Western Kentucky University
TopSCHOLAR®

Dissertations | Graduate School

12-1-2011

Assessing the Efficacy of a Modified Therapeutic Community on the Reduction of Institutional Write-ups in a Medium Security Prison

Lee Maglinger
Western Kentucky University, lee.maglinger@ky.gov

Follow this and additional works at: http://digitalcommons.wku.edu/diss

Part of the Educational Assessment, Evaluation, and Research Commons, Place and Environment Commons, Public Affairs, Public Policy and Public Administration Commons, and the Social Psychology Commons

Recommended Citation
Maglinger, Lee, "Assessing the Efficacy of a Modified Therapeutic Community on the Reduction of Institutional Write-ups in a Medium Security Prison" (2011). *Dissertations.* Paper 13.
http://digitalcommons.wku.edu/diss/13

This Dissertation is brought to you for free and open access by TopSCHOLAR®. It has been accepted for inclusion in Dissertations by an authorized administrator of TopSCHOLAR®. For more information, please contact connie.foster@wku.edu.

ASSESSING THE EFFICACY OF A MODIFIED THERAPEUTIC COMMUNITY ON THE REDUCTION OF INSTITUTIONAL WRITE-UPS IN A MEDIUM SECURITY PRISON

A Dissertation
Presented to
The Faculty of the Department of Educational Leadership
Western Kentucky University
Bowling Green, Kentucky

In Partial Fulfillment
Of the Requirements for the
Doctorate in Education Degree

By
Lee Wayne Maglinger

December 2011

ASSESSING THE EFFICACY OF A MODIFIED THERAPEUTIC COMMUNITY ON THE REDUCTION OF INSTITUTIONAL WRITE-UPS IN A MEDIUM SECURITY PRISON

Date Recommended 8-12-11

Director of Dissertation

Donald Nims

Monica Burke

Tony Paquin

Dean, Graduate Studies and Research 4-Nov-2011

Date

Acknowledgements

With gratitude I would like to express my appreciation to my Project Committee Chairman, Dr. Aaron Hughey, the chairman of my committee. His patience and encouragement have contributed greatly to the completion of the project and his generous guidance has been instrumental throughout my graduate work. I would also like to express my appreciation to the members of my dissertation committee, Drs. Donald Nims, Monica Burke, and Tony Paquin for their patience and guidance during this process.

I would also like to thank LaDonna Thompson, Commissioner of the Department of Corrections, Kevin Pangburn, Director of the Division of Mental Health, and Randy White, Warden of Green River Correctional Complex for their support, encouragement, and allowing me to conduct this research.

I would like to thank the staff and clients of the ARCH therapeutic community. They have taught me how to "run" a really unique treatment program that is unlike any other I have been involved in, a true laboratory of learning.

Finally, I want to express a special thanks to my wife, Lisa Maglinger, for her understanding, patience, and encouragement throughout this project. Many times I wanted to give up on it but she just would not except any excuses.

TABLE OF CONTENTS

Page

Acknowledgements …….. iii

Table of Contents …….. iv

List of Tables ……vi

Abstract ……vii

Chapter 1 ……..1

Problem Statement …….1

Purpose of the Study ……..2

Background ……3

Democratic and Hierarchical Types of Therapeutic Communities …….11

Therapeutic Community Concept of the Disorder of Addiction …….16

Therapeutic Community Concept of the Client …….. 20

Generic Therapeutic Community Model…..…… 25

The ARCH Modified Therapeutic Community …….. 36

Kentucky Department of Corrections Institutional Write-Up System …… 66

Chapter 2 …… 69

Literature Review.....……. 69

Conclusion …….. 90

Chapter 3 …… 91

Population and Sample ……... 91

Data Collection ……... 93

Results ……94

Conclusion.....98

Chapter 4 …….....99

Discussion ……99

Conclusion ……106

Limitations 107

Recommendations 108

References …….. 110

Appendix A ……121

Appendix B ……122

Appendix C …….....123

Appendix D …… 125

Appendix E 126

Appendix F 130

LIST OF TABLES

Table Page

Table 1. Demographics of Participants..... 92

Table 2. Distribution of Institutional Write-Ups by Dorm.....94

Table 3. Descriptive Statistics.....95

Table 4. ANOVA Summary Table.....96

Table 5. Pairwise Comparisons.....97

ASSESSING THE EFFICACY OF A MODIFIED THERAPEUTIC COMMUNITY ON THE REDUCTION OF INSTITUTIONAL WRITE-UPS IN A MEDIUM SECURITY PRISON

Lee W. Maglinger December 2011 130 Pages

Directed by: Aaron Hughey, Donald Nims, Monica Burke, and Tony Paquin

Department of Educational Leadership Western Kentucky University

This study explored the impact a modified Therapeutic Community (TC) had on reducing institutional disorder as documented by institutional write-ups. Substance abuse treatment programs are typically evaluated in terms of their ability to prevent relapse and reduce recidivism. The current study examined the efficacy of a modified TC in relation to these parameters but also explored its overall impact on prison safety and security for both the inmates and staff of a medium security prison located in Kentucky. Specifically, the number of institutional write-ups exhibited by clients participating in a modified Therapeutic Community was compared with the number of write-ups exhibited by inmates in five non-treatment units from March 2001 through October 2005. ANOVA revealed that the number of write-ups exhibited by clients in the TC were significantly lower than the number exhibited by inmates in the other five dorms [$F(4, 24) = 5.61$, $p < 0.005$]. Further, when examined by category of offense (major/minor), it was found that the write-ups of clients in the TC generally were not as severe as those exhibited by inmates in the general prison population. The implications of these findings for corrections administrators are discussed and specific recommendations are provided.

CHAPTER 1

Problem Statement

If, according to the African proverb, it takes a village to raise a child, then what would it take to maintain a substance abuse client in a prison treatment program from being involved in institutional disorder? The USA incarcerates more people than any other country in the world. That includes China, which has a much greater population than the US. According to Lipton (1998), seven out of every 10 men in the criminal justice systems are drug users. According to a report by the Pew Center on the States (2008), Kentucky's prison population jumped more than 260 percent from 5,700 inmates in 1985 to more than 20,700 in 2010. This report noted that in 2007, one in every 92 adults in the state of Kentucky was in prison. This was a higher rate than the national average of one in every 100 adults.

According to this same report, the state's inmate population is expected to grow by approximately 1,400 inmates during the next 10 years. The cost of this increase is projected to cost $161 million dollars in operations and construction costs. In 2009, state general funds costs of approximately $513 million dollars were attributed to the Kentucky Department of Corrections (Pew Center on the States, 2008).

Nevada and Kentucky have small correctional systems and were hit hard by the increase in prison populations. In Kentucky, the parole board has broad powers to determine when an inmate is released combined with an indeterminate sentencing structure and thus, they determine the size of the prison system. There are some guidelines as to how much minimum time an inmate must serve, but beyond that the parole board determines whether to grant or deny parole to an inmate. Without a change

in direction, the projections are that the inmate count will grow, over the next decade to nearly 31,000 (Pew Center on the States, 2008).

According to the previously mentioned Pew study (2008), in 2008, US corrections budgets were the fifth-largest category in states total budgets. This was behind health, elementary and secondary education, higher education and transportation in that order. The report goes on to state that correction's budgets come totally from the state's own coffers, while the others involve some matching funds from Medicare, Medicaid, federal matching funds, grants and other funding sources.

Faced with ever-decreasing funds, scrutiny from legislators wanting to make cuts in budgets, and over worked, under paid staff, prison management and administrators are also dealing with the increased numbers of substance abusers being sent to prison. Correction administrators are charged with the safety and security of the public and for the inmates placed in the Kentucky Department of Corrections (DOC). The success of these administrators is based upon keeping an orderly, secure, and safe institution. Institutional disorder, in the form of write-ups, threatens all three of these mandates. The ARCH Therapeutic Community (TC) program presents a treatment approach that addresses all three of these issues while maintaining its focus upon substance abuse treatment. It is therefore, essential that the effectiveness of the TC program be stringently evaluated.

Purpose of the Study

The purpose of the current study was to evaluate the effectiveness of the ARCH Therapeutic Community program in terms of its ability to reduce institutional write-ups compared to those of the general population inmates in a medium security prison. The

efficacy of the ARCH Therapeutic Community program was assessed in relation to its ability to reduce the numbers of and severity of institutional write-ups. This study provides empirical evidence that assists corrections administrators and substance abuse treatment providers as they strive to develop programs that are beneficial to the efficiency of the prison, while providing effective treatment to its substance abuse population.

Background

A press release from the Communications Office of then Kentucky Governor Ernie Fletcher dated August 26, 2004 stated that of the 18,000 men and women serving felony convictions in Kentucky, approximately 4,000 were incarcerated for drug- related crimes. This represents a nearly 300% increase in the number of inmates entering the prison system on drug charges over the past 10 years (Hogan, Lausche, & Keller, 2004). This press release went on to say that over 60% of the inmates were alcohol or other substance abusers, yet at that time, the state was only able to treat 19% of the prison population. The report went on to note that all substance abuse efforts would be coordinated through the Office of Drug Control Policy (ODCP). The ODCP was charged with the oversight of pilot projects specifically for prevention, education and treatment. Within the area of treatment, two areas were emphasized: increasing the number of treatment providers and increasing the number of drug courts.

In response to this initiative, the Kentucky Department of Corrections (DOC), Division of Mental Health (DMH), increased its treatment capacity to its present 1408 inmates. The distribution of the treatment beds are: 661 beds for medium security males, 100 beds for minimum-security females, and 747 beds for minimum-security male inmates. There are no treatment beds for medium security female inmates. Kentucky has

no medium security prisons for females. The security level of an inmate is determined and assigned upon entrance into the criminal justice system at the Assessment and Classification Center. Thereafter, inmates are reclassified on a yearly basis unless the inmate requests a "special reclassification" or if conditions warrant it.

The classification system that the Kentucky DOC uses to classify inmates is based upon the outcome score obtained from the National Institute of Corrections inmate classification instrument (NIC). This instrument, developed in 1982-83, is an objective - based risk assessment that yields a score based upon the crime and escape potential of an inmate. The classification system takes into account the inmate's needs, strengths and weaknesses, information from medical and psychiatric examinations, statutory and correctional guidelines, and information from the pre-sentence investigation (PSI). A validation study was conducted on this system in 2000 to update and increase the reliability of the system (Hardyman, 2001).

There are six levels of custody that inmates are assigned to contingent upon the scores obtained from the classification system. These scores are: maximum, 31 or more points (level 5); close, 19-30 points (level 4); medium, 9-18 points (level 3); restricted, 8 or less points (level A); minimum, 8 points or less (level 2); and community, 8 points or less (level 1). Some types of crimes automatically place an inmate in a maximum security level (e.g. arson, escape, murder). All inmates in the ARCH TC program must meet the scoring criteria of medium level custody. However, once a TC participant has been classified, he will remain in the program until he graduates, quits the program or is discharged no matter what his custody score is.

The model that the DMH adopted prior to 2001 was a traditional approach that included individual counseling sessions, education classes, and group therapy. The program was called the Substance Abuse Program (SAP). Oversight of this program was provided by a branch of the DMH called the Alcohol and Other Drugs of Abuse Department (AODA). There was an inmate to counselor ratio of around 20:1 in this SAP program. With budget constraints and funding problems, DMH was only able to have one program located at the Kentucky State Reformatory. This program had 100 beds with 5 counselors. The program was also not segregated from the rest of the prison community. Inmates would just "show up" for counseling sessions or class and the remaining time they were on their own. As a result, the only sense of community was during the times of group therapy.

In 2001, the DMH committed itself to the Therapeutic Community approach for all of its in-prison substance abuse treatment programs. The training for the staff of DMH, in setting up a TC program, was provided by a consulting firm out of Texas headed by Martin La Barbera. This one week training program was conducted in March 2001 at Rough River State Park in Kentucky. The training involved setting up a generic TC model, dynamics of TC, Confrontation/Encounter group, the role of a counselor in a TC program, and the TC client. This training placed the DMH staff as clients in a generic TC program with the training staff as the treatment team. DMH staff spent the time actually going through typical days in this mock TC. The DMH staff was subjected to the same types of encounters, stress, assignments, and work, much like what would be expected of a typical client in a TC program. A follow up training was conducted in September at the Luther Luckett Correctional Complex. This common training of all the DMH TC

program staff assured that all of the DMH TC programs were unified and providing similar treatment for all of the clients in the state of Kentucky. Success of the TC approach was seen as commitment of all the DMH staff to the concept of TCs.

In recent years, the thinking and focus of corrections in the United States has undergone some major changes. There has been a re-orientation in their philosophy towards those individuals placed under their supervision. This is especially true in the adult prison system. One of the changes involved a shift from exclusive control, punishment, and security, to a focus on treatment and rehabilitation (Wexler, 1995). Overcrowding, in prisons, has caused prison administrators to create programs that parole boards can use to refer inmates to in an effort to rehabilitate the offender. Also, the public wanting to see reductions in the rate of recidivism have put pressure on the corrections system to develop effective programs to combat this. As previously stated, the number of adults in state or federal prisons in the United States was 230 million which makes the incarceration rate at 1 in every 100.

Wexler (1994a) notes another reason for the changes in thinking in corrections has come from favorable results of treatment outcome studies that added to the growing body of evidence based research, and demonstrated prison-based residential treatment programs were effective in reducing recidivism. This was an important strategy for corrections to promote its main goal of public safety and security while providing humane treatment for the inmates under supervision.

The idea of providing rehabilitation to prison inmates came through a long and rather arduous process. Society in general has had the opinion that inmates are hopelessly incapable of any change, and that nothing seems to work to reduce recidivism (Rawlings,

1999). Even the names of some of the prisons in Kentucky indicated the punitive philosophy of incarceration. For example, Kentucky State Penitentiary or Kentucky State Reformatory to name two. All of the remaining prisons are called Correction Complex's. Note the names "penitentiary, "reformatory" and "corrections" as sounding sterile and rather inhumane.

In the early 1970's, punishment and deterrence became the hallmarks of the prison system. Little effort was made to try to rehabilitate an inmate. The prevailing philosophy from the public and correctional system was that they were "getting what they deserved" and "nothing seems to work". It was also during this period that an explosion in drug use and crimes, associated with drug use, intensified in the US. A high proportion of the crimes committed were due to offenders who had severe drug or alcohol related problems (Inciardi, 1979). However, the populations in the prisons continued to rise without a decline in the crime rate (Wexler, 1994b). Nationally, more than half of the inmates who were released returned to prison within three years; either for a new crime or for violating the terms of their parole (Pew Center on the States, 2008).

The public's response to this alarming increase was to put pressure on federal and state officials to enact laws for stiffer sentencing and mandatory lengths of incarceration as a means of creating a harsh deterrence for drug use. President Nixon, in October of 1970 signed the Comprehensive Drug Abuse Controlled Substances Act of 1970 into law. This became the Controlled Substances Act of 1970. This act combined over 50 different federal drug laws into one law aimed at controlling the importation and distribution of illicit drugs in the US. The main aspect of this act was that it created and defined a schedule for drugs. Schedule I are drugs that have potential to be abused but have no

appreciable medical value (e.g., heroine and marijuana). Schedule II are drugs that have a high abuse potential but do have some medical uses (e.g., morphine and cocaine) (Newman, 1970).

Two other laws were passed by the congress in the 1970s that were used to stem the tide of drug abuse. One was the Racketeer-Influenced and Corruption Organizations law (RICO) and the Continuing Criminal Enterprise (CCE) statute. Both of these laws were designed to remove the rights of drug traffickers and of all their personal assets obtained by or used in criminal activities and forfeiture of any ill-gotten gain from drugs (Harrison, Backenheimer, & Inciardi, 1995). The police and other law enforcement agents became the front line of defense in the early stages of the war on drugs. They did their jobs well, with the jail and prison populations increasing significantly. It was at this time that many new prisons started being built.

The decade of the 1980's saw the emergence of "crack" cocaine and with it another explosion of laws and stiff sentences for users and dealers. "Between 1984 and 1999, the number of defendants with drug offense charges in U.S. district courts increased about 3% annually. As a result of increased prosecutions and longer time served in prison, the number of drug offenders increased more than 12% annually" (Scalia, 2001, p. 7). The public began to push the federal government to accelerate its control of illegal drug use through the enactment of more laws.

Four major anti-drug bills were passed during this period. The first of these was the Comprehensive Crime Control Act of 1984. This act enhanced civil and criminal asset forfeiture laws and increased federal sanctions for drug crimes. In 1986, the Anti-Drug Abuse Act was enacted into law. This act restored mandatory prison sentences, imposed

new sanctions for money laundering as well as provided money for treatment and prevention. In 1988 the Anti-Drug Abuse Amendment Act was passed. This act increased the sanctions for crimes that related to drug trafficking. Finally, the Crime Control Act of 1990 was passed. This act was aimed at increasing the appropriations for law enforcement grants, and strengthening forfeiture and seizure statutes (Bureau of Justice Statistics, 1992).

These laws require the offender to serve longer mandatory sentences. The public outcry was for law enforcement to “get tough on drugs and crime". The results were that prisons began to be populated more and more by inmates who had committed drug-related crimes. During the period of the mid 1980s through 2000, drug offenders accounted for 20% of the growth in state inmate population (Harrison & Beck, 2002).

A great many of the alcoholics and addicts, after serving their time, would become rearrested very quickly for the same drug charges. The lesson learned was that putting addicts in prison was not an effective deterrent against crime. It was also not effective in reducing recidivism. This became the basis of the term "revolving doors" of the corrections systems.

In the 1980s, the stage was set for federal laws to be established that would pump millions of dollars into prevention, drug education, enforcement, and drug treatment. In 1986, the National Development and Research Institutes, Inc. (NDRI) began studies to examine drug treatment programs within prisons in the United States. The results of their research indicated that in-prison drug treatment could lower the rates of recidivism (Wexler, 1994). As previously noted, in 1986 the Anti-Drug Abuse Act was passed. A

portion of the funding for this act was earmarked for the development of drug treatment programs in prisons.

It was also around the late 1980s, that the Bureau of Justice Administration (BJA) started pilot projects and expanding drug treatment programs in prisons. The BJA was mandated with the oversight of the funding and administration of the Anti-Drug Abuse Act. Project REFORM was one of the first programs to receive funding from the BJA. The corrections departments of eleven states participated in this five-year funding cycle (1987-1991). Project REFORM set up many substance abuse initiatives and set the stage for the federal government's involvement in prison drug treatment (Wexler, Blackmore, & Lipton, 1991). Project REFORM resulted in the creation of 77 TC treatment programs.

A key element in Project REFORM was training. Corrections administrators and staff at all levels received training in substance abuse issues. Cross training programs were developed for both correction and treatment staff with the goal of making sure that everyone understood the others' function in the institution (Wexler et al., 1991).

In 1988, the Bureau of Justice the Center (BJC) began technical assistance of project RECOVERY. The assistance BJC provided was to 22 states for the initial start up or expansion of comprehensive, statewide correctional drug treatment programs. In 1990, the BJC became Center for Substance Abuse Treatment (CSAT). CSAT continued to provide technical assistance for Project RECOVERY through 1991 (Wexler, 1994).

The funding for project REFORM ended in 1991, and a new national effort began. The newly formed Alcohol, Drug Abuse and Mental Health Administration picked up the funding for project RECOVERY. The aim of the assistance provided by the Alcohol, Drug Abuse and Mental Health Administration, was to continue the work begun by

project REFORM (Lipton, 1998). As a result of these two projects, 110 TC programs were either initiated or expanded by 1997.

In 1997 CSAT became a part of the Substance Abuse and Mental Health Services Administration (SAMHSA). In 1997 SAMHSA was also put under the direction of the U.S. Department of Health and Human Services (DHHS). SAMHSA and CSAT have developed Treatment Improvement Protocols (TIPs) that are best-practice guidelines for substance abuse disorders, including dual diagnosis disorders (substance abuse and mental health). TIPs draw on the expertise and experience of leading professionals and experts in the field of substance abuse, teaching, and research to produce the guidelines for "best practice" in treatment. TIPs are offered to facilities, treatment programs, and individuals in private counseling across the United States (U.S. Department of Health & Human Services, 2004).

Democratic and Hierarchical Types of Therapeutic Communities

De Leon (2000b) notes that TC programs are a “place organized as a community in which all are expected to contribute to the shared goals of creating a social organization with healing properties” (p.12). TC programs are either democratic or hierarchical. However, Vandevelde, Broekaert, Yates, and Kooyman (2004) found that democratic and hierarchical TC programs were not two oppositional models, but were complementary models of the same theoretical approach to treatment.

Democratic TC communities view the clients in treatment as having intense and deep seated psychological disturbances. In the democratic TC program, the crime that the client commits is seen as just one symptom of a psychological problem along with addictions and other problem areas. The aim of treatment in the Democratic TC program

is to reduce all of the symptoms causing a resolution of the psychological problems the client is suffering from.

Democratic TC programs are usually supervised by professionally trained staff such as psychiatrists, therapists, psychologists and probation officers. The first democratic TC emerged in England at Belmont Hospital in 1940 (Rawlings, 1999). Dr. Maxwell Jones founded this first community because he had become frustrated in the failures from traditional psychiatric treatment programs. This TC community was founded to provide structure for individuals who had long term mental disorders. The theory behind the TC approach was that living in a healthy community would make healthy individuals. This model became the prototype of all TCs in England. As a result of his efforts, the term "therapeutic community" came into use (Center for Substance Abuse Treatment, 2006).

The second type of TC community is a hierarchical model. Hierarchical TC programs began out of Synanon Groups. These were self-help groups based upon the principals of Alcoholics Anonymous (AA) and other 12-step support groups (Rawlings, 1999). They were first founded in 1958 at Santa Monica, California by Charles Dedrich. He was a recovering alcoholic who felt AA presented a program that focused only on people who were alcoholic and thus it was too limited, especially in the area of people who were struggling to stop use of illicit drugs. In 1959, this organization was formally founded in order to provide treatment to all addicts regardless of the drug of choice. From 1959 to 1974, Synanon provided new and innovative approaches for treating individuals suffering from addiction problems.

In the late 1960s, Synanon began to make substantial changes in its approach. It moved away from a substance abuse treatment program to a permanent lifestyle

community. In 1978, Synanon closed completely, but other programs across the United States adopted many of its original principles (De Leon, 2000b).

In the United States, the hierarchical model of TCs is the preferred choice. At the time of this paper, there were no democratic TC programs operating in the United States. The hierarchical model is used all over North America. It is in this area that huge drug and drug related crime problems are wrecking havoc upon societies (Rawlings, 1999).

The hierarchical model of TC programs was developed to treat drug addicted individuals. According to Clarke (1997), the hierarchical model's philosophy of treatment maintains that a client becomes addicted to drugs for a variety of reasons, including environmental, biological and learned behavior. He noted that the way to arrest the addiction is through retraining the individual's thinking, allowing the individual to make better decisions on the use of drugs. The underlying problems, psychological or otherwise, may or may not be addressed depending upon the particular TC program. However, retraining the individual is more important in the long run and stands a better chance of helping the individual to maintain long term abstinence. This type of approach relies almost exclusively upon behavioral theories and techniques as opposed to any other theoretical framework (Rawlings, 1999).

Burdon, Farabee, Prendergast, Messina, and Cartier (2002) found that difficulties in the initiatives to implement or expand TC programs in prison settings. This was due to the conflicting core philosophies of TCs and corrections employees. The problem appeared to be because the TC program operated inside the prison and as such, the TC program became "subordinate" to corrections. The conflicting philosophies between the TC program and corrections, combined with the inherent organizational structure of

corrections, put a great deal of constraint on what the TC program would be able to accomplish (Burdon et al., 2002). Therefore, a hierarchical TC program is better suited for the prison environment than the democratic TC program. This reasoning is evident in the rigid structure as defined by the hierarchical TC program alongside more staff input and control. It just works better and makes more sense given the mindset of corrections staff. Hierarchical TC programs use rigid (Cardinal) rules and explicit behavioral norms (Right Living) that translate very well to the prison environment. According to the Treatment Improvements Protocol #44, "hierarchical TC programs maintain a high level of control over their participants, and treatment goals are always secondary to security" (Center for Substance Abuse Treatment, 2005, p.199).

Clients are expected to adhere to these rules and norms, which are reinforced by the use of contingencies (privileges, learning experiences, and sanctions). These contingencies are intended to help the client to develop responsibility, self-control, and are highly appealing to corrections staff. However, Wexler (as cited in Rawlings, 1999) noted prison environments are not able to provide real work situations that are a hallmark of TC programs. He further noted TC programs make use of their graduates in semi-staff roles during the treatment. This presents a real struggle for the corrections staff as it allows the TC program a greater degree of autonomy from their control.

According to Burdon, Prendergast, Eisen, and Messina (2003), TC programs use a variety of methods of graduated sanctions ranging from simple "verbal corrections" to "disciplinary actions or institutional write-ups" and are used by the community to respond to its member's behavioral infractions. They further noted these graduated sanctions and privileges are crucial elements of the hierarchical TC model. Sanctions and

privileges are used in the daily operations of a TC program to express the community's approval or disapproval of all anti-social behavior as well as pro-social behavior.

Clients enter both types of TC programs as volunteers. TC programs are universally volunteer programs. As previously discussed, inmates are "ordered" by a judge to be under the jurisdiction of the Kentucky DOC, they are then sent to the Roederer Classification Center in Louisville for assessment and initial level of custody. It is at this point they are identified as having a drug abuse history or addiction problem and are referred by their Classification Treatment Officer for treatment in a TC program.

Inmates can enter treatment when they meet with the parole board and are then referred for an evaluation and follow the recommendation of the evaluator. This is known as parole upon completion (PUC). This is the most often way inmates are referred into a TC program in Kentucky. It also places the burden of getting the TC program completed upon the inmate.

Inmates can also be court ordered into a TC program directly by a judge. This is known as "shock probation" and is similar to PUC. In this situation the client is shocked out of prison after he completes the treatment.

In all cases entrance into a TC program is voluntary. The TC program administrator reserves the right to accept or deny an inmate into the program. If a client decides to quit, he has the right to do so and will be returned to the general population in the prison. If a client enters treatment due to a recommendation from the parole board or a judge and subsequently quits, notification of his action is made to the PB or judge and the results are usually very punitive. De Leon (2000b) defines a TC program as a group of highly

motivates persons who follow certain interpersonal principles to help them overcome maladaptive behaviors produced by isolation.

Therapeutic Community Concept of the Disorder of Addiction

Individuals who enter a TC program are referred to as clients, residents, or program clients instead of patient or inmate (Maglinger, 2001). The reason this is done is to take the connotation of inmate or convict off of the person who is entering treatment. It is an attempt from the very start of treatment to try and get them into a treatment mode and out of the inmate convict mode. All of the experiences that confront the client upon entering treatment are designed to create a new cognitive orientation that allows for a redefinition of self from a negative isolated individual to a more pro-social one (Nielsen & Scarpitti, 1997).

The average length of treatment varies from thirty days to two years. In a research report conducted in 2002 by the National Institute on Drug Abuse (NIDA), traditional length of stays in a TC program vary from twelve to eighteen months with some component of aftercare.

Clients entering a TC program typically have not learned normal lifestyles, nor have they mastered coping skills necessary to live drug-free lives. As a result, they turn to drug use as their coping mechanism, which is a social response to this situation. This can be overcome in a TC program where skills and conventional values are learned through TC peers serving as role models, as supportive friends, and in group sharing that enhance the learning process (De Leon, 1995). Many times clients enter treatment at health risk and in social crisis. In prison settings they have been immersed in an environment that forces a person into resistive and cynical mindsets. They display little or no ability to maintain

abstinence, have developed socially deviant lifestyles, and their social and interpersonal relationships are bankrupt (De Leon, 2000b). They require the admission to an intensive treatment program, like a TC, in order to stabilize a life that is spiraling out of control. Many times clients report they had to come to prison in order to save their life. Even though that sounds strange to most people, it makes some sense, as coming to prison applies the brake on the spiraling loss of control they feel; allowing them to start over.

Upon admission to a TC program, clients are typically asked, "What is your problem?" A typical reply goes like, "I like to get high man" to which a counter might be given, "That is your symptom, not the problem" (Levy, Faltic, & Bratcher, 1977). These examples demonstrate the concept of the addiction disorder from the TC point of view. The TC treatment concept of addiction encapsulates a disorder of the whole person. It is not the drug that is the problem. The addiction is a symptom, not the essence of the disorder. The goal then of a TC program becomes a total change in lifestyle: elimination of antisocial behavior, abstinence from all drugs, and the achievement of pro-social values (Nielsen, & Scarpitti, 1997).

In a 2004 study, the author noted that a TC program is a living-learning situation. All situations and interactions that happen between a client and staff, in the course of the daily activities, became an opportunity for learning and change to take place. In particular, when a crisis occurred, it presented an opportunity for the client to react in a more pro-social way. TC programs are much like a laboratory for change. The author goes on to point out that the basic mechanism of change in a TC program comes from a wide range of life-like situations where the client can practice, in group or community

meeting, variations of alternatives to these situations in a safe environment (Kennard, 2004).

Clients often deny their own contribution to their problem and many times fail to recognize their own potential for a solution (De Leon, 2000b). TC clients also display dysfunctional behavioral patterns, such as manipulation and impulsivity. These mask and exacerbate their lack of insight into the etiology of their problems. TC programs attempt to address this lack of insight, manipulations, and impulsivity. The TC program begins by helping a client increase their awareness of the relationship between their drug-seeking thoughts or actions and the various emotions or behaviors that trigger the drug-seeking action (De Leon, 2000b).

One of the most important factors in the concept of the disorder involves the client's failure to take personal responsibility for the situation they are in. This involves taking responsibility for their actions and decisions they make. Clients may not be responsible for the genetic predisposition to abuse drugs, their early childhood experiences, how they were raised as a child, or environmental disadvantages. However, they are responsible for their choices and actions particularly with respect to drug use. When a person is in active drug use, they do not have the ability or motivation to make responsible decisions or commitment to sobriety (De Leon, 2000b). One of the outcomes of treatment is a realization that a person has a choice and that includes the choice to not use a drug. Recovery, according to the TC model, is the responsibility of the client, regardless of the development of the addiction. However, clients must voluntarily assume the responsibility for their own recovery.

The use of prescription drugs to aid clients who are undergoing withdrawal is inconsistent with the TC perspective of the addiction disorder. TC programs are not set up for medical detoxification. Clients who need to be detoxified due to recent use or "binge" episodes are referred to hospitals or detox units that are equipped to handle this type of intensive treatment. TC programs can handle routine medications, like those for high blood pressure or diabetes. A key concept in the TC view of the addiction disorder is that the use of drugs leads to avoidance of the challenges incurred in ordinary living. Learning to manage and navigate through those challenges, both the feelings and behaviors, are the hallmarks of "Right Living" and long term sobriety (De Leon, 2000b). The inference here is that psychotropic medications reinforce the disorder and could hinder the recovery process. Right Living will be discussed later in this paper.

According to the American Medical Association (AMA), addictions, either to alcohol or illicit drugs, meet the criteria to be called a disease. The AMA defines a disease as being a disability that it is primary, chronic, progressive, fatal, and treatable (Morse & Flavin, 1992). Lewis (1991) states that addictions commonly contain an underlining biological basis, characteristic signs and symptoms that get worse with time, a lack of intentional causation, and a predictable outcome. In a great deal of cases the outcome results in death either in the form of overdose or as a result of physical problems associated with the adverse effects of the drug.

However, TC programs place more importance on motivation and personal responsibility to change a client's behavior, than they do on the biological or environmental basis of drug abuse. Again, the emphasis is upon the whole person as "disordered" as opposed to a person having a disease. According to Brown (1998), this

general concept of addiction as a disorder also rejects the chronic element of the disease model, even though relapse is inherent in the recovery process.

New advances are happening in the field of addictions medicine. Current research is mounting the evidence as to the role that biological factors play in the etiology of the addiction process. All inherited factors, including certain predispositions, family genetic patterns, and individual genetic makeup, are firmly implicated. However, all of these advances are seen as providing limited understanding and guidance in the treatment of addictions. Recovery from the TC standpoint, involves change in behavior, values, emotions, and attitudes. Responsibility for recovery resides in the addicted person (De Leon, 2000b).

Therapeutic Community Concept of the Client

Clients in a TC program display a wide range of behavioral and cognitive characteristics that drive and exacerbate their addiction problems. De Leon (2000b) notes that the core of the addiction disorder is selfishness. It shapes how they perceive themselves and the world; it motivates their behaviors, emotions, interactions, and communications with others. He also states that TC clients display impulsivity, poor judgment, lack of general awareness, difficulty in making decisions, and a lack of problem solving skills. They have deficits in social, interpersonal, vocational, educational skills, and many have severe learning disabilities.

Clients in a TC program have difficulty with trust issues. According to Bell (1994) the success of a TC program is based upon trust. He notes that it underlies all aspects of the treatment process and is the main reason for dropouts in the program. He further notes that addicts, as a rule, do not trust in others or themselves. They perceive themselves as

being "unworthy" which causes them to have a low sense of worth as a member of society in which they live. They display little self-respect as to their ethical and moral relationships and tend to use manipulation to get what they want. They behave in ways that display a great amount of immaturity and irresponsibility. However, according to De Leon (2000b) all of these low self-esteem issues came before the addiction problem and are caused by childhood and adolescent experiences involving physical, emotional and sexual abuse. These experiences form the basis of mistrust the TC program must address. TC programs emphasize that the clients are able and must change these attitudes and behaviors, to become productive members of society.

Additionally, most clients enter a TC program with lack of self confidence (De Leon, 1990). Given the criminal history of the clients at GRCC, the problem of self esteem and lack of self confidence is especially evident. According to Yablousky (1989) a TC program can have a positive impact upon both self confidence and self esteem.

Clients in a TC program have extreme difficulty identifying and discussing their feelings and emotions. They also have problems understanding, communicating, experiencing, and coping with their feelings. These emotional problems are common among addicts in general and are attributed to general lack of self-regulation and maturity (De Leon, 2000b).

A hallmark characteristic underlying the emotional problems of a client in TC is low tolerance for discomfort. They have shorter delays in their actions to alleviate or escape the discomfort and lower thresholds for tolerating any form of discomfort. This causes them to react to situations in impulsive ways that are more pronounced than people who are not addicted. When faced with discomfort, they will remember the ease and comfort

that the "first" drink or drug brings. Rather than coping with the discomfort they will get "high" to avoid it. When asked about why they immediately use a drug instead of trying to cope with situations, they will tell you "it works, at least for a little while". Their actions are often self-defeating, interpersonally disruptive, and socially deviant (De Leon, 2000b). As a result, when they feel provoked, denied, or impatient, they respond by using drugs.

A common assumption of TC clients is that they have character disorders such as antisocial behavior disorder. If this is correct, they will experience little guilt or shame when they do harm to themselves or others. However, according to De Leon (2000b) this is not totally true. He notes it is not the capacity to feel guilt or shame, but a problem of coping that an addict is demonstrating. Their low tolerance for discomfort combined with selfish motivations results in ineffective ways of dealing with guilt and shame. They respond to shame and guilt by blocking out their feelings, externalizing the causes of their behavior, and use of rationalizations to overcome any guilty feelings they may experience. Finally, in desperation they resort to what has been stated in the Big Book of Alcoholics Anonymous as an "easier, softer way".

One aspect of treatment that is very important in a TC program is for a client to learning how to deal effectively with guilt. The client learns how to identify guilt feelings, the conditions that caused them, and strategies to resolve them. This is done without resorting to blocking them out or the use of drugs (Maglinger, 2001).

The source of a TC client's guilt often comes out, especially in group therapy sessions. According to DeLeon (2000b) guilt can be grouped around four categories: guilt

regarding the self, guilt regarding the family, guilt regarding society, and guilt from being a part of the TC community itself.

The community process itself provides the impetus for all of these categories of guilt to emerge. A client's behavior in the TC program might bring out some deep seeded guilt towards his family or to society. However, because the client is in a caring environment that places a premium on personal responsibility and confrontation, the TC client is able to become aware of the negative behaviors and attitudes that create guilt. They are then able to learn new and effective ways of dealing with those feelings rather than the feelings becoming sources of anger and resentment (Nielsen & Scarpitti, 1997).

According to the National Institute on Drug Abuse (2002), treatment in a TC program is designed to help clients identify, manage and express their feelings in constructive and appropriate ways. In order to accomplish this, TC programs must do several things. These include: increasing self-esteem, change their identities from addicts to recovering individuals, influence their motivation and desire to stay clean and sober, cultivate hope and belief in the recovery process, deal with the underlying issues that led to their addiction, and effect behavioral change (Nielsen & Scarpitti, 1997). Learning how to take personal and social responsibility, good ethics, and behaving as a person should instead of how they have in the past, are key concepts built into the structure of a TC program. In a similar view (Hooper, Lockwood, & Inciardi, 1993), it is important for clients to gain and understand their thoughts and feelings, both positive and negative. It is also essential they take personal responsibility for the resulting actions that arise from those feelings. They must also develop new pro-social thought, feelings and behaviors if they are to have any hope of maintaining a sober lifestyle.

"Clients in a TC program often display an extreme sense of entitlement and exaggerated reaction to perceived unfairness, need for immediate gratification in the form of instant answers, resistance through arguments, and a tendency to manipulate" (De Leon, 2000b, p. 159). They will make statements like "Why do I have to start at the orientation phase, I have already had treatment before?' Why did you let him have a day off and not me?" "Why should I have to wait?" This sense of entitlement demonstrates a common difficulty addicts have in distinguishing between their immediate wants and true needs, their not wanting to put out the effort to earn rewards, lack of being able to manage their frustration and impatience while waiting for satisfaction (De Leon, 2000b). Thus entitlement for an addict is dysfunctional. It hinders a person from becoming self-reliant and it limits a person from developing coping skills needed in the day to day interactions required of all people.

Often clients in a TC program claim the one area they need to work on most is in the area of personal responsibility. They make statements like: “If I can just learn to be more responsible, I can handle anything”. In addition to their lack of responsibility, they also site accountability and consistency as being a major part of their problems. De Leon (2000b) adds that being responsible means being responsible to one’s obligations to self and others, being held accountable means providing an honest record of self, and being consistent demands predictability in meeting obligations.

This section has presented the view of a client coming into the TC environment. It is by no means all inclusive of other behavioral, emotional and other characteristics of individuals who suffer from addiction. According to Greenall (2004), TCs demand that their clients admit they have a problem and they want to change for the better. They have

to confront feelings that they have suppressed for many years, and this sometimes proves to be very painful. At times it feels like having surgery without the benefit of an anesthetic. However, it is the goal of a TC program to provide a medium where change to the whole person can be accomplished.

Generic Therapeutic Community Model

TC programs are the longest and most intensive form of all alcohol and drug treatment programs. There are some differences in the components of prison-based TC programs, but most of them have many common components. They house clients in a segregated unit away from the influences of general population inmates in the prison. This is done to reduce the anti-social patterns that pervade the general population in most prisons and to create an atmosphere that is focused on treatment and rehabilitation. Another commonality among prison-based TC programs is the clients are involved in managing the program. For example, clients monitor other clients for rule compliance, lead and co-facilitate treatment sessions, and maintain the cleaning of the housing unit. They have a confrontational nature where both staff and clients challenge negative attitudes and anti-social behaviors in an open format; yet they are also supportive of each others' struggles to overcome their addictions and better themselves (Mitchell, Wilson, & MacKenzie, 2007).

There are 14 core components in a generic TC: community segregation, community environment, community activities, staff as community members, peers as role models, a structured day, stages or phases of treatment, work as therapy, instruction and repetition of TC concepts, encounter groups, awareness training, emotional growth training, planned duration of treatment, and aftercare (U.S. Department of Health & Human

Services, 2004). These 14 components provide a client with a sense of safety, daily structure, and communication of the values of "right living". These core components will challenge a client's beliefs and values that have developed over the years. In addition, the use of these core components will require a strong commitment from the prison administration in which the TC program is housed.

Prison administration officials tend to view drug addiction as a crime. The response to a crime is incarceration and punishment, which is the function and goal of a prison. A sanction is then imposed in order to punish or deter the offender from committing the same crime again. Rehabilitation or treatment is a secondary issue that is seen as just providing an inmate with "something to do" to occupy the time (Burdon et al., 2002). Craig (2004) found that in general, corrections staff view control-based models as the most effective form of management in jail or prison based settings. The article goes on to point out that the control-based form of management has an inhibitory and at times antagonistic effect upon the performance and goals of a treatment program. Corrections staff are charged with the primary responsibility of safety for both the inmate and staff. According to McEneaney (1996), what makes a TC program work so well in a prison setting is its full daily schedule of work, treatment, learning, and a tight structure that is compatible with the intensive supervision that security demands.

Treatment maintains that drug addiction is a chronic, relapsing disorder that is treatable. The goal of treatment, in a TC program, is to assist the client in the achievement of their optimal level of psychological functioning. “The aim, depending upon the client’s needs, is: prevention, facilitation towards healthy growth, remedial or redirecting a maladaptive

pattern of behavior, enhancement in the quality of life, and assisting the client to compensate for existing limitations to cope" (Hershenson & Power, 1987, p. 5).

According to Charkhuff and Anthony (1979), treatment is the "act of promoting constructive behavioral changes in an individual, which enhances the affective dimension of the individual's life and permits a greater degree of personal control over subsequent activities" (p. 3).

It is important that a safe environment, that is separate from the general prison culture, is conducive to effecting behavioral changes. When clients first enter a TC program, they frequently exhibit characteristics they learned while they were on the streets. They also pick up antisocial characteristics they have learned while in prison (i.e., isolation, distrust, denial, and dishonesty). Collectively, these characteristics are called the "Convict Code". It refers to an inmate's resistance to talking with staff, cooperating with or supporting the security or staff activity and sabotaging as many aspects of the operations in the prison as they possibly can. In a great many prisons, the Convict Code is enforced mentally and physically by the inmates. The TC program uses peer- pressure to confront these antisocial behaviors and Convict Code (Wexler, 1994b). This is especially evident in the group therapy sessions. It is here the clients are confronted about their behavior and learn new skills that allow them to engage in honest and open communications (Lipton, 1998).

Wilson and Snodgrass (1969) conducted a study in a prison TC program. They hypothesized that in order for a TC program to be an effective treatment modality, the clients in the highest level of the TC program would be less prone to convict code and more socialized when compared to the clients in the lower levels of the TC program. The

results of this study confirmed their hypothesis in that convict code adherence and low socialization were related. Their conclusion was that the social organization of the TC program was effective at opposing the convict code.

TC programming attempts to overcome the effects of the "Convict Code" and inmate subculture. It does so by use of the Pull-Up, confrontation, Learning Experiences, and Buddy System. These will be discussed in the next section. These TC tools are aided by housing the clients in areas where they will not be in contact with general population inmates (Lipton, 1998). TC clients housed in a segregated living space, that maintain a safe environment, combined with the aforementioned tools, along with the self-confidence they gain while in treatment, help the client to deal with the negativity of the prison in general, thus arresting the Convict Code.

La Barbera (1998) notes that community activities must adhere to the principal of “form follows function”. He states if an activity does not have a purpose, then it should not be used in the TC treatment program. He also notes clinicians, who have not been trained in social learning theory have a hard time adjusting to the TC model of activities. Especially given that all activities in a TC program have a specific purpose.

In the Office of National Drug Control Policy’s (ONDCP) Final Report of Phase II (1999) protocol, TC programs should contain at least three program phases. The suggested phases include: induction, primary treatment, and re-entry, Standard ST1. The protocol mentions that for in-prison TC programs re-entry should be modified due to the fact that Parole Boards make the decision as to when a client is released. According to Standards ST2 and ST3 of this protocol the phases should include psycho-educational

classes, positive and negative reinforcements, treatment plans that focus on abstinence and psychological growth, connection to 12 Step recovery support groups (e.g. AA, NA), and discharge planning with parole officers or other community supervisory staff. The protocol recommends that this be done at least three months prior to the client being released from prison.

Additionally, De Leon (2000b) stated that the "treatment protocol of therapeutic educational activities are organized into phases that reflect a developmental view of the change process. Emphasis is placed on incremental learning during each phase, which moves the individual to the next stage of recovery" (p. 383). In a generic TC program, this protocol was divided into four major phases (orientation, primary treatment, relapse prevention, and aftercare).

It is essential in all TC programs that the role of the staff and peer graduates is defined. Regardless of the discipline or professional status, the role of the staff is to be the rational authority, facilitator, and guide. Peer graduates come from the TC community as a result of graduation. They become role models who display positive behaviors and reflect the values of the community. Thus, positive role modeling is practiced from the program director all the way down to the client, beginning from the first day they are in treatment. Everyone models the concept of right living, thereby maintaining the integrity of the community. Role modeling also provides support and guidance, thus assuring social learning will spread throughout the program (De Leon, 2000b).

Clients in a generic TC program live, work, and participate in groups. In the process, TC clients learn to control and change their behaviors. Clients develop self-reliance,

responsibility, and become honest with themselves and others, as a result of the role modeling everyone is practicing (U.S. Department of Health & Human Services, 2004). Clients are expected to become active participants in treatment; practicing the skills they learn. This will further build and reinforce their self-confidence and coping ability. Similarly, Nielson and Scarpitti (1997) state that the most important factor for effecting change in a TC program is a community of peers who will serve as positive role models for lifestyle changes, confront a client who displays old behaviors or values, and provide positive and negative reinforcements in order elicit pro-social behavior ways.

In a generic TC program, clients are assigned work in addition to the other more traditional forms of treatment. Work can be anything from manual labor (e.g. taking out trash, sweeping or mopping floors) to holding a position in the community. “Work in a TC reflects the self-help view of substance abuse as a disorder of the whole person. In a TC program, work, is both a goal and a means of recovery" (De Leon, 2000b, p. 144). "A critical component in a TC program is teaching a classic work ethic. It embraces the entire TC perspective. Work, in a TC program, is used to support the program goals, assists in building an individual's self esteem, and reinforces the sense of community" (De Leon, 2000b, p. 78).

In traditional residential substance abuse programs, clients are required to go through the treatment before they return to their work environment or jobs. In a TC program, however, work is considered an essential element, developing self-confidence and consistency in the client. This is consistent with the TC self-help approach where all the clients are responsible for the daily operations of the program. Work also provides clients with a sense of responsibility, to the community as a whole and to each other.

As previously stated, the staff of a generic TC program includes counselors and peer graduates. Optimally, the counselors should be a mix of recovering and non-recovering staff. It gives the staff a good balance. Having non-recovering counselors, as part of a TC staff, prevents role conflict problems in the recovering counselors. Capps, Myers, and Helms (2004) examined non-recovering and recovering counselors in terms of interpersonal and job related stress. The results indicated the recovering counselors experienced higher levels of stress. The recovering counselors had significantly higher professional, as well as interpersonal, efficacy. Recovering counselors indicated that they had insight that their counterparts did not have into the etiology of the addiction. They, therefore, felt more confident in treating addicts. The results of this study made it clear that role conflict and role ambiguity were treatment concerns that require further study.

In a TC program, counselors play an important role and function. Counselors are members of the community and more importantly role model the teachings of the community. Counselors are not "healers" who stand apart from the community. Rather, they are the trustworthy rational authorities, facilitators, and guides that support a mutual self-help approach common to a TC program. They provide education and assessment to the clients as they progress through the treatment process. Individual counseling that takes place in a TC program is different than traditional counseling. Anything and everything that goes on in the community is an opportunity for counseling to take place. These opportunities may be a short intercourse lasting two or three minutes between a client and a counselor. This is opposed to the one-hour traditional session between the same. Called "teachable moments", these short sessions often have a more powerful effect in the change process than hours setting in a closed office.

The main distinction between TC programs and other forms of treatment is the use of the community as the method for changing the whole person. This has been coined as the "Community as Method" approach. According to De Leon (2000b), "the overarching goal of the community is to sustain the individual's full participation in the community so that he can achieve the social and psychological goals of lifestyle and identity change" (p. 23). A counselor should, in most cases, direct a TC client back to the community for answers to questions. This reinforces the idea the community provides help in solving most day to day issues.

TC programs use peer graduates in certain leadership and managerial functions. In the ARCH TC program, discussed later, peer graduates are called Elders. The peer graduates main function is to be positive role models for all other clients to point to. Their presence in the TC community is seen as evidence that an addict can achieve successful recovery. They are expected to role model positive behaviors, and reflect the teachings and values of the TC approach. Wexler (1995) states that ex-addict offenders, working in the TC program, are just as effective as trained clinical staff. He further notes that graduates of TC programs, who use TC graduates in their programs, are less likely to relapse during post-release periods than graduates of programs that do not include TC graduates.

Correction officers (CO) also work in the ARCH TC program and are seen as extensions of the treatment staff. As such, they are members of the community too. COs are the "only" staff on duty during the second and third shifts, (4-12 pm and 12-8 pm). COs, who work in a TC program, can demonstrate to the clients that some authority figures are trustworthy and are interested in their completing the program and going on to a drug free lifestyle. Since they are the "staff" on the second and third shifts, they are the

communicators, and enforcers of the TC message on their shifts. They are also seen as the bridge across the "we-they" gap that exists between clients, counselors, and COs. Finally, they help to legitimize the TC program to the prison administration and especially the other security staff (Lipton, 1998).

However, TC programs present a real challenge for both corrections and treatment staff. Correction officers enforce compliance of institutional rules through negative sanctions. COs favor the use of negative sanctions (punishment) to enforce compliance. Seldom do inmates receive any type of positive reinforcement for engaging in any type of positive behavior (i.e., complying with rules and institutional codes of conduct). This was validated in a series of interviews conducted with the clients and treatment staff at five prison-based TC treatment programs in California. The results of the client interviews indicated that there was too much reliance on negative sanctions and not enough use of incentives or rewards in the treatment process. Indications were that if rewards and incentives were used more often, it would reduce resistance and resentment from the clients (Burdon, Prendergast, & Frankos, 2001).

If COs are not recruited, trained and onboard with the concepts of a TC program, the results can be disastrous. According to a 1999 article, corrections officers can be at odds with the process and philosophy of a TC program. They can also disagree that the TC program is useful at all. If this is the case, they can make life difficult for the client trying to complete it, and the treatment staff trying to run it. They can be disruptive to the harmony and flow of the TC program (Farabee, Prendergast, Cartier, Wexler, Knight, & Anglin, 1999).

Negative sanctions are intended to punish the individual, who violates the institutional rules or codes of conduct. Within prisons, standard operating procedures require that violations, no matter how insignificant, be reported. Sanctions, in the form of institutional write-ups are then issued, to an offender, through a disciplinary protocol system. This ensures the maintenance of order, safety, and security of the inmates and staff (Burdon et al., 2003).

TC programs also use a graduated sanctioning system for infractions of the community's rules. These sanctions range from simple verbal correctives, called "Pull-Ups", to disciplinary actions, and in some cases the issuance of an institutional write-up. A Pull-Up is a verbal statement given by a client, or staff, to another client. These statements are reminders that a mistake is being made or that raises the awareness of a negative behavior. Negative behaviors include motivation (e.g. slouching, not paying attention), lapse in time (e.g. tardiness, attendance), and obligations (e.g. not doing work assignments).

When a client receives a Pull-Up, he is expected to listen to the Pull-Up, and respond with a statement of gratitude (e.g. "thank you, I'll get right on top of that"). The client is also not allowed to give any feedback or dialogue when he receives a Pull-Up. If he does, he has been involved in "dialogue" for which he can be given a learning experience (Maglinger, 2001). Pull-Ups are the first line of treatment tool for a behavior infraction and are focused on a making an awareness of a negative behavior. In the general population, this type of action would result in an inmate being referred to as a "rat" or "snitch". These are very bad words to be called in a prison and usually end up in some sort of violence. The use of the Pull-Up has a profound impact on the socializations of the

clients in the TC program. It is a good way of clients learning how to confront each other in a manner that does not result in violence.

TC programs also use a Push-Up to bring awareness of a client's positive behavior. Again, the client is to listen to the Push-Up and then acknowledge the Push-Up (e.g. "Thank you for that awareness"). Again, no other words are allowed, just acknowledgement of the Push-Up.

Clients enter a TC program from several sources and for several reasons. They can be self- referred with high motivation for treatment. However, one study found that clients who enter treatment under some form of coercion (e.g. parole board, circuit judge, or the result of a positive drug screen) consistently stayed in treatment longer than self-referrals (Messina, Wish, & Nemes, 2001). This study indicates that an indirect relationship between positive outcomes of treatment and legal coercion into treatment might exist. This study further found inmates that are coerced into treatment increased their likelihood of remaining in treatment longer; entering treatment earlier in the addiction process was also a predictor of completion of treatment.

Clients are referred as a result of a meeting with the Parole Board (PB). Depending upon the crime, all inmates are scheduled to meet with PB at regular intervals. At these PB hearings, they can recommend an inmate enter a TC program and complete it before their next meeting with the inmate. It is interesting that the PB only "recommends" the inmate enter and complete the program. In the past, the PB would order an inmate into treatment. In essence, this was the PB taking on the role of clinical staff, which they are not qualified to be. However, inmates take this to mean that it is more than just a

recommendation and failure to complete treatment will almost assure them of getting a deferment.

The majority of TC programs last for at least six months. According to Lipton (1998) research findings indicate treatment periods of 9 to 12 months produce better outcomes in terms of retention and reduced recidivism following parole. Research indicates that the longer a person remains in a TC program, the more likely their rehabilitation and recovery goals will be achieved (Simpson, 1997). De Leon (2000b) further states the length of time in treatment correlates with internalized learning. "Not only are TCs intense in nature but they are long in duration, typically lasting a least 6 months, but usually lasting around 12 months" (Mitchell et al., 2007, p. 355). If the client does not internalize changes made while in treatment, recovery will be incomplete.

Finally, the sense of community is the one key element that confronts all clients in a generic TC program. It is the one element that helps to bring about behavior change. It is the feeling that clients have of being in a family where there is caring and warmth among the other clients and staff. The results are that clients experience a sense of bonding, acceptance, and understanding. This family atmosphere allows TC clients to learn to love and care about others (Nielsen & Scarpitti, 1997).

The ARCH Modified Therapeutic Community

The ARCH TC program (TC program), located at the Green River Correctional Complex, in Central City, Kentucky, was started on February 1, 2001. The Green River Correctional Complex (GRCC) is a 960 bed medium security male prison. The program was originally funded with money from a federal grant and supplemented with state general funds through the Kentucky Justice Cabinet. After 2004, the federal grant was

exhausted and funding for the program was provided with state money. The primary focus of the new program was to provide an intensive residential substance abuse treatment program for the adult males in the prison.

The TC program began as and continues to be a modified therapeutic community. By modified, it means that the TC program was not totally segregated from general population inmates (i.e. canteen, weight pile and gym access, dining room access). Also, modifications were made to the dorm that housed the program. These modifications included offices, phone lines and computer line hook ups. GRCC was never intended to house a TC treatment program. In fact, none of the prisons were designed with any other intention than for housing, feeding, and instituting some form of recreation facilities.

The TC program is located in Building D on the campus of the prison. Specifically it is located in Dorm 3 of that building. Dorm 3 is a 128 bed dormitory. It is a two tier structure with 32 rooms on the upper walk and 32 on the lower walk. Two inmates share each room. Rooms in the prison are called "cells". Dorm 3 was originally designed to be the honor dorm housing one inmate per room. The cells in Dorm 3 are substantially smaller than any others in the prison, due to the design for one man. However, Dorm 3 has never been used as the honor dorm. The reason it was never done was due to a mandate from DOC to double bunk all inmates at GRCC.

This has presented a problem for GRCC in its American Corrections Accreditation (ACA) audits. The ACA is the national organization that sets "standards" for operations of prisons. Over 80% of state and federal prisons are members. Audits are conducted every 3 years. Prisons who maintain their accreditation through the ACA are viewed as exceeding the minimum requirements as set forth in state laws. GRCC has had to

continually be granted an "exemption" for this when the ACA does its audits. This makes the best possible score that GRCC can make a 98%.

The honor dorm is also located in Building D, Dorm 2. Dorm 2 houses 64 inmates who meet the criteria for honor status. This includes good behavior and completion of assigned programs. The honor dorm inmates receive a number of special privileges. It is interesting to note that TC clients, in the ARCH program, are eligible to be admitted to the honor dorm and do get on the waiting list for this dorm. However, they do not get selected due because they are in the TC program.

Dorm 3 is designed on an “open dorm” concept. All of the dorms at GRCC have this concept. The officer’s station is located in the center of each dorm with access to everything. This allows for the correction officer (CO) to observe and interact freely with the inmates in the dorm. It does, however, require a greater ability of the CO in dealing with inmates. In most of the other prisons in Kentucky, COs are segregated from this much contact. The CO is usually the only staff person in the dorm for extended periods of time. This is especially true during the institutional "count times".

Every inmate in the institution is locked into his cell during an institutional count. A "head count" is then taken and the numbers are relayed to the control center. If all inmates are accounted for, the announcement is made that "count has cleared". The inmates are then released from their cells and the institution returns to normal operations. If the count does not clear, then everything stays shut down until everyone is accounted for. That includes every staff member. This is done in order to ensure a hostage situation has not taken place.

Count time is the most stressful time in the daily life of a prison. Counts are taken four times per day. At GRCC they are done at 7:00 am, 12:00 pm, 3:00 pm, and 5:00 pm. At 10:00 pm, all inmates are secured in their cells for the night. When a count is taken, the CO makes rounds in the dorm and has to physically see each and every inmate in his dorm. This is called a "head count". Sometimes a "hard count" is ordered by the administration. This is where the CO must take the bed book and match up each inmate with his picture. The bed book is a notebook that has each inmates demographics and his current picture in it. A head count normally takes about 30 minutes to perform, while a hard count can take up to an hour. Again, it is during these counting periods that the stress level in the prison goes way up.

As noted above, the ARCH program is a modified TC program. Even though the clients are housed in a segregated unit of Dorm 3, they do have access to general population inmates through recreation, medical, canteen, dining, and during the second shift hours. They are locked in their cells from 10:00 pm until 4:00 am.

There is some attempt to control the TC client's access to general population inmates through the program's "Buddy System". The ARCH TC buddy system will be discussed later in this chapter. The Office of National Drug Control Policy (ONDCP), Therapeutic Communities in Corrections Settings Final Report Phase II (1999), highlighted several recommended standards for all TC operations. Under Standard FE.1, the report states, "To the extent possible the program should be a self-contained environment within the larger prison setting. The treatment program should be situated in a special housing unit where there is minimal mixing of treatment participants with the general population" (p.

8). Further, De Leon (2000b) notes “TC programs seek to maintain a social and psychological separateness from the settings in which they are located" (p. 102).

Antonowicz and Ross (1994) note the participants in a TC program should be removed from the anti-social prison culture and allowed to create their own sense of community. They further noted this will ensure the integrity of the TC program and assist in the maintenance of the clients in treatment. Total segregation could not be achieved at GRCC, due to physical restraints, so it was decided the TC program would be a modified TC program. A 2000 study found that modified TC programs tended to rely on counselors more than fully segregated, regular TC programs (Melnick, De Leon, Hiller, & Knight, 2000). The authors of that study stated the main reason for this was due the counselors functioning more in a gatekeeper role than in a segregated TC program.

The training for the TC program staff was provided by the DMH. They contracted a firm from Texas, headed by Martin La Barbera. He introduced the key concepts of the TC model to the staff. The staff spent a week at the Rough River State Park, Kentucky, in March 2001. During this week of training, the consultant staff and the employees from the ARCH and Turning Corners (Luther Luckett Correctional Complex) formed a mock TC program. The employees from the ARCH and Turning Corners made up the clients, of the mock TC program, and the consultants were the staff. A follow up two-day session was held in 2002 at the Luther Luckett Correctional Complex, La Grange, Kentucky. The outcome of the training resulted in the workforce equipped and prepared to implement the TC programs in their respective medium security state prisons.

Prior to admission for treatment, clients complete a Substance Abuse Application, Alcohol Use Disorder Identification Test (AUDIT) (Appendix A); Drug Abuse and

Screening Test (DAST) (Appendix B), and a self completed psychosocial history. The results of these instruments are then reviewed in a face-to-face interview with the potential client. The results of the AUDIT, DAST and personal interview are reviewed with the Diagnostic and Statistical Manual (*DSM-IV*) to see if the client meets the criteria for dependence. A client must meet the criteria for substance dependence in order to be deemed appropriate for treatment in a TC program.

The AUDIT was developed by the World Health Organization in an effort to provide a quick and effective test to measure the degree of alcohol problems. It is a 10 item self-report instrument where the respondent chooses between four possible responses. It yields a quantitative score of the degree of problems related to alcohol misuse. It is reliable, quick, easy to administer, and is useful for diagnosing individuals with alcohol problems.

According to Shields and Caruso (2003), the AUDIT is capable of generally reliable scores across varied sample conditions. Selin (2003) notes, that the test-retest reliability of the AUDIT is high. In a 2009 article, testing the reliability and validity of the AUDIT, the authors found it demonstrated internal reliability and validity. They also found that the AUDIT had a high level of specificity and was able to detect 97% of alcohol-dependent individuals (Moussas, Dadouti, Douzenenis, Poulis, Tzelembis, Bratis, Christodoulou, & Lykoures, 2009). In a study conducted in 2007, the authors found the psychometric properties (test-retest reliability and internal consistency) were favorable. Their conclusion was that the AUDIT was a very useful tool for screening individuals with alcohol use disorders (Reinert, & Allen, 2007).

Harvey Skinner, Ph.D., in 1982, developed the DAST, a 28 item self-report instrument requiring either a “yes” or “no” response to the questions. Its purpose is to yield a quantitative index score of the degree of problems related to drug misuse and to provide a practical and simple test for identifying individuals who are abusing psychoactive drugs.

The DAST has been shown to have very good concurrent and discriminate validity when the results are compared to *DSM-IV* criteria for dependence (Gavin, Ross, & Skinner, 1989). According to a 2007 study of the psychometric properties of the DAST, Yudko, Lozhkina and Fouts (2007), found that it has a high level of test-retest, inter-item, and total item-total reliability. They also found that the DAST had a high level of validity containing specificity and sensitivity.

In order for a client to meet *DSM-IV* criteria for dependence, the client must have at least three or more occurrences in the Substance Dependence Section on the *DSM-IV* Diagnostic Criteria Form (Appendix C). In addition, 95% of the clients also meet the criteria, as set forth in the *DSM-IV*, for the diagnosis of Anti-Social Personality Disorder. Clients admitted to the TC program represent some of the hardest to treat and most resistant to effect change in, due to the presence of these two diagnosis.

Clients are placed in groups of 20-24 per group. The reason they are distributed in this way is to maintain the size of each group and due to Fire Marshall's restrictions on the number of people that can be in a classroom in the Education Building located at GRCC. These groups are then called a “class”. Each class is divided into two groups of 10-12; they become the groups for group therapy. Each class moves through six-week "phase" intervals. Each phase is facilitated by a counselor who conducts psycho-educational classes, individual treatment, and group therapy during the six-week phase period.

The ARCH TC program is composed of the Orientation phase; Bridge phase; Phase A (Freshman); Phase B (Sophomore); Phase C (Junior); and Phase D (Senior) phases. In the Orientation phase the focus is on "compliance" and learning to adapt to the TC environment. In the Bridge phase the focus is upon "conformity" and making the transition to more pro-social forms of relating to others. In Phase A the focus is on Alcohol and Other Drugs of Abuse (AODA) and "consistency". In Phase B, the focus is on Anger Management, Phase C is on Criminal Thinking Errors and "commitment". Finally, in Phase D, the focus is on Relapse Prevention, Aftercare, and also on continued "commitment".

Together, these six phase comprise the total TC treatment program. Clients in the Orientation phase learn to call them collectively as the "four Cs" of treatment: compliance, conformity, consistency, and commitment.

If the client meets *DSM-IV* criteria, he is placed in the Orientation Phase of treatment. A short ceremony takes place on the first day of a client's treatment called "Investiture". The client is called to come up to the front of the daily morning community meeting. He is presented a blue vest and told that he will wear this vest as a badge of honor and as an outward sign of an inward change. The TC community gives him a rousing applause as he takes his seat in the community, within his class. The client will wear this vest the whole time he is in treatment up to the day he graduates. At graduation he will take it off and give it back to the Program Director during the graduation ceremony (Maglinger, 2001).

As stated, this phase lasts for six weeks. During this period, the client becomes thoroughly familiar with the Client Handbook. He is made aware of all of the behavioral

components of the TC program, the rules of the TC program, the Client Incentive Program (CIP) and the Learning Experiences system. The main focus of this phase of treatment is on compliance.

In the Orientation phase, the client learns how "survive" in the TC program. According to Lipton (1998) it is in the orientation phase the client strengthens readiness about needing treatment, reinforces early gains in behavior change, and reduces the anxiety of being in treatment. Survival is dependent upon the client's willingness to make changes from a "yard mentality" to a community mentality.

All of the potential clients are taken from a TC waiting list. Many are transferred from other prisons to GRCC just to complete the program as a condition of release. These clients are referred to as parole upon completion (PUC). These clients have a high motivation to complete the TC program as they will be able to go home on the day of their graduation. Other potential clients enter treatment as a way of enhancing the chances that the parole board will grant them PUC.

According to De Leon, readiness to change is an important factor in a TC program. Many potential clients come into treatment for motivations other than for the main reason to undergo a drug and alcohol treatment program. That main motivation should be to arrest the addiction and its cycle. As De Leon points out, external pressures may bring a person into the treatment process, but after they get in, development of motivation to "change" and live a drug free life will have to ensue in order to keep them in treatment (De Leon, 1990).

It is also during the Orientation Phase the greatest number of dropouts occurs. In a research report on the motivation for treatment, in a prison based TC program, De Leon

(2000a), stated that the first month of treatment produces the highest rates of dropouts from a TC program. He also notes that TC programs, in general, have a low retention and completion rates and that this is due to the total process of TC programs.

The clients of the TC program elect officers to run the community. These officers have very specific job descriptions. They are elected for a six-week period, which coincides with the length of a Phase of treatment. The positions are: Coordinator, Assistant Coordinator, Master of Ceremonies, Environmental Control Coordinator (ECC), Brother RHA-RHA, and Expeditors. These positions plus the Elders and staff comprise the Treatment Peer Review Board (TPR). In addition, clients are taught to call each other "brother" in order to encourage a sense of family in the program.

The TPR board reviews the discipline problems in an open forum. The behavioral problems that the client has been displaying have failed to be resolved by the use of the other TC tools (e.g. pull-up, learning experiences [LE], Bus Stop, and Set Back). At a TPR it is the only time while in treatment a client can and should makes excuses for his inappropriate behaviors. A staff counselor will present the behavior problems and will allow the offending client to explain his behaviors and motivation to remain in treatment. The TPR then votes on a recommendation for action on the problem. This recommendation can be dismissal. TPR will be explained in detail later in this chapter.

Treatment in the TC program starts at 7:00 a.m. All clients are to out of bed, beds made, uniforms in good order, and ready to start AM Development. AM Development is a scripted daily program that allows the staff and clients to engage in meaningful program traditions, rituals and other rites of passage. Each TC client wears a blue vest. All TC clients, as well as all inmates, at GRCC are required to wear a uniform. This is called a

“state issue” and consists of tan pants, shirt and black shoes or boots. They do have the option of wearing their own tennis shoes but they must be white only. The blue vest denotes to security staff and other inmates at GRCC, that the client is in the TC program. It also makes the TC client "stick out" among other inmates at GRCC.

The blue vest has another function that the staff and other TC clients try to instill in those who put it on. As previously stated, wearing the blue vest is an outward sign of an inward change. Clients are told to wear the vest with pride in that they are trying to accomplish something that is very hard to do. According to Patman (2002) a TC program relies on the peer group interactions to help clients confront the reality of their addiction problems, while committing to a lifestyle that will enable them to stay crime and drug free.

At 7:30 a.m. TC expeditors set up the chairs in the dorm day room of the dorm for AM development. The clients then line up by classes and step through a large arch. This large arch is the logo for the ARCH TC program. It is used for AM development, Investiture, and for graduation. As they step through the arch they step over a large wooden wedge with the word “willingness” in-graved on it. This is to represent each client’s willingness to do the requirements of the program for that one day.

Expeditors are clients that are elected by their classmates. They are in charge of setting up chairs, knowing where the members of their group are, getting copies of handouts, and setting on the TPR. They are elected at the start of each phase of treatment.

AM Development then begins with the pledge to the American flag and the song Zippah-Dee-Do-Da. Community awareness’s are given for the day, by clients and staff. A client will then present the thought for the day taken from a book, by Hazeldon, called

Daily Reflections. Clients are required, during treatment, to do three of these presentations. This is one of the things most of the clients say is the hardest thing to do. Getting up in front of the community is very stressful and requires a good bit of courage. They also have to draw a poster, which must pass examination by a staff member, goes along with their thought presentation. Then, all Learning Experiences and other seminars are presented. The AM Development continues with a review of the daily work assignment, and daily schedule boards.

These boards are black boards the ECC and Assistant Coordinator use to schedule and post all work (dorm cleaning) and the daily schedule. Each day's activities are reviewed at AM Development so that all clients and staff know where they are suppose to be and what is going on in the community.

After work and the daily schedule are reviewed, the next business is presentations of any LEs. LE presentations in front of the community provide a certain amount of fun. They are not intended to humiliate a client, but they do put some stress upon a client; especially those who are afraid of "getting up" in front of a crowd. All clients are required, at various times in treatment, to present various seminars, LEs, and other program information to the community. This helps to develop a client's self-esteem and confidence.

AM Development continues with the reading of the Cardinal Rules. The Cardinal Rules are major program norms which, if a client is caught breaking, can be grounds for immediate discharge. One client, chosen at random from the community, reads them aloud in front of the community. The Cardinal Rules of the ARCH TC program are:

1. Three unexcused absences from any scheduled TC activity will result in an institutional write-up and/or other sanctions.
2. No physical violence, threats of physical violence, or intimidation against any person.
3. No stealing or gambling.
4. No drugs, alcohol, or drug/alcohol paraphernalia, as defined by institutional rules.
5. No refusal to participate in any assigned activity.
6. A failed field test drug screen will result in an immediate mandatory institutional drug screen. If positive, the client will receive an institutional write-up and dismissal from the program.
7. If a client is sent to the Special Management Unit (SMU), resulting in disciplinary segregation times assigned, he will be discharged from the program.
8. Anyone breaking confidentiality will be immediately discharged from the TC program.

After the Cardinal Rules are read, the clients stand and recite the philosophy of the TC program. The first TC class completed this philosophy in March 2001. Since then, all TC clients must memorize this philosophy. It appears on every phase test. If a client fails writing it out on the phase test, he has to write it out 50 times in one 24 hour period. This philosophy is an important statement each client makes as to the reason the community gathers together. The TC philosophy reads, "We come together with one common goal to stay clean and sober. We realize that our lives had become unmanageable and we were powerless over our addictions. We will strive, through education and through the help of

one another and a Higher Power, to overcome our addictions, and better ourselves" (Maglinger, 2001, p. 38).

AM Development closes with all clients reciting the prayer for serenity. Clients then disperse and go to their next scheduled activity. AM development takes on an average forty-five minutes to complete. This daily meeting serves to motivate and energize the clients and get their day started on a positive note.

At approximately 3:00 pm, PM Development begins. PM Development is the means by which the ARCH TC program transitions into the evening and prepares for the day ahead (Maglinger, 2001). This is a time when the community recaps what has happened during the day and shifts the program into the evening. Again, the Expeditors set up the chairs in the day room of the dorm. The clients are seated, by class, and a scripted program is conducted that completes the day. Also, any assignments for the next day are gone over and general announcements are made. PM Development closes with the clients, standing, and singing "Happy Trails". This song is appropriate, with the words "till we meet again".

This daily regimen of AM and PM Development meetings happen Monday through Friday of every week. On Saturday and Sundays, AM and PM Development are not conducted. Clients are allowed to sleep in till 9:00 am. On the weekends clients are expected to take care of personal needs. Weekends are also when family visitations occur that allow the client to visit and allow the client to recreate. They are not allowed to interact with general population inmates and must maintain the Buddy System.

During the first week of the Orientation phase, the client attends AM and PM Development, AA or Narcotics Anonymous (NA) meetings, and are assigned work in the

dorm. It is at this point the client is assigned a sponsor. A sponsor is a client who is in the senior phase of the program. The sponsor is assigned by a staff counselor. The clients meet with their sponsor at least twice a week in the dorm. These meetings are designed to give the client feedback on their behavior, attitude, or any problems they are having adjusting to the TC community (Maglinger, 2001).

Orientation is designed to simulate what it will be like in all of the phases of treatment. An Elder manages the TC clients during this period with oversight from a staff counselor. Elders are required to be graduates of the TC program and have met certain criteria that make them especially suited to be role models and guides for new clients in the program. They meet four times a week with the Orientation phase clients. These sessions consist of classes where the first two steps of AA are discussed.

Elders are subjected to a rigorous selection process. As stated, they are required to have graduated form a DOC TC program. They have to have shown the propensity for leadership (e.g. holding a major office while in treatment), have made 90% or above on all phase tests, and did not get an institutional write-up while in treatment. They meet with the Program Director weekly for supervision. They are also required to be working on a "special project" while they are Elders in the program.

Elders teach from a prescribed set of sessions from the Recovery Dynamics Series. This is a pre-printed curriculum that teaches the history of AA and the concepts of the twelve-steps of AA. This introduces the client to being in a class, taking notes and how to behave in the community. It also allows the client the opportunity to receive some additional feedback from a former client who has successfully completed treatment and has assumed a managerial role in the community.

Near the end of the Orientation phase, the client will complete his "Petition for Admittance". This seminar is designed for two purposes. First, it requires the client describe why he thinks he is "now" ready to begin treatment. Secondly, it requires the client to identify five measurable goals that he intends to work on, for change, while he is in treatment (Maglinger, 2001). Once completed, the client will give it to his Elder for approval. It is then presented, by the client, at an AM Development meeting.

An interesting side note to this presentation is that it is very stressful on the new client to do this presentation. First of all, just getting up in front of the whole community provides some stress. The client is faced with the dilemma of coping with a stressful situation requiring him to respond in a healthy manner. Secondly, it puts the client “on the line” as he is telling what the community can expect of his behavior while in treatment. This is something that can later come back to him should he not live up to what he says he will do.

At the end of the Orientation phase, the client takes an academic test over the material he has been taught. He must score at least a 70% in order to pass this test. He then meets with the Elder and a counselor for a Phase Staffing. At this meeting, the academic score, as well as his behavior, attitude, and work responsibility is reviewed and recommendations are assigned. It is at this point the decision is made to move the client into the next phase of treatment, redo the Orientation phase, or discharge from the program.

The second phase of treatment is called the Bridge phase. In this phase the client is introduced to the concept of "Right Living" and the second of the four Cs, conformity.

Clients also must demonstrate that they have started to develop self-discipline and impulse control in this phase.

The concept of Right Living means more than just abstinence from alcohol and drugs. According to De Leon (2000b) "sobriety is a prerequisite in order to learn to live right, but right living is required to maintain sobriety. Living right, for a client, means that they will abide by the rules, increasing in their self-disclosure, participation in group, maintaining good personal hygiene, displaying good manners, respecting others in the program, and keeping all agreements" (p. 74). It also means that the client has adopted four special values: honesty in word and deed, continuous learning, developing responsible concern for others, and a strong work ethic.

In the Bridge phase the client will attend education classes and Big Book (BB) studies. The education classes are a continuation of the Recovery Dynamics course. The BB studies are conducted by an Elder. The clients read the case stories found in the back of the BB and then discuss, with the Elder, how these stories impact them. This is not group therapy, but it is a chance for clients to get to know each other in their group. They will remain in this group throughout the time they are in treatment.

During the fifth week of this phase the clients will complete their "Bridge Seminar". This seminar asks the client to describe how he has changed during the twelve weeks he has been in the program. He must specifically state some behaviors that he has made changes in. When the bridge client completes this seminar, he presents it to an Elder for approval and then presents it at an AM Development of the community. This presentation is similarly stressful, like the one he did in the Orientation phase.

At the end of the Bridge phase, the client again takes a phase test. He must score at least a 70% in order to pass the test. Again, he will meet with his Elder and staff counselor for a Phase Staffing where his academic score, behavior, attitude, and work ethic will be reviewed and recommendation made to move to the next phase of treatment.

Phase A is called the AODA Phase and the client is referred as being in the freshmen class. This phase teaches the client about the impact substance abuse has on his physiological and psychological functioning. The information is presented, in lecture format, and describes the major categories of substance abuse and why continued use is problematic to the client's health and freedom. The information also explains the biological powers of addiction and how psychological dependency develops (Maglinger, 2001).

The concept of addictions being a "whole person" disorder is taught during Phase A. All of the common elements of the disorder including detoxification, withdrawal, craving, and dependency are seen in a wider context of the client's recovery and life. "In the TC view, dependency describes the continuous behavioral, cognitive, and emotional preoccupation with drug use. The daily life of the addict is dominated by drug seeking, as well as thoughts, feelings, and social contacts related to the drug use" (De Leon, 2001b, p. 42).

Group Therapy is introduced to clients in Phase A. Group therapy is made up of the staff counselor, Elder, and between 10 to 12 clients. Clients will remain in their assigned group throughout the treatment program. Group therapy is a safe environment that encourages a client to self-disclose the challenges he is facing and the changes he is making while in treatment with his group members. Clients are encouraged to engage in

self disclosure in order to learn their experiences are similar to others. In this way they will learn that their situation in not so unique. They will also start to discover that support comes from the group therapy process.

The Center for Substance Abuse Treatment, TC training manual (2006) states that group therapy helps clients to relate to other clients' experiences with drugs and alcohol, receive positive and negative feedback from staff and peers, gain insight into the etiology of their behavior and that of other clients, express intense emotions in effective ways, and role model appropriate group behavior.

Group therapy affords the client opportunity to fully address his personal issues. De Leon (2000b) states that group therapy is the appropriate time and place for the client to learn some practical skills, resolve any conflicts inside and outside the program, express feeling and emotions, and reflect on the concepts learned. Group therapy also allows the client to experiment with new ideas, concepts, and more effective behaviors in an atmosphere that is accepting and encouraging. The aim of group therapy is to provide a medium for self-disclosure and free expression of emotions without the fear of any reprisals (De Leon, 2000b). Clients are then able to respond to each other out of "responsible concern". The development of responsibility is a major aim of the TC program; and concern is the way TC clients are to act towards each other. Clients have a responsibility and concern to themselves, the other clients in treatment, and to the TC community in whole. Clients soon learn that in group therapy they can share authentic personal information and develop trust in a safe environment (De Leon, 2000b).

In a TC program, the hallmark type of group therapy is known as the encounter group. De Leon (2000b) states that it demonstrates, by example, most of the TC Clients core

values: confronting reality, honesty, self-awareness, compassion, and responsible concern. It is used to resolve a variety of community and individual issues. A specific type of encounter group is the confrontation group which will be discussed later in this section.

In the encounter group sessions, clients are encouraged to challenge each other's behaviors, attitudes, and motivation for treatment. They can do so without the fear of any reprisal or inhibition within the group therapy setting. It is during these encounter group therapy sessions that pressure from peers helps to break down barriers that prevent the expression of emotions and resistance to change. Peer pressure encourages clients to express their emotional problems in the "here and now". Discussing emotional, behavioral, and motivation problems in this format encourages clients to identify with the issue being discussed and give feedback or encouragement to each other. The purpose of a TC encounter group is to change or modify the behavior, insure personal responsibility, and not seek explanation or comprehension. Since the purpose is to change behavior, no excuses are accepted to justify client irresponsible behavior (Broekaert, Vander Straten, D'oosterlinck, & Kooyman, 1999).

The idea of "no excuses" is not the sole concept of TC. It is a hallmark of Reality Therapy, founded by William Glasser. According to Glasser "a therapist is not interested in listening to a client's excuses, blaming, and explanations of why his plans failed. Instead of focusing on why things went wrong, the therapist should focus on what the client intends to do to accomplish what he decided to do" (Corey, 1977, p. 165). In the TC program the question that is asked is not "why" something did or did not happen, but "when" can it be expected to happen.

Group therapy serves as a "reality check" where attitudes and behaviors that support and define the concept of Right Living are reinforced; while those that do not support Right Living are challenged and changed (Maglinger, 2001). According to De Leon (2000b), right living from a TC perspective includes "certain shared assumptions, beliefs, and percepts that constitute an ideology or view of a healthy personal and social living" (p. 73).

Another type of group therapy used in the TC program is a confrontation group. Confrontation group creates an arena to raise an individual's and the community's awareness of negative or destructive behavior. This creates an opportunity to teach appropriate behavior that would be consistent with the community's definition of right living (La Barbera, 1998).

The goals of a confrontation group are to: communicate a message, teach respect for rules, and teach how to change behavior, maintain order in the community and allow ventilation of hostility and aggression in an appropriate setting. This group therapy tool is very structured with specific instructions given, by the counselor, to the clients who will be attending the session.

The confronting client must request a confrontation group in writing. This prevents a client from requesting a confrontation before using the other tools of the program first (e.g. pull-up, written pull-up). The group members set in a circle around the two clients involved in the confrontation. Two chairs are placed in the circle with the confronting client facing the client he wants to confront. They both set upon their hands during the confrontation. The confronter then states, "This is not about you, this is about your behavior". The confronter then goes on to state what he finds frustrating about the

behavior of the recipient. The recipient must paraphrase back to the confronter what he has just said. In this way, the recipient is forced to listen to the confronter tell him how he sees him behaving, pointing out that his behavior is in conflict with right living.

Even though the emphasis changes from Phase to Phase, clients will be in group therapy throughout treatment. Therefore TC clients will either be in an encounter group or confrontation group through out the treatment program.

Clients may request, or staff may schedule, an individual counseling session. These sessions are to help the client with a specific problem or for work on a treatment plan goal. Individual counseling is not used very often in the TC program. It is hard to schedule individual counseling sessions due to the fact the counselor's time is well managed by the daily activities. De Leon (2000b) notes, "… it is limited in order not to subvert the residents' use of the feedback from peers and in groups" (p. 199). Clients commonly state, when they enter treatment, that they do not "do well" in a group situation. By this they mean that they are not willing to self-disclose in a group of inmates. Clients enter treatment with what is called a "convict mentality". This attitude imparts that, "I will do my time and you do your time and don't mess around with my parole". As has been discussed, in group therapy, clients are not able to keep this façade up. Burdon et al. (2002) adds "TC participants, most of whom have become indoctrinated into the prison subculture, with its taboos on self-disclosure and sharing of personal information, have difficulty discussing personal issues in group settings" (p. 6).

At the end of Phase A, the client again takes an academic test. Following the test, the client attends a Phase Staffing with the Elder and counselor. The client's progress is discussed, assignments are given and the decision is made to either require the client to

redo the phase or move to the next phase. Once this process is completed, the client moves into Phase B or the sophomore class. This process of testing, staffing and decision to promote or redo the phase will be completed two more times.

Each Phase of the TC program has its own focus. Phase A has been covered. Phase B is focused on anger management. The goal of this phase is to help the client to reduce the emotional feelings and physiological arousal that anger causes.

In Phase B, all TC clients must complete a "mandatory" written pull-up. Many clients, especially those who are forced into the treatment program or those who continue to try to maintain some contact with the negative influences of general population inmates, often exhibit resentment and resistance to efforts to get them engaged in the treatment program activities (Burdon et al., 2003). By use of the mandatory written pull-up, the program begins to break down this resistance as clients come to see that everyone is holding each other accountable. In the TC program this is called "watching over" a brother.

Phase C (junior class), is focused on criminal thinking errors. The goal of this phase is to help clients identify and alter thinking patterns that support and maintain criminal thinking patterns characterized by offender populations. Phase D (senior class), is focused on relapse-prevention and aftercare. The goal of this phase is for the client to understand relapse “triggers” and how to prevent them from leading to relapse. Clients also develop an aftercare plan they will use when they make parole.

During the fifth week of Phase D (Senior), the client will complete a Final Seminar Form. Once it has been completed, it is given to the Phase D counselor for approval. The phase counselor will review this form for accuracy and honesty. If the form meets the

counselor's approval, then the client will present it at the next available AM Development meeting. In the Final Seminar, he addresses two issues. First, he describes some things he has learned while in treatment, and how it has impacted change in his life. The second issue is what he intends to do with what he has learned. Finally, the client makes a public review of his behavior during treatment and a review of the goals he set for himself in his Pre-Sap First Seminar.

If clients display inappropriate behavior, break program rules or the institutional code of conduct, the consequences are that they will receive a TC Sanction (e.g., pull-ups, written pull-ups, learning experiences, bus-stop, and set-back). The sanctions can also be institutional write-ups (e.g., disciplinary actions, loss of good time credit, extra work duty, and placement in special management unit). However, an institutional write-up is not the first choice of use for the staff of TC programs. Burdon et al. (2003) found that TC staff, when responding to behavioral transgressions, placed a priority on imposing TC sanctions as opposed to using standard correctional sanctions such as write-ups.

Prisons, by their nature, enforce compliance with their rules and conduct codes through the use of negative sanctions. To inmates this is known as punishment. In like manner, the ARCH TC program uses its graduates sanctions system described above. According to De Leon (2000b) sanctions are essential components of TC programs. They are used to express the extent to which the community disapproves of behaviors that are not in keeping with TC norms. Therefore, both the institutional and TC sanction systems may come into play with a TC client for the same behavioral infraction.

As has been stated earlier, the Pull-up is the first applied corrective measure for inappropriate behavior. When this does not work, or does not illicit the desired behavior

change, then a written pull-up can be employed. A written pull-up is completed on a Written Pull-up Form and it is then submitted to staff for their review. Written pull-ups are the appropriate method to bring a negative behavior to the awareness of the community or staff. Written pull-ups also allow for the possibility for a Learning Experience to be assigned by a staff member (Maglinger, 2001).

Learning Experiences (LE) are assignments given by a staff member as a natural or logical consequence resulting from an inappropriate behavior. They are not punishment, but instead are disciplinary measures used to encourage a client to make better choices in the future. They are not write-ups and do not affect a client's parole. They are not kept in a client's file and once they have been completed, they are discarded. According to De Leon (2000b) "However, learning experiences are special assignments for a particular resident to achieve a targeted behavioral or attitudinal outcome" (p. 225). In addition, clients are not allowed to dialogue about or too a staff about the LE they receive.

The authors of a study conducted in 1997 stated that LEs result in raising the awareness of a client's actions, leading the client to make changes in his behavior so that it is consistent with the TC programs expectations. This has impact on the new clients and makes them act in ways the TC program requires; thereby encouraging positive behaviors to become internalized (Nielsen & Scarpitti, 1997).

After a client has been in the program for a period of time, they can then "give back" the knowledge they have learned through role modeling. This allows them to demonstrate to the newer clients what a person can accomplish with the proper attitude and motivation. This also further perpetuates the social learning environment and structure of the TC program (De Leon 1990; Yablousky, 1989).

A Bus Stop is a special type of LE. It is employed in an effort to resolve problematic behavior or when a problem is particularly serious so as to threaten the safety or security of the program. A Bus Stop can be authorized by the Program Director only. When a client is placed on Bus Stop, he must pack up all of his possessions and bring them down to AM Development at 7:30 AM. He places his possessions in clear view of the community. He then stands at the appointed time and announces to the community, "My bags are packed".

After AM Development is concluded, he then takes his possessions back to his cell and unpacks. At PM Development, he again packs up all of his belongings and places them in clear sight of the community. At the appointed time, he again stands and announces, "The bus stops here, may I get off?" It is at this point a staff counselor makes the decision when the client can unpack for the night.

Bus Stop can be assigned for any number of days and it always includes weekends (Maglinger, 2001). In addition, a TC client who is on Bus Stop must place a large stop sign on his door that alerts the whole community that he is on Bus Stop. This is not done to humiliate the client but to remind all clients they too can end up with this major LE as a result of negative behavior. In this way, Bus Stop is seen as a deterrent.

The ARCH TC program also employs another special sanction called a "Set Back". The Set Back is an action employed as a last resort before the use of a write-up or discharge from the community. The client is required to repeat a portion of the program or even to start the program over again. This is intended to give a client a last chance to make changes in his behavior. As per TC policy, a client who fails a phase test will receive a Set Back in order to repeat that phase.

If a client receives an institutional write-up, he will also receive a TC sanction. The TC sanction is determined by the category of write-up the client receives. This practice is known as "double jeopardy" and can have a negative impact upon the motivation, treatment morale, and treatment effectiveness. However, it may be unavoidable in some cases. Given the rationale of both systems, they may serve complementary purposes. TC programs sanctions serve the purpose of reinforcing the core values of the TC program, while corrections sanctions serve the purpose of maintaining security, safety, and order within the prison as a whole (Burdon et al., 2003).

A category 1 write-up requires one week of LEs, and placement on Bus Stop for one week; a category 2 requires two weeks of LEs, and placement on Bus Stop for two weeks; and a category 3 requires three weeks of LEs, and the client is Set Back a phase. A category 4 or above write-up, is determined on a case-by-case basis and can be grounds for dismissal from the program.

The TC program employs a “Buddy System” to segregate them from contact with general population inmates in the prison. The Buddy System is an attempt to keep the client focused upon treatment. Lipton (1998) notes that clients in a TC program need isolation from general population inmates in order for them to detach from old networks. Segregation also allows for the development of relationships among the peers in the program. De Leon (2000) also notes that grouping clients into their own inner community creates a new peer culture, new values, and a new lifestyle that is intended to replace the old destructive ones. The TC Client Handbook states “Clients will be in the company of other TC clients at all times when outside of Dorm 3. Clients may choose any TC client or Elder, who is willing, to help them get to their destination” (Maglinger, 2001, p. 17).

The Buddy System is in effect every day. The only exceptions being when a client is going to sick call, pill call, court call, classification, or visitation. These exceptions are where a client cannot take another client with him.

The TC Buddy System encourages clients to limit their contact with general population inmates for several reasons. Getting around the yard becomes difficult with a constant TC companion. It also has a dampening effect on a TC client trying to make contact with a general population inmate due to the buddy not wanting to "hang around" while he talks to the inmate. Breaking the Buddy System is a major infraction in the TC program. The LE that is imposed upon a client is rigorous. It includes having to have two buddies instead of one, writing the first 164 pages of Alcoholics Anonymous Big Book (BB), a seminar on a topic chosen by a staff member, and placement on program probation. A final benefit of the Buddy System is that the buddy may either act as a positive role model or convince the client to refrain from negative behavior (e.g. take drugs from a general population inmate). This would save him from a situation where he would jeopardize his treatment.

When a client's behavior becomes too resistive, or it jeopardizes the safety and security of the program, he is then referred to Treatment Peer Review (TPR). This is the most intense and punitive tool the TC program employs as a form of sanction. Only a staff member may refer a client to a TPR. This normally happens when the client has been issued a written pull-up that is deemed by a staff member as to require its use. The TPR is made up of the TC clinical staff, Elders, and representatives of the TC community.

The client who is referred to a TPR attends the meeting and stands in front of this group. He has in his hands his vest, his program notebook and his copy of the BB. A staff member reads out the written pull-up and all other behavioral infractions he has committed up to that point. Staff, Elders, and TC clients can then ask questions of this client, mostly to the client's motivation to remain in treatment. The client may now defend himself. This is the only time in treatment a TC client is encouraged to make an excuse or otherwise defend himself.

At the end of a TPR, the client leaves the room and everyone votes on an outcome. No further discussion is allowed and a secret ballot is taken. There are only 3 outcomes on a ballot; behavioral contract, set back, or discharge. Voters can only vote for one of these. When a voter makes his choice, he folds up the ballot and brings it to the staff's table and drops it in a bucket saying "for the good of the community". The votes are then tallied. If the most votes are for a behavioral contract or set back is determined the client is brought back in front of TPR and given these results. If TPR outcome results in a discharge, then the client is told to leave. The staff will then dismiss the TPR and decide if they want to act on that recommendation.

In addition to the Pull-Up system, the ARCH TC program uses Push-Ups as immediate acknowledgements of positive behavior or attitude. Staff and TC clients use the Push-Up as positive reinforcement to strengthen and encourage targeted behavior in order to encourage them to reoccur. Burdon et al. (2003) notes, “Seldom, if ever, do inmates receive positive reinforcement for engaging in pro-social behaviors (i.e., complying with institutional rules and codes of behavioral conduct)” (p. 49). The intent of the push-up is to affirm any sign that a client is making positive change or to

encourage the client who is having difficulty in adapting to the TC treatment environment. The use of a Push-Up is also seen as a balancer for the Pull-Up (De Leon, 2000b).

Burdon et al. (2003) also note the correct role for Pull-Ups in the TC program is to facilitate change in the clients' cognitive processes by encouraging the clients' engagement in all program activities. They also note that targeted behaviors should be those that cause the client to want to participate and become involved in the treatment process. According to the TC trainers' manual, from the Center for Substance Abuse Treatment (2006), Push-Ups are important because they serve as self reinforcement for the client giving one, and encouragement for the client receiving feedback from one.

All of the tools mentioned in the TC arsenal (e.g. pull-ups, push-ups, LEs, confrontation group, Bus Stop, and TPR) are intended to teach the clients hold each other responsible and accountable for their daily behavior and actions. Through the use of these tools, clients learn to become positive role models for each other. In the TC program this is seen as more than "watching out" for a TC brother; it is more akin to "watching over" a TC brother. Watching over a brother requires the client to act in ways that will take him out of his comfort zone, challenge the convict code, and force him to act in pro-social ways. Watching over a brother requires a client to correct a peer's behavior when it is required of him to do so. This is in direct contrast with normal prison day to day activity. According to Patrick (as cited in Dietz, O'Connell, & Scarpitti, 2003) the tools of TC act in ways that are in contrast to the convict code view that all inmates are a group of individuals struggling against the mandates of the administrators and the rules of the prison.

The TC program creates an environment that is conducive to helping an individual in their efforts at recovery. The aims of the program are to bring about a total change in the whole person, to change negative behavior patterns, thinking and feelings, sub-planting them with a responsible drug-free lifestyle. De Leon (1995) states that in order to maintain "stable" recovery, an integration of emotions, skills, attitudes, conduct, and values must take place. He further points out that treatment is made available to a client in the TC community environment through the daily regime of group therapy, individual counseling, meetings, work, and interactions with staff and peers. The effectiveness of these tools is dependent upon the client who must fully engage in the total treatment process. Recovery in a self-help TC environment means that the client must make the major contribution to the change process.

At the writing of this paper, the TC program was celebrating over 10 years in existence. Its current class (60) was in their senior phase with over 750 graduates to date. It continues to evolve as a treatment platform constantly seeking new and innovative ways to assist clients to overcome their addiction.

Kentucky Department of Corrections Institutional Write-Up System

When an inmate commits an infraction of an institutional rule, or breaks the conduct code, the result is he receives an institutional write-up. Corrections Policies and Procedures (CPP) require that the write-up (see appendix D) be issued as a means of maintaining security, safety and to deter the behavior from re-occurring. The institutional write-up system works in tandem with the TC Sanction system; it supports and reinforces the core TC community values. When a TC client is given a write-up by the institution, he also is given a TC Sanction by the program, for the same offense, as delineated above.

This situation may seem to be unfair, to the TC client. However, TC clients are held to a higher standard than general population inmates. Tomry (as cited in Burdon et al., 2003) states that it is important for protocols to be established and followed by treatment and correction staff. This is especially true when assessing infractions and applying sanctions, in order to eliminate the disparities that are inherent in the two systems.

The institutional write-up system consists of seven categories of offenses. Each category has a number of violations that are grouped together because they are similar in their severity. The categories 1 and 2 are Minor Violations (e.g. Category 1.6 is improper or unauthorized use of a telephone, Category 2.2 is disruptive behavior). Each category (see appendix E) is also assigned a minimum and maximum penalty (e.g. Category 1.6 minimum penalty of 1 and maximum penalty of 4, Category 2.2 minimum penalty of 2 and maximum of 5).

When a staff member issues a write-up, it is entered into the Kentucky Offender Management System (KOMS) computer system on an Institutional Disciplinary Form (Appendix D). Once it has been placed in the offender's file it can be reviewed by anyone in the DOC, including the PB. The write-up is then assigned to an investigating officer. An investigation officer is usually a sergeant or lieutenant grade corrections officer who has received training in adjustment procedures. The Investigation Officer will then investigate the incident, interviewing the inmate/client and any witnesses. This investigation is to gather the facts of the write-up, determine if it was in fact a violation of an institutional rule or code of conduct. If the write-up is deemed to be valid, and it is a minor offense, the Investigation Officer can make the decision to refer it as a "Unit Citation", or send it on to the Institutional Adjustment Officer (AO) for a final decision.

A Unit Citation is for a minor infraction. The Dorm Unit Administrator (UA) will hear the case and make the determination if it is valid. A sanction will then be applied from Corrections Policy and Procedures (CPP) 15.2-F (Penalty Codes). In the case of a minor infraction, the penalty is usually some type of extra duty (work). The UA can also ask for a re-hearing of a write-up, in which case it is sent back to the Investigation officer to be reviewed.

As stated above, the Investigation Officer can also send a write-up for minor infraction on to the AO for final decision. All category 3 write-ups and above must be forwarded on to the AO for adjudication. The AO is a lieutenant grade corrections officer. If the write-up is deemed as not valid by the AO, it is noted on the write-up form and filed. This is called being "thrown out".

When an institutional write-up is deemed valid by the AO, it is put on a schedule to be “heard” by the AO. The AO then hears the write-up case and adjudicates guilt. The process is much like a trial and a lawyer or legal aide can represent the inmate. An inmate can hire a lawyer to represent him in these cases or he can have a legal aide represent him. Legal Aides are inmates who receive special training in CPP policy and in how to represent inmates at adjustment hearings. Again, a sanction will be applied from CPP 15.2-F. The outcomes of these hearings are then stored in the Institutional Adjustment Hearings File.

The data for this study was reviewed from the Institutional Adjustment Hearing files. Access to these files was granted by the Warden of GRCC, who has ultimate authority of inmate files at this institution.

CHAPTER 2

Literature Review

In a recent press release from the Commonwealth of Kentucky Department of Corrections (2010), it was noted the recidivism rate for the state was at its lowest rate in several years. This release stated that the three year recidivism rate was 40.3% for the 2007 inmate releases. Kentucky Governor Steve Beshear noted reducing the rate of offenders who return to prison would keep more families intact, provide for safer communities, and use the money saved from incarceration costs in other critical areas. He further noted in this press release that reversing the trend of recidivism signaled the initiatives the Department of Corrections had started in 2005 were having a very positive impact (Commonwealth of Kentucky Department of Corrections, 2010).

In the press release cited above, Kentucky Corrections Commissioner LaDonna Thompson, credited probation and parole staff for the work they had done to reduce the return of technical violators as being one of the reasons for this reduction in the recidivism rate. She also said that increased efforts in substance abuse treatment programs had also played a large role (Commonwealth of Kentucky Department of Corrections, 2010).

With the state of Kentucky in the midst of a protracted recession and strapped for funding, every dollar of taxpayer's money is under scrutiny. The philosophy of "doing more with less" is part of every conversation in every service department in the state.

Kentucky's definition of recidivism is the return of an offender to the custody of the Department of Kentucky Correctional System within two years of release from a state

institution or contract facility by parole, shock probation or completion of sentence (Commonwealth of Kentucky Department of Corrections, 2010).

Given the state's budget problems, efforts of state legislators are being focused to pass new laws for individuals who are arrested for alcohol and drug related crimes. The use of a Therapeutic Community Model, in prison settings, is a tool that can be an effective ally in the efforts to combat recidivism, thus reducing costs.

Individuals who are incarcerated are not able to work and support their families or make any other contribution to society. This makes it the most optimal time to provide substance abuse treatment. Inciardi, Martin, Butzin, Hooper, and Harrison (1997) found that it was important for inmates to start treatment while they are in prison. The main reason is because the one resource they have is an abundance of time. Therefore, there is the opportunity and time to focus on the task at hand, treatment. In addition, they point out that providing treatment to inmates in a prison presents opportunities for them to acquire pro-social values, positive work ethics, constructive interaction with graduate role models, and gain an insight into the etiology of the addiction process.

TC programs maintain that substance abuse problems are a disorder of the whole person requiring the use of long term treatment in order to make changes in a person's identity and lifestyle. Several studies that describe the psychological and social characteristics of admissions to TC programs support this perspective (e.g., De Leon, 1985, 1999). "In addition to their substance abuse and social deviancy, drug abusers who enter TCs reveal a considerable degree of psychological disability, which is further confirmed in diagnostic studies" (De Leon & Wexler, 2009, p. 168).

According to De Leon (1999) and Simpson (1997), length of stay in a treatment program was the most consistent predictor of positive post-treatment outcomes. However, the drop out rate from TC programs was relatively high with most participants dropping out of treatment a long time before their treatment is completed. Retention rates vary by program; one-year rates revealed steady increases from 30 to 45%. Dropping out occurs at the highest rate during the first 30 days of treatment and declines thereafter (De Leon & Wexler, 2009). The longer a client remains in the TC program, the better the chances the client has of completing the program (e.g., De Leon & Schwartz, 1984). This pattern indicates why most TC programs have a minimum of 6 months in treatment in order for the client to achieve the maximum benefit (i.e., a "treatment threshold").

In a 2007 study conducted at West Central Community Correctional Facility (WCCCF), the authors were interested in the relation between specific mutual aid behaviors and outcomes of TC treatment. The WCCCF received offenders from an eight county area. It is a 90 bed TC diversion program located in central Ohio for nonviolent offenders. The offenders served their time in the TC program for 6 months instead of longer sentences (diversion) they would normally have served. The WCCCF is a free standing facility, that is, it is not housed within a larger correctional facility. All of the clients were male. The results of this study were consistent with the De Leon and Schwartz study that suggested the significance of time spent in a TC was a predictor of positive outcomes once the client was released from prison (Warren, Harvey, De Leon, & Gregorie, 2007).

Therapeutic Communities are a powerful tool in the ongoing battle to help addicted people recover. They have shown to be an effective treatment approach in reducing

relapse and recidivism. In a 2010 report on the effectiveness and challenges of therapeutic communities in the United States, the authors noted that TCs have become widely accepted throughout the criminal justice systems and has become the preferred model for treating the prison inmates. The authors go on to say that research has played a major role in evaluating multiple prison TC programs and they have demonstrated significant reduction in recidivism (Wexler & Prendergast, 2010).

In a five-year report conducted by Wexler (1994a), the author reported on the progress of prison substance abuse treatment. The author stated that a movement is under way from just providing security for offenders to a new emphasis on rehabilitation and treatment. The author noted that TC programs were the preferable treatment modality for the more resistive type of offenders. The report also pointed to evidence that prison based TC programs providing nine to twelve months of treatment provided the best results.

Researchers at the University of Delaware's Center for Drug and Alcohol Studies conducted a similar study on 448 TC graduates, who had received one of three types of TC treatment protocols, compared to a control group receiving no treatment. The study lasted from six to eighteen months after all groups were released from prison. The study included three treatment groups: 1) in-prison TC treatment only; 2) work release TC treatment followed by aftercare; 3) full continuum of TC treatment followed by aftercare; and 4) the control group. The results indicated that all three TC treatment groups remained drug free longer than the control group that received no treatment. The study also found that the TC treatment group that had a full continuum TC treatment followed by aftercare had significantly better outcomes than any of the other groups in the study (Inciardi et al., 1997).

Lipton (1994) conducted a study of two large TC programs, Stay'N Out and Cornerstone. The National Institute of Drug Abuse and the Narcotic and Drug Research Incorporation (NDRI) evaluated the Stay'N Out program, comparing it with other alcohol and drug programs. The Stay'N Out program, located in New York, is a TC model program and has been identified as a national model program for drug offenders who are incarcerated.

Lipton's analysis was conducted to determine if the Stay'N Out program was more effective at reducing recidivism than alternative forms of treatment or no treatment. Lipton's study compared three groups of offenders: 1) Stay'N Out TC group; 2) a traditional substance abuse residential treatment approach; and 3) a control group receiving no treatment. The results of this study indicated long term addicts who remained in this prison based TC program were more likely to remain alcohol and drug free following release from prison. The graduates who stayed in the TC program from nine to twelve months had a 22.7% recidivism rate after three years. The recidivism rate for the traditional treatment approach and the no treatment groups was 50%. It is interesting to note that the traditional approach was no more successful than the no treatment group (Lipton, 1994).

The Cornerstone program located at the Oregon State Hospital in Salem, Oregon, was begun in 1976. It is based on a modified TC model. Evaluation studies were conducted on this program in 1984 and 1989. The average length of time for an offender to be in treatment was eleven months. Measures of recidivism were compiled for three years from 1991 to 1993. The results of this study indicated three-quarters of the graduates of the program had not been re-incarcerated after three years post release. These finding were

consistent with those in the Stay'N Out program. The study also found that the longer an inmate was in the program the more likely they were to stay clean and sober (Lipton, 1994).

This study adds to the growing body of research conducted on TC programs and provides solid evidence that prison based TC programs produce significantly lower recidivism rates among alcohol and addicted inmates. Lipton also notes that it was the total person (holistic) approach that a TC program uses that allowed the inmates to be able to return and remain for an extended period of time in society (Lipton, 1994).

A 1999 study had similar results to those of the previously mentioned studies. The re-incarceration records of 394 nonviolent offenders were examined during the first three years following their release from an in-prison TC program in Texas. The results of this study showed that 25% of those who completed the TC program and aftercare were re-incarcerated compared to 42% of the non-treatment group. This study also found that those who had completed the TC program but dropped out of the aftercare program were twice as likely to be re-incarcerated as those who had completed both (66% vs. 26%). These findings support the assertion that TC programs when combined with an aftercare component are effective in reducing the rates of recidivism (Knight, Simpson, & Hiller, 1999).

Another 1999 study was conducted to examine the impact that attending a residential aftercare program would have on recidivism following a nine month prison-based TC treatment program. The study involved 396 male inmates (293 treated and 103 untreated) from the New Vision TC program located in Kyle, Texas. The study was quasi-experimental in design and a survival regression analyses was used to predict the time

until a participant was rearrested. Three comparison groups were measured, TC only (n= 123) with no residential aftercare, TC and residential aftercare (n= 170) and an untreated control group (n= 103) who had been granted parole. The finding of this study indicated that during the follow-up period (13-23 moths) 42% of the untreated, 36% of the TC only, and 30% of the TC and residential aftercare had been rearrested for a new offense (Hiller, Knight, & Simpson, 1999).

The Hiller et al. (1999) study not only demonstrated that prison-based TC program lowered the risks for recidivism but also extended the length of time until a re-arrest. At the end of 12 months the study participants were contacted. A follow up interview was conducted in order to determine any re-arrest and to discuss satisfaction with aftercare from the TC with residential aftercare group. This study further solidifies the finding in the Inciardi et al., 1997 study described previously.

In a book by Michael Eisenberg (1999), a three year study was conducted on the recidivism of offenders participating in Texas's largest correctional substance abuse treatment program. The two programs are called the in-Prison Therapeutic Community (IPTC) and the Substance Abuse Felony Punishment for Probationers (SAFP). The samples for this study included two groups who completed IPTC (N= 672 and N= 482), and two groups who completed SAFP (n= 723 and N= 950). The results of this study indicated that those participants who completed the programs had a lower recidivism rate than those who did not. The study also found that the SAFP program was cost effective in diverting offenders from returning to prison.

TC programs have been around in the Federal Prison system since the 1980s. An evaluation of these programs was conducted in 2000. The results of this evaluation found

that inmates who had completed the TC treatment programs were significantly less likely to relapse or commit new offenses in the six months following probation than were a comparison group. This study did make an effort at controlling individual and system-level selection factors (Pelissier, Rhodes, Saylor, Gaes, Camp, Vanyur, & Wallace, 2000).

In a 2001 article, the authors completed a 42 month follow up interview on 489 clients who had completed a TC program in the Delaware correctional system. The TC program in the Delaware system is a continuum of primary (in prison), secondary (work release), and tertiary (aftercare). "The data indicated the clients who completed treatment were significantly more likely to remain drug-free and arrest-free three years after release from prison. It was also discovered, clients who completed the tertiary phase (aftercare), had a higher rate of success than either the primary or secondary phase" (Inciardi, Martin, & Surratt, 2001, p. 241).

In 2003, a study was conducted on the cost effectiveness of the CREST outreach Center. This program is a work release TC and aftercare program located in Delaware. The effectiveness of the TC program was assessed computing the number of days re-incarcerated during an 18 month, post-release follow-up period. The CREST program is a 6 month program that cost an average of $1,937 to complete. The participants in the CREST TC program were compared to participants in a regular work release program. The results of this study showed the TC participants had 29% fewer days incarcerated than the regular work release participants. This indicated that the CREST program reduced the cost of incarceration by $65 per day. The finding of this study have implications for post-release substance abuse offenders and further add to the body of

evidence that TC programs reduce recidivism (McCollister, French, Inciardi, Butzin, Martin, & Hooper, 2003).

In 2004, a study was conducted from three TC programs in Israel. This study followed 167 addicts drug use for 15 months following their release from treatment. The study specifically examined the contributions of socio-demographic characteristics, self-esteem, time in the community, psychopathology, and locus of control to successful outcome. The finding of this study showed that 90% of those who completed the TC programs were drug free. The study also found that the longer a person stayed in the TC program, the more likely they were to be drug free later. Another interesting finding of this study was that drug use at the 15 month follow-up was positively associated with prior criminal activity and negatively associated with living with a partner before entering a TC program (Dekel, Benbenishty, & Amram, 2004).

Warren et al. (2007) studied the effects of affirmations and corrective reminders (Push-ups and Pull-ups) as predictors of re-incarceration following graduation from a corrections-based TC program. The study site was the West Central Community Correctional Facility (WCCCF), located in Ohio. The WCCCF is a free-standing TC facility; not located within a larger prison. It is a 90 bed male diversion program for nonviolent drug and alcohol offenders. The program lasts for six months with about 82% successfully graduating. Logistic regression analysis indicated three of the four mutual aid behaviors were significantly predictive for re-incarceration. This study did have limitations. The participants came from only nine counties in Ohio, had a low percentage of ethnic minority representation, and had no juvenile justice participants. As such, the

external validity would be in question and would these findings be able to be generalized if the samples had higher representations as listed.

In a press release from the Kentucky Department of Corrections in 2007, it was reported that approximately two-thirds of both jail-based and prison-based TC program participants were not incarcerated at 12 months upon release. The research, conducted by the University of Kentucky Center on Drug and Alcohol Research, is part of an ongoing research partnership with the Kentucky Department of corrections (Commonwealth of Kentucky Department of Corrections, 2010).

This collaborative research involved follow up interviews from graduates of the jail and prison based TC programs. The participants were from 8 minimum and medium security Kentucky prisons, and 17 Kentucky jail programs. Research assistants made face to face and/or phone contacts with the program graduates at 6 and 12 month intervals. The interviews involved ascertaining aftercare compliance and general recovery issues at these two points in time.

According to Dr. Stanton-Tindall, Assistant Professor in the University of Kentucky Drug and Alcohol Research Studies (UKDARS), the results indicated the jail and prison based TC programs were working; it is changing behavior. In the same press release, then Kentucky Department of Corrections Commissioner John Rees, stated the research validated that TC treatment programming was heading corrections in the right direction and the money spent on the treatment was paying off in terms of reducing recidivism (Commonwealth of Kentucky Department of Corrections, 2010).

In a similar study, a randomized experiment designed to test the efficacy of a TC program. This study was called the District of Columbia Initiative (DCI). This study

looked at two residential TC programs having different treatment lengths to see if the length of treatment had anything to with reducing re-incarceration. A total of 412 clients were randomly assigned to either a standard (n= 194) or abbreviated (N= 218) treatment program. The clients were given a follow up interview, 19 months post discharge. The client's age range was from 19 to 55 years old, and 72% were male.

A study conducted in 2007 by the California Department of Corrections (CDC), the UCLA Integrated Substance Abuse Programs (ISAP), and the Office of Substance Abuse Programs (OSAP) made a recommendation that parolees have a uninterrupted continuum of care from the TC program in the prison through aftercare after the participants have been granted parole (Burdon, Dang, Prendergast, Messina, & Farabee, 2007).

This study examined the effectiveness of community-based outpatient and residential substance abuse treatment services attended by male and female parolees who had graduated from the CDC prison TC programs based upon the severity of their addiction problems. The study included 4,165 male and female participants. These participants participated in either outpatient or residential treatment following parole from prison. The dependent variable in this study was the length of time to re-incarceration within 12 months of release. The independent variables were type of aftercare (Outpatient, residential) and severity of drug/alcohol problem (high, low levels). Logistic regression analysis were performed to determine if the outpatient only versus residential only modality was a predictor of 12 month recidivism rates for the participants who were classified as having high severity versus those classified as having low severity (Burdon et al., 2007).

The results of this study indicated both the outpatient only and the residential only participants benefited approximately the same regardless of the severity of the drug or alcohol problem. The study concluded that a prison based TC program combined with either outpatient or residential aftercare was effective in reducing recidivism in a 12 month period following parole. A limitation of this study was that it did not use a control group to match the outcomes. However, the study does add to the empirical evidence that TC programs combined with an aftercare program are effective at reducing recidivism (Burdon et al., 2007).

In another study conducted in 2007, Mitchell et al. used synthesized results from 66 evaluations of incarcerated-based drug treatment programs for a meta-analysis to determine if treatment reduces recidivism. Five different types of treatment programs were evaluated for their effectiveness in reducing post-release drug use and re-offending. The five types of treatment programs studied were: TCs, residential substance abuse treatment (RSAT), group counseling, boot camps, and narcotic maintenance programs. The results of this study found the effectiveness of the TC programs was significantly more effective than the other four types in reducing recidivism. The authors stated their findings were "robust" to methodological variation, even among the most rigorous evaluations. Finally, the authors noted that administrators searching for effective, low cost treatment programs for inmates in prisons will more likely find better success going with a TC program that is intensive and focuses on the multiple problems of an addict.

Fernandez-Montalvo, Lopez, Illescas, Landa, and Lorea (2008) conducted a study on the long term outcomes from an established TC program, called the Proyecto Hombre, located at Navarre, Spain. The aim of this study was to compare the program graduates to

the program dropouts, and those who relapsed with those who did not relapse on a broad set of variables. In order to analyze the outcomes of the TC program, a long term design was used. This design had a mean of six years after leaving the TC treatment program. The sample for the study consisted of 113 graduates and 42 dropouts. Personal interviews were conducted on these participants between September 2000 and September 2004.

The results of this study indicated the program dropouts had an earlier and higher rate of readmissions for treatment and relapses than the program graduates. The study found the TC program improved the state of health for the participants and was effective in reducing criminal behavior. When comparing the graduates and dropouts across the outcome variables, there was a significant difference. All 113 of the program graduates showed improvement on the outcome variables. There was also a significant difference, between groups, when they compared the non-relapsing and relapsing participants (Fernandez-Montalvo et al., 2008).

There were some limitations noted to this study. The number of participants included in the study was small. The number of dropout participants was even smaller. This small sample size would not be large enough to allow for statistical analyses that would be more desirable or add power to the results obtained. Lastly, the authors suggest that the study was empirical in nature and it could have indicated that what had been studied was linear, that is cause and effect outcomes (Fernandez-Montalvo et al., 2008).

An innovative study was conducted to examine the effectiveness of the Kentucky correctional system in 2009. This was a systematic treatment outcome study known as the Criminal Justice Outcome Study (CJKTOS). The innovation was from the use of personal digital assistants (PDAs) by counselors in the Kentucky Department of Corrections TC

programs to gather and download clinical data on program participants that formed the baseline data for the study. These data were entered at the time of admittance into treatment by the staff, via the PDA, to UKDARS. Following the participants being released from prison, the staff at UKDARS contacted the participants for follow-up interviews 12 months post-release. The study used a stratified random sample of the program participants. A total of 700 participants were selected using this approach and contacted either by phone or face to face to complete the interview (Stanton-Tindall, McNees, Leukefeld, Walker, Thompson, Pangburn, & Oser, 2009).

The results of this study indicated the percentage of program participants who reported any use of substances at baseline was 94% and following treatment release from prison, at the 12 month interval, it was 44%. The study also found that participants who completed the TC programs had reduced rates of recidivism when compared with the state's average (Stanton-Tindall et al., 2009).

Jensen and Kane (2010) conducted research on the effects of a TC treatment approach on time to first re-arrest after release from prison. The study included males, who had been assessed by the corrections staff as needing the TC program and who had successfully completed treatment. The control group was also males, who were similarly assessed by the corrections staff and deemed as needing the TC treatment but did not complete it. Relevant covariates were controlled in the analysis. The results indicated that completion of the TC treatment program had a significantly higher positive effect on delaying time to first re-arrest by up to two years after release from prison.

Research on prison-based TC programs within the federal prison system and in various state prison systems has provided an abundance of empirical support and

evidence for the continued development of these programs. The findings from the previous studies mentioned indicate prison-based TC treatment is effective at reducing relapse to drug use and recidivism. This is especially true when the TC program is combined with an aftercare program in the community to which the TC graduates are paroled to (e.g., Wexler, Melnick, Lowe, & Peters, 1999; Martin, Butzin, Saum, & Inciardi, 1999; Knight et al., 1999). According to Pearson and Lipton (1999) the findings of the TC programs were standardized and combined using meta-analytic techniques, the weighted mean effect size for recidivism was .13 (using an R index). This can be interpreted as a 13 percent difference in recidivism between those who received a TC treatment approach and those who did not receive any treatment.

These studies have been included in this literature review to point out the effectiveness of TC programs in the reduction of relapse and recidivism. As a result of these efforts, the costs to society have been reduced. The TC programs have also helped to make society a safer place as a result of the reduction in recidivism. The typical way research has been conducted, in the evaluation of TC programs, has been in the areas of recidivism and relapse prevention. Being able to prove that TC programs reduce relapse and recidivism is impressive to legislatures and citizens in terms of costs and successful outcomes. In a 1996 article, the author states that prison treatment not only works, but also reduces the use of drugs within correctional facilities. This is an issue that has not been fully acknowledged or confronted (McEneaney, 1996).

However, few studies were conducted as to the efficacy of prison-based TC programs to reducing the costs, benefits to the correctional staff who work within a TC program, benefits to corrections management, or the effects of a TC on the reduction to inmate

behavioral problems. This research represents an effort to address this gap in the literature.

A cost-effectiveness analysis was conducted in 1999 on a Texas TC program. The effectiveness of the TC program (lower recidivism) was examined for high and low risk parolees relative to non-treated parolees. The results of this study indicated treatment was cost effective for the high risk parolees who completed the TC program than the non-treated group of parolees (Griffith, Hiller, Knight, & Simpson, 1999). This study also pointed out that the greatest cost effectiveness was found to be when an inmate completed both TC and an aftercare program.

The authors of a 2001 study examined the costs and benefits of adult and juvenile substance abuse treatment programs, focusing on reducing criminality. Various types of treatment programs were examined, including sixteen prison TC programs. The results of this study indicated that the economic return from the programs ranged from $1.91 to $2.69 per dollar invested, on average (Aos, Phipps, Barnoski, & Lieb, 2001).

McCollister and French (2002) conducted economic cost analyses research on prison TC programs in Kentucky, Delaware, Colorado, and California. The average weekly costs of operating these TC programs ranged from $37 to $68, while the average weekly cost of operating a community- based substance abuse treatment program in California was estimated to be $181. The authors also note that to put these results in perspective, you should consider the estimated weekly cost of operating a community- based program for treating mentally ill drug abusers, which was at $79. These results point out the modest cost of operating an in-prison TC.

McCollister, French, Prendergast, Wexler, Sacks, and Hall (2003), performed a cost-effectiveness analysis of the Amity TC and Vista aftercare programs. These programs were developed for criminal offenders who had alcohol and drug related involvement, and are located in California. The average cost of treatment in these programs was found to be $4,112. This converted into 51 fewer days of incarceration (36% less) than the average of an inmate in a control group they were using. The results of this study also found that when the TC programs were combined with the Vista aftercare program, an additional day of incarceration was avoided at a cost of $51 per day.

Zhang, Roberts, and McCollister (2009) conducted a study of the impact a TC program had on the management costs of a California prison. The authors developed a deconstruction method to measure the costs of correction staff time and other resources involved in various management tasks. They compared the TC program costs to non-treatment inmates. The results indicted that the TC program maintained lower management costs for disciplinary actions, reduced costs as a result of major disruptive incidents, and fewer inmate grievances.

A study was conducted in 1990 of the Stay'N Out TC program, which was established in 1977 by the New York State correctional system. The inmates in this program live in units that are segregated from the rest of the prison population. The sample for this study consisted of: (1) males (n= 435) and females (n= 247) who had completed the program; (2) males (n= 573) who had completed a milieu drug treatment program; (3) males (n= 261) and females (n= 115) who had completed a counseling drug treatment program; and (4) males (n= 159 and females (n= 38) who had applied to the program but never were admitted. Empirical support was demonstrated by: (1) The longer inmates remained in

the Stay'N Out TC program, the more successful they were after release form prison; (2) The Stay'N Out TC program effectively reduced recidivism rate; (3) The Stay'N Out TC program was more effective than either of the other forms of treatment and significantly more effective than no treatment in prison; and (4) the inmates in the Stay'N Out TC program experienced less institutional behavioral problems than either other form of treatment or those receiving no treatment (Wexler, Falkin, & Lipton, 1990).

Wexler et al. (1991) hypothesized that operating a TC program within a prison assisted the correction staff's ability to manage the inmate's behavior and reduce the incidence of their violence. The staff also felt safer in the TC program environment than in the general population areas of the prison.

In 1989 the New York City Department of Corrections (NYCDOC) established a substance abuse intervention program based upon a TC model. This treatment program was intended specifically to treat cocaine offenders in the city's jails. Ongoing data has been collected since the start of these TC programs. NYCDOC's data has indicated that: (1) Prison TC programs and community based TC programs can be adapted to jail settings; (2) TC programs reduce the level of violence and rule infractions for those in treatment; (3) TC programs help to reduce on security staff; and (4) TC programs help inmates to remain drug free during their incarceration (Klocke, 1991).

Grenders and Player (1995) conducted a study of the TC program at Grendon, located in the United Kingdom. Grendon is a prison that provides psychological treatment to inmates with mental disorders that are not serious enough to require placement in a mental hospital. The prison houses 640 inmates. The study consisted of a random sample of 213 inmates, 39 prison correction officers and 30 medical staff. Inmate record reviews

were conducted on the sample. The results of the study indicated that while at Grendon, the inmates experienced positive behavior and attitude changes. These changes produced a reduction in institutional behavioral problems. They also found that 50% of the inmates, in the study, who were transferred to another prison, remained unproblematic.

A study conducted in 2003 examined the institutional consequences of operating a TC program in a high security male institution. Institutional rule violations and grievances were examined within the treatment population and compared with rates from the general population. The finding of this study indicated the TC program inmates experienced lower levels of disorders than did the non-treatment inmates (Dietz et al., 2003).

Dietch, Koutesenak, Burgenes, and Cartier (2001) conducted a study that explored the impact a TC unit had on the morale of the staff working in that unit. This study was conducted at the Corcoran State Prison in California. The study covered a one year period between 1998 and 1999. Three surveys were completed by the corrections staff; they were designed to measure the impact working in a TC unit had on their perceptions of their jobs. In addition to the morale of the staff, this study also measured the impact inmate disciplinary problems had on the management of the unit. The results of this study indicated that working in the TC unit had a positive impact on the job satisfaction perceived by correctional staff working within the TC unit. The correctional staff perceived their work environment as generally safer and more manageable than those of other corrections staff who work in the general population prison settings.

Kinlock, O'Grady, and Hanlon (2003) conducted a six month study of treatment programs that used cognitive-behavioral methods for 170 prerelease inmates that had extensive drug and alcohol histories. The subjects in this study were randomly assigned

to a treatment and non-treatment control group. The outcomes that were examined included rule violations, citations, major rule violations, and reclassification to a higher security level following a major infraction of the rules. The TC program in this study was a modified TC program that utilized a cognitive-behavioral model in its treatment regime. The results of this study indicated that the inmates in the TC program had a significantly lower rate of being reclassified to a higher level of security than the control group.

Supervising inmates in a prison is a very stressful job. Several studies have examined the stress correctional employees endure in the daily operations of a prison. For example, two studies found there was an increased stress level on corrections staff during the day to day management and movements of the inmates in the prison. (Wacker, 1992; Keister, 1992). In a similar study, Woodruff (1993) concluded that corrections staff suffered from higher rates of ulcers, hypertension, general depression, alcoholism, strokes, and heart attacks than the general population. They also had a higher rate of divorce than the general population. It is interesting the study also found that corrections staff die at an average age of 59 as opposed to the normal average age of 75.

Deitch, Koutesenak, and Ruitz (2004) conducted a study on the impact of working in a correctional setting had on the security staff. In particular, the study was interested in the quality of professional life issues between staff working in the general population settings and working in a TC program setting. The study was conducted at three California State prisons: the Substance Abuse Treatment Facility (SATF) at California State Prison, Corcoran; California Rehabilitation Center (CRC); and R.J. Donovan Correctional Facility (Donovan). This study was very similar to the Deitch et al., 2001 study except that it was over a longer period of time and three prisons were examined instead of one.

The authors of this study surveyed 120 correctional staff, from SATF, CRC, and Donovan, using three instruments. The results of the study indicated that the staff, who worked in the treatment setting, experienced better perceived physical and psychological health as a result of lower inmate disciplinary problems, less occupational injuries, lower staff sick leave use, and a general "upbeat" nature of working in the TC units (Deitch et al., 2004).

The significance of the Deitch et al. (2001 & 2004) studies was that the inmates in the TC programs were twice as less likely to engage in violent behavior. Both studies indicated their was a reduction in the rates of staff injuries, reduction in stress from the job environment, elevated job satisfaction, reductions in assaults from inmate to staff and inmate to inmate, and a general reduction in overall disruptive behavior by the inmates in the TC programs.

Welsh, McGrain, Salamantin, and Zajac (2007) conducted a study at five Pennsylvania state prisons that examined pre and post treatment misconduct records for 1,073 inmates who participated in the TC program. Predictors included prior and current criminal history, length of sentence, age and drug dependency. The study hypothesized that treatment alone would significantly reduce inmate misconduct and institutional write-ups. The results of the study failed to show any significance in the inmate behaviors or conduct. It was discovered that misconduct over time was due to individual characteristics and the amount of time that an inmate served post treatment. This study posed in its discussion that it would be better if participants would be paroled closely after completion of treatment than for the inmates to return to the general population and be subjected to regular general population inmates.

Conclusion

"Evaluations of prison-based TC programs conducted in several states and within the federal prison system have provided empirical evidence for the continued development of these programs throughout the nation" (Burdon et al., 2002). The evidence presented in this literature supports this conclusion. There is also a growing body of research as to the effectiveness that operating a TC program can have on the management, participants in these programs, and on the cost effectiveness of them.

The substance abuse treatment field has made major advancements over the past 30 years. It has progressed from the position of "nothing will work" to the accepted view that the use of prison-based TC programs are effective in reducing recidivism. However, the effectiveness of TC programs, as a management tool, should not be overlooked. The importance of expanding upon the research presented here is imperative. Testing hypothesis of relationships among TC programs and the reduction in institutional behavior problems as a result of write-ups, may improve the security and safety for inmate, correctional employee, as well as demonstrate that it can reduce the costs of incarceration. Evidence of TC program's ability to reduce the incidents of institutional write-ups, while providing substance abuse treatment for inmates makes it a valuable tool for prison administrators, legislators and the citizens of Kentucky.

CHAPTER 3

Population and Sample

This study dealt with human subjects in an indirect way (historical data from adjustment hearing results). As such, it was not necessary to obtain informed consent from the TC clients or general population inmates. However, all appropriate materials including prospectus, application to perform the study from DOC, and Western Kentucky University's Human Subjects Review Board were submitted. Acceptance was granted (see Appendix F) with no known risk to any of the participants.

The population, for this study, consisted of the clients in the TC program (Dorm 3) during the time period of March 2001 through October 2005 and the inmates from the general population living in Dorms 1, 4, 5, and 8 for the same period. The median age for the TC clients was 30 years. The median age for the general population Dorms 1, 4, 5, and 8 inmates was 28 years. The median sentence for the TC clients was 11 years. The median sentence for the general population Dorms 1, 4, 5, and 8 inmates was 16 years. The ARCH TC client's race was 65% Caucasian, 34% Black, and 1% other. The general population inmate's race in Dorms 1, 4, 5, and 8 was 62% Caucasian, 37% Black and 1% other. Dorms 1, 4, 5, and 8 were selected as the control group for this study. Collectively, these five dorms were called the control group for the purposes of this study. It should also be noted that all participants in this study were males who meet the classification requirements for a medium custody level inmate as delineated in Chapter 1. As Table 1 illustrates, the participants were very closely related in terms of age and race breakdown. The reason for the difference in median sentence was due to the fact that all the TC clients must be no more than 12 months to meeting with the Parole Board. Also, Dorm 4

is the intake dorm where all inmates coming into the prison are first housed. Inmates with longer sentences are first housed in this dorm and then moved to other dorms later.

Dorm 2 was also not selected to be used in this study. This is the "honor" dorm for the institution. Inmates housed in this dorm have longer sentences, with an average of 25 years. All inmates in this dorm work for the Corrections Industry which pays them an hourly wage. All other inmates receive a daily stipend. The rate of pay for the TC clients is .80 per day. This dorm also only has 64 beds. The turn over rate in this dorm is 18 months on average. The median age for inmates in dorm 2 is 37 years. With these differences in mind, the researcher decided to not include this dorm in the study.

Table 1

Demographics of Participants

	Male	Median Age	Median Sentence	Caucasian	Black	Other
ARCH TC	100%	30	11	65%	34%	1%
Control group	100%	28	16	62%	37%	1%

The clients in the ARCH TC program were screened to meet *DSM-IV-TR* criteria for substance dependency only. No attempt was made to screen the TC clients as to any severity of crime, previous institutional history, antisocial behavior, or any other psychopathology. As previously noted, the ARCH TC clients are housed in Dorm 3. The average length of stay in the treatment program was 10.5 months.

The control group inmates are housed in dormitories that are similar to the ARCH TC client's dorm. Each dorm houses 128 males, with two inmates to a cell. The control group inmates are randomly assigned, by the Unit Administrators (UAs), to live in these

dormitories. The inmates from the control groups may request a cell mate but the UAs have the final approval. Also, once inmates decided to room together, and approved by staff, they sign a contract to stay in together for at least 6 months before another move will be considered. The average length of stay for the control group in this study was 6.8 months. No attempt was made to screen the control group inmates as to severity of crime, previous institutional history, antisocial behavior or any other psychopathology. All of the Dorms are essentially identical to the TC dorm. None of the inmates in the control group were in any type of substance abuse treatment program. Also, none of the inmates in the control groups had previously completed a TC program.

Data Collection

The data presented in the current study was gathered from March 2001 through October 2005. Data was obtained from existing records kept by the Adjustment Officer relevant to institutional write-ups at GRCC. Individual adjustment hearing results were kept on computer files locked in the Adjustment Office at the prison. Access to these files is only open to staff upon request to the Adjustment Officer. The researcher examined individual adjustment hearing results and information was tabulated as to the category and final disposition of each write-up.

All data collected was maintained anonymously (i.e., the researcher did not keep identifiable records in his office). This measure insured the privacy and confidentiality regarding the findings of the study, which may eventually be made public in the publication of this dissertation or any published manuscript following this study.

Results

As stated above, the primary method used to determine if the presence of a TC program reduces institutional write-ups was to examine the Adjustment Hearing Results for all the dorms. The write-ups are segregated into seven categories with categories 1-3 considered minor offenses and categories 4-7 considered major offenses. In addition each category is further broken into sub-categories (Appendix E). The results of the distribution of documented institutional write-ups are given in Table 2.

Table 2

Distribution of Institutional Write-Ups by Dorm

Category of Write-up	Dorm 3 (TC)	Dorm 1	Dorm 4	Dorm 5	Dorm 8
Category 1	47	86	75	52	100
Category 2	17	21	42	58	49
Category 3	42	208	215	106	185
Category 4	52	149	167	122	210
Category 5	05	66	41	59	60
Category 6	05	52	69	43	25
Category 7	00	06	02	05	03
Totals	168	588	611	445	632

The mean numbers and standard deviations to complete the ANOVA test are represented in Table 3.

Table 3

Descriptive Statistics

Dorm	Mean	Std. Deviation	N
d3 (TC)	24.00	22.30	7
d1	84.00	71.89	7
d4	87.29	75.96	7
d5	63.57	39.27	7
d8	90.29	79.48	7

A one-way, category by dorms, repeated measures ANOVA was performed on the data of this study. This statistical test was selected due to the fact more than two groups of means were being compared. Specifically, when the same participants participate in all the conditions of an experiment, the appropriate statistic to use is the one-way, repeated measures ANOVA (Field, 2009). When this statistical test is used, the effect of the manipulation shows up in the within-participant variance as opposed to the between-group variance. When the experimentation is carried out on the same people, the within-participation variance will include both the individual difference and the effect of the experimental manipulation. Since the experimental manipulation is carried out on everyone within a condition, any variation that is not explained by the manipulation must be due to random factors outside of the control of the experiment and unrelated to the experiment (Field, 2009).

The one-way, category by dorm, repeated measures ANOVA was selected in order to compare several means (5) and those means came from the same participants. The write-ups were treated as the subjects or dependent variable and the dorms as the conditions or groups. In the TC dorm (3) everyone had fewer write-ups so it is reasonable to assume it did not happen by chance but because the clients were housed in the TC dorm.

Table # 4 shows the results of the one-way, category by dorms, repeated measures ANOVA test. The results indicate the write-ups for dorm 3 (TC) were significantly fewer [$F(4, 24) = 5.61$, $p < 0.002$].

Table 4

ANOVA Summary Table

Source	*df*	*ss*	*ms*	*p*
Participant	4	21444.4	5361.1	.002
Between	1	170661.1	15438.4	.016
Error	24	22950.0	956.3	
Total	29	214055.5	21755.8	

Post hoc test (see Table 5) revealed dorm 3 (TC) write-ups were significantly fewer than all of the other control dorms ($p < .05$). Taken together, these results suggest the TC program does have a significant effect on the reduction of institutional write-ups at this medium security prison. It can also be noted, according to Post hoc tests, that not only was the TC dorm different from all the other dorms, but also that there was no significant

difference between any of the other control group dorms (1, 4, 5, & 8) in the current study.

Table 5

Pairwise Comparisons

Measure : MEASURE 1

(I) dorm	(J) dorm	Mean Difference (I-J)	Std. Error	Sig.
3	1	-60.000	21.419	.031
	4	-63.286	22.847	.032
	5	-39.571	9.911	.007
	8	-66.286	22.847	.027
1	3	60.000	21.419	.031
	4	-3.286	6.527	.633
	5	20.429	16.086	.251
	8	-6.286	11.678	.610
4	3	63.286	22.847	.032
	2	3.286	6.527	.633
	5	23.714	16.736	.206
	8	-3.000	11.607	.805
5	3	39.571	9.911	.007
	1	-20.429	16.086	.251
	4	-23.714	16.736	.206

	8	-26.714	16.693	.161
8	3	66.286	22.847	.027
	1	6.286	11.678	.610
	4	3.000	11.607	.805
	5	26.714	16.693	.161

The effect size formula and computation was ($\eta^2 = MS_{Between} / MS_{Error}$) or 21444.4 / 22950.0 = .93. The effect size is the ratio of the means squared between to the means error. In this study, the effect size was the amount of observed variance in the number of write-ups (dependent variable) due to living in a particular dorm (independent variable). Therefore 93% of the variance in the write-ups was due to being in a particular dorm.

Conclusion

The overall research question asked by this study was how effective a TC program is in reducing the numbers of institutional write-ups. The data from the adjustment hearing results was subjected to a one-way, repeated measure ANOVA. This statistical test showed a significant difference existed between the dorms under consideration. The post hoc tests were then conducted to determine which dorm was significantly different. The results indicated the TC dorm was significantly different from the other dorms with respect to institutional write-ups. An effect size was calculated to determine how much of the difference living in the TC dorm, as opposed to living in the other dorms, had on the amount of institutional write-ups. As stated above, this calculation revealed 93% of the variability in the amount of institutional write-ups in the prison was due to the dorm in which the inmate was living.

CHAPTER 4

Discussion

The results of this study demonstrate significantly lower rates of institutional write-ups of the clients in the TC treatment program as compared to the inmates in the four non-treatment control groups at GRCC. Also, the clients in the TC program had significantly less violent write-ups than the inmates in the four non-treatment control groups at GRCC.

One reason for the lower rate of institutional write-ups from the TC clients as opposed to the control group may be due to the TC sanctioning system. As pointed out in chapter one, clients in the TC program are required as part of being in the TC program to challenge and cause a change in each other's negative behavior. The use of the tools that are available for a TC client (e.g., pull-up, Confrontation group, TPR, and LE) may prevent rule violation behaviors and negative attitudes before they become serious enough to require an institutional write-up. This is what is known in the TC program as "watching over a brother". The TC sanctioning system is more than just a means of applying consequences, it is also a means of reacting to behaviors without the client becoming cynical or defocused from treatment. The use of the TC behavioral tools is the first choice for both clients and staff when dealing with most of the infractions of rules.

Another possible explanation for this lowered rate of institutional write-ups may be due to the correctional staff choosing to use an LE as opposed to an institutional write-up for a rule infraction or negative behavior. As noted in Chapter 1, when a client receives an institutional write- up, it is sent to the Adjustment Officer to be heard. However, this process may take several weeks before the institutional write-up is heard and adjudicated.

Corrections staff understand this rather lengthy delay before the final adjudication is made. By the time it is finally finished, the impact of any sanction imposed has lost most of its natural consequences effects. As a result little connection is made between the actual infraction and consequence. Most of the consequences for the lower category write-ups involve extra work duty. This extra duty is assigned and kept up with by an officer, causing them more work. Often the original write-up is adjusted to a lesser level write-up. In many cases the final class of write-up is nothing like what the actual infraction was. However, the correctional staff can use the TC LE for a behavior problem instead of an institutional write-up.

The benefit of using the TC LE other than an institutional write-up is evident in the immediate outcome provided by the LE. The correctional staff can see the impact the LE has upon the client within a short period of time, normally within the same day that it occurred. The Parole Board does not see an LE or any other part of the TC sanction system. As such, getting a LE does not impact a client's parole or parole eligibility. If a client receives an institutional write-up, it is posted on the KOMS record and can be reviewed by the Parole Board. This can have a negative impact on the Parole Board's decision as to grant parole.

Many times a TC client will request a correctional staff use an LE instead of an institutional write-up. As stated earlier, when a client completes an assigned LE, it is deleted from their file. The only record of the LE that is a notation made on the client's treatment plan, of the offense they committed and the date they received it. These records are kept in the client file, not the institution file. The client's treatment file is not seen by corrections administration or by the parole board unless a specific request is made. Write-

ups, as previously noted, are entered into the KOMS system and are seen by the parole board before an inmate meets with them. The clients know this and will do anything to prevent any adverse letter, notation, etc. from ending up in KOMS. So they would naturally request, from an officer or any staff, they receive an LE instead of an institutional write-up.

Only clients in the TC program can receive an LE for a rule or behavioral infraction instead of or in addition to an institutional write-up. All of the other inmates at the prison cannot request or receive a LE. This is a "special situation" dictated by the TC program requirements. When the TC program was started several inmate grievances were filed by inmates not in the TC program stating that the LE system was not fair to all inmates. General Counsel for the DOC was consulted and this grievance was denied due to the fact that the TC program was a voluntary program with "unique properties" that allowed for the use of alternatives to CPP policies.

If the number of LEs were combined with the actual institutional write-ups for the TC clients, it would have increased the total numbers for Dorm three. Approximately 30 LEs are turned in each week on clients in the TC program. The use of the LE system by the staff, opposed to using the institutional write-up system accounts for about 10% of the weekly LEs. This would account for 156 LEs over the year. If you added in this number with the number of write-ups the TC program obtained, it would increase the totals significantly.

However, the use of LEs is encouraged by the staff; the option is often employed in the TC program for very minor infractions, many of which are not covered in the institutional write-up system. It is also used to help clients learn to hold each other

accountable and in general interact with each other in a pro-social way. It also has the added benefit of reducing a clients' perception that failure leads to punishment. Any TC program that has a low amount of LEs is probably not very healthy. As such, including the LEs with the institutional write-ups was not a part of this study.

Another possible reason for the lowered rates of institutional write-ups by the TC clients may be due to staff laziness. When a staff person generates an institutional write up, they are required to complete a lengthy form that takes at least 30 minutes to enter on the computer. This write up is then scrutinized by an Investigating Officer and then by the Adjustment Officer. The staff person may have to testify at the adjustment hearing on the write up. At any of these steps the write up can be dismissed, thrown out, or adjusted to a lower level of write-up. As a result of all these extra reviews, it just becomes easier for the staff person to turn the behavioral infraction in as a written pull up knowing that it will result in a LE. The staff person is able to justify in their mind that they are just "working with" the TC program norms. It saves the staff person time and effort and they still end up with a sanction. Since TC clients are not allowed to dialogue about a written pull up, it makes it easy for a staff person to just "put them on paper" and let the TC staff deal with it.

The treatment environment itself may be a possible reason for the lowered rates of institutional write-ups for the TC clients. Three groups of people constantly monitor TC clients on a daily basis; treatment staff, security staff, and other clients in the program. When a behavior problem or rule infraction occurs it is dealt with within the community through the TC sanction tools (e.g., pull-up, written pull-up, etc.). Also, using the

previously mentioned confrontation group is a very effective way of preventing or diffusing an emotional situation that could escalate into a fight.

The inmates in the control group dorms do not have a mechanism to diffuse or resolve behavioral issues like the TC clients. They can request protective custody if they feel threatened. This would involve their being place in the Special Management Unit (SMU), otherwise know as the "jail" within the prison. However, the inmates that are not part of the treatment program are not eligible to use any of the TC behavioral sanctions and rewards. They may, however, file grievances based upon their perception of unequal treatment (Burdon et al., 2003).

The most important process that causes change in a client's behavior and attitude in a TC program is likely the peers in the community who confront other clients when negative attitudes or behaviors are displayed; and who serve as role models for lifestyle change to occur. They do so by use of positive and negative reinforcements in the form of the TC sanctioning tools (Neilson & Scarpitti, 1997). Peer interaction and confrontation that hold clients accountable for their attitudes and behaviors can be strong deterrents to infractions of institutional rules and criminal behavior.

The TC Buddy system may be another possible reason that the TC clients received less institutional write ups than the control group. The TC Buddy System forces clients to work together in order to get from place to place on the institution's yard. Clients have to "work things out" and do more planning ahead in order to get from place to place within the prison. Since they have to make an effort to get around, they spend less time on the yard and are thus less exposed to situations where they might get an institutional write up.

As stated above, the Buddy System requires a TC client have a fellow client with him at all times when he ventures out of Dorm 3. In addition to requiring the TC client to make better plans, the Buddy System forces them into a more pro-social way of interacting with other TC clients and corrections staff. TC Clients learn to ask for help which goes against everything that happens in a prison environment. The norm in a prison setting is "you do your time and I'll do mine, don't mess with me and I won't mess with you".

TC clients hold each other accountable and responsible for their behavior and attitudes. Clients in the TC program are instructed from the very beginning, that they are to "watch over" a brother. They are required during each phase to demonstrate holding other clients accountable. They do so by generating written pull-ups on other TC clients and by doing a live demonstration on another client in the presence of a staff member. This is known as showing ownership of the program. In phase B, as stated above, a client is required to complete a mandatory written pull-up on a co-client. It may be due to the emphasis upon accountability and mandatory written pull-ups. These are responsible for modifying behaviors and reducing criminal activity which results in reductions in institutional write ups.

According to Lipton (1998) recovery in a TC program involves changing clients' negative behavior patterns, attitudes, and dysfunctional roles that were learned in the interactions they had with their criminal peers. He further notes that recovery depends on learning by doing and participating in the community through the various roles that are required of a TC client. The act of holding another client accountable for their behaviors, both positive and negative, helps to gradually cause a change in the identity and lifestyle

of a client. Frankel (as cited in Nielsen & Scarpitti, 1997) notes that a TC program provides the mechanism and context to cause a change in behavior. These changes are designed to create a new cognitive orientation that allows for a redefinition of self. TC clients learn to control their behavior through holding each other accountable, and thus become more honest with others and themselves. The result is that they develop increased responsibility and self-reliance (U.S. Department of Health and Human Services, 2004). The reduction of institutional write-ups may be due to the TC programs' emphasis on accountability combined with the lengthy period of reinforcement in the TC program that brings about this redefinition of self.

The TC program at GRCC may be unique program. Each of the individual TC programs in the state are allowed to make adjustments to the program to suit the particular prison environment in which it is housed. There may be something about the TC program that makes it effective in reducing write-ups that was not evident to the researcher in this study. The average amount of direct services (e.g., individual, and group therapy) is 10.0 hours per client per week. This is much higher than any of the other DOC TC programs (7.0 hours per client per week). This increased amount of time in direct treatment may account for the lowered rate of write-ups. This may be a direction for further research.

Possibly, the GRCC itself is a unique prison. GRCC has a reputation as being a "laid back" prison. Inmates have a lot of room to move about due to the open concept of the prison. Inmates have a variety of programs that they can become involved in, including obtaining their GED, taking college courses, masonry, carpentry or other vocational classes. All inmates at GRCC are required to hold a job. If they do not obtain and hold a

job they are placed in 90 day unassigned status. This status requires the inmate to be locked in his cell from 12:00 pm till 8:00 am each day. As a result most of the inmates hold a job and are thus busy most of the day. This keeps everyone out of trouble.

Another reason the TC clients received fewer institutional write-ups could be due to the client's self correcting their behaviors before actually being admitted to the program. Clients are aware of the TC sanctioning system before they are admitted. It is described in the application for admission. The client is also told if he gets a write-up after he has been accepted into the program, he will have to wait up to six months and then reapply. As a result of this "probationary period" potential clients come into the program with a clean institutional record and with their behavior somewhat modified. To test this possible effect, all of the write-ups earned before admission to the program could be tabulated and compared to the post treatment results.

Finally, a majority of the clients in the TC program were recommended to complete the TC program either by the Parole Board or by their case manager. Therefore, it may be the threat of failing to complete treatment rather than the effects of the TC program on the reduction of write-ups. However, Prendergast and his colleges (as cited in Dietz et al., 2003) note “coercive treatment appears to be just as effective as non-coercive treatment at controlling inmate behavior” (p. 221).

Conclusion

Prison-based TC programs have become widely accepted as the most effective form of treatment for inmates with severe substance abuse diagnosis (Wexler et al., 1991). As the DOC and correction administrators are faced with budgets and mandates to “do more with less”, programs that demonstrate efficiencies while providing mandated treatment

will be sought after. Empirical support has demonstrated the effectiveness of TC programs in reducing relapse and recidivism. As a result, taxpayers, DOC, administrators, and inmates are bettered served in terms of saved dollars, increased security and the return of inmates to becoming contributing citizens in society. This study points out an additional benefit to the administrators of the DOC. The TC program is an effective tool for the control and management of inmates within the prison. The reduction of institutional disorder (write ups) will save money due to reduced need of staff to investigate and adjudicate the write ups. More important, because of reduced behavioral problems and the violence that is associated with it, the TC program may save the lives of inmates directly and staff indirectly.

This study also describes the framework for understanding how and why the TC program at GRCC provides effective treatment to inmates in a medium security prison. The framework is unique in that it attempts to show the dynamic ongoing processes occurring among the different elements of the program. These elements combine to produce a global change in clients that become the basis for their being able to return to society and live drug free lives.

Limitations

The results of the current study should be viewed with caution. Only one TC program was examined. It may be the results of this TC program are unique and are not transferable to other medium security prisons. To control for programmatic variables, it may be that another study could be attempted that would include all of the Kentucky DOC, TC programs. Including all of the TC programs would increase the population sample and reduce possible sample bias.

As mentioned above, the use of LEs only for TC clients could be considered as a limitation in this study. General population inmates are not able to receive LEs for some infractions that the TC clients get. However, TC client behavior that would not be considered as an infraction in the general prison (i.e., slouching in a chair, not having name badge on correctly, or not having uniform ironed) is given a great deal of attention and results in LEs. Therefore, TC clients enjoy the benefits of an LE as opposed to a write-up, but their behavior is held to a higher standard and they receive sanctions for minor behavior infractions that would go unnoticed in the general population.

Another caution is that the clients' behaviors may have changed before treatment. Clients who were given "parole upon completion" would have an additional pressure to conform that is not attributed to the program. Future studies could include the number and type of write-ups the TC clients and control group participants received before they entered treatment. They could then be tracked during treatment to see if this changed.

Given the results of the current study, it would appear TC programs have a positive effect on the reduction of institutional write-ups and therefore improve the quality of the environment for the clients and DOC staff alike. Costs reductions, in terms of added personnel, repair to possible damage to state property, and medical treatment from violent acts as results of inmate disorder may be realized. These benefits are attractive to the administrators, clients, and taxpayers of the state of Kentucky.

Recommendations

It is important to note other benefits of a TC program have application beyond prison-based TC programs. These should be considered in any new initiative or planned expansion of existing substance abuse treatment programs. The application of the concept

of inmates holding each other accountable for their behavior and their involvement in the operations of the dorm may cause reductions in write-ups similar to those in the TC program. According to De Leon (2000b) "the essential elements of the TC resonate the ideals of good society, the values of right living, the obligation to be role models, the power of self-help, and the use of community as method to facilitate individual growth" (p. 393). It is in these ways TC programs can enhance the quality of life for an individual while they are incarcerated.

Increasing the safety and security of inmates and staff, while at the same time maintaining the protection of society, is the primary goal of the correctional system. The TC program has demonstrated it can have a significant impact on meeting this goal. This study took a "sample" of the population of TC programs. In order to generalize these findings it is recommended that the same data be collected from several medium security prisons. By increasing the sample size and including more general population dorms the results would increase the confidence that TC programs have a positive effect upon the reduction of institutional write-ups.

This research adds to the body of research on the efficacy of TC programs within the prison system. Currently there are more than 120 revised standards that cover 11 domains that have undergone field testing conducted by the Office of National Drug Control Policy and Therapeutic Communities of America. These standards dictate the essential treatment elements in the TC approach to the treatment of substance abuse problems in a prison setting.

References

Aos, S., Phipps, P., Barnoski, R., & Lieb, R. (2001). The comparative costs and benefits of programs to reduce crime: A review of national research findings with implications for Washington state. Retrieved from http://www.wsipp.wa.gov/rptfiles/costbenefit.pdf.

Antonowicz, D., & Ross, R. (1994). Essential components of successful rehabilitation programs for offenders. *International Journal of Offender Therapy and Comparative Criminology, 38,* 97-104.

Bell, D. (1994). Connection in therapeutic communities. *International Journal of Addictions, 29*(4), 525-543.

Broekaert, E., Vander Straten, G., D'oosterlinck, F., & Kooyman, M. (1999). Therapeutic community for ex-addicts: A view from Europe. *Therapeutic Communities: The International Journal for Therapeutic and Supportive Organizations,* 20(4), 255-266.

Brown, B. S. (1998). Towards the year 2000: Drug use-Chronic and relapsing or a treatable condition? *Substance Use and Misuse, 33*(12), 2515-2520.

Burdon, M., Farabee, D., Prendergast, M., Messina, N., & Cartier, J. (2002). Prison based therapeutic community substance abuse programs: Implementation and operational Issues. *Federal Probation, 66*(3), 3-8.

Burdon, W., Dang, J., Prendergast, M., Messina, N., & Farabee, D. (2007). Differential effectiveness of residential versus outpatient aftercare for parolees from prison-based therapeutic community treatment programs. *Substance Abuse Treatment Prevention and Policy, 2*(10), 1-14.

Burdon, W., Prendergast, M., Eisen, V., & Messina, N. (2003). Sanctions and rewards in

a prison-based therapeutic community. *Federal Probation, 67*(2), 47-52.

Burdon, W., Prendergast, M., & Frankos, C. (2001). *Prison-based therapeutic community treatment from the perspective of the participants.* Unpublished manuscript.

Bureau of Justice Statistics. (1992). Crime and the justice system. Washington, D.C.: Department of Justice, Office of Justice Programs.

Capps, E., Myers, B., & Helms, J. (2004). Therapeutic community: The effects of training and personal substance abuse history on job stress professional efficacy. *Journal of Forensic Psychology Practice, 4*(3), 31-49.

Center for Substance Abuse Treatment. (2005). *Substance abuse treatment for adults in the criminal justice system. A treatment improvement protocol (TIP) Series 44*. (DHHS Publication No. 05-4056). Rockville, MD: Substance Abuse and Mental Health Services Administration.

Center for Substance Abuse Treatment. (2006). *Therapeutic community curriculum: Training Manual. (*DHHS Publication N. 06-4121). Rockville, MD: Substance Abuse and Mental Health Service Administration.

Charkhuff, R., & Anthony, W. (1979). *The skills of helping.* Amherst, MA: Human Resources Development Press.

Clarke, D. (1997). Therapeutic communities for drug misusers. *Prison Service Journal, 5,* 111.

Commonwealth of Kentucky Department of Corrections. (2010). Research shows jail and prison-based substance abuse treatment initiatives working [press release]. Retrieved from http://corrections.ky.gov/news/researchshows.htm. 01/31/11.

Corey, G. (1977). *Theory and practice of counseling and psychotherapy.* Belmont, CA:

Wadsworth Publishing Company, Inc.

Craig, S. (2004). Rehabilitation versus control: An organizational theory of prison management. *The Prison Journal, 84*(4), 92-114.

De Leon, G., & Wexler, H. (2009). The therapeutic community: An evolving knowledge base. *Journal of Drug Issues, 39*(1), 167-178.

De Leon, G. (1990). The therapeutic community and behavioral sciences. *International Journal of Addiction, 25*(1), 1537-1557.

De Leon, G. (1995). Therapeutic communities: A theoretical framework. *International Journal of Addictions, 30*(12), 1603-1645.

De Leon, G. (1999). Drug abuse: Origins and interventions. In G. De Leon (Ed.), *Therapeutic communities*: *Research and applications* (395-430). Washington, DC: American Psychologist Association.

De Leon, G. (2000a). Motivation for treatment in a prison-based therapeutic community. *American Journal of Alcohol Abuse, 2,* 1-10.

De Leon, G. (2000b). *Therapeutic community: Theory, model, and mode.* New York: Springer Publishing Company.

De Leon, G., & Schwartz, S. (1984). The therapeutic community: What are the retention rates? *American Journal of Drug and Alcohol Abuse, 53,* 51-56.

Dekel, R., Benbenishty, R., & Amram, Y. (2004). Therapeutic communities for drug addicts: Prediction of long-term outcomes. *Addictive Behaviors, 29*(9), 1833-1837.

Deitch, D., Koutesenak, I., Burgenes, M., & Cartier, J. (2001). Does in-custody therapeutic community substance abuse treatment impact custody personnel? *Corrections Compendium, 2*(2), 4-26.

Deitch, D., Koutesenak, I., & Ruiz, A. (2004). In-custody therapeutic community substance abuse treatment: Does it have an impact on custody personnel? *Criminal Justice Policy Review, 15*(1), 61-83.

Dietz, E., O'Connell, D., & Scarpitti, F. (2003). Therapeutic communities and prison management: An examination of the effects of operating an in-prison therapeutic community on levels of institutional disorder. *International Journal of Offender Therapy and Comparative Criminology, 47*(2), 210-223.

Eisenberg, M. (1999). *Three year recidivism tracking of offenders participating in substance abuse treatment programs.* Austin, TX: Texas Criminal Justice Policy Council.

Farabee, D., Prendergast, M., Cartier, J., Wexler, H., Knight, K., & Anglin, D. (1999). Barriers to implementing effective correctional drug treatment progress. *The Prison Journal, 79*(2), 150-162.

Fernandez-Montalvo, J., Lopez, G., Illescas, C., Landa, N., & Lorea, I. (2008). Evaluation of a therapeutic community treatment program: A long term follow-up study in Spain. *Substance Use and Misuse 43,* 1362-1377.

Field, A., (2009). *Discovering statistics using SPSS* (3rd ed.). London, England: SAGE Publications, Ltd.

Gavin, D., Ross, H., & Skinner, H. (1989). Diagnostic validity of the drug abuse screening test in the assessment of DSM III drug disorders. *British Journal of Addiction, 84*, 301-307.

Greenall, P. (2004). Life in a prison-based therapeutic community: One man's experience. *British Journal of Forensic Practice, 6*(1), 33-38.

Grenders, E., & Player, E. (1995). *Grendon: A study of a therapeutic community*. Oxford, England: Clarendon Press.

Griffith, J., Hiller, M., Knight, K., & Simpson, D. (1999). A cost effectiveness analysis of in-prison therapeutic community treatment and risk classification. *Prison Journal, 79*(4), 352-368.

Hardyman, P. (2001). *Revalidation of the Kentucky Department of Corrections classification system: Final report*. Washington, DC: University of Amsterdam, Institute on Crime, Justice & Corrections.

Harrison, L., Backenheimer, M., & Inciardi, J. (1995). *Cannabis use in the United States: Implications for policy.* In Cohen, P. & Sas, A. (Eds). Cannabisbeleid in Duitsland. Washington, DC. University of Amsterdam.

Harrison, P., & Beck, A. (2002). Prisoners in 1980. U.S. Department of Justice, Bureau of Justice Statistics. Washington, DC: U.S. Government Printing Office.

Hershenson, D., & Power, P. (1987). *Mental health counseling: Theory and practice.* New York: Pergaman Books, Inc.

Hiller, M., Knight, K., & Simpson, D. (1999). Prison-based substance abuse treatment, residential aftercare and recidivism. *Addiction, 94* (6). 833-842.

Hogan, D., Lausche, J., & Keller, J. (2004, August 1). *Kentucky leading the nation in its efforts to curb drug abuse and be effective on crime* [Press release]. Retrieved from http://odcp.ky.ky.gov/news/pressreleases/ODCP08262004.htm.

Hooper, R., Lockwood, D., & Inciardi, J. (1993). Treatment techniques in corrections based therapeutic communities. *Prison Journal, 73*(1), 290-306.

Inciardi, J. (1979). Heroin use and street crime. *Crime and Delinquency, 25*(1), 335-346.

Inciardi, J., Martin, S., Butzin, C., Hooper, R., & Harrison, L. (1997). An effective model of prison-based treatment for drug involved offenders. *Journal of Drug Issues, 24*, 261-278.

Inciardi, J., Martin, S., & Surratt, H. (2001). Therapeutic communities in prisons and work release: Effective modalities for drug-involved offenders. In B. Rawlings & R. Yates (Eds.), *Therapeutic communities for the treatment of drug users* (241-256). London, England: Jessica Kingsley Publishers.

Jensen, E., & Kane, S. (2010). The effect of therapeutic community on the time to first re-arrest: A survival analysis. *Journal of Offender Rehabilitation, 49*(3), 200-209.

Keister, D. (1992). You put your life on the line. *Corrections Today, 54,* 146.

Kennard, D. (2004). The therapeutic community as an adaptable treatment across different settings. *Psychiatric Quarterly, 75*(3), 295-302.

Kinlock, T., O'Grady, K., & Hanlon, T. (2003). The effects of drug treatment on institutional behavior. *The Prison Journal, 83*(3), 257-276.

Klocke, K. (1991). Drug related crime and addicted offenders: A proposed response. *Notre Dame Journal of Law Ethics and Public Policy, 5*(3), 639-649.

Knight, K., Simpson, D., & Hiller, M. (1999). Three-year re-incarceration outcomes for in-prison therapeutic community treatment in Texas. *Prison Journal, 79*(3), 337-351.

La Barbera, M. (1998). TC counselor training: Skill building a how-to-manual on clinical tools common to therapeutic communities. Unpublished manuscript.

Levy, E., Faltic, G., & Bratcher, T. (1977). The development and structure of the drug free therapeutic community. *Addiction Therapist, 2*(2), 44.

Lewis, D. (1991). Comparison of alcoholism and other medical diseases: Internists

view. *Psychiatric Annals, 25*, 256-265.

Lipton, D. (1994). The correctional opportunity: Pathways to drug treatment for offenders. *Journal of Drug Issues, 24*, 331-349.

Lipton, D. (1998). Therapeutic communities: History, effectiveness and prospects. *Corrections Today, 60*(6), 50-67.

Maglinger, L. (2001). Therapeutic community handbook. Unpublished manuscript.

Martin, S., Butzin, C., Saum, C., & Inciardi, J. (1999). Three year outcomes of therapeutic community treatment for drug-involved offenders in Delaware: From prison to work release to aftercare. *Prison Journal, 79*(3), 294-320.

McCollister, K., & French, M. (2002). The cost of drug abuse treatment in criminal justice settings. *Treatment of Drug Offenders: Policies and Issues, 6*(5), 29-37.

McCollister, K., French, M., Inciardi, J., Butzin, C., Martin, S., & Hooper, R. (2003). Post release substance abuse treatment for criminal offenders: Cost effectiveness analysis. *Journal of Quantitative Criminology, 19*(4), 389-407.

McCollister, K., French, M., Prendergast, M., Wexler, H., Sacks, S., & Hall, E. (2003). Is in-prison treatment enough? A cost effectiveness analysis of prison-based treatment and aftercare services for substance abusing offenders. *Law and Policy, 25*(1), 63-82.

McEneaney, K. (1996). Substance abuse treatment in prison saves money and makes sense. *Alcoholism and Drug Abuse Weekly, 8*(24), 24-32.

Melnick, G., De Leon, G., Hiller, M., & Knight, K. (2000). Therapeutic communities diversity in treatment elements. *Substance Use Misuse, 35*(12-14), 1819-1847.

Messina, N., Wish, E., & Nemes, S. (2001). Therapeutic community treatment may

reduce future incarcerations: A research note. *Federal Probation, 65*(1), 40-62.

Mitchell, O., Wilson, D., & MacKenzie, D. (2007). Does incarceration-based drug treatment reduce recidivism? A meta-analytic synthesis of the research. *Journal of Experimental Criminology, 3*(4), 353-375.

Morse, R., & Flavin, D. (1992). The definition of alcoholism. *Journal of the American Medical Association, 268*(8), 1012-1014.

Moussas, G., Dadouti, G., Douzenenis, A., Poulis, E., Tzelembis, A., Bratis, D., ... Lykoures, L. (2009). The alcohol use disorders identification test AUDIT: Reliability and validity of the Greek version. *Annuals of General Psychiatry, 8*(11), 255-276.

National Institute on Drug Abuse. (2002). Research report: Therapeutic community. (NIH publication number 2, 4877). Washington, D.C.: Author.

Neilsen, A., & Scarpitti, F. (1997). Changing the behavior of substance abusers: Factors influencing the effectiveness of therapeutic communities. *Journal of Drug Issues, 27* (2), 279-298.

Newman, J. (1970). *What every person needs to know about drugs.* Washington, DC: US News & World Report publishers.

Office of National Drug Control Policy. (1999). *Therapeutic communities in correctional settings: The prison based TC standards development projects*. Final report of phase II (NCJ-179365). Retrieved from https://www.ncjrs.gov/ondcppubs/publications/pdf/therap_comm.pdf.

Patman, C. (2002). Therapeutic communities: Thinking outside the box. *Corrections Today, 29*(1), 15-19.

Pearson, F., & Lipton, D. (1999). A meta-analytic review of the effectiveness of corrections-based treatments for drug abuse. *Prison Journal, 79*(4), 384-410.

Pelissier, B., Rhodes, W., Saylor, W., Gaes, G., Camp, S., Vanyur, S., & Wallace, S. (2000). *TRIAD drug treatment evaluation project: Final report of three-year outcomes.* Washington, DC: Federal Bureau of Prisons.

Pew Center on the States (2008). *One in 100: Behind bars in America 2008* (Report Number 1). Retrieved from http://www.pewcenteronthrstates.org/upl oadedFiles/One%20in%20100pdf.

Rawlings, B. (1999). Therapeutic communities in prisons: A research review. *The International Journal for Therapeutic and Supportive Organizations, 20*(3), 1-17.

Reinert, D., & Allen, J. (2007). The alcohol use disorder identification test: An update of research findings. *Alcoholism: Clinical & Experimental Research, 31*(2), 185-199.

Scalia, J. (2001). Federal drug offenders, 1999 with trends 1984-99. U.S. Department of Justice, Bureau of Justice Statistics. *Washington, D.C.: U.S. Department of Justice, 8*, 7.

Selin, K. (2003). Test-retest reliability of the alcohol use disorder identification test in a general population sample. *Alcoholism: Clinical and Experimental Research, 27*(9), 1428-1435.

Shields, A., & Coruso, J. (2003). Reliability of the alcohol use disorder identification test. *Educational and Psychological Measurement, 63*(3), 404-413.

Simpson, D. (1997). The relation of time spent in drug abuse treatment to post treatment outcomes. *American Journal of Psychiatry, 136,* 449-1453.

Stanton-Tindall, M., McNees, E., Leukefeld, C., Thompson, L., Pangburn, K., & Oser, C.

(2009) Systematic outcomes research for corrections-based treatment: Implications from the criminal justice Kentucky treatment outcomes study. *Journal of Offender Rehabilitation, 48*(8), 710-724.

U.S. Department of Health and Human Services. (2004). *Substance abuse treatment for adults in the criminal justice system: A treatment improvement protocol (TIP)Series 44* (DHHS Publication No. (SMA) 05-4056). Rockville, MD: Substance Abuse and Mental Health Services Administration.

Vandevelde, S., Broekaert, E., Yates, R., & Kooyman, M. (2004). The development of the therapeutic community in correctional establishments: A comparative retrospective account of the democratic and the hierarchical concept based TC in prisons. *International Journal of Social Psychiatry, 50*(1), 66-79.

Wacker, T. (1992). What it means to be an officer. *Corrections Today, 54*, 144-146.

Warren, K., Harvey, C., De Leon, G., & Gregorie, T. (2007). I am my brother's keeper: Affirmations and corrective reminders as predictors of re-incarceration following graduation from a corrections-based therapeutic community. *Offender Substance Report, 11*, 3.

Welsh, W., McGrain, P., Salamantin, N., & Zajac, G. (2007). Effects of prison drug treatment on inmate misconduct. *Criminal Justice and Behavior, 34*(5), 600-615.

Wexler, H. (1998a). A message from researchers: Prison-based treatment works. *Alcoholism & Drug Abuse Weekly, 6* (33), 15-18.

Wexler, H. (1994b). Progress in prison substance abuse treatment: A five-year report. *Journal of Drug Issues, 24*, 349-361.

Wexler, H. (1995). The success of therapeutic communities for substance abusers in

American prisons. *Journal of Psychoactive Drugs, 27*(3), 57-66.

Wexler, H., Blackmore, J., & Lipton, D. (1991). Project reform: Developing a drug abuse treatment strategy for corrections. *Journal of Drug Issues, 21*(2), 469-490.

Wexler, H., Falkin, G., & Lipton, D. (1990). Outcome evaluation of a prison therapeutic community for substance abuse treatment. *Criminal Justice and Behavior, 17*(1), 71-92.

Wexler, H., Melnick, G., Lowe, L., & Peters, J. (1999). Three year re-incarceration outcomes for Amity in-prison therapeutic community and aftercare in California. *Prison Journal, 79*(3), 312-336.

Wexler, H., & Prendergast, M. (2010). Therapeutic communities in the United States' prisons: Effectiveness and challenges. *Therapeutic Communities,* 31(2), 157-175.

Wilson, J., & Snodgrass, J. (1969). The prison code in a therapeutic community. *Journal of Criminal Law, Criminology, and Police Science, 60*(4), 472-478.

Woodruff, L. (1993). Occupational stress for correctional personnel, part 1. *American Jails, 15*, 15-20.

Yablousky, L. (1989). *The therapeutic community.* New York: Garden Press.

Yudko, E., Lozhkina, O., & Fouts, A. (2007). A comprehensive review of the psychometric properties of the drug abuse screening test. *Journal of Substance Abuse Tests, 32*(2), 189-198.

Zhang, S., Roberts, R., & McCollister, K. (2009). An economic analysis of the in-prison therapeutic community model on prison management costs. *Journal of Criminal Justice, 37*(4), 388-395.

APPENDIX A

ALCOHOL USE DISEASE IDENTIFICATION TEST (AUDIT)

Name _____ Number _____ Date _____

01. How often do you have a drink containing alcohol?
(0) Never (1) monthly or less (2) 2-4 times a month (3) Weekly (4) Daily

02. How many drinks containing alcohol do you have on a typical day when you drink?
(0) 1 or 2 (1) 3 or 4 (2) 5 or 6 (3) 7 to 9 (4) 10 or more

03. How often do you have 6 or more drinks on one occasion?
(0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily

04. How often during the last year have you needed a drink in the morning to get yourself going after a heavy drinking session?
(0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily

05. How often during the last year have you found that you were not able to stop drinking once you had started?
(0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily

06. How often during the last year have you failed to do what was normally expected from you because of drinking?
(0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily

07. How often during the last year have you had a feeling of guilt or remorse after drinking?
(0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily

08. How often during the last year have you been unable to remember what happened the night before because you had been drinking?
(0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily

09. Have you or someone else been injured as a result of your drinking?
(0) No (2) Yes, but not in the last year (4) Yes, in the last year

10. Has a relative, friend, doctor, or other health worker been concerned about your drinking or suggested that you cut down on your drinking?
(0) No (2) Yes, but not in the last year (4) Yes, in the last year

APPENDIX B

DRUG ABUSE SCREENING TEST (DAST)

DAST (Drug Abuse Screening Test) Name: _____

01. Have you used drugs other than those required for medical reasons?	Yes	No
02. Have you abused prescription drugs?	Yes	No
03. Do you abuse more than one drug at a time?	Yes	No
04. Can you get through the week without using drugs (other than those required for medical reasons)?	Yes	No
05. Are you always able to stop using drugs when you want to?	Yes	No
06. Do you abuse drugs on a regular basis?	Yes	No
07. Do you try to limit your drug use to certain situations?	Yes	No
08. Have you had "blackouts" or "flashbacks" as a result of drug use?	Yes	No
09. Do you ever feel bad about your drug abuse?	Yes	No
10. Does your spouse (parents) ever complain about your involvement with drugs?	Yes	No
11. Do your friends or relatives know or suspect that you abuse drugs?	Yes	No
12. Has drug abuse ever created problems between you and your spouse?	Yes	No
13. Has any family member ever sought help for problems related to your drug use?	Yes	No
14. Have you ever lost friends because of your use of drugs?	Yes	No
15. Have you ever neglected your family or missed work because of your use of drugs?	Yes	No
16. Have you ever been in trouble at work because of drug abuse?	Yes	No
17. Have you ever lost a job because of drug abuse?	Yes	No
18. Have you gotten into fights when under the influence of drugs?	Yes	No
19. Have you ever been arrested because of unusual behavior while under the influence of drugs?	Yes	No
20. Have you ever been arrested for driving under the influence of drugs?	Yes	No
21. Have you engaged in illegal activities to obtain drugs?	Yes	No
22. Have you ever been arrested for possession of illegal drugs?	Yes	No
23. Have you ever experienced withdrawal symptoms as a result of heavy drug intake?	Yes	No
24. Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, or bleeding)?	Yes	No
25. Have you ever gone to anyone for help for a drug problem?	Yes	No
26. Have you ever been in a hospital for medical problems related to your drug use?	Yes	No
27. Have you ever been involved in a treatment program specifically related to drug use?	Yes	No
28. Have you been treated as an outpatient for problems related to drug abuse?	Yes	No

APPENDIX C

DSM-IV DIAGNOSTIC CRITERIA FORM

Client Name _____ Inmate # _____

Substance Abuse (1 or more occurring within a 12 month period)

1. _____ Recurrent substance abuse resulting in a failure to fulfill major role obligations at work, school, or home.
2. _____ Recurrent substance use in situations in which it is physically hazardous.
3. _____ Recurrent substance-related legal problems.
4. _____ Continued substance use despite having persistent or recurring social or interpersonal problems caused or exacerbated by the effects of the substance.

Substance Dependence (3 or more occurring within the same 12 month period)

1. _____ Tolerance
   _____ a. A need for markedly increased amounts of the substance to achieve intoxication or desired effect.

   OR

   _____ b. Markedly diminished effect with continued use of the same amount of the substance.
2. _____ Withdrawal
   _____ a. Characteristic withdrawal syndrome for the substance.

   OR

   _____ b. The same (or 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 effort to cut down or control substance use.
5. _____ A great deal of time is spent in activities necessary to obtain the substance, use the substance, 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.

DSM-IV DIAGNOSTIC CRITERIA FORM

ABUSE		DEPENDENCE
_____305.00	Alcohol	303.90 _____
_____305.70	Amphetamine	304.40 _____
_____305.20	Cannabis	304.30 _____
_____305.60	Cocaine	304.20 _____
_____305.30	Hallucinogens	304.50 _____
_____305.90	Inhalants	304.60 _____
_____305.50	Opiates	304.00 _____
_____305.90	Phencyclidine (PCP)	304.90 _____
_____305.40	Sedative, Hypnotic or Anxiolytic	304.10 _____
_____305.90	Other Substance	304.90 _____
	Poly-substance (3 groups)	304.80 _____
	Nicotine	305.10 _____

COURSE SPECIFIERS

_____With physiological dependence (evidence of tolerance or withdrawal)
_____Without physiological dependence (no evidence of tolerance or withdrawal)
_____Early full remission (1-12 months, no criteria for abuse or dependence)
_____Early partial remission (1-12 months, met 1 or more criteria for abuse or dependence)
_____Sustained full remission (1-12 months or longer, not met criteria for abuse or dependence)
_____Sustained partial remission (1-12 months or longer, met 1 or more criteria for abuse or dependence)
_____Agonist Therapy (prescribed medication, 1 month, no criteria for abuse or dependence)
_____Controlled environment (no access or restricted access, 1 month, no criteria for abuse or dependence

Primary Diagnosis: _____

Secondary Diagnosis: _____

Summary: _____

_____

_____ _____
Staff Signature **Date**

APPENDIX D

ALL INFORMATION CONTAINED ON THIS DOCUMENT MUST BE PRINTED OR TYPED

KENTUCKY DEPARTMENT OF CORRECTIONS
DISCIPLINARY REPORT FORM
PART 1- WRITE-UP AND INVESTIGATION

Name_____Number_____ Date & Time of Incident_____
Work Assignment_____ Institution_____ Housing Unit _____
The following incident was observed by me or otherwise (include statement of verification if application):
Place _____
Staff Involved _____
Inmates Involved _____
Description of Incident _____
_____
_____
_____
_____
_____
_____
Disposition of Physical Evidence _____
Date & Time of Report _____
Reporting Employee's Signature _____ Title _____

INVESTIGATION

Supervisor's Review – Name _____ Date _____ Time _____
Report of Investigating Officer _____
_____
_____
_____
_____
_____
_____
_____
Charge _____ Category _____
Investigating Officer _____ Title _____

I have received a copy of this report. I have been advised of my right to call witnesses and have an inmate legal aide or staff representative at my hearing. I understand it is my responsibility to make arrangements for inmate legal aide representation and witnesses.

Does inmate waive 24-hour notice? ____ Yes _____ No
Witnesses Requested _____
Waives Presence at hearing _____ Pleads guilty _____
Assigned Legal Aide/Staff Counsel _____Yes _____No; Name _____
If eligible, I request to be heard by a hearing Officer an waive Adjustment Committee hearing. ____Yes ____ No
Inmate's Signature _____ Date _____ Time _____
Anticipated Date _____ Time _____ Location of hearing _____

White – Inst Central file
Yellow-- Central Office
Pink -- Adj. Comm.
Gold -- Inmate

cc-1226
(Rev. 6/92

APPENDIX E

Kentucky Department Of Corrections Write-Up Categories

CATEGORY							
1-1 Faking illness or injury							
1-2 Improper /unauthorized use of state equip/materials							
1-3 Possession of money less than 20.00 amount authorized							
1-4 Illegal possession of canteen tickets							
1-5 Littering							
1-6 Improper or unauthorized use of a telephone							
1-7 Improper use of a pass							
1-8 Illegal possession of any item not on auth. Prop. List							
1-9 Failure to have and display I.D card							
1-10 Failure to abide by any pub inst. Sch.. or doc. Rule							
1-11 Unauthorized removal of food from any food service area							
1-12 Abusive, vulgar, obscene, or threat. lang. gestures / action							
CATEGORY II (MINOR VIOLATIONS)							
2-1 Possession of contraband							
2-2 Disruptive behavior							
CATEGORY III (MAJOR VIOLATIONS)							
3-1 Interfering with an employee in the perform. of his duty							
3-2 Refusing or failing to obey a direct order							
3-3 Violation of mail or visiting regulations							
3-4 Breaking or entering into another inmate's locker, living							
3-5 Unexcused absence from assignment							
3-6 Refusing or failing to carry out a work assignment							
3-7 Bucking an inmate line							
3-8 Involvement in writing, cir., or signing of petitions							
3-9 Failure to clean bed area or pass bed inspection							
3-10 Unauthorized changing of bed assignments							
3-11 Physical action against another inmate with no injury							
3-12 Inflicting injury to self							
3-13 Charging another inmate for services							

3-14 Violation of the Furlough Code of Conduct							
3-15 Being in a restricted or unauthorized area							
3-16 Unauthorized communication between inmates							
3-17 Forgery							
3-18 Violating a condition of any outside work detail							
3-19 Failure to abide by penalties imposed by Adj. Com.							
3-20 Abusive, disrespecting, vulgar, obscene directed towards employee							
3-21 Lying to an employee							
3-22 Unauthorized com. with any member of staff or public							
3-23 Violating the institutional dress code CPP 17.1							
3-24 Violation of institutional telephone rules							
3-25 Use or possession of tobacco products in unauthorized area							
CATEGORY IV (MAJOR VIOLATIONS)							
4-1 Physical action resulting in injury to another inmate							
4-2 Unauthorized use of drugs or intoxicants							
4-3 failure to appear at a class. hearing, or other sch. mtg.							
4-4 interfering with a drug test or cell search							
4-5 smuggling of contraband into, out of, or within the institution							
4-6 engaging in extortion or blackmail							
4-7 refusing / failing to comply with inst. Count / lockup pro.							
4-8 no-violent demonstration / inciting a non-violent demonstration							
4-9 unauthorized absence from the institution							
4-10 negligent/deliberate destruction of state prop. < $100.00							
4-11 obtaining goods, money, privileges or ser. under false pre							
4-12 inappropriate sexual behavior							
4-13 gambling or possession of gambling paraphernalia							
4-14 Stealing / possession of state, personal prop < $100.00							
4-15 unauthorized transfer of money or property							
4-17 indecent exposure							

4-18 misuse of authorized or issued medication							
4-19 making threat or intimidating statements							
4-20 refusing to submit to a breathalyzer or search							
4-21 pursuing or dev a relationship that is unrelated to a correction activity							
4-22 possession of drug para, including recipes							
4-23 stalking							
4-24 cruelty to animals							
4-25 placing per add in any pub / internet							
4-26 possession of unaccountable canteen items							
CATEGORY V (MAJOR VIOLATIONS)							
5-1 negligently /altering property at or > than $100.00							
5-2 destroying/tampering with life safety equip, sec. devices							
5-3 eluding or resisting apprehension							
5-4 loan sharking, collecting or incurring debts							
5-5 stealing / possession of stolen state, per. prop. > $100.00							
5-6 bribery							
5-7 tampering with physical evidence/ hindering an investigation							
5-8 using mail to obtain money, goods, or services by fraud							
5-9 possession of or displaying gang paraphernalia							
5-10 involvement in gang activity							
5-11 physical action against another inmate if 3 or more are involved							
5-12 violent demonstration							
CATEGORY VI (MAJOR VIOLATIONS)							
6-1 inciting to riot or rioting							
6-2 escape							
6-3 deliberately / negligently causing a fire							
6-4 possession / promoting dangerous contraband							
6-5 poss. of money > $20. in excess of authorized amount							

6-6 possession of tokens or money if not authorized							
6-7 possession of staff uniform clothing or uniform items							
6-8 taking property by force or threat of force							
6-9 using an unauthorized object as a weapon to fac. escape							
6-10 refusal to submit to medical examination							
6-11 creating or causing a health hazard							
6-12 enforcing or threatening gang activity							
6-13 inappropriate sexual behavior with another person							
6-14 tattooing or piercing self/others or allowing it							
6-15 unauthorized use of drugs or intoxication. after testing pos. x3							
6-16 refusing to submit to a drug test within 3 hours							
6-17 possession, creating, writing or photo. child porno							
6-18 prostitution as defined in KRS 529.010							
CATEGORY VII (MAJOR VIOLATION)							
7-1 physical action against an employee or non-inmate							
7-2 physical action resulting in death/serious injury to inmate							
7-3 sexual assault							
7-4 physical action resulting in death to employee or non-inmate							
7-5 hostage taking							
7-6 concealing an item that punctures/penetrates the skin of emp.							

APPENDIX F

WESTERN KENTUCKY UNIVERSITY
Institutional Review Board
Office of Research
301 Potter Hall
270-745-4652; Fax 270-745-4211
E-mail: Paul.Mooney@wku.edu

In future correspondence, please refer to HS11-285, April 25, 2011

Lee Maglinger
c/o Aaron Hughey
Counseling & Student Affairs
WKU

Lee Maglinger:

Your research project, *Assessing the Efficacy of a Modified Therapeutic Community on the Reduction of Institutional Write-Ups in a Medium Security Prison*, was reviewed by the IRB and it has been determined that risks to subjects are: (1) minimized and reasonable; and that (2) research procedures are consistent with a sound research design and do not expose the subjects to unnecessary risk. Reviewers determined that: (1) benefits to subjects are considered along with the importance of the topic and that outcomes are reasonable; (2) selection of subjects is equitable; and (3) the purposes of the research and the research setting is amenable to subjects' welfare and producing desired outcomes; that indications of coercion or prejudice are absent, and that participation is clearly voluntary.

1. In addition, the IRB found that you need to orient participants as follows: (1) signed informed consent is not required; (2) Provision is made for collecting, using and storing data in a manner that protects the safety and privacy of the subjects and the confidentiality of the data. (3) Appropriate safeguards are included to protect the rights and welfare of the subjects.

This project is therefore approved at the Exempt from Full Board Review Level.

2. Please note that the institution is not responsible for any actions regarding this protocol before approval. If you expand the project at a later date to use other instruments please re-apply. Copies of your request for human subjects review, your application, and this approval, are maintained in the Office of Sponsored Programs at the above address. Please report any changes to this approved protocol to this office. A Continuing Review protocol will be sent to you in the future to determine the status of the project. Also, please use the stamped approval forms to assure participants of compliance with The Office of Human Research Protections regulations.

Sincerely,

Paul J. Mooney, M.S.T.M.
Compliance Manager
Office of Research
Western Kentucky University

cc: HS file number Maglinger HS11-285