

The author(s) shown below used Federal funds provided by the U.S. Department of Justice and prepared the following final report:

Document Title: Process Assessment of Correctional Treatment (PACT), Final Project Report

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Document No.: 184506

Date Received: September 25, 2000

Award Number: 98-RT-VX-K004 ; 96-IJ-CX-0024

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Final Project Report

Process Assessment of Correctional Treatment (PACT)

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This project was funded by Grant No. 98-RTVXK00496-IJ-CX-0024 awarded by the National Institute of Justice, Office of Justice Programs, U.S. Department of Justice. Points of view in this document are those of the authors and do not necessarily represent the official position or policies of the U.S. Department of Justice. Special appreciation is extended to Ron Goethals, Director of the Dallas County Community Supervision and Corrections Department and to Julien Devereux, Bill Hornyak, Barbara Jiles-Smith, and the clinical staff at the Dallas County Judicial Treatment Center who assisted in conducting this study.

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Abstract

The systematic study of correctional substance abuse treatment requires the use of a comprehensive and well-planned evaluation system. This report, therefore, provides an extensive summary of the data collection procedures used during the Process Assessment of Correctional Treatment (PACT) project (NIJ #98-RTVXK00496-IJ-CX-0024) funded as part of a family of studies through the Residential Substance Abuse Treatment for State Prisoners (RSAT) program. Special attention is placed on describing the assessment procedures used, baseline and during-treatment questionnaires, and to the composite indices that can be scored from each. Extensive information that can be used to inform programmatic changes were collected, and important assessment areas to both practitioners and stakeholders were highlighted.

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Research has shown that intensive rehabilitation services provided to serious offenders in correctional settings can reduce criminality and drug use following incarceration (Andrews et al., 1990; Gendreau, 1996). Particularly within prisons, long-term residential treatment programs (such as therapeutic communities • TCs) have been found to reduce post-incarceration involvement in illicit drugs and crime (Lipton, 1995). These findings are highlighted in numerous studies (Field, 1989; Inciardi, Martin, Butzin, Hooper, & Harrison, 1997; Knight, Simpson, Chatham, & Camacho, 1997; Wexler, De Leon, Thomas, Kressel, & Peters, 1999; Wexler, Falkin & Lipton 1990), in a congressionally-mandated review completed by the University of Maryland (Preventing Crime: What Works, What Doesn't, What's Promising, MacKenzie, 1997), in the NIDA-funded Correctional Drug Abuse Treatment Effectiveness meta-analysis (CDATE, Lipton, Pearson, Cleland, & Yee, 1998; Pearson & Lipton, 1999), and in a recent series of special issues of the Prison Journal (Simpson, Wexler, & Inciardi, 1999a, 1999b). However, relatively little is known about the Treatment Process • that is, the metaphorical “black box” • within correctional substance abuse treatment that leads to improved outcomes.

Figure 1 describes a conceptual and empirically-validated model (Simpson, Joe, Rowan-Szal, & Greener, 1995; 1997; Simpson, Joe, Greener, & Rowan-Szal, in press) that we used to guide a process evaluation of the Dallas County Judicial Treatment Center (DCJTC). This framework provided the theoretical foundation for the data system we used for this project as we classified and tracked the progress of probationers as they received intensive treatment in this corrections-based Therapeutic Community (TC). The model asserts that the treatment episode represents a series of interrelated events, each presenting an opportunity to collect data. For example, the individual's treatment experience began when they underwent clinical records processing at admission to the program. At this point, a comprehensive baseline assessment of the risks, needs, and problems each offender showed while they were in the community was completed. This included constructing detailed social histories, classifying drug problems, assessing mental health and abuse histories, and determining the level of behavioral risk for

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contracting HIV/AIDS, and detailing criminality and criminal involvement. Collecting these types of data can help program administrators and staff to understand who is being placed in their facility, and whether these placements are appropriate for the prescribed level of services (Knight & Hiller, 1997, Knight, Hiller, & Simpson, in progress). The problems that offenders present at intake, in turn, can influence the therapeutic process as individualized treatment plans are developed to address the most serious and immediate needs.

As shown in the “early engagement” phase of the central box of the model presented in Figure 1, these background characteristics also may influence how probationers perceive their peers, program staff, and their own willingness to become involved in and commit to their recovery during the first few months of the treatment episode (Hiller, Knight, & Simpson, 2000; Broome, Knight, Knight, Hiller, & Simpson, 1997). Pretreatment levels of motivation, for example, have been shown to play an important role in the development of therapeutic relationships with counselors and to indirectly determine the likelihood of rearrest following treatment in a 4-month modified TC for probationers (Broome et al., 1997). Therapeutic activities and feelings of personal progress made during the early engagement phase also impact the “early recovery” stage of the treatment process when the probationers are making important behavioral and psychosocial changes that will facilitate long-term recovery upon return to the community. Prospective data collection (based on both probationer self-report and on formal documentation of treatment contact) can be made throughout the treatment episode -- thus providing the opportunity to track changes over time and to determine who will be retained the expected length of time in the program. Also, monitoring offender self-perceptions and their appraisals of the therapeutic intervention is essential because remaining in correctional substance abuse treatment been shown to be related both to offender motivation (De Leon, Melnick, Thomas, Kressel, & Wexler, 2000) and to their satisfaction with the programming they received (Hiller, Knight, & Simpson, 1999).

This final project report, therefore, describes the measures and methods used in the Process Assessment of Correctional Treatment (PACT) project, which was funded by the

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National Institute of Justice through the Local Evaluation of the Residential Substance Abuse Treatment (RSAT) grants program (Grant No. 98-RTVXK00496-IJ-CX-0024). This report provides a detailed overview of the treatment program and includes a description of the characteristic of both the offenders and treatment staff. An extensive overview of the evaluation system used in the PACT also is presented, and composite measures that can be scored from each data collection form are described. A more detailed study that examines this application of the TCU Process Model is presented in the summary report from this project (see Hiller, Knight, Rao, & Simpson, 2000).

Method

Program Description

The Dallas County Judicial Treatment Center (DCJTC), located in Wilmer, Texas, was founded in 1991 by a council of 15 county and district judges as a response to Texas House Bill #2335, which authorized the development of residential correctional treatment centers for the diversion of drug-involved felony offenders from long-term incarceration. Essentially, this program represents the final and most restrictive sanction these judges use before imposing state jail or prison terms. Offenders frequently wait in jail (up to 6 months) after being committed to treatment for a slot to open. No systematic screening procedures, however, were used during the time covered by this RSAT process evaluation. That is, court officers during their presentencing investigations did not use a standardized information base to guide judges in making decisions about committing an offender to treatment or about which ones had greater needs for intensive therapeutic intervention.

As shown in Figure 2, the DCJTC is a 6-month residential substance abuse treatment facility with a 228-bed capacity, including four 35-bed units for males and three 20-bed cottages for females. It is managed by Cornell Corrections, Inc., under contract from the Dallas County Community Supervision and Corrections Department. Like many corrections-based treatment programs (see Wexler, 1995, Knight et al., 1997), the DCJTC is modeled after the traditional

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community-based therapeutic community (TC), and it is provided in three major phases, including (a) orientation, (b) main treatment, and (c) re-entry. Treatment includes group and individual counseling, behavior modification, peer-to-peer therapy, life skills training, vocational and educational instruction, regular meetings with an on-site probation officer, and emphasizes 12-Step recovery, criminal thinking patterns, and relapse prevention. Offenders advance through a hierarchical recovery sequence whereby they receive progressively more responsibilities and privileges, as they become more senior members of their treatment “family.” Traditional TC therapeutic techniques are used, including confrontation groups, “pull-ups,” and morning and evening meetings. However, there are no special interventions directed at facilitating treatment engagement and retention.

Counselors

In June 1998, the TCU Background Record was completed by 38 counselors, which elicited information on age, gender, ethnicity, drug use history (including recovery status), educational background, and counseling experience. Most of the counselors were female (61%) and African American (45%) or Caucasian (40%); their average age was 40. In terms of educational background, 22% had finished only high school, 42% had a two-year associates degree, and 36% had a Bachelor’s degree or higher. Thirteen percent had been a drug abuse counselor for at least 10 years, 26% had between 5 and 9 years of experience, and 61% had 4 or fewer years of experience. Furthermore, 71% of the counselors had experience with 12-step programs. When setting was considered, 21% had between 6 to 14 years of experience counseling offenders in corrections-based programs, 26% had 3 to 5 years experience, and 53% of the counselors had 2 years or less (see Table 1; c.f., Barthwell et al., 1995). In addition to the professional counselors, the DCJTC also maintained part-time medical and psychiatric staff to provide additional diagnostic and specialized services, such as mental and physical health screening and the prescription of psychotropic medication for residents with depression and anxiety problems. Due to budgetary limitations, neither extensive interviews nor focus groups could be conducted with the program staff.

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Sample

Data were collected from 429 felony probationers admitted to the DCJTC between January and December 1998. Social history indicators showed that they were predominantly male (70%), African American (48%) or Caucasian (39%), and had never been married (43%). Most (60%) were between the ages 17 and 34 (average age was 32). About two-thirds (64%) had a high school diploma or its equivalent and many were unemployed (50%) prior to the arrest that led to their mandated treatment at the DCJTC (See Table 2).

Like community-based TCs (see De Leon, 1984, 1991; De Leon & Schwartz, 1984), many residents left the program before they had completed the expected treatment duration of 6 months. An average of 5% of the total sample dropped out each month, with 30% quitting prior to completing treatment (see Figure 3). Examination of the reasons for discharge (described in Figure 4) from treatment showed that 68% of offenders completed treatment, 15% quit against staff advice (ASA), 12% were discharged for rules violations, and 5% left for other reasons (e.g. medical problems). The 2% difference between those retained 180 days (70%), and those who graduated (68%) was due to 12 residents that were retained about 6 months but still were discharged ASA (9 cases) or noncompliant (3 cases).

PACT Data System Overview

Many of the data collection forms used in this study originated in the Drug Abuse Reporting Program (DARP), the first multisite evaluation of community-based treatment funded by the National Institute on Drug Abuse (NIDA, Sells & Simpson, 1976; Simpson & Sells, 1982, 1990). These instruments were modified more recently for use in a project entitled Improving Drug Abuse Treatment, Assessment, and Research (DATAR, Simpson, Chatham, & Joe, 1993; Simpson, Dansereau, & Joe, 1997). This evaluation system was adapted further for use in residential correctional settings (also see Knight et al., 1997 for a version used in an in-prison therapeutic community). Revisions to these forms (referred to below as the TCU DCJTC data collection instruments) included rewording items to reference the 6 months prior to the commitment arrest as the timeframe for the collection of baseline information.

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Written, informed consent was obtained from each resident prior to the collection of the TCU DCJTC assessments. During their first week of treatment, residents completed a comprehensive intake battery that included, the (a) Initial Assessment, (b) Self-Rating Form (SRF), and (c) Intake Interview (Simpson, Knight, & Hiller, 1997, also see Figure 5). The Initial Assessment was a brief, structured counselor-led interview completed within 24 hours of treatment entry that recorded sociodemographic background information and drug use history. Immediately following this, residents also completed the Self-Rating Form, a 95-item self-report instrument designed to assess psychosocial functioning and treatment motivation at intake. Finally, a counselor administered the Intake Interview approximately 2 to 7 days after the Initial Assessment, after residents had time to become acquainted with the program and staff. It included detailed questions on the resident's social background, family and peer relations, health and psychological status, criminal involvement and history, and drug use problems. The number of TCU assessments collected as part of the admission process, including forms completion and missing rates are described in Table 3.

Indicators of during treatment process and therapeutic progress were based on program records and on the (a) TCU Resident Evaluation of Self and Treatment (REST), and (b) TCU Counselor Rating of Client (CRC). The prospective collection of the REST and CRC at the end of treatment months 1, 3, and 6 were linked to major landmarks in a residents' treatment episode (end of orientation, 90-day treatment plan, and discharge plan; respectively). Description of the number of these forms completed or missing also is shown in Table 3.

INTAKE BATTERY

TCU INITIAL ASSESSMENT

A short face-to-face interview was conducted with a counselor at treatment intake to gather information for state-required diagnostic profiles. It was divided into four major sections: (a) mental status, (b) background and psychosocial functioning, (c) alcohol and other drug use, and (d) psychological status. Indication of a severe mental impairment was gauged through four questions adapted from the Mini-Mental Status Exam (Folstein, Folstein, & McHugh, 1975),

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such as “What day is it?” and “Where are you?” Information on demographic background and psychosocial functioning included age, ethnicity, insurance coverage, living arrangements, education level, and employment as well as a self-assessment of areas in which the individual felt they needed help (e.g., emotional and psychological problems, substance abuse). Frequency of drug use as well as clinical criteria for drug dependence classification comprised the bulk of the interview; a brief section on psychological problems rounded out this form.

Composite Measures

Drug dependence. Four independent sections in the Initial Assessment were used to assess Diagnostic and Statistical Manual IV (DSM-IV; American Psychiatric Association, 1994) criteria for dependence and abuse criteria for *Alcohol, Cannabis, Cocaine, and Opioids*. Wording of these items closely followed those found in the DSM-IV, and scoring was identical (i.e., 3 or more criteria met for classification of dependence, 1 or more for abuse on corresponding items). As shown in Figure 6, over half (56%) of the probationers were clinically-dependent on alcohol (15% met abuse criteria), 70% were dependent on cocaine (3% more for abuse), 36% on marijuana (14% for abuse), and 16% on opiates (an additional 1% for abuse).

Psychological problems. Similar to the findings of Joe, Brown, and Simpson (1995), two brief measures were created from responses to items on the Initial Assessment that elicited indications of psychological dysfunction (i.e., “Not counting the effects from alcohol or drug use, have you ever experienced serious depression?”). The *pathology index* (coefficient alpha = .66) was comprised of a set of symptoms that included depression, serious anxiety or tension, hallucinations, trouble understanding, concentrating, or remembering, and trouble controlling violent behavior. The majority of the probationers (74%) scored 1 or above on this measure, and the average numbers of symptoms reported was 1.8 (standard deviation = 1.48). The *suicidal ideation* composite (coefficient alpha = .82) focused on two questions that asked probationers if they had ever had “serious thoughts of suicide” or “attempts at suicide.”

TCU SELF-RATING FORM (SRF)

This 95-item self-report instrument has been used with a variety of community- and institution-based samples, including prisoners, probationers, and parolees, as well as clients in outpatient methadone treatment. It is organized along three major conceptual divisions, including (a) psychological functioning, (b) social functioning, and (c) motivation for treatment, and each subscale is comprised of at least six items. Administration protocol for this study required that probationers to self-administer the form with minimal help from the counselor (e.g. counselors were allowed to clarify terms or definitions) by indicating their agreement with each statement using a Likert scale that ranged from 1 = “strongly disagree” to 7 = “strongly agree.” For additional information, see Knight, Holcom, and Simpson (1994), who provide a detailed summary of the development of the SRF as well as an extensive assessment of its psychometric properties. Measurement properties for this sample are described in Table 4 and below.

Composite Measures

Psychological functioning. As shown in Table 4, current levels of psychological functioning were assessed through scales for *depression* and *anxiety* (coefficient alphas of .67 and .74, respectively), and through ratings of *self-esteem* and *decision-making confidence* (coefficient alphas of .66 and .71). Sample items for the anxiety scale included “You feel anxious or nervous,” “You have trouble sleeping,” and “You have trouble sitting still for long.” In addition to these measures of psychological symptoms, the SRF also included the *Pearlin Mastery Scale* (Pearlin & Schooler, 1978) to assess general feelings of self-efficacy (coefficient alpha = .72). For this, residents indicated their agreement with statements such as “You have little control over the things that happen to you” and “There is little you can do to change many of the important things in your life.”

Social functioning. Social functioning indicators were comprised of scales for *hostility*, *risk-taking*, and *childhood problems* (coefficient alphas ranged from .74 to .79, see Table 4). Ratings for hostility were made on items like “You have urges to fight or hurt other,” “You get mad at other people easily,” and “You like others to feel afraid of you.” Unlike findings from

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prior samples (see Knight et al., 1994), an additional scale, social conformity, had low internal consistency reliability (coefficient alpha = .58).

Treatment Motivation. Finally, motivation for treatment was based on the *problem recognition*, *desire for help*, and *treatment readiness* scales (coefficient alphas = .82, .67, and .72, respectively; see also Joe, Knezek, Watson, & Simpson, 1991; Simpson & Joe, 1993). As discussed by Simpson and Joe (1993), these scales represent conceptually distinct “stages” of treatment motivation beginning with problem recognition and culminating with treatment readiness. Items for these scales are described in Table 4.

TCU INTAKE INTERVIEW

This comprehensive face-to-face interview was organized into nine major sections including, (a) sociodemographic background, (b) family background, (c) peer relations, (d) criminal history, (e) health and psychological status, (f) drug history, (g) AIDS-risk assessment, (h) interviewer comments, and the (i) the client assessment profile. Questions on the offender’s sociodemographic background elicited standard types of information such as age, ethnic identification, marital status, number of children, living arrangements, education level, employment history, and major sources of financial support. Characteristics of the family of origin were assessed next and included reports on parental behavior (i.e. employment, crime and deviance, drug use, warmth), and current patterns of familial interaction were established. The peer relations section was designed to determine the relative size of each offender’s social group as well as its level of participation in criminal and drug use activities. Typical items were “How many hours each week (on average) did you generally spend with friends while doing drugs or involved in crime-related activities?” and “Before entering this treatment program, had you ever been a gang member?” Next, a comprehensive criminal history was established, including arrest history (adult and juvenile), incarceration history, illegal activity in the preceding 30 days, and current legal status. A crime chart was used to document lifetime arrests, arrests in the preceding 6 months, and recent activity for 16 offense categories including several types of property and violent crimes. The health and psychological status part of the Intake Interview examined

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lifetime and current serious health problems as well as recent treatment for psychiatric problems (including prescriptions for psychotropic medication). The drug history chart allowed counselors to quickly and conveniently collect data for 15 types of drugs, including the age a drug was first used, the frequency of use in the preceding 30 days and 6 months, and whether a drug had ever been injected or injected in the previous month. Recent alcohol use was explored further on the next page and detailed information on drinking patterns and amounts of alcohol consumed were documented. Additional questions prompted self-reported reasons for using alcohol and drugs such as “being in a place or situation that made you want them,” “to help increase energy and alertness,” and “because you felt sick with physical pain.” Finally, an exhaustive treatment history was collected; focusing on the number of times the offender was abstinent from drugs for longer than 3 months, and the types of treatment that had been received previously (i.e., inpatient, residential, hospital-based, outpatient, or methadone). The TCU/HIV AIDS-Risk Assessment (Simpson, 1997) was incorporated into the next section of the Intake Interview, and data on sexual and injection behavior associated with increased rates of exposure to HIV/AIDS was collected. Finally, the interviewer completed the last two segments of the form, which documented their comments on the offender’s behavior during the interview as well as their clinical assessment of how important it was for the individual to receive help with a series of problems (e.g., employment, family, drug use). Although numerous composite measures could be created from the data collected on this form (see Joe and Simpson, 1993), for brevity, only a few measures will be summarized below.

Composite Measures

Peer group functioning. A series of questions asked the offenders to rate their peers on a Likert scale ranging from 0 = “never” to 4 = “always.” Based on previous work (see Simpson & Joe, 1993; Hiller, Knight, & Simpson, 1999) and a principal components factor analysis, five composite indices were constructed, including *prosocial behavior* (coefficient alpha = .93; $M = 2.18$) using items like “Your friends work regularly on a job?” and “Your friends spend time with their families?” *Deviance and criminality* (coefficient alpha = .90; $M = 1.44$) asked

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questions like “Your friends trade, sell, or deal drugs?” and “Your friends do other things against the law?” The level of respect a resident’s peer group showed for them was reflected in the *leadership* (coefficient alpha = .85; \underline{M} = 2.13) measure, which was comprised of statements like “Your friends look to you as leader?” and “Your friends ask for your advice about their problems?” Another variable, *problem peers* (coefficient alpha = .80; \underline{M} = 1.63), described the probationers’ perceptions that their relationships had generated trouble for them, including ratings for “Your friends cause problems for you?” and “Your friends take risks or chances?” Finally, *support for recovery* (coefficient alpha = .79; \underline{M} = 1.88) assessed the level of peer group encouragement a resident might receive for quitting drugs (e.g., “Your friends believe drug use causes problems” and “Your friends think drug treatment can be helpful”). Examination of intercorrelations among these scales showed a strong, positive association between prosocial peers and support for recovery, and between deviance and criminality and problem peers. A modest, negative relationship was observed between prosocial peers and deviance and criminality (see Table 5).

Behavioral risks for HIV/AIDS. Like those developed by Simpson et al. (1994), two measures were constructed to quantify behaviors shown to be associated with an increased probability of contracting the HIV/AIDS virus. The *risky needle exposure index* was formed by adding estimates (from two separate items, coefficient alpha = .67) reflecting the number of times dirty drug injection equipment had been shared. Overall, prevalence rates were low with only 14% of the sample reporting any HIV/AIDS-risky injection drug use behavior. The *risky sex exposure index* described the number of times an individual had sex without using a condom with someone who was not their spouse or primary sexual partner, with someone who was an injection drug user, or in exchange for drugs, money, or gifts. Internal consistency reliability, however, was low (coefficient alpha = .54) suggesting that the individual items should be analyzed separately.

Multi-Form Composite

Criminal classification index. A measure for classifying risk for recidivism among the probationers, modeled after the Lifestyle Criminality Screening Form (LCSF; Walters, White, & Denney (1991), was constructed from information collected in the Initial Assessment, Intake Interview, and SRF. The original LCSF is a “chart audit” usually scored using information in an offender’s pre-sentence investigation report (Walters, 1998). Conceptually, it emphasizes four behavioral dimensions related to a criminal lifestyle, including *irresponsibility*, *self-indulgence*, *interpersonal intrusiveness*, and *social rule breaking* (Walters, 1990, 1998). It has good reliability and related psychometric properties (Walters, 1997), and Walters (1998) recommends clinical interpretations based on a total composite score to define “high” (values of 10 and above), “moderate” (7 to 9), and “low” (6 and below) risk categories. In our adaptation of this assessment model, at least two items from each LCSF behavioral dimension were represented in the criminal classification index (coefficient alpha = .66). Items for this composite focused on marital and family relations, education, employment history, substance abuse, and criminal history (especially serious offenses). As summarized in Table 6, scores based on the TCU DCJTC forms ranged from 0 to 15 points (mean = 8). Thirty-four percent of the sample were classified as high risk, 36% moderate, and 30% low. Objective data from official records, however, were unavailable for comparison to this criminality index.

DURING TREATMENT ASSESSMENTS

TCU RESIDENT EVALUATION OF SELF AND TREATMENT (REST)

This survey was collected three different times during the probationer’s tenure at the program (i.e., Months 1, 3, and 6). The first section of the REST was a repeated assessment of the SRF, thus providing multiple time series data for assessment of changes in psychosocial functioning from baseline through during treatment intervals. The following two sections were adapted from De Leon (1997), and focused on the offender’s perceptions of the structure of the program, and on their experiences while in treatment. The remaining sections of the form

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included evaluations of the counselor, self-evaluation of the resident's personality, and ratings of group and individual sessions. Hiller (1996) provides additional data on the REST from a sample of parolees who received in-prison therapeutic community treatment.

Composite Measures

Program structure. Based on finding reported in Hiller (1996), resident evaluations of the structural characteristics of the treatment program were made using four scales. *Program environment* (coefficient alpha = .84) described the physical components of the treatment setting such as the morning and evening meetings, work assignments, and rules and regulations (i.e., "house rules and tools"). The second scale, *staff empathy* (coefficient alpha = .87; summarized in Table 7), was made up of appraisals of the caring and helpfulness of the treatment and security personnel. Resident evaluations of their peers and of their treatment group's cohesiveness were reflected in the *peer support* composite (coefficient alpha = .86). The final scale, *sessions* (coefficient alpha = .75), recorded resident satisfaction with their individual and group process counseling sessions.

Treatment experience. As shown in Table 7, resident appraisals of their treatment episode were based on three composite indices. The first, *personal involvement* (coefficient alpha = .80), assessed the extent to which an individual felt committed to and how much they were participating in the therapeutic process. *Personal progress* (coefficient alpha = .79) reflected probationer satisfaction with self-improvements in how they handled the issues surrounding their drug abuse and emotional problems. Finally, *trust* (coefficient alpha = .80) allowed residents to indicate if they felt comfortable and psychologically "safe" around the treatment staff and other clients.

Counselor impact. More detailed assessment of the client-counselor relationship was elicited through probationer feedback and included scales for *counselor effectiveness* and *counselor rapport* (coefficient alphas = .93 and .90, respectively; see Table 7). The effectiveness of treatment counselors was gauged through items like (the counselors--) "Motivate and encourage you," "Develop a treatment plan with reasonable objectives for you," and "Help you

make changes in your life.” Also, the depth of the rapport between client and counselor was established through (your counselors--) “Are easy to talk to,” “Respect your opinions,” and “Understand your situation and problems.”

COUNSELOR RATING OF CLIENT (CRC)

Repeated CRC assessments (Months 1, 3, and 6) were completed by each client’s primary counselor who rated them on set of 25 adjectives (like honest and sincere and manipulative) using a Likert scale ranging from 1 = “strongly disagree” to 7 = “strongly agree.” Counselors also indicated the extent to which counseling activities with each client focused on activities like responding to crises or discussing relapse situations and triggers.

Composite Measures

Client attributes. Exploratory principal components factor analysis identified four scales from the counselor ratings of the client’s characteristics with an Eigenvalue greater than 1. *Treatment engagement* was composed of 8 items (coefficient alpha = .89; \underline{M} = 4.42) and described an individual’s involvement in their treatment using statements like the client “participates in group discussions,” “pays attention,” and “clearly expresses thoughts and feelings.” Seven attributes comprised the *rapport with others* scale (coefficient alpha = .86; \underline{M} = 4.95). This included items like the client is “easy to talk to,” “warm and caring,” “liked by other clients,” and “liked by staff.” A client’s level of *denial* (coefficient alpha = .79; \underline{M} = 4.04) was gauged through ratings on items like the client is “in denial,” “unmotivated to recover,” and “manipulative.” Finally, *psychological problems* (coefficient alpha = .71; \underline{M} = 3.77) were based on the counselor’s judgments about a client being “hostile or aggressive,” “depressed,” “impulsive,” “nervous or anxious,” or “easily distracted.” Examination of scale intercorrelations (see Table 8) showed that rapport and engagement shared a strong, positive association, but both were related negatively to ratings of denial and to psychological problems.

Counseling foci. Principal components analysis also identified four main themes addressed by counselors during sessions with their clients. Similar to the composite index described by Simpson et al. (1995), *self-confrontation* (coefficient alpha = .87; \underline{M} = 4.88)

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addressed topics like “assuming appropriate responsibility,” “reducing denial,” and “improving objectivity.” The second major counseling dimension, *life skills development* (coefficient alpha = .89; \underline{M} = 4.92), included an emphasis on “improving communication skills,” “developing coping plans and strategies,” and “making new friends.” *Family* (coefficient alpha = .85; \underline{M} = 5.22) was comprised of these items, “discussing family issues,” “establishing trust and rapport,” “exploring feelings,” “specifying short-term objectives,” and “improving family relations.” Finally, *financial management* (coefficient alpha = .89; \underline{M} = 4.03) focused on “managing finances,” “discussing occupational issues,” and “defining long-range goals.”

In conclusion, the evaluation system described in this report provides a basis for examining the metaphorical “black box” of the treatment process in greater detail. Promising areas of inquiry into this topic include (1) treatment satisfaction (Hiller et al., 1999), (2) treatment expectations (McCorkel, Harrison, & Inciardi, 1998), (3) the peer environment within the TC (Broome, Knight, Hiller, & Simpson, 1996; Hiller et al., 1999), (4) the offender-counselor relationships (Broome et al., 1996, 1997), and (5) procriminal thinking and attitudes (Walters, 1996; Walters & Elliott, 1999). Improved posttreatment outcomes likely will be realized only through serious efforts to understand and to improve the processes underlying therapeutic progress in correctional treatment settings.

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Table 1
Background Characteristics and Levels of Professional
Experience for DCJTC Counselors in 1998

	Total (N = 38)
% Female	61
Race/Ethnicity	
% African American	45
% Caucasian	40
% Hispanic	8
% Other	7
Age	
% 20-29	14
% 30-39	30
% 40-49	39
% 50 +	17
Average age	40
% Recovering from Abuse of Illicit Drugs	32
% Recovering from Abuse of Alcohol	38
Education	
% High School Graduate	22
% 2-Year- Degree	42
% 4-Year Degree	31
% Graduate Degree	5
Experience as a Drug Counselor	
% 4 Years or Less	61
% 5-9 Years	26
% 10 Years or More	13
Experience Counseling Offenders	
% 2 Years or Less	53
% 3-5 Years	26
% 6-14 Years	21
% Experience with 12 Step Program	71

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Table 2
Background Characteristics for Admissions to the DCJTC in 1998

	Total
% Male	70
Race/Ethnicity	
% African American	48
% Caucasian	39
% Hispanic	9
% Other	4
Marital Status	
% Never Married	43
% Married	27
% Divorced/Separated/Widowed	30
Age	
% 17-24	26
% 25-29	14
% 30-34	20
% 35-39	18
% 40-66	22
Average age	32
Education	
% High School Graduate	40
% GED	24
% Vocational Certification	27
Average Highest Grade	11
Employment	
(30 Days prior to last arrest)	
% None	50
% Part-time	11
% Full-time	39

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Table 3
Description of the Total Number of Forms Collected, Completed, or Missing for the
Process Assessment of Correctional Treatment (PACT) Evaluation Project

TCU Form Title	No. of Forms Completed	No. of Forms Possible ¹	% Complete ²	% Missing ³
Intake Battery⁴				
Initial Assessment	419	428	97.9	2.1
Self-Rating Form	421	428	98.3	1.7
Intake Interview	419	425	98.6	1.4
During Treatment Forms				
Resident Eval of Trt (Mon. 1)	399	405	98.5	1.5
Resident Eval of Trt (Mon. 3)	349	358	97.5	2.5
Resident Eval of Trt (Mon. 6)	296	307	96.4	3.6
Counselor Rating Client (Mon. 1)	402	415	96.9	3.1
Counselor Rating Client (Mon. 3)	353	371	95.1	4.9
Counselor Rating Client (Mon. 6)	300	315	95.2	4.8

Note. N = 429, but 1 resident was discharged prior to beginning the scheduled paperwork at admission to treatment.

¹ Values in this column are contingent upon whether a resident had left treatment before the form was scheduled to have been completed.

² Values are based on dividing the number of forms completed by the number of forms possible.

³ Values represent the percentage of forms that could have been collected but were not.

⁴ Ninety percent of the missing forms from the intake battery were due to very early treatment discharges (i.e., within 7 days) which caused problems with the collection of forms.

Table 4
Descriptive Statistics, Item-to-Total Correlations, and Coefficient
Alphas for the TCU Self-Rating Form (SRF)

Scale/Items ¹	Mean	SD	Item-to- Total <u>r</u>
Psychological Functioning			
<i>Self-esteem</i> (coefficient alpha = .66)	4.04	1.18	----
You have much to be proud of	4.88	2.03	.23
In general, you are satisfied with yourself	3.81	1.94	.40
You feel like a failure (R)	3.53	1.95	.49
You feel you are basically no good (R)	5.33	1.75	.48
You wish you had more respect for yourself (R)	2.45	1.78	.37
You feel you are unimportant to others (R)	4.22	2.13	.41
<i>Depression</i> (coefficient alpha = .67)	3.46	1.16	----
You feel sad or depressed	4.19	2.02	.53
You have thoughts of committing suicide	1.72	1.40	.33
You feel lonely	4.30	2.10	.46
You feel interested in life (R)	2.22	1.62	.22
You feel extra tired or run down	3.89	2.13	.40
You worry or brood a lot	4.42	1.98	.46
<i>Anxiety</i> (coefficient alpha = .74)	3.63	1.30	----
You have trouble sitting for long	3.61	2.18	.43
You have trouble sleeping	3.34	2.14	.47
You feel anxious or nervous	4.35	2.01	.49
You have trouble concentrating or remembering things	3.77	2.07	.37
You feel afraid of certain things, like elevators, crowds, or going out alone	2.60	2.01	.38

Table 4 (Continued)

Scale/Items	Mean	SD	Item-to- Total r
<i>Anxiety</i> (continued)			
You feel tense or keyed up	3.85	2.01	.59
You feel tightness in your muscles	3.87	2.08	.50
<i>Decision Making Confidence</i> (coefficient alpha =.71)			
You consider how your actions will affect others	4.82	.92	----
You plan ahead	5.44	1.56	.43
You think about probable results of your actions	4.41	1.88	.46
You have trouble making decisions (R)	4.71	1.73	.45
You think of several different ways to solve a problem	4.53	1.92	.36
You analyze problems by looking at all the choices	5.15	1.53	.38
You make decisions without thinking about consequences (R)	5.00	1.56	.46
You make good decisions	3.78	1.97	.35
You think about what causes your current problems.	4.29	1.69	.40
<i>Self Efficacy</i> (coefficient alpha =.72)			
You have little control over the things that happen to you (R)	6.10	1.24	.12
There is really no way you can solve some of the problems you have (R)	5.26	1.08	----
There is little you can do to change many of the important things in your life (R)	4.77	2.00	.45
You often feel helpless in dealing with the problems of life (R)	5.11	1.99	.53
Sometimes you feel that you are being pushed around in life (R)	5.48	1.87	.56
What happens to you in the future mostly depends on you	4.32	2.02	.46
You can just do about anything you set your mind to do.	4.29	1.95	.48
	6.38	1.21	.23
	6.48	1.08	.29

Table 4 (Continued)

Scale/Items	Mean	SD	Item-to- Total <u>r</u>
Social Functioning			
<i>Childhood Problems</i> (coefficient alpha = .74)	3.71	1.33	----
You skipped school while growing up	4.68	2.32	.35
You took things that did not belong to you when you were young	3.92	2.28	.39
You had good relations with your parents while growing up (R)	2.78	2.04	.49
You had feelings of anger and frustration during your childhood	4.11	2.22	.57
You got involved in arguments and fights while growing up	4.10	2.13	.44
While a teenager, you got into trouble with school authorities or the police	3.70	2.38	.48
You had good self-esteem and confidence while growing up (R)	3.43	2.08	.41
You were emotionally or physically abused while you were young	3.00	2.35	.37
<i>Hostility</i> (coefficient alpha = .79)			
You feel mistreated by other people	3.29	1.91	.26
You like others to feel afraid of you	2.02	1.49	.31
You have urges to fight or hurt others	1.96	1.53	.57
You have a hot temper	3.04	2.02	.63
Your temper gets you into fights or other trouble	2.93	2.02	.67
You get mad at other people easily	3.07	1.91	.64
You have carried weapons, like knives or guns	3.84	2.50	.37
You feel a lot of anger inside you	3.86	2.15	.56

Table 4 (Continued)

Scale/Items	Mean	SD	Item-to-Total r
Risk Taking (coefficient alpha = .77)	4.07	1.24	----
You like to take chances	4.88	1.80	.47
You like the "fast" life	3.88	2.07	.51
You like friends who are wild	3.10	1.96	.56
You like to do things that are strange and dangerous	4.67	1.92	.48
You avoid anything dangerous (R)	3.93	2.03	.47
You only do things that feel safe (R)	4.24	1.89	.51
You are very careful and cautious (R)	3.80	1.80	.41
Social Conformity (coefficient alpha = .58)	5.33	.86	----
You feel people are important to you.	6.00	1.32	.32
You feel honesty is required in every situation	5.78	1.56	.37
You have trouble following rules and laws (R)	4.29	2.09	.29
You depend on "things" more than "people" (R)	4.47	1.81	.21
You keep the same friends for a long time	4.73	2.01	.14
You work hard to keep a job	5.21	1.92	.34
Your religious beliefs are very important in your life	5.81	1.58	.34
Taking care of your family is very important	6.39	1.19	.38
Motivation For Treatment			
Problem Recognition (coefficient alpha = .82)	5.59	1.16	----
Your drug use is a problem to you	6.26	1.38	.62
Your drug use is more trouble than it's worth	6.32	1.52	.35
Your drug use is causing problems with the law	6.23	1.48	.51
Your drug use is causing in thinking or doing your work	4.89	2.12	.57
Your drug use is causing problems with family or friends	5.69	1.83	.62

Table 4 (Continued)

Scale/Items	Mean	SD	Item-to-Total r
<i>Problem Recognition</i> (continued)			
Your drug use is causing problems in finding or keeping a job	4.65	2.35	.50
Your drug use is causing problems with your health	4.43	2.13	.39
Your drug use is making your life become worse and worse	6.02	1.61	.66
Your drug use is going to cause your death if you do not quit soon	5.85	1.69	.54
<i>Desire For Help</i> (coefficient alpha =.67)			
You need help in dealing with your drug use	6.11	.87	----
It is urgent that you find help immediately for your drug use	6.39	1.32	.59
It is urgent that you find help immediately for your drug use	6.21	1.40	.58
You are tired of the problems caused by drugs	6.57	1.14	.52
You will give up your friends and hangouts to solve your drug problems	6.38	1.29	.41
You can quit using drugs without any help (R)	5.17	2.21	.20
Your life has gone out of control	5.34	1.90	.32
You want to get your life straightened out	6.73	.72	.35
<i>Treatment Readiness</i> (coefficient alpha =.72)			
You have too many outside responsibilities now to be in this treatment program (R)	5.67	.98	----
You have too many outside responsibilities now to be in this treatment program (R)	5.28	1.99	.37
This treatment program seems too demanding for you (R)	5.17	1.74	.37
This treatment may be your last chance to solve your drug problems	6.08	1.47	.42
This kind of treatment program will <u>not</u> be helpful to you (R)	5.93	1.60	.44

Table 4 (Continued)

Scale/Items	Mean	SD	Item-to-Total r
<i>Treatment Readiness</i> (continued)			
You plan to stay in this treatment program for awhile	6.32	1.26	.48
You are in this treatment program because someone else made you come (R)	4.14	2.40	.29
This treatment program can really help you	6.32	1.20	.60
You want to be in a drug treatment program	6.11	1.40	.56
<i>External Pressure</i> (coefficient alpha =.49)			
You could be sent to jail or prison if you are not in this treatment	5.37	1.06	----
You feel a lot of pressure to be in this treatment	6.17	1.55	.26
You have legal problems that require you to be in treatment	3.90	2.07	.19
You are concerned about legal problems	5.82	1.83	.41
You have family members who want you to be in treatment	5.18	1.99	.34
	5.79	1.79	.15

Note. An (R) indicates that the item scoring should be reflected.

¹ Uses a Likert scale of 1 - "strongly disagree" to 7 - "strongly agree"

$N = 421$

Table 5
Intercorrelations Between Intake Peer Functioning Indices

	Prosocial	Deviance	Leader	Problems	Recovery
Prosocial	1.0	-.28	.42	-.13	.44
Deviance		1.0	.24	.70	-.05
Leader			1.0	.24	.39
Problems				1.0	-.06
Recovery					1.0

N = 419

Table 6
Mean Scores and Item Frequencies for the Criminality Classification Index¹

Subscale/Item	Total Sample (N=417)
Irresponsibility (Mean/SD)	1.08 (.91)
% School dropout (1)	61
% Longest job held	
< 6 months (2)	11
≥ 6 months but < 24 months (1)	24
≥ 24 months (0)	65
Self-Indulgence (Mean/SD)	2.42 (.59)
% Drug abuse history (2)	98
% Marital Background	
Divorced or never married, with children (1)	47
Never divorced or never married, no children (0)	53
Interpersonal Intrusiveness (Mean/SD)	1.60 (1.52)
% Any prior intrusive offense ³ (1)	57
% Number of intrusive offenses	
Three or more (2)	18
One or two (1)	39
None (0)	43
% Ever used weapons in an offense (1)	30
Social Rule Breaking (Mean/SD)	2.99 (1.25)
% Arrest history ⁴	
Five or more (2)	61
Two to four (1)	34
One or none (0)	5
% Age at first arrest	
≤ 14 years (2)	12
> 14 years but < 19 years (1)	42
≥ 19 years (0)	46
% School disciplinary problems (1)	76
Composite criminality classification index⁵	8.09 (2.74)
% High risk (scored 10 and above)	34
% Moderate risk (scored between 7 and 9)	36
% Low risk (scored less than 7)	30

Note: The number in the parentheses reflects the value assigned for a criteria with a positive answer on an item.

¹ Based on the Lifestyle Criminality Screening Form (Walters, White, & Denney, 1991).

² Percentages were rounded to the nearest whole number.

³ Intrusive offenses included burglary, robbery, violence against others (e.g., aggravated assault), arson, and sex offenses (e.g., rape).

⁴ Arrest history excludes traffic violations.

⁵ Composite cutoff scores recommended by Walters (1998).

Table 7
Descriptive Statistics, Item-to-Total Correlations, and Coefficient
Alphas for the TCU Resident Evaluation of Self in Treatment (REST) Survey

Scale/Items	Mean	SD	Item-to Total r
Evaluation of Program Structure¹			
<i>Program Environment</i> (coefficient alpha = .84)	5.30	1.09	----
Organization of meetings	5.17	1.43	.63
House rules and tools	5.03	1.63	.60
Work assignments	5.43	1.41	.58
Privileges	4.92	1.87	.50
Unit/cottage structure	5.51	1.41	.56
Morning meetings	5.41	1.50	.66
Evening meetings	5.60	1.33	.69
<i>Staff Empathy</i> (coefficient alpha = .87)	5.27	1.36	----
Caring of treatment staff	5.56	1.56	.70
Helpfulness of treatment staff	5.55	1.57	.70
Caring of security staff	4.95	1.68	.75
Helpfulness of security staff	5.04	1.62	.73
<i>Peer Support</i> (coefficient alpha = .86)	5.34	1.24	----
Caring of other members	5.39	1.43	.78
Helpfulness of other members	5.37	1.47	.75
Your similarity (or likeness) to other members of this program	5.31	1.51	.62
General sense of family	5.28	1.50	.70

Table 7 (Continued)

Scale/Items	Mean	SD	Item-to Total r
<i>Sessions</i> (coefficient alpha = .75)	5.55	1.25	----
Lecture classes	5.40	1.55	.63
Agenda/process groups	5.41	1.52	.60
Individual counseling	5.84	1.56	.49
Treatment Experience²			
<i>Personal Involvement</i> (coefficient alpha = .80)	5.51	1.0	----
You feel and show concern about group members	5.71	1.21	.59
You accept being confronted by other group members	5.27	1.55	.48
You use the group to confront others about feelings	4.81	1.65	.50
You are willing to talk about your feelings in the group	5.49	1.50	.59
You say things to give support and understand to others in the group	5.75	1.29	.67
You give honest feedback	6.04	1.13	.61
<i>Personal Progress</i> (coefficient alpha = .79)	5.65	1.09	----
You understand your feelings and how they can influence behavior	5.53	1.41	.42
You have made progress with your drug/alcohol problems	5.97	1.25	.66
You have progress with your emotional or psychological issues	5.32	1.60	.68
You have made progress toward your treatment goals	5.79	1.26	.68

Table 7 (Continued)

Scale/Items	Mean	SD	Item-to Total r
<i>Trust</i> (coefficient alpha = .80)	5.18	1.26	----
You trust other community members	4.53	1.68	.59
You trust security staff	5.08	1.66	.68
You trust treatment staff	5.65	1.54	.65
You have developed positive friendships	5.47	1.47	.54
Counselor Impact ^{2,3}			
<i>Effectiveness</i> (coefficient alpha = .93)	5.89	1.12	----
Teach you useful ways to solve problems?	5.92	1.30	.79
Motivate and encourage you?	5.93	1.40	.80
Help you develop confidence in yourself?	5.87	1.38	.80
Are well organized and prepared for each counseling session?	5.82	1.38	.70
Develop a treatment plan with reasonable objectives for you?	5.99	1.29	.77
Keep you focused on solving specific problems you had?	5.88	1.37	.76
Remember important details from your earlier sessions?	5.80	1.38	.73
Help you make changes in your life?	5.94	1.32	.79
<i>Rapport</i> (coefficient alpha = .90)	5.82	1.07	----
Are easy to talk to?	5.88	1.40	.65
Speak in a way that you understood?	6.06	1.19	.69

Table 7 (Continued)

Scale/Items	Mean	SD	Item-to Total r
<i>Rapport</i> (continued)			
Respect you and your opinions?	5.74	1.47	.73
Understand your situation and problems?	5.81	1.43	.76
Are trusted by you?	5.50	1.50	.67
Help you view problems/situations more realistically than before?	5.90	1.29	.73
Focus your thinking and planning?	5.87	1.27	.67

¹ Uses a Likert scale of 1- "terrible" to 7 - "great"

² Uses a Likert scale of 1- "strongly disagree" to 7 - "strongly agree"

³ Residents were instructed to circle the answer that best described their counselor.

N = 399

Table 8
Intercorrelations for CRC Client Attribute Scales

	Engagement	Rapport	Denial	Psyc Prob
Engagement	1.0	.72	-.65	-.54
Rapport		1.0	-.70	-.49
Denial			1.0	.48
Psyc Prob				1.0

N = 402

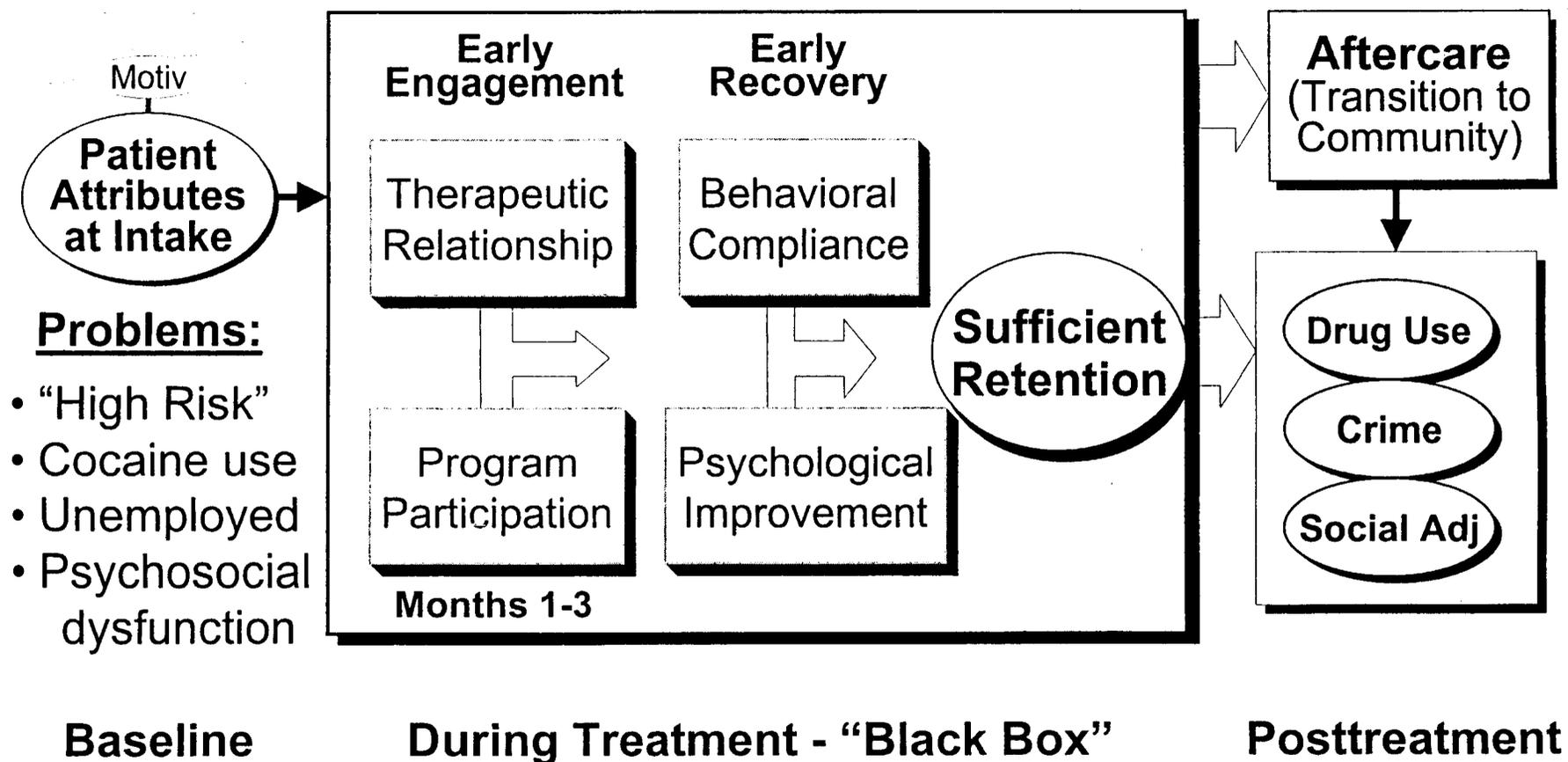


Figure 1. TCU Treatment Process Model



Primary Treatment (residential)

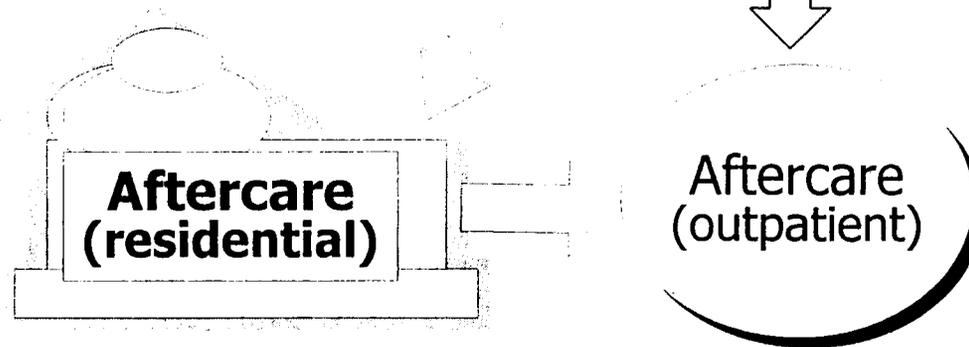
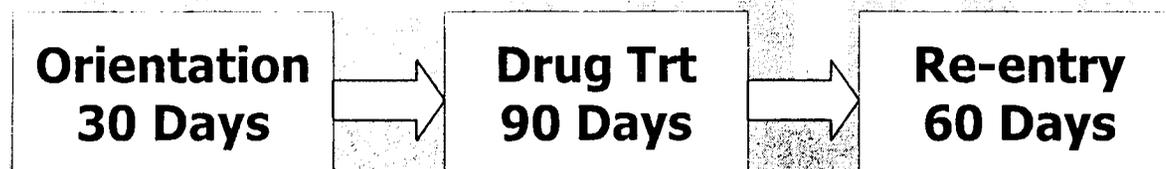


Figure 2. Movement of Felony Offenders Through the DCJTC

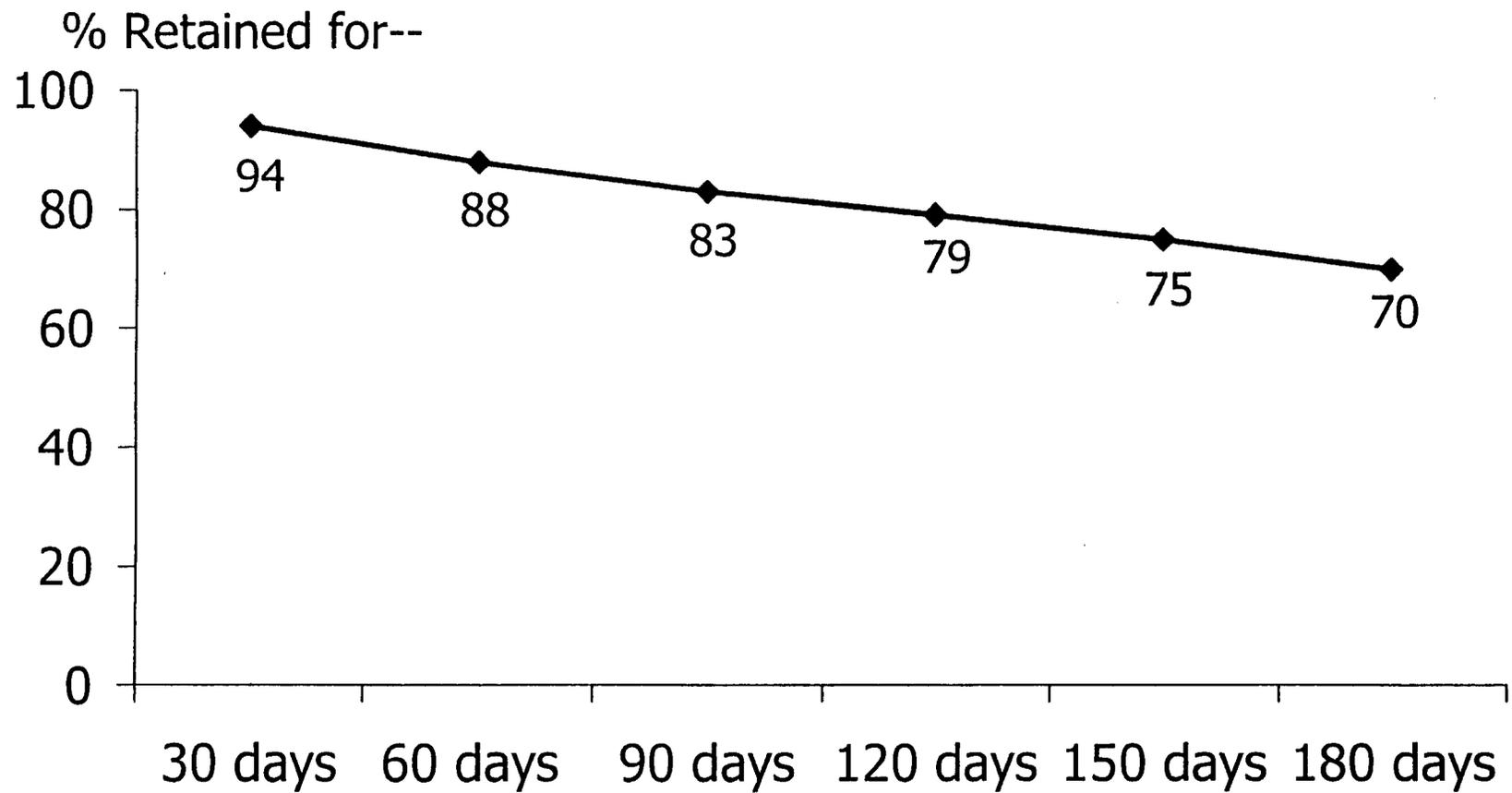


Figure 3. Retention Rates in Primary Residential Treatment

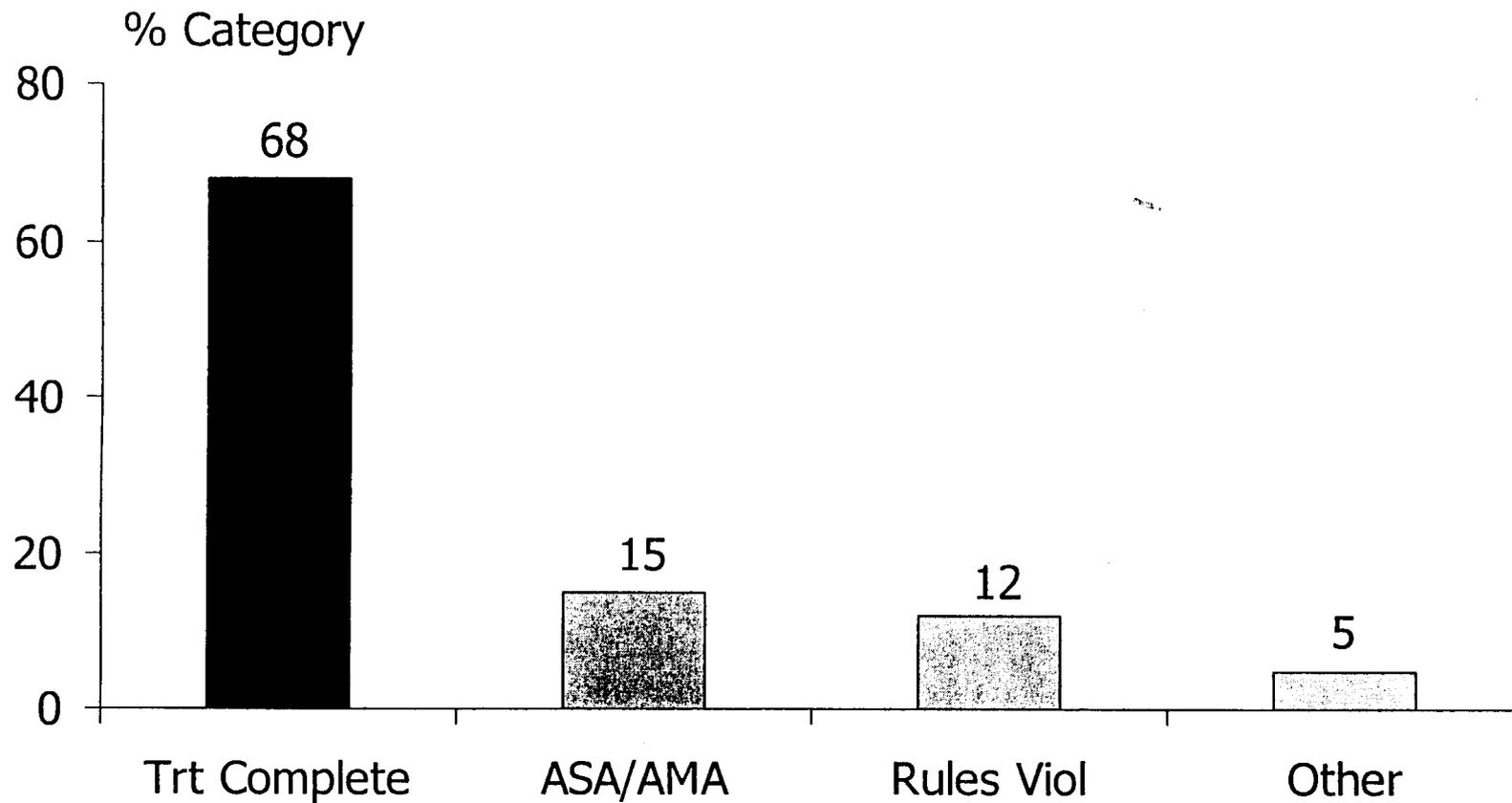


Figure 4. Reasons for Discharge from the DCJTC

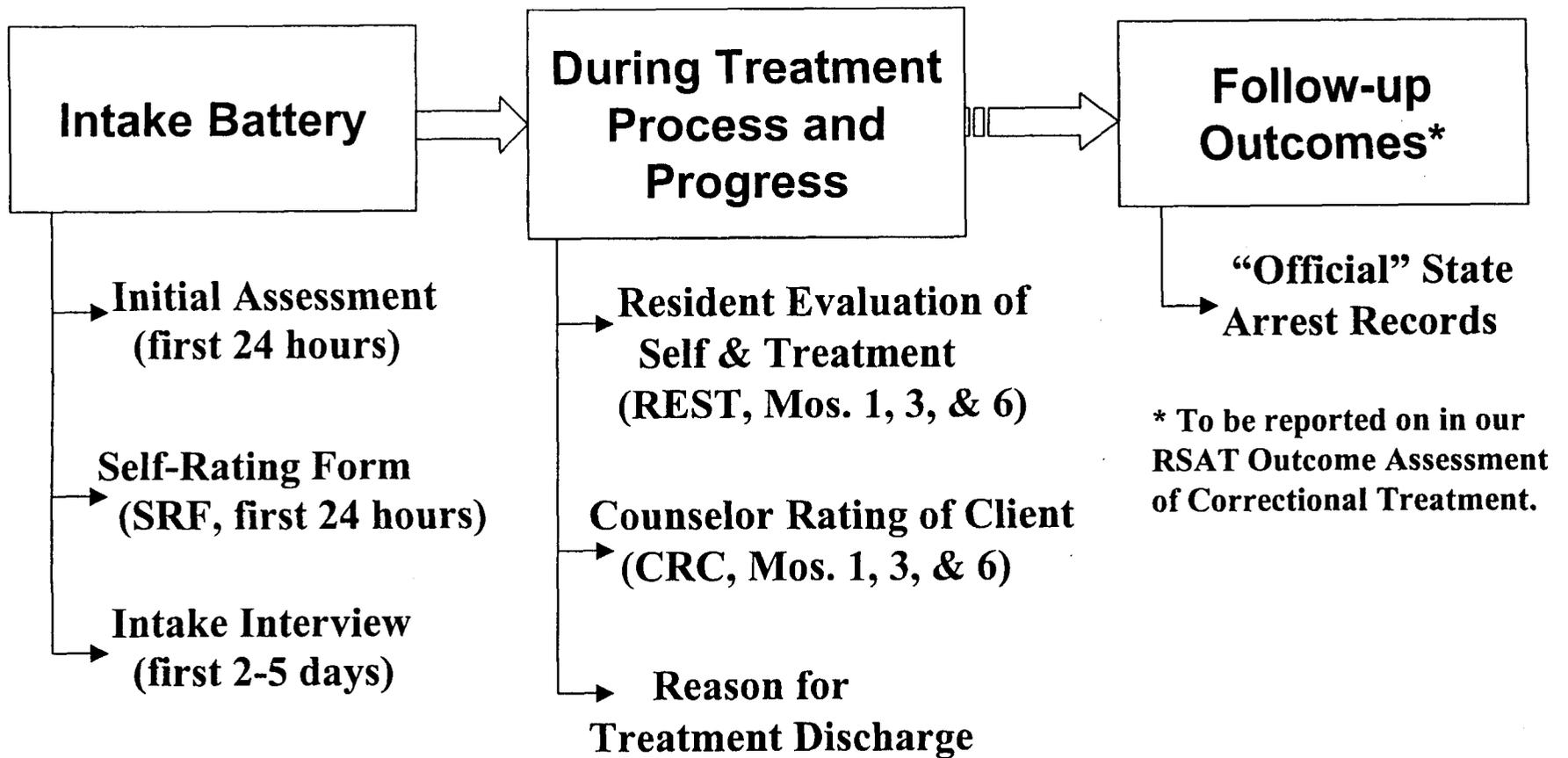


Figure 5. TCU DCJTC Data Collection Instruments

DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
COMMUNITY RELATIONS SERVICE (CORS)

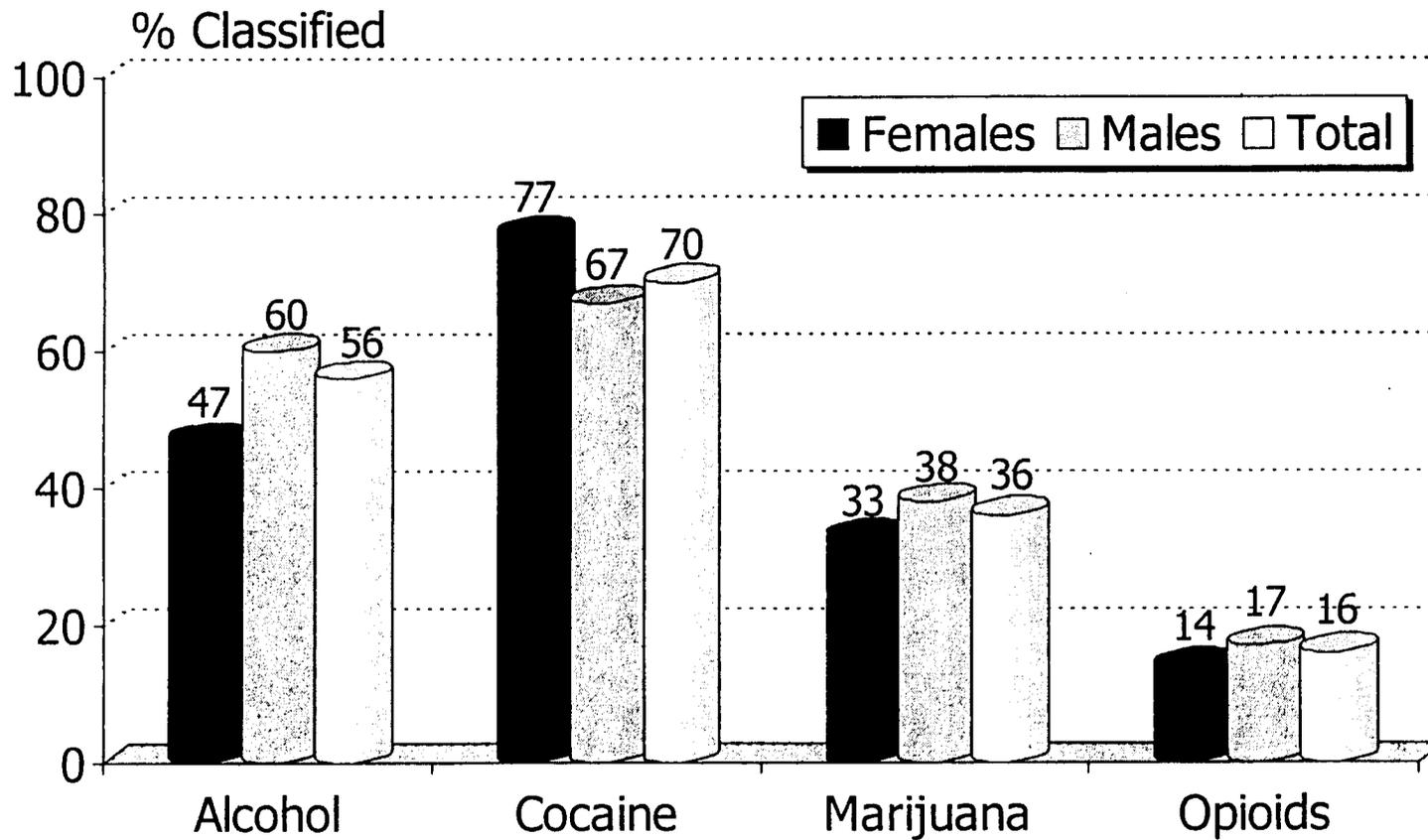


Figure 6. DSM-IV Substance Dependence Classification