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A Modified Therapeutic Community: Reducing Violence in a Medium Security Prison

Lee Maglinger
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A MODIFIED THERAPEUTIC COMMUNITY: REDUCING VIOLENCE IN A MEDIUM SECURITY PRISON

A Thesis
Presented to
The Faculty of the Department of Counseling and Student Affairs
Western Kentucky University
Bowling Green, Kentucky

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

By
Lee Wayne Maglinger
February 2006
A MODIFIED THERAPEUTIC COMMUNITY: REDUCING VIOLENCE IN A MEDIUM SECURITY PRISON

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# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acknowledgements</td>
<td>iii</td>
</tr>
<tr>
<td>Table of Contents</td>
<td>iv</td>
</tr>
<tr>
<td>List of Tables</td>
<td>vi</td>
</tr>
<tr>
<td>Abstract</td>
<td>vii</td>
</tr>
<tr>
<td>Chapter 1</td>
<td>1</td>
</tr>
<tr>
<td>Problem Statement</td>
<td>1</td>
</tr>
<tr>
<td>Purpose of the Study</td>
<td>1</td>
</tr>
<tr>
<td>Background</td>
<td>2</td>
</tr>
<tr>
<td>Types of Therapeutic Communities</td>
<td>6</td>
</tr>
<tr>
<td>Concept of the Disorder</td>
<td>9</td>
</tr>
<tr>
<td>Concept of the Client</td>
<td>12</td>
</tr>
<tr>
<td>Generic Therapeutic Community</td>
<td>16</td>
</tr>
<tr>
<td>The ARCH Modified Therapeutic Community</td>
<td>22</td>
</tr>
<tr>
<td>Department of Corrections Institutional Write-Up System</td>
<td>41</td>
</tr>
<tr>
<td>Chapter 2</td>
<td>43</td>
</tr>
<tr>
<td>Review of the Literature</td>
<td>43</td>
</tr>
<tr>
<td>Conclusion</td>
<td>53</td>
</tr>
<tr>
<td>Chapter 3</td>
<td>54</td>
</tr>
<tr>
<td>Research Hypothesis</td>
<td>54</td>
</tr>
<tr>
<td>Population and Sample</td>
<td>54</td>
</tr>
<tr>
<td>Section</td>
<td>Page</td>
</tr>
<tr>
<td>-------------------</td>
<td>------</td>
</tr>
<tr>
<td>Data Collection</td>
<td>56</td>
</tr>
<tr>
<td>Data Analysis</td>
<td>56</td>
</tr>
<tr>
<td>Results</td>
<td>57</td>
</tr>
<tr>
<td>Chapter 4</td>
<td>67</td>
</tr>
<tr>
<td>Discussion</td>
<td>67</td>
</tr>
<tr>
<td>Conclusion</td>
<td>70</td>
</tr>
<tr>
<td>References</td>
<td>73</td>
</tr>
<tr>
<td>Appendix A</td>
<td>79</td>
</tr>
<tr>
<td>Appendix B</td>
<td>80</td>
</tr>
<tr>
<td>Appendix C</td>
<td>81</td>
</tr>
</tbody>
</table>
# LIST OF TABLES

<table>
<thead>
<tr>
<th>Table</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Distribution of Documented Violent and Non-Violent Write-Ups</td>
<td>57</td>
</tr>
<tr>
<td>2</td>
<td>Write-Ups by Program Cross-tabulation</td>
<td>58</td>
</tr>
<tr>
<td>3</td>
<td>Pearson Chi-Square Tests A</td>
<td>59</td>
</tr>
<tr>
<td>4</td>
<td>Distribution of Documented Violent Write-Ups by Category</td>
<td>61</td>
</tr>
<tr>
<td>5</td>
<td>Serious Write-Ups by Program Cross-tabulation</td>
<td>63</td>
</tr>
<tr>
<td>6</td>
<td>Pearson Chi-Square Tests B</td>
<td>64</td>
</tr>
</tbody>
</table>
A MODIFIED THERAPEUTIC COMMUNITY: REDUCING VIOLENCE IN A MEDIUM SECURITY PRISON

Lee W. Maglinger  February 2006  82 Pages

Directed by: Donald Nims, Aaron Hughey, and Fred Stickle

Department of Counseling and Student Affairs  Western Kentucky University

This study explores the impact a modified therapeutic community has on institutional disorder. Treatment programs are normally evaluated by their ability to prevent recidivism and relapse. This study examines the efficacy of a modified therapeutic community in reducing the number and severity of write-ups of its clients in a medium security male prison. The study describes research findings regarding the relationship between the write-ups of clients in a modified therapeutic community compared with the write-ups of inmates in a non-treatment unit. To carry out this study, the author reviewed the write-up records from the treatment program and a non-treatment unit for the period of March 2001 through October 2005. The results of this study indicated that the write-ups of the modified therapeutic community clients, as a whole, were less severe as compared to the general population clients residing in a similar dorm. They were also proportionally less specifically violent. The implication of this research for corrections administration was also discussed.
CHAPTER 1

*Problem Statement*

A recent shift has occurred in the Kentucky prison system. With increased numbers of arrests and incarcerations of individuals with substance abuse crimes, an emphasis has been placed upon treating these inmates in the prison. Corrections administrators have been required to set up substance abuse treatment programs; however, the mission of prisons is not treatment or rehabilitation, but to maintain the safety and security of the inmates. The success of corrections administration is based on the ability of keeping a safe, secure, and orderly institution. Institutional disorder, in the form of write-ups, threatens all three of these mandates. The ARCH Therapeutic Community program contains the elements necessary to deal with the issues of treatment and safety. Therefore, it is imperative that its effectiveness 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 violent institutional write-ups by comparing the numbers and severity of the inmates involved to those of the general population. The efficacy of the ARCH Therapeutic Community program will be assessed in relation to its ability to reduce the numbers of and severity of violent write-ups. As such, this study should provide information which will be helpful to corrections administrators and substance abuse treatment providers as they continue to develop programs that are beneficial to the efficiency of the prison and provide effective treatment to its substance abuse population.


**Background**

According to a press release from the Communications Office of Kentucky Governor Ernie Fletcher dated August 26, 2004, “Statistics show that of the 18,000 men and women serving felony convictions in Kentucky, approximately 4,000 are 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, p.1). The release goes on to say that over 60% of the inmates are substance abusers, yet the state has the capacity to treat only 19% of these inmates. It further states that the response to substance abuse problems would, in the future, be coordinated through the Office of Drug Control Policy (ODCP). This office was charged with the oversight of pilot projects specifically for prevention, education, and treatment. Within the realm of treatment, two areas were emphasized: increasing the number of drug courts and increasing the number of treatment facilities.

In response to this initiative, the Kentucky Department of Corrections (DOC), Division of Mental Health (DMH), increased the number of treatment beds from 222 to 951 as of January 2005. The distributions of the treatment beds are: 316 beds for medium security males, 88 beds for minimum security females, and 547 beds for minimum security male inmates. There are no treatment beds for medium security female inmates. Kentucky has no medium security prison 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 scheduled basis or sooner if conditions warrant it.
The approach to treating substance abuse by the DMH prior to 2001 was based on a model of group therapy, education, and individual counseling. This was called the Substance Abuse Program (SAP) with oversight from the branch of the DMH called the Alcohol and Other Drugs of Abuse Department (AODA). The SAP program was heavily weighted towards individual counseling and group therapy and had an inmate to counselor ratio of around 20:1. 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 and had 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 changed its approach for addressing substance abuse in all of its programs by introducing the concept of Therapeutic Community (TC). The training for the staff of DMH, in setting up a TC program, was provided by a consulting firm from Texas headed by Martin La Barbera. This training was conducted over a one-week period in March 2001. The training included 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. The staff was put in the role of a TC client while the training team played the role of staff/counselor. As a result of this training, all the TC programs in Kentucky started out with a significant level of uniformity.

In recent years a shift has occurred in correctional policy. There has been a noticeable shift from the emphasis upon security towards treatment and rehabilitation. This change
has come about as a result of the overcrowding in prisons and the public wanting to see a
reduction in the rate of recidivism. Also, this movement can be attributed to the growing
body of evidence-based research that indicates prison-based residential treatment
programs are effective in reducing recidivism (Wexler, 1994).

The concept of providing rehabilitation to prison inmates has come through a long and
rather arduous process. Society in general has the opinion that inmates are hopelessly
incapable of any change and that nothing seems to work to reduce recidivism (Rawlings,
1994). Even the names of some of the prisons in Kentucky indicated the punitive
philosophy of incarceration (e.g., Kentucky State Penitentiary or Kentucky State
Reformatory).

In the early 1970's, an effort was made to rehabilitate some inmates but this was soon
replaced by a philosophy that the inmate was just getting what he deserved. As a result,
punishment and deterrence became the hallmarks of the prison system. However, the
populations in the prisons continued to rise without a decline in the crime rate (Wexler,
1994).

During the early 1970's, an explosion in drug use and crimes associated with drug use
intensified in the United States. The public's response to this alarming increase was to
put pressure on the congress and local officials to enact laws for stiffer sentencing and
harsh deterrence for drug use. Law enforcement became the front line of defense and they
did their jobs well, with the jails and prison population increasing significantly. It was at
this time that many new prisons were 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 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 result of all of these laws, mandatory sentences, and public outcry to “get tough on drugs” and crime was that the jails and prisons became overcrowded.

Many addicts and alcoholics, who served their time, would become rearrested very quickly for the same drug charges. With this revolving door, it was evident that putting addicts and drug dealers into prison was not an effective means of reducing recidivism nor was it effective as a deterrent.

This set the stage for federal laws to be established in the 1980s that pumped millions of dollars into prevention, drug education, enforcement, and drug treatment. In 1986 the “Anti-Drug Abuse Act” was passed. This Act had a portion of its funding earmarked for drug treatment in prisons. At the same time, 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).

In the late 1980’s, the Bureau of Justice Administration (BJA), started the expansion of drug treatment programs in prisons. The BJA’s responsibility was guiding the funding and administration of the Anti-Drug Abuse Act. They provided funding for several projects, one of which was Project REFORM. The corrections departments of eleven

The Center for Substance Abuse Treatment (CSAT) came into existence and took over for BJA around 1991. They created Project RECOVERY. Its goal was to continue technical assistance in fourteen states for an eighteen-month period (1991-1993). Since that time, CSAT became the primary federal agency for funding substance abuse treatment (Wexler, 1994).

CSAT is now part of the Substance Abuse and Mental Health Services Administration (SAMHSA) that is within the U.S. Department of Health and Human Services (DHHS). CSAT has developed Treatment Improvement Protocols (TIPs) that are best-practice guidelines for substance abuse disorders. TIPs draws on the expertise and experience of research, experts, clinicians, and others to produce the guidelines. These guidelines are then offered, free of charge, to individuals and facilities across the United States (U.S. Department of Health & Human Services, 2004).

Types of Therapeutic Communities

A TC programs is 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” (De Leon, 2000b, p.12). They fall into two basic types: democratic or hierarchical. However, in an article of comparison of the two types, it was noted by the authors, that they were not two oppositional models, but must be seen as being complementary (Vandevelde, Broekaert, Yates, & Kooymen, 2004).
Democratic TC communities tend to view the clients in treatment as having deep disturbances. The client’s offense is regarded as symptomatic of a deeper psychological problem. The aim of treatment is to effect a deep change in these problems. The clients often display evidence of personality disorders in conjunction with alcohol, drug or sexual abuse. Professionally trained staff such as psychiatrists, therapists, psychologists, and probation officers operated them. The first democratic TC emerged in England at Belmont Hospital in 1940 (Rawlings, 1999).

The second type of TC community is hierarchical. They trace their roots back to Synanon Groups, which 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 Montica, California. Charles Dedrich, who was an alcoholic, is credited as the founder of Synanon. He and a few of his AA companions met weekly for “free association” group meetings. These meetings evolved into encounter groups that had dramatic effects upon the members. In 1959, this organization was formally founded to treat any addict, no matter what the drug of choice was. For the next fifteen years Synanon was the leader and innovator in the field of addiction treatment. Then it began to develop organizational problems resulting in its assuming a diminished role in the addictions field (De Leon, 2000b).

The hierarchical models of TC programs are popular in the United States. There are no current democratic TC programs operating in the United States. The hierarchical model is used all over North America where there is a huge drug and drug-related crime problem (Rawlings, 1999).
The hierarchical models of TC programs are aimed primarily at drug abusers. The treatment philosophy holds that a client becomes addicted to drugs for a variety of reasons, and that the way to arrest the addiction is through retraining (Clarke, 1997). The underlying problems, psychological or otherwise, may or may not be addressed depending upon the particular TC program. The treatment method is almost universally behavioral as opposed to psychodynamic or other theoretical framework (Rawlings, 1999).

The hierarchical TC program is better suited for the prison environment than the democratic TC program. This is due to the fact that it is more rigidly structured and the staff has more input. This works better and makes more sense with the mindset of corrections staff. Hierarchical TC programs use rigid (Cardinal) rules and explicit behavioral norms (Right Living). 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 and self-control and are highly appealing to corrections staff. However, Wexler (as cited in Rawlings, 1999) noted that prisons do not readily provide the real work situations that are a hallmark of TC programs. Also, TC programs stress the use of graduates during treatment as a semi-staff. Corrections staff has difficulty dealing with this, as it requires greater freedom inside the TC program.

The methods of graduated sanctions range from “verbal corrections” to “disciplinary actions or write-ups” and are used within the community to respond to behavioral transgressions. Privileges and Sanctions are an essential part of the hierarchical TC
model. They are used to express the community’s approval or disapproval of a client’s behavior or attitude (Burdon, Prendergast, Eisen, & Messina, 2003).

In both types of TC programs the clients are volunteers. They are usually identified when they enter the correctional system. In the case of inmates entering corrections in Kentucky, they are identified at the Assessment and Classification Center in Louisville. They are also identified as having a drug abuse history when they meet with the parole board and are then referred for an evaluation and follow the recommendation of the evaluator. They can also be court ordered by a judge into treatment. However, from a TC program point of view, entrance into treatment is still voluntary. 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 his admission was due to a recommendation from the parole board or a judge, and he quits, notification is made to that effect.

An operational definition, of a TC program, is that they are highly structured communities requiring abstinence from alcohol and drugs, with emphasis on personal growth, peer support and self-help. They are designed to provide ethical and moral boundaries along with expectations for personal growth (De Leon, 2000b).

Concept of the Disorder

Individuals who enter a TC program are referred to as clients or program clients instead of patient, or inmate (Maglinger, 2001). The length of stay 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 present a picture of a disorder that goes beyond the addiction. Many times they are at health risk and are in social crisis. They display little or no ability to maintain abstinence, have poor social and interpersonal functions are poor, and have developed a socially deviant lifestyle (De Leon, 2000b). They require the admission to a TC program to stabilize a life that is spiraling out of control and start the long process of lifestyle change.

Upon admission to a TC program, clients are typically asked, “What is your problem?” The reply is usually, “Dope man, I shoot dope” and is usually countered with, “That is your symptom, not the problem” (Levy, Faltic, & Bratter, 1977, p.44). This illustration gives the concept of the disorder from the TC point of view. It is the whole person, the attitude, behavior, values, and lifestyle and not just the drug that is the focus of treatment.

In a 2004 study the author noted that a TC program is a living-learning situation where all situations that happen between the client and staff, in the course of the daily activities, become opportunities for learning. In particular, when crisis occurs, it presents an opportunity for change and learning to take place. 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 replay, in group or community meetings, these situations and make alternative choices (Kennard, 2004).

Clients in a TC program are usually individuals whose lives have been controlled by drug use, drug seeking and whose ability to live orderly, sober lives is underdeveloped. In
their reasons for using drugs, they deny their own contribution to their problem or fail to recognize their own potential for the solution (De Leon, 2000b).

One of the most important factors in the concept of the disorder involves clients' failure to take responsibility. This involves taking responsibility for their actions and decisions they make. Clients may not be responsible for the predisposition to abuse drugs, their early childhood, how they were raised and/or disadvantages they underwent during childhood, but they are responsible for their choices and actions particularly with respect to drug use. When they are in active drug use, they do not have the ability to make responsible decisions or commitment to sobriety (De Leon, 2000b). One of the outcomes of treatment is a realization that they have a choice and that includes a choice not to use a drug.

Another important factor in the concept of the disorder is in the use of prescription drugs for withdrawal. As a rule, TC programs are not set up for medical detoxification. Clients who need this type of treatment are referred to hospital or detox units that are equipped to handle this type of treatment. Routine medications for clients who have a chronic medical condition such as hypertension or diabetes can be maintained in a TC program. A key assumption in the TC concept of the disorder is that the use of drugs lends itself to the avoidance of the challenges of ordinary living. Learning to manage those challenges, both feelings and behaviors, are the hallmarks of maintaining recovery and sustaining right living (De Leon, 2000b). The inference here is that psychotropic medications reinforce the disorder and could hinder the recovery process.
In the medical community, addictions meet the criteria to be called a disease. The criterion for something to be considered a disease is that it is chronic, progressive, and morbid. According to Lewis (1991), addictions contain a biological basis, characteristic symptoms and signs that get worse, a lack of intentional causation, and a predictable outcome that in most cases results in death.

TC programs place more importance on responsibility and motivation for behavior change than they do on the biological basis of drug abuse. Again, the emphasis is upon the whole person as disordered instead of 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.

In the past decade extensive advances have been made in the field of addictions. Research is mounting evidence as to the contribution biological factors are making on the etiology of addiction. Genetics, familial predispositions, and other inherited factors are firmly implicated. However, all of these advances are seen as only providing limited understanding and provide little guidance for 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).

*Concept of the Client*

Clients in a TC program display a wide range of behavioral and cognitive characteristics that interact and support addiction’s problems. At the core of the addiction disorder is the whole person, how he perceives himself and the world, through his behaviors, emotions, interactions, and communications with others.
Typically, TC clients display poor judgment, lack of problem solving skills, difficulties in decision-making and poor general awareness. They also lack social, vocational, interpersonal, and educational skills. Many have learning disabilities (De Leon, 2000b).

Clients in a TC program display negative self-perceptions in terms of low self-esteem and a negative identity. They have problems in terms of their sense of personal worth and worth as a member of society in which they live. They display little self-respect as to their ethical and moral relationships to their family. It should be noted, however, that all of the low self-esteem came before the addiction problem and stems from childhood and adolescent experiences involving both physical, emotional and sexual abuse (De Leon, 2000b).

Clients in a TC program display dysfunctional characteristics. They have problems understanding, communicating, experiencing, and coping with their feelings. These emotional problems are common among addicts in general and are attributed to immaturity and lack of self-regulation (De Leon, 2000b).

Low tolerance for discomfort is a hallmark characteristic underlying the emotional problems of TC clients. They have lower thresholds for tolerating discomfort and shorter delays in their actions to alleviate or escape the discomfort. Their actions are often socially deviant, interpersonally disruptive and self-defeating (De Leon, 2000b). Because of this, when they feel provoked, denied, or impatient, they respond by using drugs.

It has been a common assumption that addicts have associated character disorders such as antisocial behavior disorder. If this is correct, they experience little guilt or
shame. According to De Leon (2000b), this is not the case. It is not the capacity to feel guilt or shame, but a problem of coping. Their lack of self-discipline combined with a low tolerance for discomfort results in ineffective ways of dealing with guilt and shame. They respond to guilt and shame by blocking them out, resorting to the over utilization of rationalizations or denial to overcome the guilty feelings. Finally, in desperation they rely upon drugs to avoid the guilt an escape the shame.

One of the important treatment aspects in a TC program is learning how to deal effectively with guilt. The client learns how to identify the types of guilt feelings, the conditions in which they occur and strategies to either resolve them or make them more tolerable. This is done without resorting to blocking them out or the use of drugs (Maglinger, 2001).

During treatment, the source of a TC client’s guilt often comes out. According to DeLeon (2000b), that guilt can be grouped around four categories: guilt regarding the self, guilt regarding the family, guilt regarding the TC community that they are part of, and guilt regarding society at large.

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 rooted guilt towards his family, or to society. This could happen in a group session or in an individual counseling session. Clients, in a TC program, are taught “skills” which help them to cope with guilt in ways that are productive and do not end up in drug use.

According to the 2002 NIDA research report on TC programs, treatment is designed to help clients identify, manage, and express their feelings in constructive and appropriate
ways. Learning personal and social responsibility, good ethics, and behaving, as a person should instead of how they have in the past, are concepts built into the structure of a TC program.

Clients in a TC program display dysfunctional social characteristics of entitlement, distrust, and irresponsibility. According to Bell (1994), the success of a TC program is based upon trust. This trust underlies all aspects of the treatment and is the main reason for high dropout rate in TC programs.

According to De Leon (2000b), entitlement is an unrealistic expectation concerning wants and needs with a blurring of the two. Clients, in a TC program, commonly make statements like: “The food stinks in this prison,” “Why can’t we get our own time in the weight pile?” “Why isn’t everybody treated the same way in this program?” De Leon further points out that entitlement is a limitation of one’s ability to cope with performance demands, expecting instead that others will provide what they need. This makes the person become more dependent upon others.

Often clients in a TC program claim that the one area they need the most work on 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 cite 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 accountable means providing an honest record of self, and being consistent demands predictability in meeting obligations.
Generic Therapeutic Community Model

The basic components of a generic TC include: “community segregation, community environment, explicit treatment phases, staff and peer role modeling, client job/work activities, and encounter groups” (U.S. Department of Health & Human Services, 2001, p.200). These activities go on daily in a TC program and provide the client with a sense of structure, the “experience” of community, safety, and a means of communicating the values of the program. These components require changes in the values that clients and staff have developed over the years. They also require a strong commitment from the prison or other administration in which the TC program is housed.

In a 2002 study, the authors note that prison administration tends to view drug addiction as a crime. Security’s goals are based upon the philosophy incarceration and punishment. The response to the crime is usually some sort of sanction in order to punish or deter the offender for committing the same crime again. Treatment or rehabilitation is only a secondary issue (Burdon, Prendergast, Messina, & Cartier, 2002). Craig (2004) found that corrections staff see control-based models as the most effective form of management in institutional settings. However, the authors point out that the control-based form of management has an inhibitory effect upon the goals and performance of treatment programs. Corrections staff are charged with the primary responsibility of safety for both the inmate and staff.

Treatment, in general, takes the opposite point of view, that drug addiction is a treatable, but chronic and relapsing disorder. The goal of treatment can be defined as assisting clients to achieve their optimal level of psychological functioning. “The aim,
depending upon the client’s needs, are: 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 Carkhuff and Anthony (1979, p.3), 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.”

Wexler (1994) notes that a safe environment, that is separate from the general prison culture, is conducive to effecting behavioral changes. He further maintains that a safe environment, along with the self-confidence gained in treatment, helps the client to deal with the negativity of the prison in general.

La Barbera (1998) notes that community activities must adhere to the principal of “form follows function.” If an activity, in the community, does not have a purpose, then it should be eliminated. He also notes that clinical staffs, which have been trained in theory other than social learning theory, have a hard time adjusting to the TC model of activities having a specific purpose.

In the Therapeutic Communities in Correctional Settings, 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, p. 383) states that the “treatment protocol of therapeutic educational activities are organized into phases that reflect a developmental view of the change process. Emphasis is on incremental learning at each phase, which moves the individual to the next stage of recovery.”

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

Clients in a generic TC program live, work participate in groups and in the process, learn to control their behavior. As a result of the role modeling, the client will develop self-reliance, responsibility, and become honest with themselves and others (U.S. Department of Health & Human Services, 2001). Clients are expected to become active
participants, practicing the skills they learn which further builds their self-confidence and coping ability.

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., mopping the floor, taking out trash) to holding a position in the community. “Work in the TC reflects the view of substance abuse as a disorder of the whole person and its reality orientation to recovery. In a TC program, work, is both a goal and a means of recovery” (De Leon, 2000b, p. 144).

In most residential substance abuse programs the client is required to go through the treatment “first” before he returns to the work environment. In a TC program, work is considered an essential element, developing self-confidence and consistency in the client.

Staffing for the generic TC program includes counselors and graduates or peer counselors. Optimally, the counselors should be a mix of recovering and non-recovering staff. It gives the staff a good balance and prevents role conflict in the recovering counselors. However, one study examined recovering and non-recovering counselors in terms of duty-related and interpersonal stress. The results indicated that 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 felt more competent to treat addictions and had insight that their counterparts did not have into the etiology of the addiction. From the results it was clear that implications for role ambiguity and role conflicts were evident (Capps, Myers, & Helms, 2004).
Counselors play an important role and function in a TC community. They are members of the community. This means that they must role model the teachings of the community. They provide education and assessment to the clients as they progress through the treatment process. However, the 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 two-three-minute episodes between counselor and client. This is opposed to the one-hour traditional session between the same. These short counseling session episodes are called “teachable moments” and are intended to assist the client in the change process.

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, p. 23), “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.” Since the primary treatment agent is the community itself, the counselor should always direct the client to go back to the community and deal with a situation there.

In addition to the treatment staff, correction officers, who work in the TC program are seen as extensions of the treatment staff. As such, they are members of the community too. Indeed, on the second and third shifts of a day, the correction officer is the “only” staff on duty.
This presents a challenge for both corrections and treatment. Correction officers enforce compliance with institutional rules through negative sanctions. These sanctions punish the individual, who violates the institutional rules. Standard operating procedures require that violations, no matter how insignificant, be reported. Sanctions, in the form of institutional write-ups, are then applied through a disciplinary protocol system. This ensures the maintenance of order, safety, and security of the inmates and staff.

TC programs also use a sanction system for infractions of the community’s rules. These sanctions range from simple verbal correctives, called “Pull-Ups”, to disciplinary actions including write-ups. The Pull-Up is a verbal statement given by a client or staff to another client. These statements are reminders that raise 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 required to listen 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 (Maglinger, 2001). Pull-Ups are the first line of treatment tool for a behavior infraction and are focused on a specific behavior. This has a profound impact on the socializations of the clients in the TC program.

In addition to the Pull-Up, TC programs use a “Push-Up” to bring awareness of a client’s positive behavior. Again, the client is to listen and acknowledge the Push-Up (e.g., “Thank you for that awareness”).
Clients enter a TC program from several sources and for several reasons. They can be self-referred. These clients have the highest motivation for change and are thus the type most sought after by TC programs. However, in Farabee, Prendergast, & Anglin's study (as cited in Messina, Wish & Nemes, 2001), clients who come into 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. This would indicate an indirect relationship between positive outcomes and legal coercion. This study further found that coerced admissions increased the likelihood of the clients remaining in treatment and in entering treatment earlier in the addiction process.

Clients are referred as a result of a meeting with the parole board. Depending upon the crime, all inmates are scheduled to meet with parole boards at regular intervals. At these meetings, the parole board can recommend that an inmate enter a TC program and complete it before their next meeting with the inmate. It is interesting that the parole board just "recommends" the inmate to enter and complete the program. Clients take this to mean that it is more than a recommendation and failure to complete will almost assure them of getting a deferment.

The ARCH Modified Therapeutic Community

The ARCH program at Green River Correctional Complex in Central City, Kentucky was started in February 2001. The program was started with money from federal and state grants with a focus on providing substance abuse treatment for adult male inmates.
The ARCH program began as a modified therapeutic community. By modified, it means that the program was not totally segregated from general population inmates (i.e., canteen, weight pile and gym access, dining room access). Also, before any clients were admitted, modifications were made to the dorm that housed the program. These modifications included offices, phone lines, and computer line hook-ups.

The ARCH program is housed in Dorm 3, of building D, on the campus of the prison. Dorm 3 is a two-tiered “open dormitory” with 64 beds on the upper walk and 64 beds on the lower walk. The dorm was originally designed to be the honor dorm housing one inmate per room. The rooms are called cells. The cells of dorm 3 are smaller than other cells in the prison. Dorm 3 has never housed the honor dorm. The honor dorm is Dorm 2 and houses 64 inmates who meet 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 and do get on the waiting list for this dorm but do not get selected due to being in the TC program.

Another feature of Dorm 3 is the “open dorm” concept. All of the dorms at the prison have this concept. The officer’s station is located in an area that is in the center of the dorm with access to everything. This allows for the correction officer 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. Also, the CO is usually the only staff in the dorm for long periods of time.
As stated previously, the ARCH program is a modified TC program. While 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 off shift hours. There is some attempt to control this through the “Buddy System,” which will be discussed later in this chapter. In the Therapeutic Communities in Correctional Settings, Final Report Phase II (1999), the Office of National Drug Control Policy (ONDCP) 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, p. 102) notes “TC programs seek to maintain a social and psychological separateness from the settings in which they are located. Antonowicz and Ross (1994) note that for the maintenance and integrity of treatment, the participants in a TC program should be removed from the anti-social prison culture and allowed to create their own sense of community. Since total segregation could not be achieved, it was decided that the ARCH program would be a modified TC program. Additionally, a 2000 study found that modified TC programs tended to rely on counselors more than regular TC programs (Melnick, De Leon, Hiller, & Knight, 2000).

The training for the ARCH TC program staff was provided by the DMH. They hired a consulting firm from California, headed by Martin La Barbera. He introduced the key concepts of the TC model. 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 staffs
from the ARCH and Turning Corners (Luther Luckett Correctional Complex) formed a mock TC program. The staffs 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 results of the training were that the staffs of these two medium security state prison TC programs were ready to start up TC programs at their respective institutions.

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, before admission to treatment. The results of these instruments are then reviewed in a face-to-face interview with the potential client. These results are applied to the Diagnostic and Statistical Manual (DSM-IV-TR) to see if the client meets the criteria for dependence. A client must meet the criteria for 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 among four possible responses. It yields a quantitative score of the degree of problems related to alcohol misuse. According to Shields and Caruso (2003) the AUDIT is capable of generally reliable scores across varied sample conditions. Additionally, Selin (2003) notes that the test-retest reliability of the AUDIT is high.

Harvey Skinner, in 1982, developed the DAST. It is a 28-item, self-report instrument using 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-TR* criteria for dependence (Gavin, Ross, & Skinner, 1989).

In order for a client to meet *DSM-IV-TR* criteria for dependence, the client must have at least three or more occurrences in the Substance Dependence Section on the *DSM-IV-TR* Diagnostic Criteria Form (Appendix C). In addition, 90% of the clients also meet the criteria for the diagnosis of Adult Anti-Social Behavior. With these two diagnosis, the clients admitted to the ARCH TC program, represent some of the hardest to treat and most resistant to effect change.

Clients are placed in groups of approximately 20 per group. These groups are then called a "class." Each class is then divided into two groups of ten that become the groups for group therapy. Each class moves through six-week phase intervals. Each phase has a counselor and a focus for the phase. In the ARCH TC program, Phase A focus is on Alcohol and Other Drugs of Abuse (AODA), Phase B is on Anger Management, Phase C is on Criminal Thinking Errors, and Phase D is on Relapse Prevention and Aftercare. The clients also go through a Pre-Treatment Phase where they learn about the basics of treatment and being in the community.

If the client meets *DSM-IV-TR* criteria, he is then placed in the Pre-Treatment Phase that lasts for approximately two to three months. The client is made thoroughly aware of the Client Handbook. This is a period of time where the staff can observe the client's
behavior and adjustment to being in the community. Acceptance into the treatment
phases is contingent upon the completion of the Pre-Treatment Phase (Maglinger, 2001).

It is also during the Pre-Treatment Phase that the greatest number of dropouts occurs.
In a research report on the motivation for treatment in a prison based TC program De
Leon (2000a) found that community based TC programs have their highest drop out rates
during the first month of treatment. He also notes that TC programs, in general, have a
low retention and completion rates. He notes that this is due to the process of TC
programs.

The clients of the ARCH 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 elected positions are:
Coordinator, Assistant Coordinator, Master of Ceremonies, 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 reviews the discipline problems that have failed to be resolved by the use of
the other TC tools (e.g., pull-up, LE, Bus Stop, and Set Back). It is the only time, while in
treatment, that a client can and should makes excuses for his behavior. The TPR will
present the behavior problem and will allow the offending client to explain his behavior
and motivation for treatment. The TPR then votes on a recommendation to the Program
Director for action on the problem. This recommendation can be dismissal.
A typical day in the ARCH TC program starts at 7:00 AM. All clients are to be out of bed, beds made, uniforms in good order, and ready to start AM Development. Each client is issued a “blue vest.” 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 is the only color that is different on the yard at the prison and makes the TC client “stick out.”

At 7:30 AM the Expeditors set up the chairs in the dorm day room. The clients then line up by classes and step through a large arch. As they step through the arch they step over a large wooden wedge with the word “willingness” engraved on it. This is to represent each client’s willingness to do the requirements of the program for that day. Expeditors are clients that are elected by their class who are in charge of setting up chairs, knowing where the members of their group are, getting copies of handouts, and sitting on the Treatment Peer Review Committee. They are elected at the start of each phase of treatment.

AM Development then starts with the pledge to the flag and the song Zippah-Dee-Do-Da. Awareness’s are then made 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. They also have to draw a poster, suitable for framing, which goes along with their presentation; then all Learning Experiences and other seminars are presented. The AM Development continues with a review of the Structure Board.
The Structure Board is a black board where the clients write the daily schedule and other information on. Each day it is reviewed at AM Development so that all clients know where they are suppose to be and what is going on in the community.

AM Development continues with the reading of the Cardinal Rules. These are eight rules that, if caught breaking them, a client can be discharged immediately. One client, chosen at random from the community reads them. 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 ARCH TC program. The first TC class completed this philosophy in March 2001. It must be remembered and is included on all phase academic tests. This philosophy is an important statement that each client makes each day as to why the community gathers together. The ARCH 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, still standing, reciting the prayer for serenity. Clients then disperse and go to their next scheduled activity. The whole process takes on an average forty-five minutes. It reminds a person of a family gathering around a kitchen table at breakfast.

PM Development occurs at 2:30 PM. Again, the Expeditors, set up the chairs in the day room of the dorm. The clients come together and a program is conducted that completes the day. Assignments are gone over for the next day and general announcements are made. PM Development closes with the clients standing and singing Happy Trails.

AM and PM Development format continues Monday through Friday of every week. On Saturday and Sundays, AM and PM Development are not conducted. On the weekends clients are expected to get personal needs taken care of and this is when family visitations occur.
During the first part of the Pre-Treatment phase, the client attends AM and PM Development, Alcoholics Anonymous (AA) or Narcotics Anonymous (NA) meetings, and are assigned work in the dorm. It is at this point that the client is assigned a sponsor by the staff. A sponsor is a client who is in the treatment phase of the program. The staff assigns a sponsor. 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 community (Maglinger, 2001).

The last six weeks of Pre-Treatment is more formal and is designed to simulate what it will be like in the actual treatment phase. An Elder in the TC program runs this period. Elders are graduates of the 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 Pre-Treatment clients. These sessions consist of classes where the first two steps of AA are discussed.

The Elder teaches from a prescribed set of sessions from Recovery Dynamics. This is a curriculum that teaches the history of AA and the concepts of twelve-step support group material. It gets the client use to being in a class, taking notes, and behaving in the community. It also allows them some additional feedback from a client who has successfully completed treatment and has assumed an influential role in the community.

Near the end of the Pre-Treatment phase, the client will complete a Pre-Treatment First Seminar. This seminar is designed for two purposes. The first is to have the client describe why he is now ready for treatment. The second is for the client to record five goals he will work on for change while he is in treatment. Once completed, the client will
give it to his sponsor and the Elder for their 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 Pre-Treatment 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 that the decision is made to move the client into Phase A of treatment, redo the Pre-Treatment Phase, or discharge from the program.

The treatment phase of the ARCH TC program begins with Phase A. It is called the AODA Phase and the client is referred as being in the freshmen class. This module presents the impact that substance abuse has on the physiological and psychological functioning of a person. Information is presented, in lecture format, describing the major categories of substance abuse and why continued use is problematic to the client’s health
and freedom. The information in this module also explains the biological powers of addiction and how psychological dependency develops (Maglinger, 2001).

Clients in Phase A are introduced to the concept of addictions being a whole person disorder. 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).

In Phase A, clients are introduced to group therapy. Group therapy is composed of ten or fewer clients from their class, an Elder, and a counselor. Once a client is placed in a group, he will remain in this group throughout the remainder of his treatment. The small group experience allows the client to share his challenges and self-change with others in a safe environment. Clients are encouraged to self disclose in order to learn that their experiences are similar to others and that support comes from the group therapy process.

Group therapy affords the client the opportunity to experiment with new methods of coping with old problems. It allows the client to experiment with new, more effective, behaviors, through role-playing in an atmosphere that is less threatening than society in general. Clients, then, can respond to each other out of “responsible concern.” Responsibility is the essential focus and concern is the way the clients are suppose to treat each other. Thus, clients have a responsibility and concern to themselves, the other clients in treatment, and to the community in whole. The clients perceive group
therapy, as being a laboratory where they can try and fail or try and succeed in an atmosphere that is safe.

Clients are encouraged to challenge each other’s motivation, attitude, and behaviors without the fear or inhibition within the group therapy setting. It is during these confrontations that pressure and stress breaks down the barriers that prevent the expression of emotions and resistance to change. In turn, this enables clients to express their emotional problems in the “here and now.” Other clients, then, can identify with the issue being discussed and give feedback or encouragement to each other. The purpose is to change the behavior, assure responsibility, and not seek explanation or comprehension. As a result, no excuses are accepted to justify present irresponsible behavior (Broekaert, Vander Straten, D’oosterlinck, & Kooyman, 2005).

Group therapy serves as a “reality check” where attitudes and behavior that support recovery are reinforced, while attitudes and behavior that do not support Right Living are challenged (Maglinger, 2001). According to De Leon (2000b, p. 73), 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.”

Another type of group therapy that goes on in the ARCH 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, and creates an opportunity to teach appropriate behavior that would be consistent with the community’s definition of right living” (La Barbera, 1998, p.51).
The goals of a confrontation group are to communicate a message, teach respect for rules, 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 grouping 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 sit 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 sit 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 is frustrated about in 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 and thus will either be in an encounter group or confrontation group.

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 ARCH TC program. It is hard to schedule due to the fact that the counselor’s time is well managed by the daily
activities. De Leon (2000b, p. 199) notes “it is limited in order not to subvert the residents’ use of the feedback from peers and in groups.” 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 is an idea of an inmate 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, p.6), 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.”

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 either to 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 ARCH 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. Phase C (junior class), is focused on criminal thinking errors. The goal of this phase is help clients identify and alter thinking patterns that support and maintain criminal thinking patterns that characterize 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 that they will use when they make parole.

Just before the client completes Phase D, he completes his Final Seminar Form. He then gets it approved by the Phase D counselor and presents it at an AM Development meeting. In the Final Seminar, he covers what he has learned from six months of treatment and what he intends to do with what he has learned. The client also reviews his behavior during treatment and if he accomplished his goals he set in his Pre-Sap First Seminar.

In the ARCH TC program punishment for inappropriate behavior take the form of TC Sanctions (e.g., Pull-ups, Written Pull-ups, Learning Experiences, Bus-stop, and Set Back), or institutional write-ups (e.g., disciplinary actions, loss of good time credit, extra work duty, and placement in special management unit). The 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.

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 the Written Pull-up Form and is submitted to staff. Written Pull-ups may be the appropriate method to bring the negative behavior to the awareness of the community or staff. They
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, p. 225), “Learning Experiences are special assignments, for a particular resident, to achieve a targeted behavioral or attitudinal outcome.” In addition, clients are not allowed to dialogue about or too a staff about the LE they receive.

A Bus Stop is employed when pull-ups or LE’s have not resolved a problematic behavior or when a problem is particularly serious so as to threaten the safety or security of the program. A Bus Stop is only authorized by the Program Director. When a client is placed on Bus Stop, he must pack up all of his possessions and place them on his bed by 7:30 AM. He then stands during AM Development and announces to the community, “My bags are packed.” At PM Development, he again stands and announces, “The bus stops here, may I get off?” The staff then 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).

The final TC Sanction is the Set Back. The Set Back is a punitive 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. A client can also be Set Back as a result of failing a phase academic test.

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. 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. A category 4 or above write-up, is considered on a case-by-case basis.

In an effort to control TC clients from contact with general population inmates, the ARCH TC program employs a “Buddy System.” The Buddy System is an attempt to keep the client focused upon his treatment and away from the prison mentality of the yard. The Client Handbook states “Clients will be in the company of other TC clients at all times when outside of Dorm 3. The Clients may choose any TC client or Elder, who is willing to go with them to their destination” (Maglinger, 2001, p. 17). The Buddy System is in effect every day, and the only exceptions are 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.

There are two reasons the Buddy System works to encourage clients to limit contact with general population inmates. First, it makes it harder to get around when you have to have another client with you. Second, the buddy may not want to stay around while the client makes contact with general population inmates. If a client is caught breaking the Buddy System, he is required as part of the LE to have two buddies with him when he
leaves the dorm. A final benefit of the Buddy System is that the buddy may be able to convince the client to not act inappropriately (e.g., take drugs from a general population inmate) and thus save him from a situation where he put his treatment in jeopardy.

The ARCH TC program uses Push-ups as immediate acknowledgements of positive behavior or attitude. They are positive affirmations, given by clients or staff, to encourage and strengthen the likelihood that a targeted behavior will reoccur. Burdon et al. (2003, p. 49) 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)” De Leon (2000b) adds that the intent of the Push-up is to affirm any sign of progress or to encourage the client who is experiencing difficulty. The Push-up serves as a self-reinforcer, providing positive feedback at every opportunity.

By use of Pull-ups, Push-ups, LEs, confrontation group, Bus Stop, TPR, clients hold each other responsible and accountable for their daily behavior and actions. Clients become role models for each other. This is termed by the treatment program, as “watching over a brother.” Watching over a brother requires the client to extend himself by being responsible to display correct behavior and correct his brother’s behavior when it is required of him to do so. All of this is in direct contrast with normal prison society. According to Patrick (as cited in Dietz, O’Connell, & Scarpitti, 2003) this type of behavior is in contrast to the prison society’s view that they are a group of individuals struggling against the mandates of the administrators and their rules.
Department of Corrections Institutional Write-Up System.

When an inmate commits an infraction of an institutional rule, the result is that he receives an institutional write-up. In most cases, the policies and procedures require that the write-up be given as a means of insuring safety and security and to deter the behavior from happening again. However, this write-up system works along side of the TC Sanction system, which supports and reinforces the TC community values. The result is that the TC client is given a write-up by the institution and a TC Sanction by the program, for the same offense. From the client’s point of view, this maybe judged to be unfair. According to Tomry, (as cited in Burdon, et al., 2003) it is important that protocols be established and followed by correction and treatment staff for assessing infractions and applying sanctions 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 due to being 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 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 recorded on the Institutional Disciplinary Form. This form is then submitted to the Operations Office of the institution where it is assigned to an Investigation Officer. The Investigation Officer then investigates the incident to ascertain if it is in fact a violation of institutional rule. If the write-up is
deemed to be valid, it is then sent to the Adjustment Officer. The Adjustment Officer
hears the write-up and adjudicates guilt. The write-up is then assigned to the category and
a penalty is affixed. The process is much like a trial and a lawyer or legal aide can
represent the inmate. The results are then stored in the Institutional Adjustment Hearings
File.
CHAPTER 2

Literature Review

Providing drug abuse treatment to inmates while they are incarcerated makes good sense both economically and medically. Since inmates are in custody and cannot work to support their family or make a valuable contribution to society, it is the optimal time to “do treatment.” Providing drug treatment programs in prison settings is essential to the modern correctional system.

Therapeutic Community programs are a powerful treatment approach in the war on drugs. They have shown to be an effective means of reducing recidivism and lowering drug relapse. In California, Texas, and other states, similar positive effects have been documented (Dietz, O’Connell, & Scarpitti, 2003).

The John Howard Association, a correctional watchdog of the Illinois Correctional system, published a revised policy statement in 2003, making a strong argument for TC programs as the best approach to drug treatment for addicted inmates in the Illinois penal system. In this policy statement they strongly urged the Illinois prisons to use the TC program model, stating that it was one of the best instruments in maintaining high standards for humane and effective correctional programs. The policy statement noted that TC programs provide safe offender reintegration into society, reduces the costs of future criminal justice processing, and reduces health maintenance costs. This last notation is due in part as a benefit as inmates learn and assume healthier lifestyles.

In a 2002 report prepared for the National Council Department of Corrections
Substance Abuse Advising Council, it was found that TC programs produced the best results in reducing drug use and recidivism. The report noted that a six-month treatment in a TC program, produced significantly better outcomes than other forms of treatment for the same duration (North Carolina Department of Corrections, 2002).

A 1997 study, conducted by researchers at the University of Delaware’s Center for Drug and Alcohol Studies, included four 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) a control group receiving no treatment. The study included 448 subjects and lasted from six to eighteen months after they were released from prison. The results indicated that the full continuum had significantly better outcomes than any of the other groups and all three groups receiving treatment remained drug free longer than the no treatment group (Inciardi, Martin, Butzin, Hooper, & Harrison, 1997).

Wexler (1994), in a five-year report on the progress of prison substance abuse treatment, noted a movement away from the emphasis on security towards rehabilitation and treatment. The report contended that TC programs were the preferable method of treatment for the more severely addicted offenders. The report also asserted evidence that prison based TC programs provided the best results when the length of treatment is from nine to twelve months.

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

Other analysis was also conducted to determine if the Stay’N Out program was more effective at reducing recidivism than no treatment or using an alternative form of treatment. The results of Lipton’s study reported that hard-core abusers who remained in the prison based TC program were more likely to be successful upon release from prison. Inmates who stayed in the program from nine to twelve months had a 22.7% recidivism rate after three years. This was opposed to the 50% recidivism rate for the groups that received no treatment or an alternative form of alcohol and drug treatment program (Lipton, 1994).

The Cornerstone program began in 1976 at the Oregon State Hospital in Salem, Oregon. Two evaluation studies were conducted on this program in 1984 and 1989. Inmates in this TC program completed an average of eleven months of treatment. Measures of recidivism were compiled for three years. The results indicated that around three-quarters of the graduates were not re-incarcerated. These findings were consistent with the findings found in the Stay’N Out program and showed that increased time in treatment was linked to more positive results (Lipton, 1994).

Lipton’s study goes on to point out that the research conducted on these two TC programs provides solid evidence that prison-based TC programs produce significantly lowered recidivism rates among alcohol and drug addicted inmates. He further notes that the TC program’s holistic approach is what seemed to make the difference in dealing
with the social and psychological impediments in returning an inmate to an acceptable social functioning level in society (Lipton, 1994).

These studies have been included in this literature review to point out the effectiveness of TC programs in reducing recidivism and relapse. As a result, the costs to society are reduced. A great amount of research has been conducted on TC programs. The typical way of evaluating not only TC programs, but also all alcohol and drug programs, is to measure the recidivism and relapse rates. However, little research has been conducted on the effects of TC programs, in the prison, on the management of inmates.

A study conducted in 1991 hypothesized that operating a TC program within a prison increased the correction staff’s ability to manage the inmates and lower the incidence of violence (Wexler, Blackmore & Lipton, 1991).

A review of California’s first TC program was conducted in 2001. The program celebrated its ten-year anniversary at that time. The special report noted a reduction in violence in the TC unit. The TC unit afforded a safer work environment for the staff and the correction officers who worked in the unit reported that they felt more involved or connected to the inmates in the unit. The report also noted fewer disciplinary problems in the TC unit. These findings add up to a cost savings for the management of the institution. An interesting note in this report was that the inmates in the TC unit were some of the most antisocial, strong gang affiliated and had an average of eight years of time served in prison (Mullen, Rowland, Arbiter, Yablansky, & Fleishman, 2001).

Another interesting finding of California’s first TC program review was that there was a reduction in sick leave, reduction in work injury, and an increase in the perceived
quality of life impact among corrections officers assigned to the TC unit. Correctional Officers, historically, have health problems at a rate two times greater than the general population. The significance of this finding is important as it indicates that TC programs not only are effective in providing a safe environment for the participants in treatment, but they also have a positive impact upon the work environment for the staff. From a management point of view, the TC unit provided an all around win scenario as it reduced costs to the institution and improved the health and morale of its staff (Mullen, et al, 2001).

In another 2001 study, the results corroborate the results of the previous study. This study also explored the impact a TC program had on the corrections staff working in the unit. The study covered a one-year period from 1998 to 1999 at the Corcoran State Prison in California. The corrections staff completed three surveys designed to measure the impact working in the TC unit had on their job. The study also assessed the impact disciplinary violations and rule violations had on the management of the unit. The results indicated that the TC program had a positive effect on the corrections staff. The staff perceived their work environment as better than those of other corrections staff in the general prison setting (Deitch, Koutessenak, Burgener, & Cartier, 2001). They also perceived their psychological and physical well being as being better than the staff’s in the general prison setting.

The significance of the Deitch et al. (2001) study was that the inmates not in the TC program were twice as likely to engage in violent behavior. Also, a clear trend was established showing a lower rate of absenteeism among correctional staff that worked in
the TC unit. The study further suggested that the TC program benefits, for prison management, included a reduction in the stress of the job environment, elevated job satisfaction ratings, a reduced rate of staff injuries, a reduction in assaults from inmate to inmate and inmate to staff, and a general reduction in disruptive behavior by the inmates in treatment (Deitch, Koutesenak, Burgener, & Cartier, 2001).

Researchers from the University of Baltimore, in 2003, conducted a study of alcohol and drug treatment programs that used cognitive-behavioral methods. The results indicated that treatment programs that use cognitive-behavioral methods reduced the numbers of offenders being reclassified to higher security level facilities. The study included 170 prerelease inmates with extensive alcohol and drug abuse histories. The subjects were randomly assigned to a treatment and non-treatment control group. The study covered a six-month period. The outcomes examined included citations and rule violations, self-reported major rule violations, and reclassification to a higher security facility following a major infraction of the rules (Kinlock, O’Grady, & Hanlon, 2003).

The treatment program from the previous study was not a true TC program; however, it was a modified TC program. These typically use cognitive-behavioral approaches and reflect a similar period of time for the inmate to be in treatment.

According to Taxman (1998), TC programs, as well as other cognitive approaches, are more likely to bring about desired behavior changes. In general, TC programs focus on attitudes, behaviors, and cognitions. These attributes are more likely to demonstrate improvement using the more directed approach than other nondirective approaches.
The John Howard Association’s 2003 revised policy statement noted that TC programs provided a wide range of benefits to inmates and corrections management. The benefits for the correction’s department included fewer officers needed to maintain security in the units, reduced rates of prison property destruction by inmates, cleaner dormitories, and fewer disciplinary reports. This was due to program staff involvement, in dealing with program inmate behavioral problems rather than security staff involvement. The benefits to the inmates in the TC program included reduced tension in the unit and freedom from sexual harassment from other inmates and staff, reduced physical harassment (like gang activity or fighting), the development of good personal hygiene, and a reconnection between the inmate and his religious or spiritual tradition.

An interesting study conducted in 2000 looked at the relationship between psychopathology, which is typically associated with inmates, and high drop out rates in a TC program. The study included 104 inmates at the Grendon Therapeutic Prison. The Hare Psychopathology Checklist was used to measure the degree of psychopathology. The results indicated that high scores on this instrument correlated with increased information reports and failure to progress from assessment to the therapy stage of treatment. This study added to the growing evidence of the connection between psychopathology and prison inmate behavioral problems. It also supported the association between psychopathology and early drop out or discharge rates from TC programs (Shine & Hobson, 2000).

Kennard (2004) found that TC programs were very effective at creating an atmosphere of personal exploration and open-mindedness. This was in direct contrast to regular
prison culture, or convict mentality. He also found that TC programs seemed to reduce the incidences of violent disturbances. Another finding from this study was that small TC programs housed within large prisons reacted very poorly when security was tightened in cases like security alerts or during lockdowns. During these periods, the whole atmosphere reverts back to a prison instead of a treatment program. Clients become afraid and mistrust develops. Kennard noted that the relaxed atmosphere of the TC program provided an opportunity for the staff to become more involved in “helping” instead of just proving security for the clients. However, it was noted that a few of the staff felt that this relaxed atmosphere was perceived as a threat to their authority and control.

There have been a number of studies conducted on occupational stress as it relates to correctional staff in the day-to-day supervision of inmates. Two studies found that the management and movement of inmates on a daily basis in a prison resulted in significant increase in stress levels on the corrections staff (Wacker, 1992; Keister, 1992). Research also indicates that correction staff suffer from higher rates of heart attacks, ulcers, depression, hypertension, divorce, and alcoholism, than the global population and die at an average age of 59 as opposed to the normal age of approximately 75 (Woodruff, 1993).

In a 2004 study, sponsored by the University of California, the researchers explored what impact of working in a TC program had on the correction staff. This study was conducted using 120 correction staff. They examined the number of sick leave occurrences, occupational injuries, inmate urinalysis results, and inmate disciplinary
problems. The results of the study suggested that corrections staff working in a TC unit experience a less stressful job environment, fewer injuries, reduced sick leave, fewer assaults on staff by inmates, and less disruptive behavior by the inmates in the TC unit (Deitch, Koutsenok, & Ruiz, 2004).

Wexler and Lipton’s study (as cited in Prendergast, Farabee, & Cartier, 2002), found that TC programs may have positive effects on the social environment and behavior that inmates display in a prison. The study found that a TC program operating in a prison reduced the use of drugs, raised staff morale, decreased the incidents of inmates selling drugs, and reduced the incidents of disciplinary actions for clients and staff in the treatment unit.

In another 2002 study, conducted on a TC program in a new California prison, the results demonstrated that, in addition to the reduction in recidivism, the program had an immediate positive effect on the staff and inmates. This study was conducted over a one-year period from 1998 to 1999. The TC program, called Substance Abuse Treatment Facility (SATF), was opened in 1997. This TC program lasts approximately eight months and is broken into three phases. An aftercare program follows this when the client makes parole. The study examined the environment of the treatment program including absenteeism of the treatment staff working in the unit, use of drugs by the clients, unit staff ratings of the SATF program, and disciplinary actions taken on clients in treatment (Prendergast, et al., 2002).

Random drug screens were conducted in the Prendergast, et al. study among the SATF participants with only 23 positive drug screens reported. The California state prison rate,
of positive drug screens, during the period of this study, was 4.8%. The SATF rate was less than 1%. Disciplinary actions were examined and the results of the SAFT indicated a lower rate of incidents than the general population of the prison (73.2% & 79.3% respectively). Staff absenteeism showed a lower rate for the security officers who worked in SAFT than the staff who worked elsewhere in the prison. Prendergast, et al administered the Correctional Institution Environment Scale (CIES) to the corrections staff working in SAFT. This instrument assesses social climates of jails and prison environments. The data from the SAFT staff was compared to a national sample of corrections staff. The results indicated that the SAFT staff had a more positive impression of their working environment than did the national sample.

Lowe (as cited in Dietz, et al., 2003) also examined the effects, of operating a TC program in a prison had on the management in that unit. This study was part of an ongoing process evaluation conducted on the RIGHTURN substance abuse program in a California state prison. This study found that inmates living in the RIGHTURN TC unit had fewer behavioral incidents than inmates living in the general population of the prison. Furthermore, the TC inmates had less serious behavioral incidents and had less time credit loss as a result of getting a behavioral incident than the general population inmates. The analysis of the study indicated that the operation of a TC program had a positive effect on the management of the prison.
Conclusion

"Evaluations of prison-based TC programs conducted in several states and within the federal prison system have provided empirical support for the continued development of these programs throughout the nation" (Burdon et al. 2003, p. 47). These studies find that TC programs, when combined with an aftercare program following release from prison are effective at reducing recidivism and drug relapse.

The effectiveness of TC programs, as a management tool, should not be overlooked. The importance of expanding research by testing the relationships among TC programs, client institutional disorder (write-ups), and prison management may improve the safety and security for both inmate and staff and reduce the costs of incarceration. Furthermore, evidence of TC program’s ability to reduce the incidents and severity of violent write-ups, while providing treatment to individuals suffering from substance abuse problems, would make it very valuable to prison administration.
CHAPTER 3

Methodology

The ability to maintain a safe and secure environment, for the inmates, in a prison, is the primary responsibility of prison administration. Institutional disorder represents a clear problem in meeting this responsibility and is, therefore, of paramount importance. The ARCH TC program, at GRCC, is designed to provide substance abuse treatment to individuals with those problems and it provides other benefits to the institution. One of these benefits is that it is a useful management tool in the control of inmate behavior.

Treatment providers, clients, taxpayers and especially prison administration need demonstrated evidence of the ARCH TC program’s value. Careful analysis of the data generated by the current study provides an important part of this evidence. This study represents an attempt to assess the efficacy of a modified TC program in the reduction of severity in institutional write-ups.

Research Hypothesis

Clients who participate in the ARCH TC program exhibit significantly lower severity of violent institutional write-ups than the general population inmates at GRCC.

Conversely, the null hypothesis tested during the course of the study was:

Null Hypothesis

Clients who participate in the ARCH TC program exhibit no significant difference in severity of violent institutional write-ups than do general population inmates at GRCC.

Population and Sample

The population, for this study, consisted of the clients in the ARCH TC program for
the period of March 2001 through October 2005 and the inmates, from the general population, living in Dorm 1, for the same period. The participants’ median age for the ARCH TC clients was 32 years. The median age of the Dorm 1 general population inmates was 34 years. The median sentence for the ARCH TC clients was 11 years. The median sentence for the Dorm 1 general population inmates was 16 years. The ARCH TC clients were 70% Caucasian, 29% Black, and 1% other. The Dorm 1 general population inmates were 62% Caucasian, 37% Black and 1% other. Dorm 1 was selected randomly as the control group for this study.

The clients in the ARCH TC program were screened to meet DSM-IV-TR criteria for substance dependency only, and no attempt was made to screen for violent history. Also, no attempt was made to screen for antisocial or other psychopathology. The custody level for all subjects in this study was medium security level. The ARCH TC clients are housed in Dorm 3 with an average length of stay of 9.5 months.

General population inmates are housed in dormitories that are similar to the ARCH TC client’s dorm. Each dorm houses 128 individuals, with the exception of the honor dorm, which houses 64. Inmates are randomly assigned to live in these dormitories with an average length of stay of 3.5 months before they request a move or are moved by the corrections staff. No attempt was made to screen these inmates as to severity of crime, previous institutional history, or any psychopathology.
Dorm 1 was selected as the control group to be used in the current study. This Dorm is essentially identical to the TC dorm and is part of building D of the prison. Inmates in Dorm 1 were not in any form of substance abuse treatment program.

**Data Collection**

The data presented in the current study was gathered from March 2001 through October 2005. Data used were obtained from existing records kept by the Adjustment Officer relevant to institutional write-ups a 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 were maintained anonymously, (e.g., 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.

**Data Analysis**

Descriptive statistics were generated for the variables considered in the current study. These data were analyzed using SPSS 10.0 software, which provides accurate and reliable statistical data evaluation. Because the types of data were of a categorical nature (meaning that for each category infraction type, the client or inmate either had it or he did not), two Pearson Chi-square tests of association were used. The results of both analyses speak to the existence of a relationship between the “program” variable (i.e., TC or
Dorm1) and the “write-up type” variables (i.e., severity of write-up and violent/non-violent write-up).

Results

As stated, the primary method used to determine if inmate behavior is affected by the presence of a modified TC was to examine the Adjustment Hearing Results. Initially, the write-ups were segregated into two groups: violent and nonviolent infractions. Categories 1-3 are considered minor violation categories. Categories 4-7 are considered major.

The results of the distribution of documented violent and nonviolent write-ups are given in Table 1.

Table 1: Distribution of Documented Violent and Nonviolent Write-ups

<table>
<thead>
<tr>
<th>Write-up category</th>
<th>ARCH Clients</th>
<th>Dorm 1 Inmates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Violent write-ups</td>
<td>12</td>
<td>168</td>
</tr>
<tr>
<td>Nonviolent write-ups</td>
<td>146</td>
<td>476</td>
</tr>
<tr>
<td>Total write-ups</td>
<td>158</td>
<td>644</td>
</tr>
</tbody>
</table>

The results in Table 2 indicate that there was a significant association between program type (i.e., TC vs. Dorm 1) and type of write-up (i.e., nonviolent vs. violent). Specifically, the ARCH TC clients had relatively lower percentage of violent write-ups (7.6%) as compared to Dorm1 general population inmates (26.1%).
As noted previously, the Pearson Chi-Square was employed to assess the relationship between the two categorical variables. The Pearson Chi-Square is used to test a hypothesis of no association of columns and rows in tabular data. The null hypothesis
states that there would be no relationship between the two variables of the study. The results in Table 3 indicate the Pearson Chi-square significance was .001, which is less than the confidence level of .05, and thus the null hypothesis can be rejected. The Fisher Exact Test was also run on the data, due to the small \( n \), in order to compute the exact probability under the null hypothesis of obtaining the current distribution of frequencies across cells, or one that is more uneven. Again, the results in Table 3 indicate the Fisher Exact Test significance was .001, which is less than the confidence level of .05, and thus the null hypothesis can be rejected.

### TABLE 3: Pearson Chi-Square Tests

<table>
<thead>
<tr>
<th>Test</th>
<th>Value</th>
<th>df</th>
<th>Sig. (2-sided)</th>
<th>Exact Sig. (2-sided)</th>
<th>Exact Sig. (1-sided)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pearson Chi-Square</td>
<td>24.924</td>
<td>1</td>
<td>.001</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Continuity Correction</td>
<td>23.873</td>
<td>1</td>
<td>.001</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Likelihood Ratio</td>
<td>29.885</td>
<td>1</td>
<td>.001</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fisher’s Exact Test</td>
<td></td>
<td></td>
<td>.001</td>
<td></td>
<td>.001</td>
</tr>
<tr>
<td>Linear-by-linear Association</td>
<td>24.893</td>
<td>1</td>
<td>.001</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

N of Valid Cases: 802

---

a. Computed only for a 2x2 table

b. 0 cells (.0%) have expected count less than 5. The minimum count is 35.46
Table 4 gives the specific violent infractions in each category obtained by the ARCH clients and the Dorm 1 general population inmates. The highest-level category in this table for the ARCH clients was a category 3.11. This category includes “horse-playing” which is what most of the ARCH clients received. Anecdotal evidence indicates that TC clients tend to engage in this activity as a form of “letting off steam.” The second highest category, for ARCH clients, was a category 4.01. This is the typical fight that occurs in the prison that ends up in both inmates going to medical and being treated for minor bruises, abrasions, and scratches. It also usually ends up in both inmates being locked up in the Special Management Unit (SMU). Since this a violation of a TC Cardinal Rule, it means the client is discharged from treatment. There were three episodes of this category write-up during the study period. Two of these category 4.01 write-ups were the result of fights between a treatment client and a general population inmate following a pick up basketball game. This is interesting in that it gives further credence to the need for total segregation of the treatment clients from the general population inmates.

Table 4 also indicates that the highest level of violent write-up for Dorm 1 general population inmates was a category 4.01. As stated above, this type of write-up is where one or both of the inmates end up with minor physical problems but both end up being placed in SMU. In an interview with the Adjustment Officer, it is interesting to note that
this type of fighting usually is the result of an inmate “owing something” as a result of a gambling debt. The second highest category of write-ups for the Dorm 1 general population inmates was the 3.11. The third highest write-up category for the Dorm 1 general population inmates was the category 2.02, disruptive behavior infraction. This category of write-up is usually given when an inmate is making loud noises (e.g., yelling from the top tier to the bottom in the dormitory unit) and will not quite down even though he has been warned too. This write-up is also given when an inmate throws something from the top or bottom tier to the bottom or top (e.g., door key, clothes, empty cup).

Table 4: Distribution of Documented Violent Write-Ups by Category

<table>
<thead>
<tr>
<th>Violent Offense Write-Up Category</th>
<th>ARCH Clients</th>
<th>Dorm 1 Inmates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Category 1.13  Abusive/Vulgar language.</td>
<td>2</td>
<td>19</td>
</tr>
<tr>
<td>Category 2.02  Disruptive behavior.</td>
<td>1</td>
<td>26</td>
</tr>
<tr>
<td>Category 3.11  Fighting, physical action with no injury to another inmate.</td>
<td>4</td>
<td>34</td>
</tr>
<tr>
<td>Category 4.01  Physical actions resulting in injury to an inmate.</td>
<td>3</td>
<td>59</td>
</tr>
<tr>
<td>Category 5.10  Involvement in gang activity.</td>
<td>1</td>
<td>12</td>
</tr>
<tr>
<td>Category 6.01  Inciting to riot or rioting.</td>
<td>0</td>
<td>9</td>
</tr>
<tr>
<td>Category 6.12  Enforcing gang activity.</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Category 7.01</td>
<td>Assault or physical action against an employee.</td>
<td>0</td>
</tr>
<tr>
<td>Category 7.02</td>
<td>Assault or force resulting in the death or serious injury to an inmate.</td>
<td>0</td>
</tr>
<tr>
<td>Category 7.04</td>
<td>Assault or physical action resulting in the death or injury to an employee.</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total Write-Ups</strong></td>
<td></td>
<td>12</td>
</tr>
</tbody>
</table>

A second Pearson Chi-Square Test was performed on the data, which included all write-ups recorded during the time period of the study. The results indicate a significant relationship between the program the client or inmate was in and the severity of the write-up he committed. This analysis examined the differences in frequencies of write-ups for the ARCH TC clients and the Dorm 1 general population inmates at each level of severity (i.e., category 1-7). The result indicates the “direction” or type of relationship between variables.

The findings indicate that there is an overall significant difference between the ARCH TC clients and Dorm 1 general population inmates. A much higher percentage (77.9%) of the write-ups of the ARCH TC clients are “non-serious” or minor category type (i.e., occurring in category 1-3 of the write-up categories). This is in contrast to the Dorm 1 general population inmates for whom a much lower percentage (41.8%) occurs in
category 1-3 write-ups. In addition, the Dorm 1 general population inmates had a higher percentage (58.2%) of write-ups in the serious or major categories (4-6) compared to the ARCH TC clients (22.2%). The differences by each write-up category type are shown in Table 5.

Table 5: Serious Write-ups by Program Crosstabulation

<table>
<thead>
<tr>
<th>Write-up Category</th>
<th>ARCH Clients</th>
<th>Dorm 1</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Category 1</strong></td>
<td>Count</td>
<td>48</td>
<td>61</td>
</tr>
<tr>
<td></td>
<td>Expected Count</td>
<td>21.5</td>
<td>87.5</td>
</tr>
<tr>
<td></td>
<td>% within serious</td>
<td>44.0</td>
<td>56.0</td>
</tr>
<tr>
<td></td>
<td>% within program</td>
<td>30.4</td>
<td>9.5</td>
</tr>
<tr>
<td></td>
<td>% of Total</td>
<td>6.0</td>
<td>7.6</td>
</tr>
<tr>
<td><strong>Category 2</strong></td>
<td>Count</td>
<td>8</td>
<td>46</td>
</tr>
<tr>
<td></td>
<td>Expected Count</td>
<td>10.6</td>
<td>43.4</td>
</tr>
<tr>
<td></td>
<td>% within serious</td>
<td>14.8</td>
<td>85.2</td>
</tr>
<tr>
<td></td>
<td>% within program</td>
<td>5.1</td>
<td>7.1</td>
</tr>
<tr>
<td></td>
<td>% of Total</td>
<td>1.0</td>
<td>5.7</td>
</tr>
<tr>
<td><strong>Category 3</strong></td>
<td>Count</td>
<td>67</td>
<td>162</td>
</tr>
<tr>
<td></td>
<td>Expected Count</td>
<td>45.1</td>
<td>183.9</td>
</tr>
<tr>
<td></td>
<td>% within serious</td>
<td>29.3</td>
<td>70.7</td>
</tr>
<tr>
<td></td>
<td>% within program</td>
<td>42.4</td>
<td>25.2</td>
</tr>
<tr>
<td></td>
<td>% of Total</td>
<td>8.4</td>
<td>20.2</td>
</tr>
<tr>
<td><strong>Category 4</strong></td>
<td>Count</td>
<td>35</td>
<td>263</td>
</tr>
<tr>
<td></td>
<td>Expected Count</td>
<td>58.7</td>
<td>239.3</td>
</tr>
<tr>
<td></td>
<td>% within serious</td>
<td>11.7</td>
<td>88.3</td>
</tr>
<tr>
<td></td>
<td>% within program</td>
<td>22.2</td>
<td>40.8</td>
</tr>
<tr>
<td></td>
<td>% of Total</td>
<td>4.4</td>
<td>32.8</td>
</tr>
<tr>
<td><strong>Category 5</strong></td>
<td>Count</td>
<td>0</td>
<td>35</td>
</tr>
<tr>
<td></td>
<td>Expected Count</td>
<td>6.9</td>
<td>28.1</td>
</tr>
<tr>
<td></td>
<td>% within serious</td>
<td>0</td>
<td>100.0</td>
</tr>
</tbody>
</table>
The results in Table 6, performed on this second set of data (Table 5), indicates a Pearson Chi-Square significance of .001 which is less than the confidence level of .05 and thus once again the null hypothesis can be rejected and the study hypothesis can be accepted. The degrees of freedom (df) for this second Chi-Square was set at 5.

**TABLE 6: Pearson Chi-Square Tests B**

<table>
<thead>
<tr>
<th></th>
<th>Value</th>
<th>df</th>
<th>Significance (2-sided)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pearson Chi-Square</td>
<td>94.244</td>
<td>5</td>
<td>.001</td>
</tr>
<tr>
<td>Likelihood Ratio</td>
<td>108.615</td>
<td>5</td>
<td>.001</td>
</tr>
<tr>
<td>Linear-by linear Association</td>
<td>75.545</td>
<td>1</td>
<td>.001</td>
</tr>
<tr>
<td>N of Valid Cases</td>
<td>802</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

a. 0 cells (.0%) have expected count less than 5. The minimum expected count is 6.90 p< .05
Since the null hypothesis can be rejected, there is an indication that the differences between the expected and observed frequencies were too great to be attributed to sampling fluctuations. Also, the Pearson Chi-Square values were "statistically significant" and so the conclusion is that the frequencies found would not be expected on the basis of chance alone.

Study Limitations

There are several limitations to this study. The study was conducted in one correctional institution. Characteristics that are inherent to GRCC could have influenced the outcomes of the study. Second, there is the potential for self-selection bias due to the fact that the participants, in the study, were not randomly selected. Third, the sample size prevents generalizations to other institutions even though it did allow conclusions to be drawn about the participants studied. The findings may be influenced by differences in the sample size of the ARCH TC clients and Dorm1 inmates. If the ratio of inmates who had write-ups to inmates who never were written-up in each group differed significantly, the group with the lower \( n \) may be underrepresented in terms of the actual write-up counts that would exist with similar sample sizes. Additionally, only one dorm was chosen as the control group. There could have been factors that made that dorm not representative of the general population of the prison. To enhance the reliability of the findings, all of the dorms could have been matched against the treatment dorm.

While ignoring some of the issues described above related to the differences in \( n \) across the groups, it appears that the write-ups of the ARCH TC group as a whole were
less severe as compared to the Dorm1 group and also are proportionally less specifically violent.
CHAPTER 4

Discussion

The results of this study indicate significantly lower rates of violent institutional write-ups of the ARCH TC clients as compared with non-treatment Dorm 1 inmates at GRCC. Also, the ARCH TC clients had significantly fewer violent write-ups than the non-treatment Dorm 1 inmates at GRCC.

The first possible reason for the lower rate of violent institutional write-ups from the ARCH TC clients as opposed to the Dorm 1 inmates may be due to the TC Sanction system. As stated in chapter one, clients in the TC program are supposed to challenge each other’s behavior. The use of the Pull-up, LE, Written Pull-up, Bus Stop, and especially the confrontation group may function as a deterrent for behavior before it reaches the level of a write-up. These TC sanctions may serve as a stopgap that the staff uses before they resort to the use of the institutional write-up.

A second possible reason for this lowered rate of violent institutional write-ups may be that the correctional staff chooses to use the LE as opposed to a write-up for an infraction. When a client is written-up, it must go through the Adjustment Office and be “heard.” This may take up to three weeks before that happens. Corrections staff understand this. However, as covered earlier, if the correctional staff uses an LE for a behavior problem, it has an immediate effect upon behavior. The correctional staff can see the impact the LE has upon the client. It is also understood that the parole board does not see the LE, whereas, they do see a write-up and that may have an impact upon their
obtaining parole.

A third possible reason for the lowered rate of violent write-ups may be because a client may request that he receive an LE instead of a write-up. As stated earlier, when an LE is completed, it is deleted from the file. The only record that is kept is the numbers and date they got them. These records are kept in the client file, not the institution file, and are not seen by corrections administration or by the parole board. Write-ups are deposited in the institutional file and are seen by the parole board before an inmate meets with them. Given this, a client would naturally request from an officer that he receive an LE instead of a write-up.

A fourth possible reason for the lowered rates of violent write-ups received may be due to what is termed here as “convenience.” To issue a write-up calls for a staff person to fill out a lengthy form that requires an in-depth account of what occurred in the incident. They are subjected to questioning from the investigating officer and then they have to testify at the adjustment hearing. Each of these steps may result in the write-up’s being dismissed or its being adjusted to a lower level of write-up. Since the corrections staff can just issue an LE, without the scrutinization of the write-up system, and it does not get challenged, it becomes a convenience to just issue an LE. Also, ARCH TC clients are not allowed to dialogue about the LE; so again, it is a convenience for the corrections staff to issue an LE.

A fifth possible reason for the lowered rates of violent write-ups may be due to the effect of the environment itself. Clients are under constant monitoring from correction staff, treatment staff, and from the other clients in the program. Each “brother” becomes a
role model for the other and whenever a behavior problem occurs, it is dealt with within the community (e.g., pull-up, written pull-up, etc.). Behavior disputes between two clients can be addressed in a confrontation group as opposed to escalating into a fight. Dorm 1 general population inmates do not have the ability to resolve problems between two inmates in a safe environment.

A sixth possible reason for the lowered rates of violent write-ups may be due to the Buddy System. Clients are forced to rely upon themselves, deal with situations within the community, and assist each other instead of the corrections staff. By having to have a buddy with him all the time, it forces the client out of a convict mentality into a more socially acceptable way of living. Clients come to rely and depend upon one another. They also hold one another accountable and responsible for their behavior. It may be that this, holding each other accountable, is responsible for modifying the behaviors and reducing the criminal activity resulting in violent write-ups. Clients in the ARCH TC program are instructed from the very beginning that they are responsible for themselves and for their “brother” in treatment. As stated earlier, they are to “watch over a brother.”

A seventh reason for the lowered rates of violent write-ups may be due to the “uniqueness” of the ARCH program at GRCC itself instead of TC programs in general. There may be something about this TC program that makes it effective in reducing write-ups that was not evident to the researcher in this study. It may also be that something is unique about GRCC itself. Analysis could be done to see if the prison has the typical medium security inmate and what that typical inmate includes.
The findings of this study are consistent with and supportive of those reported by Wexler, et al. (1991), Mullen, et al. (2001), and Deitch, et al. (2001). In particular, the results of this study were closely related with those of the Deitch study. The inmates in Dorm 1 were three times more likely to get violent write-ups than the ARCH TC clients.

The findings of this study are also consistent with those reported in the Prendergast, et al. (2002) and Dietz, et al. (2003) studies. The clients in the ARCH TC program had significantly fewer total write ups (19.7%) as compared to the Dorm 1 general population inmates (80.3%).

Finally, it must be noted that most of the clients in the ARCH TC program were recommended for an evaluation and follow that recommendation by the parole board. 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, p. 221) note “coercive treatment appears to be just as effective as non-coercive treatment at controlling inmate behavior.”

**Conclusion**

As correction administrators continue to be faced with shrinking budgets and demands to “do more with less.” programs that meet this need will continue to be sought out. Therapeutic Communities have demonstrated effectiveness in reducing relapse and recidivism. The result is a savings to corrections budgets and to the taxpayers in general. This study points out an additional benefit to corrections. TC programs can be used for the control and management of inmates within the prison. The reduction of violence between inmates and inmates and inmates and staff will save money in terms of less
need of staff for supervision and medical costs as a reduction of the violence. More important, it may save the lives of inmates and staff.

The results of the current study should be viewed with caution. Only the ARCH TC program was examined. It may be that the results 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 both of the medium security prison TC programs. This would also increase the population sample and reduce possible sample bias. Also, it may be that the clients, in the ARCH TC program, behaviors had changed before treatment. Analysis could have included the number and type of write-ups they had received before they entered treatment and then they could be tracked during treatment to see if this changed.

However, given the results of the current study, it appears that TC programs have a positive correlation on the reduction of violent write-ups and therefore improve the environment for the clients and staff alike. In the same manner, costs are reduced in terms of added personnel, repair to possible damage to the property, and medical treatment from violent acts. These benefits are attractive to corrections administrators.

The other benefits of a TC program may be expanded beyond just for the treatment of substance abuse inmates. Application of the concepts of inmates holding each other accountable for their behavior, being good role models for each other, accepting no excuses for inappropriate behavior, and the client’s own involvement in the operations of the living unit may see reductions in violent write-ups similar to those in the ARCH TC program. According to De Leon (2000, p.393) “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.” It is in these ways that TC programs can enhance the quality of life for an individual while he is incarcerated. This research will add to the body of research on the efficacy of TC programs within the prison system.

Future recommendations, as a result of this study, point to including data from the other medium security prisons. This would increase the sample size and increase the randomization of subjects thereby addressing the study limitations described in chapter three.

Another recommendation would be to use data from the Honor Dorm at GRCC and compare the results. Honor dorm inmates are held to the highest standards in any institution. They receive more incentives than TC clients or general population clients and are removed from the dorm if they receive a category 3 or above write up.

A final recommendation would be to collect the data over a longer period of time. Data could be collected over a five-year period, thus increasing the confidence of the findings as a result of expected “chances” of additional write ups.
References


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-TR 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-TD DIAGNOSTIC CRITERIA FORM

ABUSE

______305.00  Alcohol  DEPENDENCE
______305.70  Amphetamine
______305.20  Cannabis
______305.60  Cocaine
______305.30  Hallucinogens
______305.90  Inhalants
______305.50  Opiates
______305.90  Phencyclidine (PCP)
______305.40  Sedative, Hypnotic or Anxiolytic
______305.90  Other Substance
______305.90  Poly-substance (3 groups)
______305.10  Nicotine

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