4%	29.0%	48.4%	1.6%	8.1%	27.4%	62.9%	1.6%	9.7%	30.6%	58.1%
FP	8.7%	4.3%	32.6%	54.3%	6.7%	6.7%	15.6%	71.1%	4.4%	4.4%	20.0%	71.1%
FR	9.6%	16.0%	24.5%	50.0%	5.4%	11.8%	15.1%	67.7%	4.4%	13.2%	19.8%	62.6%
GV		27.6%	31.0%	41.4%		14.3%	17.9%	67.9%		14.8%	22.2%	63.0%
GO	9.3%	16.7%	38.9%	35.2%	7.4%	14.8%	27.8%	50.0%	7.4%	14.8%	37.0%	40.7%
GH	3.7%	3.7%	14.8%	77.8%	3.7%	3.7%	3.7%	88.9%	7.4%	18.5%	3.7%	70.4%
GR	9.3%	23.3%	30.2%	37.2%	4.7%	9.3%	20.9%	65.1%	2.3%	14.0%	32.6%	51.2%
HC	5.2%	9.4%	31.3%	54.2%	1.1%	6.3%	17.9%	74.7%	2.1%	5.2%	28.1%	64.6%
LVF	3.6%	7.1%	17.9%	71.4%		3.6%	10.7%	85.7%	3.6%		14.3%	82.1%
LVM		12.8%	23.1%	64.1%		5.1%	20.5%	74.4%		7.7%	17.9%	74.4%
MA	4.2%	12.5%	29.2%	54.2%	1.4%	4.2%	20.8%	73.6%	4.2%	2.8%	29.2%	63.9%
MS	12.3%	12.3%	19.3%	56.1%	7.0%	5.3%	15.8%	71.9%	3.5%	7.0%	19.3%	70.2%
ON	29.3%	19.5%	17.1%	34.1%	12.2%	14.6%	14.6%	58.5%	14.6%	14.6%	12.2%	58.5%
SH	8.8%	11.8%	14.7%	64.7%	2.9%	8.8%	5.9%	82.4%	9.1%	15.2%	15.2%	60.6%
SS		8.1%	32.4%	59.5%		2.7%	24.3%	73.0%		10.8%	21.6%	67.6%
TA		3.7%	25.9%	70.4%		3.7%	7.4%	88.9%	3.7%	3.7%	11.1%	81.5%
WA	8.3%	11.1%	25.0%	55.6%	2.8%	8.3%	19.4%	69.4%	5.6%	8.3%	22.2%	63.9%
WE	19.5%	12.2%	22.0%	46.3%	5.0%	7.5%	20.0%	67.5%	7.3%	12.2%	19.5%	61.0%
WIF		25.0%	25.0%	50.0%		25.0%		75.0%			25.0%	75.0%
WIM	8.7%	4.3%	43.5%	43.5%		8.7%	47.8%	43.5%		8.7%	34.8%	56.5%
WY	7.5%	20.8%	18.9%	52.8%	1.9%	13.2%	20.8%	64.2%	7.5%	7.5%	20.8%	64.2%
TOTAL	8.7%	13.9%	26.6%	50.9%	3.7%	8.5%	19.2%	68.5%	4.4%	9.7%	22.9%	63.0%

Summary of MQA Survey Responses for Visited Prisons

Prison	Q19(e) – Accept Responsibility				Q20(a) – Open/Frank Discussions				Q20(b) – Disagreements Resolved			
	Not True	Somewhat True	Mostly True	Very True	Not True	Somewhat True	Mostly True	Very True	Not True	Somewhat True	Mostly True	Very True
AL	9.5%	4.8%	14.3%	71.4%	23.8%	33.3%	28.6%	14.3%	40.0%	30.0%	20.0%	10.0%
AK I		5.6%	19.4%	75.0%	11.1%	30.6%	33.3%	25.0%	13.9%	30.6%	36.1%	19.4%
AK II	3.7%		22.2%	74.1%	14.8%	25.9%	40.7%	18.5%	33.3%	18.5%	40.7%	7.4%
BH	3.7%	11.0%	13.4%	72.0%	28.0%	24.4%	20.7%	26.8%	36.6%	28.0%	24.4%	11.0%
CY	2.3%	4.5%	15.9%	77.3%	37.2%	27.9%	14.0%	20.9%	37.2%	23.3%	32.6%	7.0%
EA		6.5%	12.9%	80.6%	18.0%	29.5%	27.9%	24.6%	14.5%	27.4%	41.9%	16.1%
FP	6.5%		8.7%	84.8%	13.6%	13.6%	25.0%	47.7%	15.9%	22.7%	29.5%	31.8%
FR	2.1%	5.3%	9.6%	83.0%	15.4%	29.7%	22.0%	33.0%	22.8%	35.9%	22.8%	18.5%
GV		6.9%	6.9%	86.2%	17.2%	31.0%	24.1%	27.6%	20.7%	51.7%	17.2%	10.3%
GO	3.7%	5.6%	16.7%	74.1%	20.0%	23.6%	41.8%	14.5%	23.6%	30.9%	27.3%	18.2%
GH	7.4%			92.6%	15.4%	11.5%	26.9%	46.2%	19.2%	34.6%	15.4%	30.8%
GR		7.0%	23.3%	69.8%	24.4%	26.8%	31.7%	17.1%	30.0%	32.5%	20.0%	17.5%
HC		3.1%	11.5%	85.4%	9.3%	24.7%	32.0%	34.0%	19.6%	29.9%	34.0%	16.5%
LVF		3.6%	7.1%	89.3%	7.1%	21.4%	35.7%	35.7%	11.1%	29.6%	33.3%	25.9%
LVM		2.6%	15.4%	82.1%	10.0%	20.0%	27.5%	42.5%	15.4%	28.2%	38.5%	17.9%
MA	1.4%	1.4%	15.3%	81.9%	8.3%	33.3%	27.8%	30.6%	22.2%	19.4%	43.1%	15.3%
MS	5.3%	5.3%	12.3%	77.2%	24.1%	31.0%	25.9%	19.0%	22.8%	38.6%	28.1%	10.5%
ON	4.9%	12.2%	4.9%	78.0%	29.3%	17.1%	19.5%	34.1%	39.0%	26.8%	19.5%	14.6%
SH	2.9%	2.9%	2.9%	91.2%	8.6%	20.0%	17.1%	54.3%	11.4%	28.6%	25.7%	34.3%
SS		5.3%	10.5%	84.2%	11.1%	19.4%	30.6%	38.9%	13.9%	22.2%	33.3%	30.6%
TA		3.7%	3.7%	92.6%	11.1%	18.5%	29.6%	40.7%	18.5%	25.9%	11.1%	44.4%
WA	5.6%		8.3%	86.1%	19.4%	27.8%	19.4%	33.3%	25.0%	30.6%	30.6%	13.9%
WE	5.0%		20.0%	75.0%	37.5%	15.0%	20.0%	27.5%	26.8%	22.0%	31.7%	19.5%
WIF			25.0%	75.0%	12.5%	62.5%	12.5%	12.5%	22.2%	22.2%	55.6%	
WIM		4.3%	17.4%	78.3%	27.3%	45.5%	18.2%	9.1%	52.2%	21.7%	21.7%	4.3%
WY	1.9%	3.8%	17.0%	77.4%	32.1%	22.6%	24.5%	20.8%	30.8%	25.0%	30.8%	13.5%
TOTAL	2.4%	4.5%	12.7%	80.4%	18.8%	25.5%	26.4%	29.3%	24.2%	28.7%	29.6%	17.5%

Summary of MQA Survey Responses for Visited Prisons

Prison	Q20(c) – Participants Are Divided				Q20(d) – Seek Out Variety of Opinions				Q20(e) – Viewpoints Are Considered			
	Not True	Somewhat True	Mostly True	Very True	Not True	Somewhat True	Mostly True	Very True	Not True	Somewhat True	Mostly True	Very True
AL	35.0%	30.0%	25.0%	10.0%	25.0%	50.0%	20.0%	5.0%	20.0%	30.0%	30.0%	20.0%
AK I	45.7%	42.9%	2.9%	8.6%	22.2%	36.1%	25.0%	16.7%	16.7%	41.7%	16.7%	25.0%
AK II	51.9%	14.8%	22.2%	11.1%	14.8%	29.6%	29.6%	25.9%	25.9%	33.3%	18.5%	22.2%
BH	45.1%	19.5%	17.1%	18.3%	32.1%	23.5%	30.9%	13.6%	40.2%	31.7%	18.3%	9.8%
CY	27.9%	44.2%	9.3%	18.6%	34.9%	18.6%	32.6%	14.0%	44.2%	25.6%	16.3%	14.0%
EA	45.2%	33.9%	9.7%	11.3%	24.2%	32.3%	21.0%	22.6%	27.9%	34.4%	21.3%	16.4%
FP	54.5%	22.7%	18.2%	4.5%	13.3%	20.0%	26.7%	40.0%	26.7%	15.6%	22.2%	35.6%
FR	52.7%	25.3%	9.9%	12.1%	22.0%	27.5%	23.1%	27.5%	30.0%	28.9%	22.2%	18.9%
GV	57.1%	32.1%		10.7%	6.9%	44.8%	24.1%	24.1%	13.8%	44.8%	20.7%	20.7%
GO	56.4%	29.1%	9.1%	5.5%	16.7%	31.5%	35.2%	16.7%	33.3%	27.8%	24.1%	14.8%
GH	65.4%	23.1%	7.7%	3.8%	7.4%	29.6%	25.9%	37.0%	11.5%	30.8%	38.5%	19.2%
GR	41.5%	22.0%	19.5%	17.1%	22.0%	24.4%	26.8%	26.8%	26.8%	26.8%	26.8%	19.5%
HC	50.5%	27.8%	13.4%	8.2%	10.3%	25.8%	33.0%	30.9%	14.4%	24.7%	38.1%	22.7%
LVF	57.7%	23.1%	3.8%	15.4%	17.9%	14.3%	39.3%	28.6%	25.0%	25.0%	25.0%	25.0%
LVM	45.0%	20.0%	17.5%	17.5%	12.5%	20.0%	32.5%	35.0%	15.0%	25.0%	35.0%	25.0%
MA	43.7%	31.0%	9.9%	15.5%	11.3%	18.3%	40.8%	29.6%	21.1%	23.9%	39.4%	15.5%
MS	50.0%	15.5%	15.5%	19.0%	24.6%	36.8%	22.8%	15.8%	39.3%	23.2%	26.8%	10.7%
ON	48.8%	29.3%	4.9%	17.1%	24.4%	36.6%	22.0%	17.1%	37.5%	32.5%	12.5%	17.5%
SH	67.6%	20.6%	11.8%		5.7%	25.7%	31.4%	37.1%	11.8%	32.4%	23.5%	32.4%
SS	57.1%	20.0%	11.4%	11.4%	5.7%	20.0%	37.1%	37.1%	8.3%	25.0%	30.6%	36.1%
TA	57.7%	23.1%	7.7%	11.5%	11.1%	25.9%	33.3%	29.6%	18.5%	25.9%	14.8%	40.7%
WA	41.7%	33.3%	13.9%	11.1%	25.0%	19.4%	36.1%	19.4%	16.7%	38.9%	19.4%	25.0%
WE	48.7%	20.5%	17.9%	12.8%	36.6%	17.1%	26.8%	19.5%	37.5%	12.5%	27.5%	22.5%
WIF	37.5%	25.0%	12.5%	25.0%	37.5%	37.5%		25.0%	25.0%	37.5%	12.5%	25.0%
WIM	56.5%	30.4%	13.0%		39.1%	39.1%	8.7%	13.0%	30.4%	52.2%	13.0%	4.3%
WY	45.3%	30.2%	13.2%	11.3%	31.4%	23.5%	21.6%	23.5%	35.8%	28.3%	20.8%	15.1%
TOTAL	49.2%	26.6%	12.3%	12.0%	20.2%	26.8%	28.5%	24.4%	26.3%	28.7%	24.8%	20.1%

Summary of MQA Survey Responses for Visited Prisons

Prison	Q20(f) – People Afraid to Talk				Q20(g) – Not Afraid to Disagree				Q20(h) – Learn A Lot From Opinions			
	Not True	Somewhat True	Mostly True	Very True	Not True	Somewhat True	Mostly True	Very True	Not True	Somewhat True	Mostly True	Very True
AL	18.2%	31.8%	18.2%	31.8%	18.2%	27.3%	36.4%	18.2%	14.3%	33.3%	14.3%	38.1%
AK I	17.1%	40.0%	14.3%	28.6%	13.9%	33.3%	19.4%	33.3%	8.3%	30.6%	36.1%	25.0%
AK II	18.5%	29.6%	11.1%	40.7%	25.9%	7.4%	44.4%	22.2%	18.5%	22.2%	29.6%	29.6%
BH	14.6%	25.6%	18.3%	41.5%	21.5%	26.6%	20.3%	31.6%	29.3%	28.0%	24.4%	18.3%
CY	23.3%	37.2%	14.0%	25.6%	7.1%	21.4%	23.8%	47.6%	18.6%	32.6%	30.2%	18.6%
EA	39.3%	32.8%	14.8%	13.1%	19.4%	19.4%	29.0%	32.3%	9.7%	40.3%	30.6%	19.4%
FP	28.9%	24.4%	20.0%	26.7%	6.8%	4.5%	27.3%	61.4%	6.8%	20.5%	25.0%	47.7%
FR	15.4%	30.8%	17.6%	36.3%	12.2%	23.3%	24.4%	40.0%	15.6%	32.2%	25.6%	26.7%
GV	21.4%	42.9%	14.3%	21.4%	10.7%	14.3%	21.4%	53.6%	10.3%	31.0%	31.0%	27.6%
GO	25.9%	35.2%	18.5%	20.4%	24.1%	24.1%	24.1%	27.8%	12.7%	25.5%	29.1%	32.7%
GH	22.2%	33.3%	11.1%	33.3%	11.1%	18.5%	29.6%	40.7%		15.4%	30.8%	53.8%
GR	17.1%	29.3%	14.6%	39.0%	12.2%	26.8%	22.0%	39.0%	17.1%	34.1%	22.0%	26.8%
HC	27.8%	40.2%	14.4%	17.5%	10.4%	20.8%	26.0%	42.7%	5.2%	19.6%	30.9%	44.3%
LVF	10.7%	17.9%	25.0%	46.4%	7.1%	32.1%	28.6%	32.1%	14.3%	14.3%	25.0%	46.4%
LVM	22.5%	30.0%	17.5%	30.0%	7.5%		40.0%	52.5%	5.0%	17.5%	40.0%	37.5%
MA	18.1%	41.7%	13.9%	26.4%	15.5%	23.9%	32.4%	28.2%	15.5%	28.2%	28.2%	28.2%
MS	31.0%	24.1%	19.0%	25.9%	10.7%	26.8%	41.1%	21.4%	15.5%	29.3%	27.6%	27.6%
ON	26.8%	14.6%	9.8%	48.8%	17.1%	14.6%	26.8%	41.5%	17.1%	29.3%	22.0%	31.7%
SH	41.2%	32.4%	8.8%	17.6%	8.6%	11.4%	25.7%	54.3%	2.9%	34.3%	20.0%	42.9%
SS	24.3%	35.1%	18.9%	21.6%	5.6%	16.7%	30.6%	47.2%	5.6%	16.7%	25.0%	52.8%
TA	37.0%	29.6%	14.8%	18.5%	7.4%	25.9%	18.5%	48.1%	3.7%	40.7%	18.5%	37.0%
WA	8.3%	36.1%	22.2%	33.3%	8.3%	8.3%	27.8%	55.6%	11.1%	25.0%	33.3%	30.6%
WE	43.9%	17.1%	22.0%	17.1%	12.5%	22.5%	27.5%	37.5%	24.4%	12.2%	34.1%	29.3%
WIF	12.5%	25.0%	25.0%	37.5%		33.3%	22.2%	44.4%		33.3%	11.1%	55.6%
WIM	21.7%	34.8%	17.4%	26.1%	9.1%	36.4%	22.7%	31.8%	9.1%	50.0%	27.3%	13.6%
WY	22.6%	32.1%	9.4%	35.8%	15.4%	23.1%	19.2%	42.3%	8.0%	36.0%	16.0%	40.0%
TOTAL	23.8%	31.5%	16.1%	28.7%	13.1%	20.8%	27.2%	38.9%	12.6%	27.8%	27.2%	32.3%

Summary of MQA Survey Responses for Visited Prisons

Prison	Q20(i) – Hard Time if Disagree			
	Not True	Somewhat True	Mostly True	Very True
AL	20.0%	45.0%	10.0%	25.0%
AK I	33.3%	25.0%	16.7%	25.0%
AK II	33.3%	22.2%	18.5%	25.9%
BH	30.5%	23.2%	20.7%	25.6%
CY	23.3%	27.9%	9.3%	39.5%
EA	30.6%	24.2%	14.5%	30.6%
FP	44.4%	22.2%	13.3%	20.0%
FR	22.0%	27.5%	11.0%	39.6%
GV	41.4%	31.0%	3.4%	24.1%
GO	27.3%	32.7%	21.8%	18.2%
GH	55.6%	11.1%	22.2%	11.1%
GR	31.7%	31.7%	14.6%	22.0%
HC	21.1%	27.4%	26.3%	25.3%
LVF	14.3%	28.6%	25.0%	32.1%
LVM	13.2%	44.7%	18.4%	23.7%
MA	21.1%	31.0%	15.5%	32.4%
MS	31.0%	19.0%	12.1%	37.9%
ON	39.0%	17.1%	4.9%	39.0%
SH	62.9%	17.1%	11.4%	8.6%
SS	41.7%	25.0%	8.3%	25.0%
TA	37.0%	14.8%	11.1%	37.0%
WA	33.3%	22.2%	11.1%	33.3%
WE	47.5%	20.0%	5.0%	27.5%
WIF	25.0%	37.5%	12.5%	25.0%
WIM	13.0%	30.4%	30.4%	26.1%
WY	34.6%	17.3%	15.4%	32.7%
TOTAL	30.8%	25.6%	15.3%	28.4%