

**FINAL REPORT ON THE
SUBSTANCE ABUSE PROGRAM
AT THE CALIFORNIA SUBSTANCE
ABUSE TREATMENT FACILITY (SATF-SAP)
AND STATE PRISON AT CORCORAN**

A REPORT TO THE CALIFORNIA LEGISLATURE

**Submitted by
The California Department of Corrections
Office of Substance Abuse Programs**

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PREFACE

The Senate Budget and Fiscal Review Subcommittee #4 on Legislative, Executive, Public Safety, and General Government resolved on April 2, 1997, "that the Department provide to the subcommittee a report on the Legislative Analyst's Office recommendation for redirecting some of the evaluation funding." In response to the subcommittee's action, the California Department of Corrections' (CDC) Office of Substance Abuse Programs (OSAP), in cooperation with the Legislative Analyst's Office, and Douglas Anglin and Michael Prendergast of the University of California, Los Angeles (UCLA) Integrated Substance Abuse Program (ISAP), prepared a report for the subcommittee's consideration. The report included a proposed evaluation of the California Substance Abuse Treatment Facility (SATF) and State Prison at Corcoran, which would examine the in-prison and aftercare programs and their corresponding service elements.

This final report was prepared by UCLA/ISAP and is consistent with the proposed evaluation submitted to the Senate Budget and Fiscal Review Subcommittee. The report summarizes the historical context, implementation, and 12-month recidivism outcomes of the SATF-SAP at Corcoran and is submitted pursuant to the authorizing legislation, which calls for an annual report on or before January 1.

FINAL REPORT ON THE CALIFORNIA SUBSTANCE ABUSE TREATMENT FACILITY (SATF) AND STATE PRISON AT CORCORAN

Executive Summary

This executive summary highlights the major findings of the UCLA Integrated Substance Abuse Program's process and outcome evaluation of the California Substance Abuse Treatment Facility—Substance Abuse Program (SATF-SAP). The purpose of this report is to provide a brief overview of the SATF-SAP and describe the results of UCLA-ISAP's 5-year process and outcome evaluation.

Overview of the SATF-SAP

The SATF at Corcoran has a housing capacity of 6,013 prison beds. The treatment facilities were specifically designed to provide housing and residential substance abuse treatment for 1,056 (1,478 with 40% overcrowding) Level I and II offenders. The CDC is responsible for custodial operations at this facility, with treatment services being provided by two California-based private contractors: Walden House and Phoenix House. The decision to contract with two providers was based on the large number of clients to be served. Both contractors, however, offer treatment programming consistent with the therapeutic community (TC) model.

Process Evaluation

The process evaluation focused on the proximal (during treatment) impact of the SATF-SAP. Specifically, five in-prison indicators of treatment effectiveness were monitored: disciplinaries, drug tests, non-parole inmate departures, inmate appeals, and aftercare referrals.

Disciplinaries. The longitudinal disciplinary data show a relatively stable trend for higher rates of reported violations in the SATF non-treatment facilities, relative to the SATF-SAP facilities. The mean rate of reported inmate rules violations during the 15-quarter evaluation period was identical (3.7 per 100 inmates) for both treatment facilities and 73% higher (6.4 per 100 inmates) in the non-treatment comparison facilities. Mean rates of reported violence-related violations were also lower (0.9 per 100 inmates) in the SATF treatment facilities versus 1.5 per 100 inmates in the non-treatment facilities.

Drug Tests. A total of 27,992 tests were conducted between February 1998 and December 2001 producing 53 (0.19% of the total) positive results for drug or alcohol use. In contrast, random drug tests at four other California prisons as part of the California Department of Corrections' Drug Reduction Strategy revealed a drug (and/or alcohol) use prevalence of 8% prior to the implementation of weekly random testing (Prendergast, Farabee, & Campos, 2000).

Non-parole Inmate Departures. From program activation in September of 1997 through December of 2001, 1,141 inmates were removed from treatment prior to their release to parole. Non-parole departures accounted for 17.2% of all inmate departures from the SATF-SAP. Approximately half (50.7%) of all SATF-SAP non-parole departures were due to disciplinary actions, followed by 47.0% for custody actions, 1.6% for mental health concerns, and 0.7% for inmate death or injury.

Inmate Appeals. First-level appeals data from both the SATF-SAP facilities (F&G) and

the non-treatment comparison facilities (A&B) were evaluated on a quarterly basis as an indicator of inmate satisfaction within their respective facilities. Although there were wide variations in rates during specific quarters, the overall rates per 100 inmates during the 15-quarter evaluation period for all facilities were similar. The mean rate of first-level appeals (per 100 inmates) in SATF treatment facility F was 10.2, in treatment facility G the rate was 9.0, and in the combined non-treatment facilities the rate was 10.4.

Aftercare Referrals. The cumulative percentage of SATF-SAP inmates who accepted an aftercare referral during the evaluation period is 47.5%. This percentage has, with some fluctuation, increased over the course of the program. Program participants were offered one of three modalities of post-release aftercare: residential, sober living coupled with mandatory drug-free outpatient services, and drug-free outpatient services only. Of those who accepted referrals, most agreed to enter residential treatment programs (41.3%), followed by outpatient services only (30.7%), and sober living combined with drug-free outpatient services (28.0%). However, our data indicate that not all program participants who accepted an aftercare referral actually entered treatment in the community. According to aftercare billing records, 25% of SATF parolees from the outcome study cohort entered some form of CDC-sponsored aftercare within one year of prison release.

Outcome Evaluation

The analyses summarized below are based on a sample of outcome study participants from the SATF-SAP (N=404) and a matched, untreated comparison group drawn from Avenal State Prison (ASP) (N=404). Subjects for this study were recruited between June of 1999 and June of 2000.

SATF versus Comparison Group. Overall, 52.7% of the study subjects had been returned to custody within 12 months of release. The likelihood of returning to custody during this period did not differ significantly by treatment condition, with approximately 53.5% of SATF parolees being returned compared to 51.9% of parolees from the comparison sample. Among recidivists, the two groups were also similar in terms of the types of offenses committed.

Outcomes by Program. Using the same outcome (12-month return to custody), we also examined between-program effects. Fifty-four percent of Walden House subjects and 53% of Phoenix House subjects had been returned to custody during the 12-month follow-up period. This difference was not statistically significant.

Special Populations. Over the past four years, a number of issues have arisen concerning appropriate admission (or exclusionary) criteria for referral to the SATF-SAP. Four “special populations” in particular have been the focus of these discussions: mentally ill, sex offenders, drug traffickers, and coerced clients. For this reason, we compared 12-month return-to-custody outcomes for these four special populations and their relative performance by treatment condition. Our analyses revealed no significant interactions between treatment condition and mental illness, sex offender status, or type of drug offense. However, there was a significant interaction between coercion and treatment condition, with the poorest outcomes occurring among those who were referred to the SATF-SAP in spite of not having a desire for treatment. This group was 40% more likely to have been returned to custody than the untreated subjects who reported that they did not want to receive treatment (65.0% versus 46.5%, respectively). Among those who reported that they wanted to receive treatment, SATF participants performed

slightly better than the untreated comparison group (52.2% versus 58.7%, respectively).

Time in Program (TIP). To assess the impact of the TIP effect in the current sample, we divided the distribution of months in program into four categories: (1) ≤ 5 months (16.3%), (2) 6-7 months (26.6%), (3) 8-9 months (31.9%), and (4) ≥ 10 months (25.1%). On average, inmates in the outcome study spent 7.7 months (SD=2.9) at the SATF-SAP, ranging from less than 1 month to 22.2 months. Although the between-group differences were not statistically significant, there was a trend for those remaining in treatment for at least 6 months to have lower recidivism than those in treatment for 5 months or less.

Aftercare. According to aftercare billing records, 25% of the SATF-SAP parolees in the outcome study cohort were admitted to some form of CDC-sponsored aftercare after release from the institution. Of these, 63.7% entered a residential program, 58.2% entered a sober living environment, and 30.8% entered an outpatient program.¹

Although the SAP graduates were eligible for six months of aftercare, the mean length of stay in a residential program was approximately 2.5 months; 3.1 months in a sober living environment. Regarding outpatient treatment, billing records indicate that SATF parolees received an average of 42 units of services. However, levels of participation in these services varied considerably. Of the full SATF study cohort, only 11.2% remained in a residential or sober living program for 3 months or longer, or received an equivalent of outpatient service units (i.e., 36 units, assuming 3 weekly sessions for 3 months).

Self-Reported Drug Use. SATF-SAP subjects were less likely to report any follow-up drug use than Avenal subjects (58% versus 62%, respectively). However, this difference was not statistically significant. To assess changes in *levels* of substance use, SATF-SAP and comparison subjects were compared with regard to self-reported frequency of alcohol, marijuana, cocaine, crack, and methamphetamine use. These substances were selected because they were reported by at least 5% of the total sample as being a primary substance. For all of these substances, our analyses revealed a significant effect for time, that is, overall alcohol and illicit drug use declined between the baseline and follow-up periods. However, these changes did not vary by treatment condition. Alcohol was the most commonly cited primary problem substance at baseline and at follow-up, and was by far the most commonly reported substance to be used first upon release from the SATF.

Cost Analysis

For Phoenix House, the total economic cost of treatment in fiscal year 2000 was \$1,813,838 and the total accounting cost was \$1,813,437. The cost of labor was the largest component of total cost (\$1,421,462). The average caseload for the Phoenix House program was 715 inmates, with an average length of stay in the program of 36 weeks. Thus, the annual cost (both accounting and opportunity) per client was \$2,537, or \$49 per week. The opportunity cost per treatment episode was \$1,752 (\$1,751 for accounting cost). The total annual cost of the Walden House program was \$1,916,663. The largest component of program cost was program personnel (\$1,677,897). The average caseload in fiscal year 2000 was 734 inmates, who stayed

¹ Total percentages exceed 100% because parolees could enter more than one modality during their 6-month period of eligibility following release.

an average of 26.2 weeks in the program. The annual cost per client was \$2,611 (\$50 per week). The average cost per treatment episode was \$1,312.

Conclusions & Recommendations

Overall, the SATF-SAP appeared to have had a positive impact on in-prison behaviors and prison management. Relative to untreated inmates, SATF-SAP inmates had fewer disciplinarys (and were less likely to have committed violent infractions) and, according to random drug test data, levels of drug and alcohol use were extremely low. Likewise, there was a positive trend over time for SATF-SAP parolees to accept an aftercare referral. The rate of appeals filed, however, did not differ between treated and untreated inmates at the SATF.

In contrast, post-release recidivism rates did not differ between the SATF-SAP and matched comparison subjects in the outcome study. The likelihood of being returned to custody (for any reason) did not differ significantly by treatment condition, nor did the two groups differ in the type of first re-offense. However, there was a trend for the SATF-SAP subjects to be less likely than comparison subjects to be returned to custody for a drug offense. In addition, there appeared to be a trend for those who spent at least 6 months at the SATF-SAP to have better post-release outcomes than those who spent 5 months or less in treatment. This effect remained even after controlling for discharge status.

One of the problematic aspects of the SATF-SAP concerned aftercare attendance. Although an increasing proportion of SATF-SAP participants accepted some kind of aftercare referral, only about 11% received 3 or more months of treatment in the community. While these subjects had lower recidivism rates than other SATF-SAP parolees, this small group is unlikely to represent the entire SATF-SAP population. Hence, using existing data it is not possible to predict how the other SATF-SAP parolees would have performed had they entered aftercare and remained for a sufficient period of time.

In our fifth annual report to the legislature on the SATF (Anglin et al., 2002), we made several recommendations that we believe deserve to be revisited here. These included reducing program size, developing programs in less-remote areas, decreasing the number of involuntary participants, and mandating aftercare.

The analyses conducted as part of the 12-month outcome study provide support for three additional recommendations:

Pay greater attention to alcohol. As described in Section III F, alcohol was the most commonly cited problem substance at the time of the baseline and 12-month follow-up interviews; it was also by far the most commonly reported substance to be used first following release from the SATF. In light of recent evidence that nearly 40% of state prisoners were under the influence of alcohol during their most recent offense (Martin, 2001), the rather vague restrictions concerning alcohol use while on parole (i.e., “not in excess”) may need to be revisited.

Compare SATF-SAP outcomes across yearly cohorts. Because the SATF-SAP has continued to develop since we selected the subjects for the initial outcome study (June 1999-June 2000), it is possible that those receiving treatment at the SATF-SAP in later years may show improved outcomes. To examine this, matched cohorts from 1998, 2001, 2002, and 2003 should be identified and compared with regard to recidivism rates and survival curves. This proposed

analysis is currently under review by OSAP officials.

Base policy decisions on evaluation of the full CDC treatment initiative. Over the past decade, the number of prison-based TC programs grew from three programs totaling 500 beds in 1996 to 32 programs totaling 7,650 beds in 2002. UCLA-ISAP is conducting process and/or outcome evaluations in 17 of these programs. Because these programs vary in size, the population served, and the organization providing the treatment services, we believe that broad policy decisions regarding these programs should be postponed until the evaluation results for the entire CDC treatment initiative are available (est. June 2004).

In summary, results of UCLA-ISAP's five-year evaluation of the SATF-SAP suggest that there were some benefits of treatment with regard to inmates' in-prison behaviors (e.g., reduced levels of infractions, lower rates of drug use, and lower levels of absenteeism among correctional staff; see Prendergast et al., 2001), which may have led to some cost savings in prison management. However, our evaluation did not reveal any significant differences in recidivism between the SATF-SAP participants and the matched comparison group from Avenal State Prison. Plans to conduct further analyses to determine actual in-prison cost savings, as well as a recidivism study of subsequent SATF-SAP release cohorts, are currently under review by OSAP officials.

FINAL REPORT ON THE CALIFORNIA SUBSTANCE ABUSE TREATMENT FACILITY (SATF) AND STATE PRISON AT CORCORAN

The purpose of this report is to summarize the final results of UCLA-ISAP's 5-year process and outcome evaluation of the SATF-SAP. Specifically, this report describes the historical context of the SATF-SAP project, the implementation of program, the in-prison effects of therapeutic community treatment, and 12-month recidivism outcomes of SATF participants relative to a matched cohort of offenders at a similar institution (Avenal State Prison) where treatment was not available during the time that this evaluation was being conducted.

I. SATF-SAP: Historical Context and Overview

A. Previous Research

State-based substance abuse programs often serve as laboratories for the development of innovative treatment approaches, particularly when they include a strong evaluation component. Among therapeutic communities (TCs), some of the most notable examples are New York's *Stay'n Out* program (Wexler, Falkin, Lipton, & Rosenblum, 1992), Oregon's *Cornerstone* program (Field, 1984; 1989), Delaware's *Key/CREST* project (Inciardi, Lockwood, & Martin, 1994), and California's own *Amity* (Wexler, 1996) and *Forever Free* (Prendergast, Wellisch, & Wong, 1996) programs. Summaries of these evaluation findings, which support the effectiveness of prison-based TCs, can be found in the first and second annual reports.

It should be noted that random assignment in field evaluations of this kind is rarely achieved. Therefore, it is possible that some of the positive effects of these programs may actually reflect the differences between those inmates who opt for, and remain in, treatment rather than those who do not. However, a recent evaluation of prison-based treatment within the Federal Bureau of Prisons revealed significant reductions in post-treatment drug use and recidivism even after controlling for a number of individual- and system-level selection factors (Pelissier et al., 1998).

In this same report, Pelissier et al. (1998) provide a critical review of the previous evaluations of prison-based substance abuse treatment. Because many of these evaluations have served as models for the California initiative, the conclusions of this review deserve some attention here. After reviewing the methodologies of five prominent prison treatment evaluations (i.e., Stay 'n Out, Cornerstone, Key/Crest, New Vision at Kyle, and Amity), the authors observed the following six common sources of methodological bias:

- **Lack of random assignment.** For practical and ethical reasons, random assignment of subjects to either a treatment or control group is rare. Thus, in the absence of a true experimental design, it is difficult to disentangle the effects of treatment from the characteristics of the inmates who chose (or were chosen) to enter treatment.
- **Incongruent follow-up periods.** The failure to control for post-release time at risk can significantly impact outcomes. For example, the TC participants in the Stay 'n Out evaluation were at risk for an average of 34.7 months, whereas the other groups were at risk for 41 months. Thus, a 6-month differential in time at risk could plausibly account for higher recidivism among the comparison subjects. Disparate risk periods

are also a problem when researchers do not account for the time a parolee spends in a controlled residential aftercare program for the first 6-12 months following release—a confound acknowledged by Wexler et al. (1999) in their evaluation of the Amity Program.

- **Use of dropouts as comparison subjects.** Because of the difficulty in identifying appropriate non-treatment comparison groups, researchers sometimes compare treatment graduates with those who drop out of the program or who are removed for custody reasons. While the rationale of this approach is to contrast subjects by level of treatment exposure, it is confounded by other (often unmeasured) variables that are associated with program termination or completion. The Cornerstone program, for example, had a graduation rate of only 20%. It is unlikely that this small percentage can be assumed to represent all those initially referred to the program.
- **Failure to use appropriate multivariate controls.** In spite of using non-equivalent treatment and comparison groups, Pelissier et al. point out that few evaluators incorporate appropriate statistical controls to enhance the comparability of the study groups. For example, controlling for self-reported motivation levels for treatment and substance abuse severity would allow for more direct comparisons of groups in a quasi-experimental design.
- **Failure to account for aftercare selection bias.** In most cases, participation in community-based substance abuse treatment following release from prison is voluntary. As a result, not all offenders who receive prison-based treatment opt for aftercare; and of these, not all remain in treatment for the recommended period of time (typically 3-6 months). Thus, it is likely that those who choose to continue to participate in treatment after they are released from prison—and do so for an extended period of time—differ from other prison treatment graduates who do not. There are many reasons why parolees decide to participate in aftercare: a commitment to self-change, the need for housing (among residential treatment participants), receiving pressure from one's field parole agent, etc. Because the potential reasons for choosing aftercare are diverse, statistically controlling for these intrinsic differences is a complicated undertaking, and is sometimes impossible. Nevertheless, the bias associated with self-selecting into aftercare must be taken into account—if not in the analysis, then in the interpretation.
- **Poor follow-up rates for interviews.** Evaluation studies that include data collected through follow-up interviews are also subject to selection bias. Follow-up rates lower than 80% have been shown to result in positively biased outcome estimates (Nemes et al., 2002). For example, one study reviewed by Pelissier et al. had an overall follow-up rate of 60%. In addition, subjects who had been recommitted to prison were not interviewed.

As described in Section III, the design of the present study was able to address most of these common methodological problems in the correctional substance abuse treatment literature. Although we were unable to achieve random assignment to treatment and non-treatment conditions, our design did include one-to-one matching based on factors such as age, race, commitment offense, custody level, and prior history of a sex offense. Regarding comparability

of risk periods, the window of detection was truncated at 12 months for all study subjects, eliminating the negative bias for the earliest release cohorts.² Nor does the current study use treatment dropouts as a comparison group. Rather all those assigned to the treatment condition remained in that condition regardless of their subsequent performance in prison or after release. The present study also incorporated a number of static (e.g., age and race/ethnicity) and dynamic (e.g., motivation for treatment) variables to control for possible systematic variations between the treatment and comparison groups that were not controlled for in the matching process. Selection bias associated with voluntary aftercare participation is accounted for by treating the initial assignment (SATF-SAP versus Avenal State Prison) as the primary unit of analysis. Subsequent behaviors such as in-prison infractions or the refusal of aftercare are viewed as dependent measures of these conditions, rather than as criteria for removal from the assigned condition. Lastly, regarding follow-up rates for outcome interviews, follow-up rates for the present study exceed 80% of the original sample, with no variation between treatment and comparison subjects. Specifically, of the original outcome study cohort, 80.3% participated in a 12-month follow-up interview (81.4% of those who were still alive), 15.6% could not be located, 2% refused, and 2% were unable to participate in the follow-up study because they were deceased or medically incapacitated.

B. Enabling Legislation (AB 10) (Chapter 585, Statutes of 1993, Assembly Bill 10, Costa)

Responding to the rapid growth in the state's prison population and the positive findings from evaluations of prison-based treatment programs, the California Legislature passed Assembly Bill No. 10, which established the California Substance Abuse Treatment Facility (effective October 1, 1993).

- (a) The Department of Corrections is hereby authorized to construct and establish a secure substance abuse treatment facility for minimum and medium security inmates...
- (b) Only inmates who have a history of substance abuse shall be housed in the secure substance abuse treatment facility. The Department shall give priority to housing inmates in the facility who the Department determines meet all of the following criteria:
 - (1) The inmate desires to participate in substance abuse treatment;
 - (2) The inmate is incarcerated for crimes in which substance abuse was a factor;
 - (3) The inmate has sufficient time remaining on his or her commitment to complete a full substance abuse treatment program while incarcerated.
- (c) The secure substance abuse treatment facility shall be a minimum and medium security facility and shall house only inmates determined to be either Level I or Level II security levels as determined by the Department's inmate classification system. The facility shall be designed specifically to provide intensive substance abuse treatment to all inmates housed in the facility.

² Because many SAP parolees had repeated episodes of aftercare, it was not possible to define a continuous 12-month post-aftercare period that would serve as the at risk time frame. Hence, some of the effectiveness of aftercare is likely to be function of reduced time at risk for those attending residential or sober living programs.

- (d) All inmates housed in the secure substance abuse treatment facility shall receive comprehensive substance abuse treatment. Treatment shall be multifaceted and highly structured, with clearly defined rules and explicit expectation with regard to inmate behavior. Programs shall reinforce positive behavior and encourage inmates to develop social skills through limited self-government within treatment groups. Treatments shall include, but not be limited to, individual and group substance abuse counseling and workshops, victim awareness, academic and vocational education, physical fitness, drug testing, and planning for successful and sober reentry upon parole. The existing institutional treatment components of the Right-Turn Program at the R. J. Donovan Correctional Facility and the Female Offender Substance Abuse Program at the California Institution for Women and their aftercare components shall serve as models for these treatment programs.
- (e) The same range and intensity of treatment services shall be available to inmates whenever the facility is operated at a level that is greater than its designed bed capacity.
- (f) The Department shall monitor the progress of parolees released from the secure substance abuse treatment facility and report to the Legislature annually on or before January 1. These reports shall include data on the rate of recidivism and relapse to substance abuse of inmates released from these facilities.

C. Facilities Design and Description

The SATF at Corcoran has a housing capacity of 6,013 prison beds. The treatment facilities were specifically designed to provide housing and residential substance abuse treatment for 1,056 Level I and II offenders (1,478 with 40% overcrowding). CDC is responsible for custodial operations at this facility, with treatment services being provided by two California-based, private contractors: Walden House and Phoenix House. The decision to contract with two providers was based on the large number of clients to be served.

The prison includes space for 1,478 substance abuse treatment beds housed in two separate secure facilities F and G. Each treatment facility has three housing units, each containing four 44-bed treatment clusters. Each cluster contains 11 four-man dorms, rooms for treatment-related activities, interviewing, and staff support. This design allows each cluster to operate semi-autonomous programs geared toward the needs of the respective inmate populations. Inmates in facilities F and G are completely separated from the general prison population, a situation seldom attained in other prison-based TCs.

D. Programming

The SATF-SAP involves a residential, in-prison phase as well as a community phase (which may or may not be residential). These two treatment phases are described below.

1. The Therapeutic Community Model. The TC model was chosen for the SATF because its effectiveness had been demonstrated in a number of prison settings such as the Stay'n Out program in New York, the Key-CREST program in Delaware, and the Amity program in California. The TC philosophy regards substance abuse as a disorder of the whole person. Rather than being construed as a disease, addiction is perceived as a symptom of a larger disorder. Consequently, the thrust of treatment is not to change the inmate's addictive behavior, but to change the inmate. In fact, most TCs make chemical detoxification a prerequisite to enter the

program.

Because of the holistic nature of its goals, the TC environment is designed to promote pro-social goals, attitudes, and behaviors. The TC culture pervades all aspects of the inmates' daily life, emphasizing respect and responsibility in a structured environment.

According to George De Leon (1994), the generic TC model is composed of 12 components: a community environment, community activities, peers as role models, structure, phase format, work as therapy and education, TC concepts (e.g., view that substance abuse is part of a disorder of the whole person), peer encounter groups, awareness training, emotional growth training, planned treatment duration, and continuity of care.

An overview of treatment phases for the Walden House and Phoenix House programs is provided in the first and second legislative reports. Aside from some minor differences, both the Walden House and Phoenix House programs adhere to the same, basic TC philosophy and structure. The in-prison treatment lasts from 6 to 18 months. Programs are structured and include a minimum of 20 hours per week of substance abuse treatment, as well as 10 or more hours of structured optional activities (OSAP, 1997). In particular, each inmate assigned to the SATF participates in a half-time (4 hours) work/training assignment within the facility and a half-time (4 hours) treatment assignment. The prison-based portion of the treatment program is sequentially structured into three phases: orientation, primary treatment, and pre-release transitioning.

In response to the large number of inmates who are involuntary admitted to the SATF-SAP, both Walden House and Phoenix House have developed designated treatment Induction Units for new admissions. The purpose of these units is to introduce new inmates to the TC concept, provide an overview of the program, conduct the standard intake assessments, and develop treatment plans. The proposed length of the induction phase is 30 days, although inmates often progress through this phase more quickly when there is a surge in subsequent admissions.

2. *Continuing Community Care.* It is evident from prior research findings on prison-based drug treatment that community-based continuing care is integral to producing long-term, positive post-treatment outcomes. In accordance with these findings, the SATF-SAP has strongly emphasized the provision of continued treatment services once the SATF-SAP inmates are paroled back into the community.

The goal of the SATF Continuing Care is to provide an effective and efficient statewide network to ensure a continuum of care for SATF program participants. This is to be accomplished by:

- Formulating appropriate and realistic Community Service Plans (CSPs) that express specific treatment goals;
- Involving Substance Abuse Coordinating Agencies (SASCAs) in each Parole Region whose role is to contract for community treatment beds and act as gatekeepers/case managers to oversee the provision of aftercare services.

Although treatment while on parole is not mandatory, all inmates paroling from the SATF are expected to continue in some type of community-based substance abuse treatment services. Eligible programs must be licensed by the California Department of Alcohol and Drug

Programs. While participation in community treatment occurs after release, the planning and coordination of the treatment resources takes place prior to release from the SATF-SAP. Transitional Treatment Teams at Walden House and Phoenix House work with SATF-based parole agents to develop CSPs for each SATF-SAP participant, providing specific and detailed treatment information to the community-based providers who will provide for the continuum of community-based treatment services upon his release from custody.

The CSP considers the parolee's substance abuse treatment needs, accomplishments, and areas of concern, and outlines an individualized program that utilizes community resources to address the participant's other social services needs. Specific information about the participant's family situation and his plan for employment may impact the decision as to which treatment service modality he will use in the community. For example, if the parolee is employed upon release from the SATF-SAP, non-residential services are most often the treatment of choice. However, it should be emphasized that the modality used in the community will principally be based on the substance abuse treatment needs of the parolee.

These plans also target other community-based resource needs and serve as the vehicle through which the SASCA case manager and/or the community-based provider establishes a treatment relationship with the inmate, prior to release, to assist in promoting the smooth transition into the community-based treatment program.

Parole. The presence of parole agents at the SATF-SAP represents an important distinction from most in-prison TCs in other State Departments of Corrections. The rationale for having in-house parole representation is based on the widely documented need to coordinate continuing care plans well in advance of an inmate's discharge date and to ensure that the TC graduate continues to participate in treatment after being discharged. The SATF-SAP parole agents assist the inmates in developing their CSPs and establishing community-based goals that promote the successful completion of parole. Inclusion of parole in this transition phase is expected to enhance the continuity of services for TC graduates, as well as to increase the likelihood of compliance once the inmate is no longer in the institution.

Substance Abuse Services Coordinating Agencies (SASCAs). SASCAs facilitate the parolees' transition into the community by linking those who successfully complete their term in the prison-based SAP to the appropriate type and level of community-based treatment. SASCAs are responsible for establishing contracts between themselves and the community-based providers.

There is a SASCA located in each of the state's four Parole Regions. They are:

- WestCare, Parole Region I
- Walden House, Parole Regions II & III
- Mental Health Systems, Parole Region IV

II. Process Evaluation

This section focuses on the proximal (during treatment) impact of the SATF-SAP. Specifically, 5 in-prison indicators of treatment impact are described: disciplinaries, drug tests,

non-parole inmate departures, inmate appeals, and aftercare referrals.

A. Disciplinary

The analysis of inmate disciplinary rates reported in the treatment facilities (F&G) and the non-treatment comparison facilities (A&B) was part of the impact evaluation from April 1998 through December 2001. The goal was to determine whether the presence of an in-prison therapeutic community was associated with lower levels of inmate disruptive behavior. A related goal was to determine whether the presence of the treatment program was associated with lower levels of specific types of disruptive behaviors (e.g., violence).

It should be noted that the comparison of disciplinary rates between treatment facilities and non-treatment facilities was not based on an experimental design. Hence, it is possible that a number of factors may contribute to any observed differences between the study conditions. It should also be noted that exclusionary criteria for SATF-SAP admission prevented inmates with recent episodes of pronounced disruptive or violent behavior (i.e., assault, escape attempt, in-prison drug trafficking, etc.) from entering the program. SATF-SAP candidates must have had less than 18 months left to serve on their sentence and not have had a record of Protective Housing Unit (PHU) or Secured Housing Unit (SHU) placement in the 12 months prior to program admission. SATF-SAP admissions could not have had mental health problems that would warrant their classification above the Correctional Clinical Case Management Services (CCCMS) level nor could they have been validated members or associates of known prison gangs. Finally, it should be noted that SATF-SAP inmates who failed to complete the treatment program due to disciplinary action were often transferred to the non-treatment facilities. Therefore, population characteristics must be considered when interpreting these findings.

However, the presence of over 90 treatment-provider staff in the treatment facilities enhanced inmate supervision and likely increased the detection and reporting of inmate rules violations.

Appendix A shows the quarterly rates of disciplinary issued by facilities F&G (treatment) and the combined A&B (non-treatment) facilities. Since the non-treatment facilities each house an average of 200 more inmates than do the treatment facilities, total reported violations are shown in rates per 100 inmates.

The data show that the mean rates of reported inmate rules violations during the 15-quarter evaluation period are identical (3.7 per 100 inmates) for both treatment facilities and 73% higher (6.4 per 100 inmates) in the non-treatment comparison facilities. Mean rates of reported violence-related violations were also lower (0.9 per 100 inmates) in the treatment facilities than in the non-treatment facilities (1.5 per 100 inmates).

B. Drug Tests

In order to assess the level of illicit drug and alcohol use within the SATF-SAP, the prison's Quality Control Unit began mandatory random drug testing of SATF-SAP inmates in February of 1998. A weekly sample of 10% of the SATF-SAP inmate population was required to provide urine specimens. Those refusing to provide a urine specimen were counted as testing positive and were subject to sanctions, including removal from the treatment facility.

A total of 27,992 tests were conducted between February 1998 and December 2001 producing 53 (0.19% of the total) positive results for drug or alcohol use. In contrast, random drug tests at four other California prisons as part of the California Department of Corrections' Drug Reduction Strategy revealed a drug (and/or alcohol) use prevalence of 8% prior to the implementation of weekly random testing (Prendergast, Farabee, & Campos, 2000).

C. Non-parole Inmate Departures

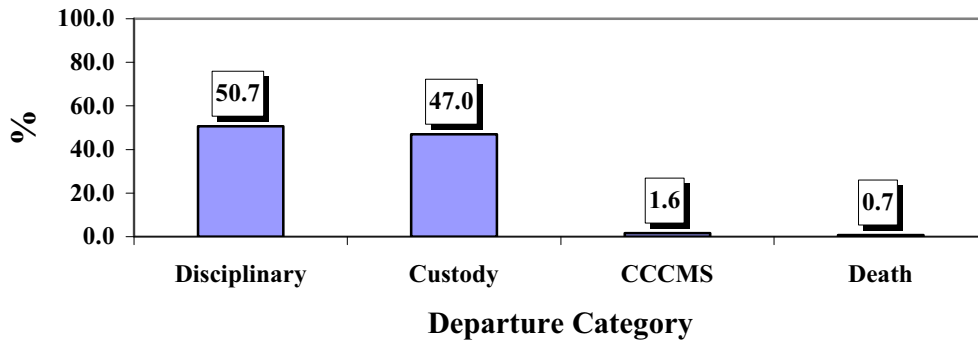
If parole from the SATF-SAP constitutes a successful completion of the in-prison treatment program, then it is important to determine the number of inmates who are removed from the program prior to parole. It is equally important to note the reasons the inmates are removed and the length of time the inmates spent in the treatment program prior to their removal.

From program activation in September of 1997 through December of 2001, 1,141 inmates were removed from treatment prior to their release to parole. Non-parole departures accounted for 17.2% of all inmate departures from the SATF-SAP. Reasons for non-parole inmate departures are reported in one of the following four categories:

1. **Disciplinary:** Inmates were removed by action of the institution because they posed a risk to the safety of the institution, staff, or other inmates. Inmates were removed for persistent failure to abide by program rules or participate in program activities.
2. **Custody:** Inmates were removed once a felony or INS hold, warrant, or detainer was discovered. Inmates were also removed due to pre-parole transfers to other institutions, enemy concerns, or inappropriate endorsement to the SATF-SAP.
3. **CCCMS:** Inmates were removed because they were under Correctional Clinical Case Management Services (CCCMS) and their level of mental illness precluded full participation in the treatment program.
4. **Death:** Inmates were removed because they died while in the program.

As shown in Figure 1, approximately half (50.7%) of all SATF-SAP non-parole departures were due to disciplinary actions, followed by 47.0% for custody actions, 1.6% for CCCMS concerns, and 0.7% for injury or death.

Most of the disciplinary removals were for repeated failure to participate in the treatment program and for inmate fighting (mutual combat). The majority of custody removals were for pre-parole transfers of high-control parolees, felony holds, and inappropriate endorsement of the inmate to the SATF-SAP (e.g., classification points too high, no history of drug/alcohol abuse, or inappropriate sentence length). The relatively low level (1.6%) of removals for CCCMS concerns is notable since the percentage of CCCMS within the SATF-SAP rose from an average of 9.2% of the total population in June 1998 to an average of 20.0% during the period from July 2000 through June 2001, reaching a peak of 21.2% during September 2000. All of the 8 reported deaths were for medical reasons.

Figure 1: Reasons for Non-parole SATF-SAP Departures (N=1,141)

The mean length of program participation prior to a non-parole departure was 4.8 months for all such departures since March 1998. However, this mean has varied (by quarter and facility) throughout the evaluation period. For example, during the period July 2000 through June 2001, the mean length of stay, per quarter, ranged from a low of 3.6 to a high of 8.8 months. These variations in the means are directly correlated to the proportions of removals in the two largest categories (i.e., disciplinary and custody). Custody removals for felony holds and classification committee action may take several weeks to several months to be effected. Additionally, removals for pre-parole transfers occur only near the end of the inmate's sentence. Removals for disciplinary actions are normally effective immediately upon report of the violation. Therefore, the mean length of program participation was greater in those quarters where there was a larger proportion of removals due to custody actions.

D. Inmate Appeals

First-level appeals data from both the SATF-SAP facilities (F&G) and the non-treatment comparison facilities (A&B) were evaluated on a quarterly basis as a proxy measure of inmate satisfaction within their respective facilities. According to the *California Code of Regulations, Title 15, Crime Prevention and Corrections*, inmates have the right to "...appeal any departmental decision, action, condition, or policy perceived by those individuals as adversely affecting their welfare..." (Article 8, Section 3084.1s). Because of the disparate population sizes between treatment and non-treatment facilities, first-level appeals were recorded as a rate per 100 inmates (see Appendix C for longitudinal trends). Although there were wide variations in rates during specific quarters, the overall mean rates (for all appeals categories) per 100 inmates during the 15-quarter evaluation period were similar for all facilities. The rate in treatment facility F was 10.2, in treatment facility G the rate was 9.0, and in the combined non-treatment facilities the rate was 10.4.

A further analysis was conducted on the three appeals categories that reflected the most often cited concerns of SATF-SAP inmates during focus groups (i.e., Medical, Program, and Complaints Against Staff). Because the institution reported only the number of adjudicated (processed) first-level appeals by specific category, this measure was used to determine the rate per 100 inmates used in the analysis (see Appendix C for longitudinal trends). It should be noted that, although focus group inmates were randomly selected for participation, they had to voluntarily sign consent to participate and, even then, were not required to attend the groups.

Subsequently, even with the random selection process there may have been elements of self-selection bias among the final group participants. Thus, the three appeals categories most often cited during the focus groups as areas of inmate concerns may not be representative of the entire SATF-SAP population.

SATF-SAP focus group inmates consistently cited medical issues as their greatest concern, and our analysis shows that treatment inmates were, indeed, more likely to file appeals in this category than were the comparison inmates. The mean rates (per 100 inmates) for this category by facility are 2.35 for treatment facility F, 1.95 for treatment facility G, and 1.57 for the combined non-treatment facilities A&B. The analysis also indicates a trend for the rates of appeals in this category to rise over time for all facilities.

SATF-SAP focus group inmates frequently cited program-related issues as a concern. Treatment inmates stated that the SAP curriculum was repetitious and non-engaging, involuntary participants could not leave the program without severe consequences, and the SATF-SAP offered limited vocational training opportunities. However, analysis of the data indicates that SATF-SAP inmates were not more likely to file appeals in this category than were the comparison inmates. The mean rates (per 100 inmates) in this category by facility are, .89 for treatment facility F, .71 for treatment facility G, and .71 for the combined non-treatment facilities A&B. Although the rates in this category vary widely from quarter to quarter, there appears to be a trend toward lower rates near the end of the evaluation period for all facilities.

Focus group participants from the SATF-SAP also cited several concerns regarding both custody and treatment staff. Inmates in the treatment facilities stated that custody staff attitudes and behavior often mirrored that found in higher-level security facilities. Treatment personnel were described as being condescending, lacking in the necessary training and skills, and more concerned with inmate supervision and discipline than in substance abuse treatment. Treatment inmates stated that the boundary lines between the roles and responsibilities of custody and treatment personnel were often poorly defined or delineated. The SATF-SAP inmates said that this often created confusion and tension between the custody officers and treatment staff. However, SATF-SAP inmates were less likely to file appeals in the Complaints Against Staff category than were the non-treatment comparison inmates. The mean rates (per 100 inmates) in this category by facility are; .62 for treatment facility F, .82 for treatment facility G, and .85 for the combined non-treatment facilities A&B. The greater disparity between the two treatment facilities (F&G) compared with that between facility G and the non-treatment facilities (A&B) may be explained by anecdotal data collected during focus groups with the treatment personnel. Treatment staff in facility G consistently cited inmate supervision and discipline as a top priority when responding to questions regarding their duties and job functions. Treatment staff participants in the focus groups from facility F were far less likely to include inmate discipline as a top priority duty.

E. Aftercare Referrals

The overall percentage of SATF-SAP inmates who accepted an aftercare referral during the evaluation period is 47.5%. As can be seen in Appendix B, this percentage has, with some fluctuation, increased over the course of the program.

Program participants were offered one of three modalities of post-release aftercare: residential, sober living/halfway house coupled with drug-free outpatient services, and drug-free outpatient services only. As shown in Figure 2, most of the SATF-SAP parolees accepted referrals to residential treatment programs (41.3%), followed by outpatient services only (30.7%), and sober living combined with drug-free outpatient services (28.0%).

Figure 2: *Distribution of Modalities Used in Aftercare Referrals (N=2,610)*

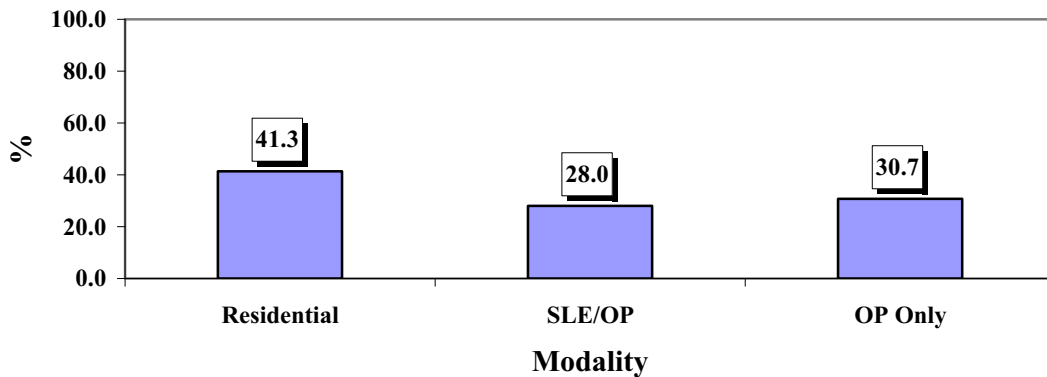
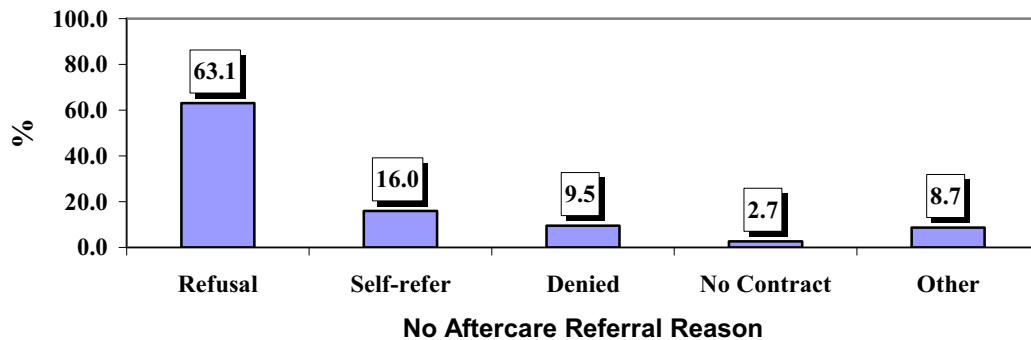


Figure 3: *Reasons for Not Receiving an Aftercare Referral (N=2,881)*



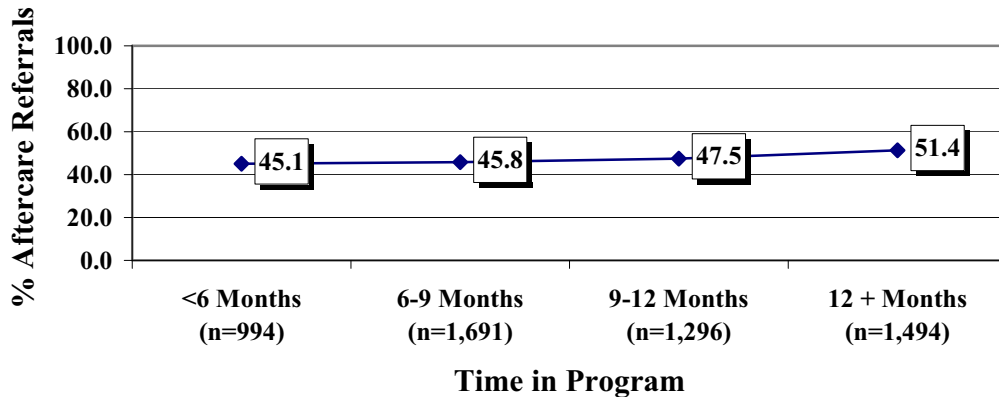
There were several reasons for the absence of an aftercare referral. As shown in Figure 3, the greatest reason was inmate refusal of aftercare (63.1%). This was followed by the inmates’ desire to self-refer to treatment (16.0%), the denial of treatment by SATF-SAP transitional staff, SATF-SAP parole, or the community-based treatment provider (9.5%), the absence of service contracts between the SASCA and treatment agencies in the community (2.7%), and 8.7% classified as “other” (i.e., discharge instead of parole, and earlier-than-expected parole dates).

Among the 273 SATF-SAP parolees who were denied aftercare treatment, 252 (92.3%) were Penal Code 290 Registrants (registered sex offenders). Eighteen (6.6%) were classified as high-control parolees or as R-suffix (having a sex offense history, though not a 290 Registrant), and 3 (1.1%) were denied a referral because of their CCCMS classification.

The average length of stay among all parolees at the SATF-SAP was 10.2 months

(SD=5.2), with a range of .1 to 51.2 months. Since it is plausible that those with more time in the program would be more likely to have become engaged in the treatment process and would be more likely to accept a referral to aftercare, a comparison was made between those SATF-SAP parolees who did and did not accept a referral by time in program. Indeed, only in the cohort of SATF-SAP participants who were in the program at least 12 months did a majority of the parolees accept a referral to post-release aftercare (see Figure 4). The differences across time periods, however, were not statistically significant.

Figure 4: *Percent of Aftercare Referrals by Time in Program (N=5,475)*



III. Outcome Evaluation (12-Month Return to Custody)

The SATF outcome evaluation consists of two data sources: (1) 12-month return-to-custody (based on official records from the California Department of Corrections), and (2) self-reported behaviors (pre- and post-incarceration). Sections A through E summarize return-to-custody results based on records obtained from the Offender-Based Information System (OBIS); Section F describes self-reported data regarding drug and alcohol use; and Section G summarizes two additional studies conducted with these data concerning HIV risk and psychosocial changes during treatment.

Random assignment to treatment and non-treatment conditions was not possible for this study. Therefore, to ensure that the subjects in the comparison group were in fact comparable to those in the SATF-SAP, a one-to-one matching procedure was employed. For each SATF-SAP inmate who agreed to participate in the outcome study, a list of similar (non-treatment) inmates from the comparison institution was generated, among those with less than one year left to serve. This list was based on downloads from the CDC Offender-Based Information System (OBIS) database. Specific matching criteria consisted of age, race/ethnicity, commitment offense, custody level, and prior history of sex offenses.

Once this list was generated, the research staff reviewed each prospective comparison subject's central file to determine whether or not there was evidence of prior substance abuse. This process is consistent with that used by correctional classification counselors to identify and refer inmates to institutional treatment programs. Of those who had evidence of a substance abuse history, three names were randomly selected as possible comparison subjects. To recruit these inmates for participation, the research staff would request an audience with small groups of potential subjects, explain the purpose of the study, and obtain consent from those who

volunteered to participate. The baseline interview would either be conducted at this time or scheduled within the next few weeks. Ninety-three percent of the SATF inmates who were invited to participate in this study agreed to do so; the participation rate for the comparison institution was 76%.³ Background characteristics of the resulting SATF and comparison samples are shown in Table 1.

Table 1: *Demographic Characteristics of SATF-SAP and Avenal (Comparison) Subjects (N=808)*

<u>Demographics</u>	SATF-SAP (N=404)	Comparison (N=404)	Total (N=808)
Age (mean)	36.1 (SD=9.6)	36.1 (SD=8.8)	36.1 (SD=9.2)
Race/Ethnicity			
<i>African American (%)</i>	40.2	41.6	40.9
<i>Hispanic (%)</i>	18.6	20.1	19.3
<i>White-Non Hispanic (%)</i>	37.2	35.9	36.6
<i>Other (%)</i>	3.9	2.5	3.2
Never Married (%)	45.6	46.5	46.1
Education			
<i>Years completed (mean)</i>	11.1 (SD=1.9)	11.4 (SD=1.9)	11.2 (SD=1.9)
<i>HS Grad./GED (%)</i>	36.5	42.1	39.3
Employment (6 mos. prior to incarceration)			
<i>None, not in labor force (%)</i>	19.6	16.8	18.2
<i>None, could not find (%)</i>	18.4	22.3	20.3
<i>Odd Jobs (%)</i>	14.6	5.5	10.0
<i>Part-time (< 35 hrs/wk) (%)</i>	6.7	7.4	7.1
<i>Full-time (>35 hrs/wk) (%)</i>	40.7	48.0	44.4 ***

***p<.001

The SATF-SAP and Avenal (comparison) subjects are virtually identical to one another with regard to age, race/ethnicity, and marital status. Avenal subjects are slightly more likely than SATF-SAP subjects to have graduated from high school, although this difference was not statistically significant. In fact, among the demographic variables shown in Table 1, the only significant difference was for employment status, with Avenal subjects being more likely than SATF-SAP subjects to have held full-time employment during the 6 months prior to incarceration.

A. SATF versus Comparison Group

³ According to the field research staff, the disparity in participation rates between the treatment and comparison sample was largely due to the fact that most of the inmates in the latter group had full-time job assignments. Consequently, a larger percentage of potential comparison subjects were reluctant to participate in the study since it would have resulted in lost work time. In contrast, because the treatment subjects were only employed part time, participating in the study did not necessarily conflict with their work schedules.

The most fundamental question addressed by an outcome evaluation is how the treatment group performed relative to the non-treatment group. For this analysis, the two institutional treatment providers (Walden House and Phoenix House) were combined to form a single treatment group, which was contrasted with the matched comparison group from Avenal State Prison.

Overall, 52.7% of the study subjects had been returned to custody within 12 months of release. As seen in Figure 5, the likelihood of returning to custody during this period did not differ significantly by treatment condition, with 53.5% of SATF subjects being returned compared to 51.9% of parolees from the comparison sample.⁴ Of those who returned to custody within this period, SATF participants (62.5%) were significantly more likely than comparison subjects (51.2%) to have done so for a new offense (rather than for a technical violation). Figure 6 shows the distribution of first offenses for those returned to custody within one year of release. Although the between-group differences are not statistically significant, there is a notable trend for SATF-SAP subjects to be less likely than comparison subjects to have been returned to custody for a drug offense.

Figure 5: *One-Year Return-to-Custody: SATF versus Comparison (N=801)*

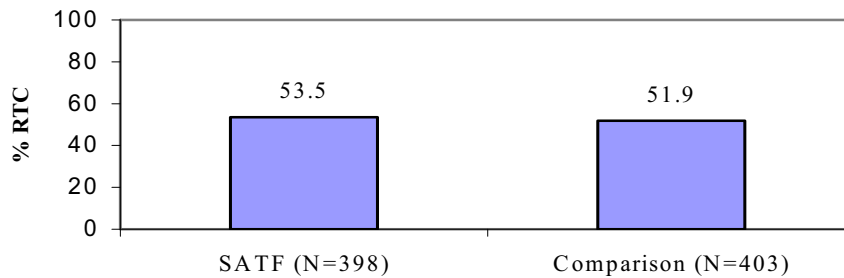
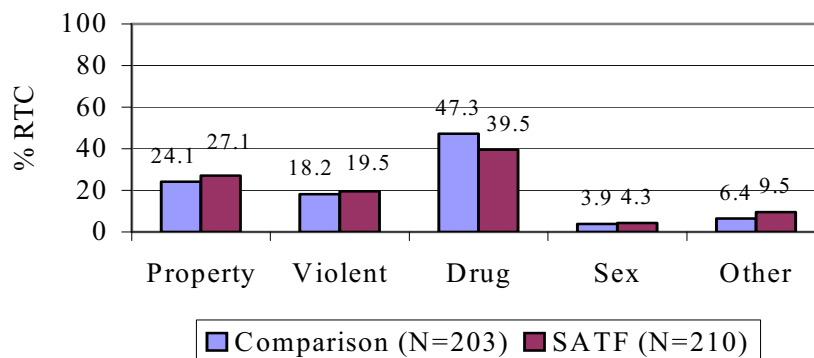


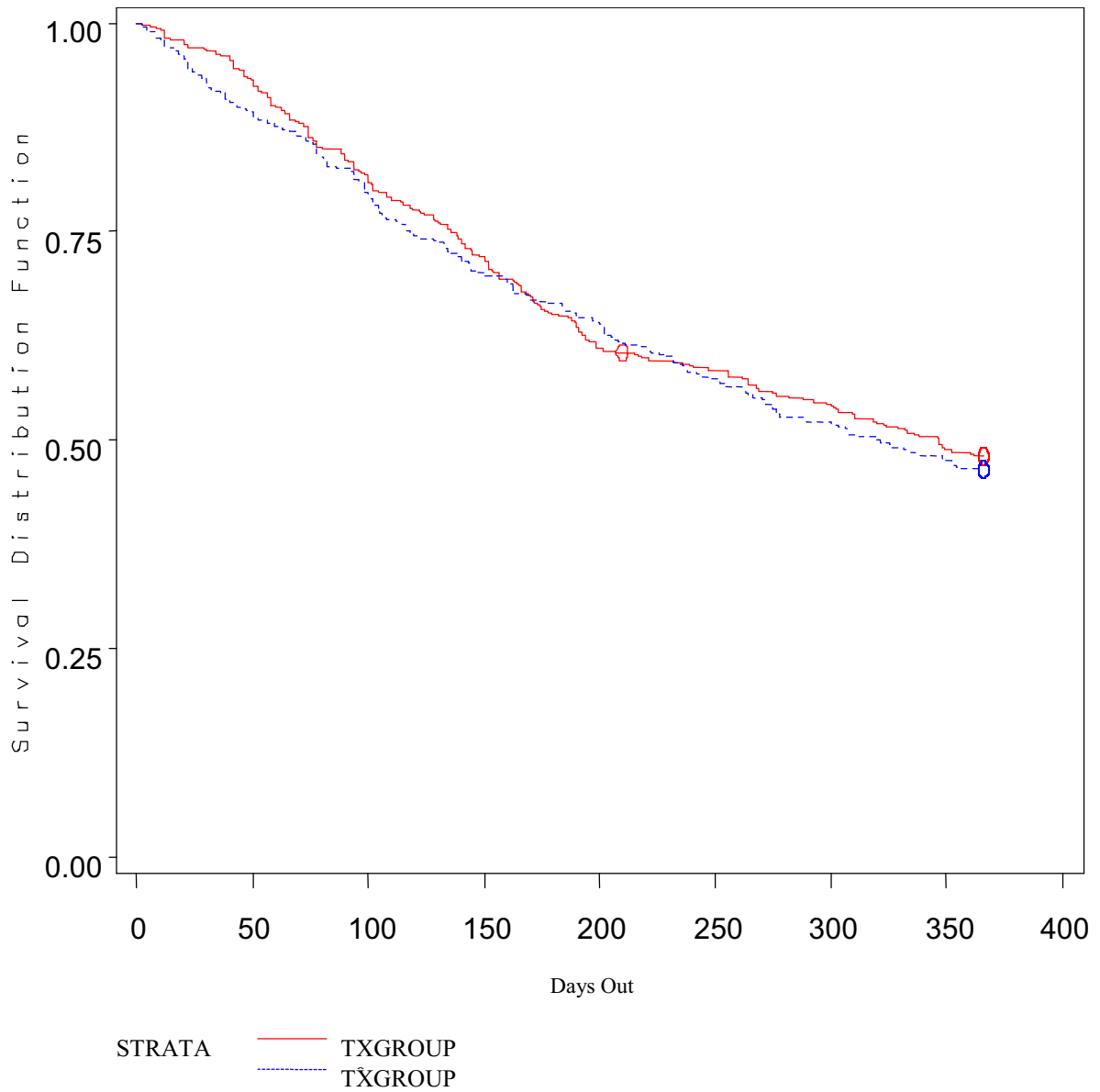
Figure 6: *Distribution of Offenses for First Return-to-Custody within One Year*



⁴ Statistical significance criterion for all comparisons is $p < .05$.

Figure 7 shows the survival curves for the SATF and comparison study subjects over the 12-months following release (measured in days). Based on this curve, we can see that the two groups show similar patterns in recidivism risk over time, with slightly less than half of the subjects from both groups “surviving” (i.e., not returned to custody) by the end of the 12-month follow-up period.

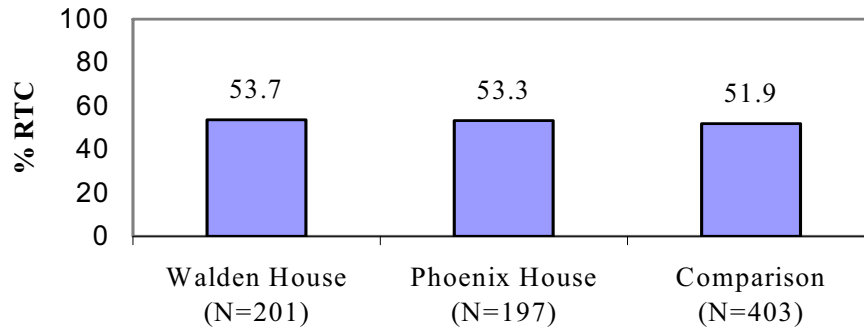
Figure 7: *Survival Analysis Comparing 12-Month Recidivism Among Releases from SATF (TXGROUP=1) and Avenal State Prison (TXGROUP=0)*



B. Outcomes by Program

Using the same outcome (12-month return to custody), we also examined between-program effects. As shown in Figure 8, 54% of Walden House subjects and 53% of Phoenix House subjects had been returned to custody during the 12-month follow-up period. This difference was not statistically significant.

Figure 8: *One-Year Return-to-Custody by Study Condition (N=801)*



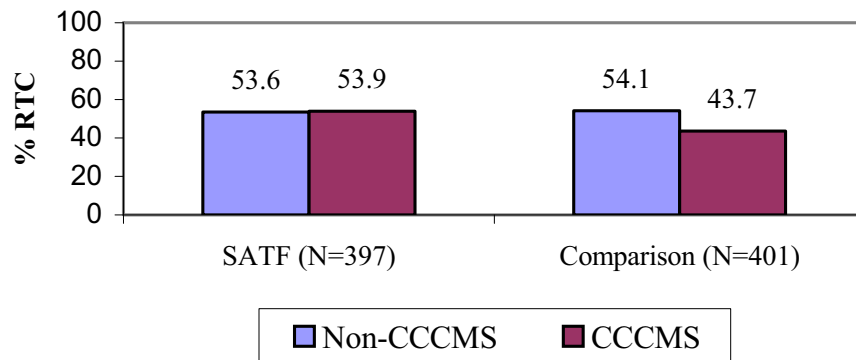
C. Special Populations

Over the past four years, a number of issues have arisen concerning appropriate admission (or exclusionary) criteria for referral to the SATF-SAP. Four “special populations” in particular have been the focus of these discussions: mentally ill, sex offenders, drug traffickers, and coerced clients. In this section, we compare 12-month return-to-custody outcomes for these three special populations and their relative performance by treatment condition. Because the outcomes of the Walden House and Phoenix House programs were not significantly different, they are recombined here to form a single SATF treatment condition.

Mentally ill. A common concern among the SATF-SAP treatment providers has been the growing percentage of Correctional Clinical Case Management Services (CCCMS) inmates referred to treatment. Indeed, whereas CCCMS or Enhanced Outpatient Program (EOP) inmates account for approximately 11% of the total inmate population, they account for 26% and 21.7% of the SATF-SAP and comparison group samples, respectively. In focus groups conducted with treatment staff, participants consistently reported that CCCMS inmates were the most problematic inmates to treat. According to these counselors, treatment at the SATF-SAP was contraindicated for mentally ill inmates because of their limited comprehension skills and tendency to be either disruptive or disengaged from the therapeutic process.

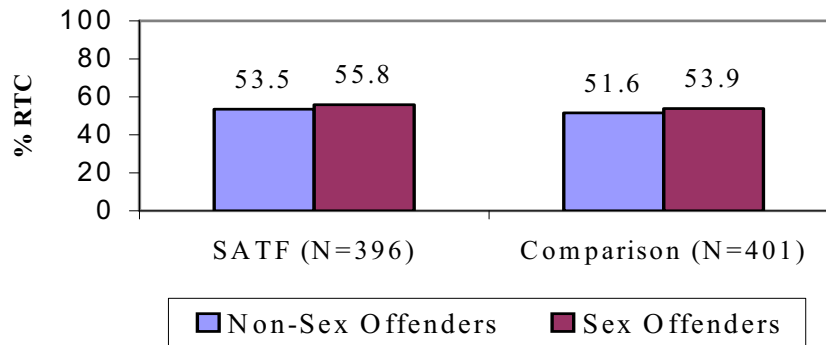
However, in terms of recidivism, mental health status was not a significant predictor. As shown in Figure 9, CCCMS inmates paroling from the SATF-SAP were no more likely to have been returned to custody than non-CCCMS inmates at the SATF-SAP. Among the inmates at the comparison institution, CCCMS inmates were slightly less likely than non-CCCMS inmates to have been returned to custody, although this trend was not statistically significant. (Designation of CCCMS status was determined from CDC records at the time of study enrollment.)

Figure 9: One-Year Return-to-Custody by Mental Health Status and Study Condition (N=798)



Sex offenders.⁵ As with the mentally ill offenders, there has been some question over the appropriateness of treating inmates with sex offense histories in a general population facility. Over the course of the last five years, we have reported that treatment staff have found it difficult to provide effective treatment strategies for the sex offender residents. This is due to institutional problems (e.g., sex offenders reportedly tend to remain silent about their criminal behavior in a therapeutic modality that emphasizes honest confrontation), as well as issues related to parole, with many 290 Registrants being denied residential aftercare by community-based treatment providers. Sex offenders accounted for 13% of both the SATF-SAP and comparison group samples.

Figure 10: One-Year Return-to-Custody by Sex Offender Status and Study Condition (N=803)



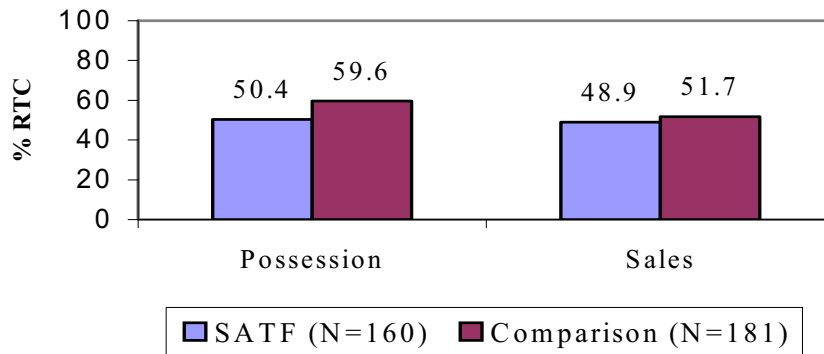
As seen in Figure 10, sex offenders were slightly more likely to have been returned to custody within one year of release. However, none of the variations by sex offender status or treatment condition is statistically significant.

⁵ For this analysis, sex offender status was based on the presence of an R-suffix in the institutional database. Although the majority of R-suffix inmates are also 290 Registrants, our review of randomly selected central files indicated that approximately 20% of R-suffixes are not.

Drug traffickers. The general category of “drug offenders” actually subsumes a heterogeneous group of offenders ranging from those who possess drugs for personal use to those involved in the manufacture, transport, and sale of drugs. Consequently, commitment for a drug offense does not necessarily imply that the offender has a drug problem. Among the 404 SATF participants in the outcome study, 160 (40%) were committed for a drug offense (44.8% of the comparison sample). Of the SATF drug offenders, 71.9% had been committed for possession (compared to 51.9% of the drug offenders in the comparison sample), and 28.1% had been committed for sales (compared to 48.1% of the drug offenders in the comparison sample). Thus, whereas the proportions of drug offenders did not differ between the SATF and comparison samples, the distribution of offense types within this category did.

Assuming that those charged with possession are more appropriate treatment referrals than those primarily involved with sales, we compared 12-month return-to-custody percentages between these two groups by study condition. As shown in Figure 11, there was a notable trend for those with possession commitment offenses to be less likely to recidivate if they were assigned to the SATF-SAP rather than the comparison group. This difference, however, was not statistically significant ($p=.19$).

Figure 11: *One-Year Return-to-Custody by Type of Drug Offense and Study Condition (N=341)*



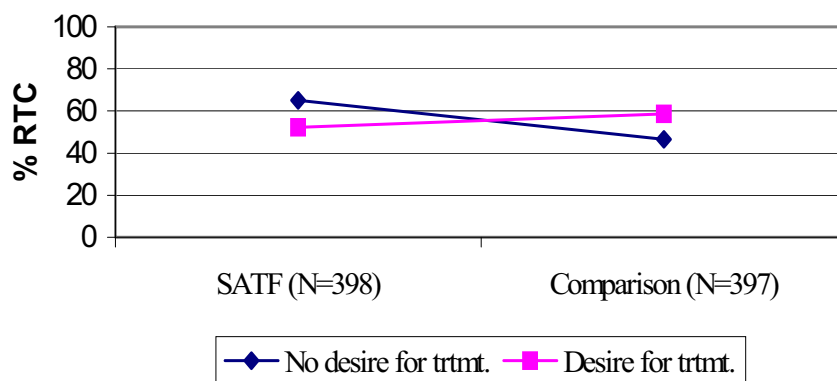
Coerced clients. Although a number of evaluations of prison-based substance abuse treatment programs have been published, all of the programs evaluated included voluntary clients as subjects (Inciardi, Martin, Butzin, Hooper, & Harrison, 1997; Knight, Simpson, Chatham, & Camacho, 1997; Prendergast, Wellisch, & Wong, 1996; Wexler, De Leon, Thomas, Kressel, & Peters, 1999). That is, despite the coercive environment of the prison generally, inmates with substance abuse problems were informed of the availability of treatment and then decided whether to participate. It was not clear, however, whether the outcomes of involuntary treatment participants in prison would be similar to the outcomes found in community-based treatments or to the outcomes of voluntary prison-based programs. The issue of involuntary treatment has been raised routinely in focus groups with counselors, correctional staff, and

inmates at the SATF-SAP.

To assess the impact of coercion on the effectiveness of the SATF treatment program, we compared return-to-custody outcomes among inmates who: (1) wanted treatment but did not receive it (N=168; 21.0%), (2) wanted treatment and did receive it (N=356; 44.5%), (3) did not want treatment and did not receive it (N=229; 28.6%), and (4) did not want treatment but did receive it (N=47; 6.0%). Those who received treatment were the inmates at the SATF-SAP; those who did not receive treatment were the inmates at Avenal State Prison. The measure of the inmates' desire for treatment was collected as part of the baseline interview for all subjects in the outcome study. The item read, "You believe you would like to receive drug/alcohol treatment while in prison." The response options were as follows: 0=Disagree Strongly, 1=Disagree Somewhat, 2=Not Sure, 3=Agree Somewhat, or 4=Agree Strongly. Inmates responding to this statement with a 0 or 1 were coded as not wanting treatment. Those responding with a 2 or above were coded as being amenable to treatment.

As shown in Figure 12, the poorest outcomes occurred among those who were referred to the SATF-SAP in spite of not having a desire for treatment. In fact, this group was 40% more likely to have been returned to custody than the untreated subjects who reported that they did not want to receive treatment (65.0% versus 46.5%, respectively). Among those who reported that they did want to receive treatment, however, SATF participants performed slightly better than the untreated comparison group (52.2% versus 58.7%, respectively). For those who did *not* want treatment, the difference in recidivism percentages between SATF and Avenal subjects was statistically significant ($p < .05$).

Figure 12: One-Year Return to Custody by Desire for Treatment and Study Condition (N=800)



It should be pointed out, however, that the current study was designed for making treatment versus non-treatment comparisons. The derivation of subgroups based on desire for treatment, as we have presented in this section, should be interpreted with caution and as suggestive rather than conclusive. For example, those in the high-coercion group (SATF-SAP participants who did not want treatment) also tended to be younger, to have more extensive criminal justice histories, and to report fewer substance-related problems. However, subsequent analyses revealed that this relationship persisted even after controlling for these background differences in a multivariate model.

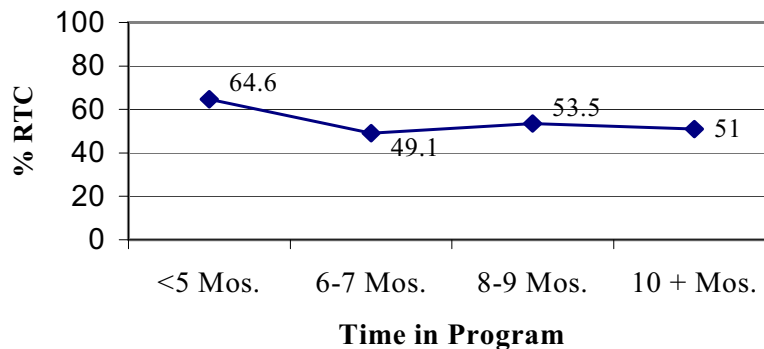
D. Time in Program

The time in program, or “TIP,” effect is commonly reported in the substance abuse literature as a “dosage” measure of treatment. These studies have resulted in estimates of critical thresholds for treatment retention ranging from 90 days (Simpson, Joe, & Brown, 1997) to up to one year (Wexler et al., 1992). Whereas these estimates are often confounded by selection bias (i.e., those who choose to remain in treatment longer may be more committed to their recovery than those who drop out),⁶ the SATF-SAP treatment admission policy partially controls for this effect. Specifically, at least among those who successfully complete the program, the amount of time an inmate spends in treatment at the SATF-SAP is more a function of the remaining time on his sentence than a prerogative of the inmate.

To assess the impact of the TIP effect in the current sample, we divided the distribution of months in program into four categories: (1) ≤ 5 months (16.3%), (2) 6-7 months (26.6%), (3) 8-9 months (31.9%), and (4) ≥ 10 months (25.1%). On average, inmates in the outcome study spent 7.7 months (SD=2.9) at the SATF-SAP, ranging from less than 1 month to 22.2 months.

Figure 13 shows the 12-month return-to-custody percentages by these four TIP categories. Although the between-group differences are not statistically significant, there is a trend for those remaining in treatment for at least 6 months to have lower recidivism than those in treatment for 5 months or less.

Figure 13: One-Year Return to Custody by Time in Program (N=398)



E. Aftercare

There is increased evidence that the prison-based component of treatment may serve primarily as an orientation or transitional phase for the community-based component. In fact, outcomes from the Amity program at the R.J. Donovan Correctional Facility revealed that inmates participating in prison treatment only (i.e., without aftercare) tended to have similar one-year post-treatment outcomes to those receiving no treatment at all (Lowe, Wexler, & Peters,

⁶ Indeed, those who paroled from the SATF tended to be less likely to recidivate within 12 months than those who were removed from the program prior to parole (52.3% versus 67.7%, respectively). This difference, however, was not statistically significant.

1998).

For the present analysis, aftercare participation was determined by billing records provided by the two institutional providers. Overall, 91, or 24.9%, of the SATF parolees in our study cohort were admitted to some form of CDC-sponsored aftercare after release from the institution. Of these, 63.7% entered a residential program, 58.2% entered a sober living environment, and 30.8% entered an outpatient program.⁷ Interestingly, according to billing records, only 47.2% of those who were admitted to a sober living environment also participated in outpatient services. In contrast, the majority (89.3%) of those who were admitted to an outpatient program also had billing records indicating that they had been admitted to a sober living environment.⁸

Table 2: *Days in Aftercare by Modality*

<u>Modality</u>	<u>N</u>	<u>Mean</u>	<u>SD</u>	<u>Range</u>
Residential	58	75.8	64.8	2-305
Sober Living	55	93.1	80.1	1-428
Outpatient	29	41.9	42.0	2-145

As shown in Table 2, the mean length of stay in a residential program was 75.8 days (2.5 months); 93.1 days (3.1 months) in a sober living environment. Regarding outpatient treatment, billing records indicate that SATF parolees received an average of 42 units of services. However, as seen by the standard deviations (SDs) and ranges, levels of participation in these services varied considerably. Of the full SATF study cohort of parolees, only 11.2% remained in a residential or sober living program for 3 months or longer, or received an equivalent of outpatient service units (i.e., 36 units, assuming 3 weekly sessions for 3 months). This threshold was applied based on previous research indicating that a minimum of 3 months of treatment is typically required to produce meaningful changes in behavior (Simpson, Joe, & Brown, 1997).

Because only one in ten SATF parolees entered aftercare and remained for a significant period of time, it is unlikely that this subgroup represents the entire SATF population.⁹ Consequently, it would be inappropriate to generalize the results from this subgroup to the SATF-SAP client population as a whole. In fact, the common reliance on such comparisons has fostered growing skepticism concerning the use of non-rigorous evaluations to inform policy decisions regarding correctional treatment. A recent report from a committee of the National

⁷ Total percentages exceed 100% because parolees could enter more than one modality during their 6-month period of eligibility following release.

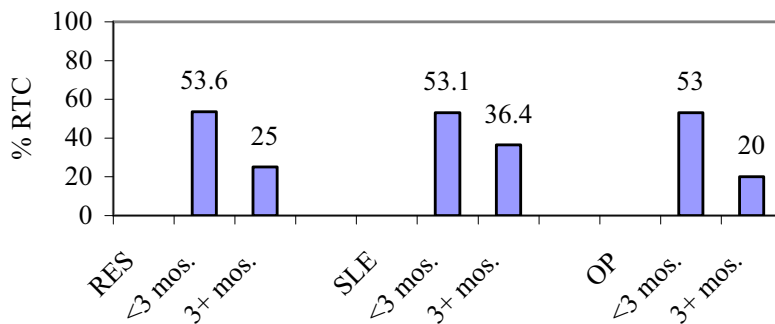
⁸ It is possible that the billing data—particularly for this early cohort—do not account for every episode of aftercare treatment. Self-reported levels of aftercare participation tended to be substantially higher than estimates based on billing records. In fact, according to the 12-month follow-up interviews, aftercare participation was reported by 48% of Walden House parolees, 39% of Phoenix House parolees, and 21% of the comparison group parolees. Nevertheless, billing data are used in this analysis because of the inherent credibility and because they are more likely than self-report to accurately document CDC-funded aftercare treatment.

⁹ For example, those attending aftercare were more likely to have at least a high school diploma and to have volunteered for SATF treatment initially. In fact, SATF volunteers were approximately two and a half times more likely to enter aftercare than involuntary admissions to SATF (24% versus 9%, respectively).

Research Council concluded regarding the literature on correctional drug abuse treatment: “A number of studies of prison-based programs seem to demonstrate positive postrelease outcomes, including reductions in drug use and crime along with improvements in employment, when inmates who have gone through prison treatment are compared with those who have not...However, research conducted to date has not yet convincingly demonstrated the effectiveness of prison treatment programs. Even in studies that find a significant relationship between completion of a treatment program and post-release outcomes, the overall positive effect is attenuated by inconsistent findings. Moreover, positive treatment outcomes may be attributable to selection bias (e.g., the high level of commitment of offenders who completed the program rather than the capacity of the program to change their behavior)” (National Research Council, 2001; p. 8.16).

However, because this *subgroup* approach has become a convention in the correctional treatment field, we provide these comparisons as well—not as an overall measure of effectiveness of the SATF-SAP, but rather as a means to compare these findings with other evaluations employing this same approach. The comparisons for participation in residential (RES) and outpatient (OP) treatment shown in Figure 14 are significant at the .05 level. The comparison between those residing in a sober living environment (SLE) for at least 3 months and those with less than 3 months of SLE was marginally significant (p=.06). It should be reiterated that the numbers of SATF study subjects in the 3+ month aftercare conditions are quite small ($n^{RES}=20$; $n^{SLE}=22$, and $n^{OP}=10$) making generalizations problematic. Overall, SATF-SAP participants who received at least 3 months of any form of aftercare ($n=41$)¹⁰ were significantly less likely to have been returned to custody than those who did not ($n=365$; 31.7% versus 54.6%, respectively).

Figure 14: One-Year Return to Custody Rates by Aftercare Participation*



* Note: The “<3 mos.” categories include those who attended aftercare for less than 3 months as well as those who received no aftercare.

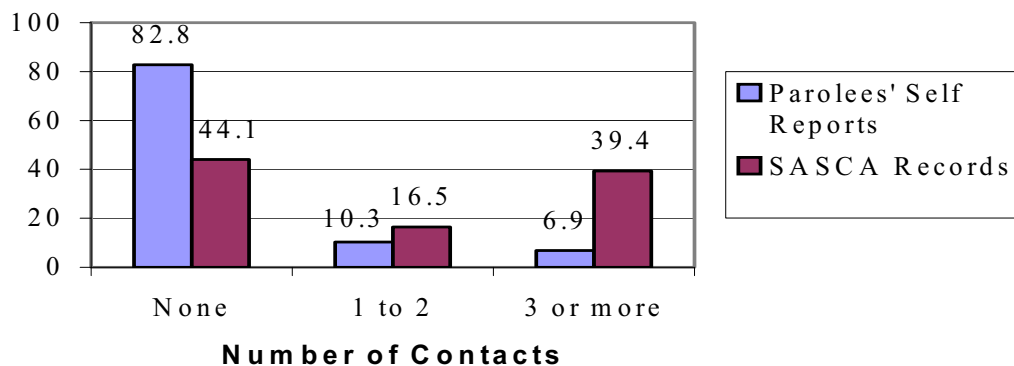
Substance Abuse Services Coordinating Agencies. The low level of aftercare attendance cannot be attributed to any single factor. Focus groups conducted with SATF participants over the past 5 years have revealed that inmates refuse (or are refused for) aftercare for a number of reasons, including lack of availability in their county of commitment, desire to

¹⁰ This total is less than the sum of aftercare participants by modality because some parolees attended more than one type of treatment.

return to their own homes, exclusion from residential treatment due to having a high-control parole status, or a simple lack of desire to continue living in a structured environment following prison. And, as mentioned above, only a small number of SATF participants who expressed a desire to enter aftercare actually entered the program to which they were referred and remained there for at least 3 months.

In recognition of the critical post-release transitional phase, Substance Abuse Services Coordinating Agencies (SASCAs) were established to facilitate parolees’ re-entry into the community by linking them to the appropriate types and levels of community-based treatment and making periodic contacts with parolees for one year. According to SASCA records, 55.9% of the SATF parolees in the outcome study sample had been contacted at least once during the 12 months following release from prison.¹¹ Further, SASCA records indicate that these parolees had been contacted an average of 7.3 times (SD=7.7), with the number of contacts ranging from 1 to 55. In contrast, only 17.2% of the parolees in our study sample reported being contacted by a SASCA representative during this period. Those who were contacted reported an average number of 4.6 contacts (SD=9.4), ranging from 1 to 64. (see Figure 15).

Figure 15: *Frequency of SASCA Contacts Based on Parolees’ Self Reports and SASCA Records During the 12 Months Following Release From SATF (N=290)*



It is likely that some of this discrepancy is due to the fact that self-report data are subject to bias (intentional or unintentional). It is also possible that SASCA contact logs reflect case managers’ contacts with program staff or parole agents to monitor the parolees’ progress. These may have occurred without the parolees’ knowledge. Furthermore, whereas the parolees were asked to report the number of SASCA-initiated contacts, SASCA records may have counted contacts regardless of who initiated them. Through an extension in the SATF evaluation contract, however, we intend to examine the SASCA case management process more closely, as well as to document changes that have occurred since this early study cohort was released.

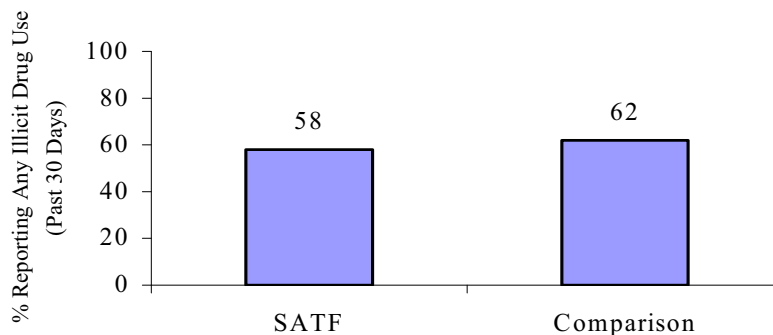
¹¹ Non-parole discharges were excluded from this analysis since they were not eligible to receive CDC-funded aftercare.

F. Self-Reported Drug Use

To assess pre- and post-treatment changes in substance use, baseline reports of alcohol and illicit drug use during the past 30 days prior to entering prison were compared with alcohol and drug use during the 30 days prior to the follow-up interview. (For study subjects who had been returned to jail or prison during the 12-month follow-up period, the 30-day reporting window referred to the period preceding the date of their reincarceration.)

Although all subjects in the comparison group had evidence of alcohol and/or drug problems in their official records, the baseline prevalence of any self-reported illicit drug use in the past 30 days was lower among comparison subjects than among SATF participants (70.3% versus 77.4%, respectively). To control for this baseline difference, our analyses of any illicit drug use during the 30 days prior to the follow-up interview were limited to those subjects reporting any illicit drug use during the 30 days prior to entering prison ($n^{\text{Avenal}}=284$; $n^{\text{SATF}}=312$). As shown in Figure 16, SATF subjects were slightly less likely to report any follow-up drug use than Avenal subjects. However, this difference was not statistically significant.¹²

Figure 16: Any Self-Reported Illicit Drug Use in the Past 30 Days (Prior to the Follow-Up Interview) by Treatment Condition (N=596)



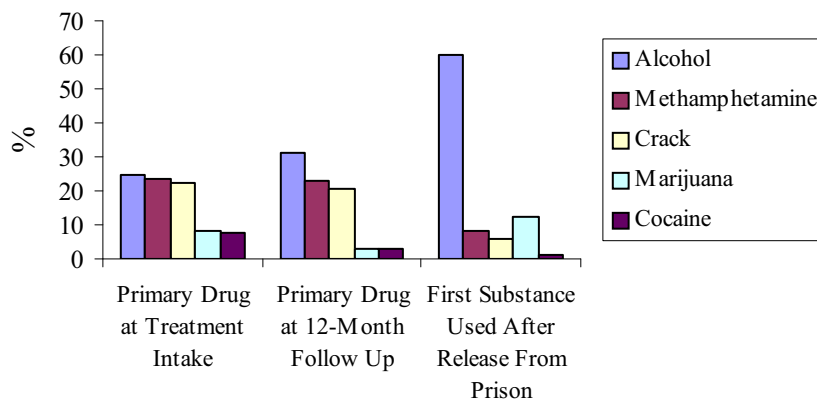
To assess changes in *levels* of substance use, SATF and comparison subjects were compared with regard to self-reported frequency of alcohol, marijuana, cocaine, crack, and methamphetamine use. These substances were selected because they were reported by at least 5% of the total sample as being a primary substance. Subjects were asked to rate their levels of past-month use of each of these substances on a nine-point scale (0=never, 1=1-3 times, 2=1 time per month, 3=2-3 times per month, 4=1 time per week, 5=2-6 times per week, 6=1 time per day, 7=2-3 times per day, and 8=4 or more times per day). Each of these substances was then analyzed separately (again, controlling for any baseline use) and tested for an interaction between treatment condition (SATF versus Avenal) and time (baseline versus follow-up). For all

¹² It should be noted that urinalysis (UA) data could not be used to corroborate self-reported substance use because only a minority of study participants (1) were not re-incarcerated at follow-up, and (2) agreed to provide a urine specimen. As a result, UA data are unlikely to be representative. Overall, 31% of these UAs were positive for an illicit substance.

of these substances, our analyses revealed a significant effect for time, that is, overall alcohol and illicit drug use declined between the baseline and follow-up periods. However, the slope of these pre-post changes did not vary by treatment condition. Graphical depictions of these results (by substance) can be found in Appendix D.

Over the course of conducting the baseline and follow-up interviews, it became apparent that the prevalence of problematic alcohol use was substantial. In fact, alcohol was the most commonly cited primary problem substance at baseline and at follow-up, and was by far the most commonly reported substance to be used first upon release from the SATF (see Figure 17).

Figure 17: *Self-Reported Primary Drug and First Substance Used After Release from SATF (N=379)*



These data suggest the importance of targeting alcohol as well as illicit drugs during prison treatment. In addition, these findings raise some concern over traditional parole policies that lay emphasis on illicit drug use while requiring that alcohol “not be used in excess.”

G. Other Findings

Data from this evaluation facilitated several sub-studies of additional topics related to offender substance-abuse treatment. Two of these studies are summarized below: (1) Methamphetamine Use and HIV Risk, and (2) Psychosocial Changes During Treatment. (Copies of these reports can be ordered through www.uclaisap.org.)

Methamphetamine Use and HIV Risk (Farabee, Prendergast, & Cartier, in press). Recent epidemiological surveys of illicit substance use show particularly high prevalence of methamphetamine (MA) use in the western and southwestern United States—most notably California. Moreover, MA is a preferred substance among California arrestees. The current study capitalized on these high prevalence rates to ascertain the level of injection- and sex-related HIV risk associated with MA use among offenders. The present study was based on the interview data collected from the 808 inmates comprising the study sample from the SATF and Avenal State Prison (32% of whom were current MA users) to examine the associations between MA use and HIV risk behaviors. Specifically, we conducted a series of logistic regressions to predict participation in two injection-related risk behaviors (sharing needles; sharing cooker, cotton,

rinse water) and three sex-related behaviors (unprotected sex with non-partner, unprotected sex with injection drug user, and unprotected sex in exchange for money or drugs) during the past 6 months. Methamphetamine users were significantly more likely than non-users to have injected drugs during the 6 months prior to their current incarceration. Among injectors, however, injection-related risks, such as needle cleaning, sharing, etc., were not significantly associated with MA use. However, past 6-month sex-related risks were dramatically higher for MA users, even after controlling for background differences between the two groups. The results of this study underscore the importance of addressing the inflated sex-related HIV/AIDS risk among MA-using offenders, particularly given the rapid spread of MA use in other states where HIV seroprevalence among correctional populations is already high.

In-Treatment Psychosocial Changes (Prendergast et al., 2002). Given the high proportion of criminal justice treatment clients in the United States, a major policy and program issue in drug treatment is the appropriateness and effectiveness of coercing offenders to enter and remain in treatment. As part of the comprehensive evaluation of the SATF, we conducted an analysis of during-treatment psychosocial changes of inmates admitted voluntarily and those admitted involuntarily to the treatment program. Our main focus was on psychological functioning (self-esteem, depression, anxiety, decision making, and self-efficacy) and social functioning (hostility, risk taking, and social conformity). Regardless of voluntary or involuntary admission status, treatment participants exhibited significant during-treatment change on most of measures of psychosocial functioning, although significant change was more likely on measures of psychological than on social functioning. In addition, similar percentages of both groups were paroled from treatment (as opposed to being discharged from the program prior to parole) and agreed to attend community treatment.

IV. Cost Analysis¹³

An economic cost analysis was performed on the two in-prison Therapeutic Community (TC) programs operating at the California Substance Abuse Treatment Facility (CA SATF) in Corcoran, California. Estimating the costs of prison-based treatment requires an incremental analysis of resource use because common resources in the prison (e.g., housing, food, security) are not directly associated with the treatment program. The costs of treatment are the additional costs above standard incarceration costs (i.e., the total costs associated with incarceration and treatment minus the standard cost of resources provided to the general prison population).

The cost data for the SATF programs were collected using the Drug Abuse Treatment Cost Analysis Program (DATCAP; www.DATCAP.com). The DATCAP is a structured data collection instrument developed by French and colleagues, which outlines both program revenues and costs (French, 2001a; French, 2001b). The instrument is used to collect resource use and other data to estimate total annual cost, distinguishing between economic and accounting cost. Economic cost refers to the value of all resources utilized in delivering the program, including resources that have been donated or subsidized. Economic cost is referred to as *opportunity cost*, which defines the true value of program resources as the forgone opportunity to

¹³ The cost analysis was conducted by Kathryn McCollister, Ph.D., at the Health Services Research Center at the University of Miami, and was based on data provided by Phoenix House and Walden House.

employ these resources in an alternative capacity. Accounting cost refers to the direct expenditures associated with providing treatment, as summarized on program expenditure reports. Any resources that are “on hand,” donated, or subsidized are not included in accounting costs. The DATCAP has been applied to a variety of treatment interventions such as methadone maintenance, outpatient drug-free, long-term residential, short-term residential, prison-based programs, and employee assistance programs (e.g., French, et al., 1997; French & McGeary, 1997; McCollister & French, 2002; Salomé & French, 2001).

All values are expressed in 2000 dollars. Program costs included personnel, supplies and materials, contracted services, and equipment. The costs of the Phoenix House program are summarized in Table 3. The total accounting cost was \$1,813,437. A small differential between program economic and accounting costs (\$400) was present due to the opportunity cost of program equipment; however, this differential did not affect the average cost estimates described below. The cost of labor was the largest component of total cost (\$1,421,462). The average caseload for the Phoenix House program was 715 inmates, with an average length of stay in the program of 36 weeks. Thus, the annual accounting cost per client was \$2,536, or \$49 per week. The accounting cost per treatment episode was \$1,751.

The costs of the Walden House program are summarized in Table 4. No differential was present between accounting and opportunity costs for this program as all program resources were acquired at market value. The total annual cost of the Walden House program was \$1,916,663. The largest component of program cost was program personnel (\$1,677,897). The average caseload in fiscal year 2000 was 734 inmates, who stayed an average of 26.2 weeks in the program. The annual cost per client was \$2,611 (\$50 per week). The average cost per treatment episode was \$1,312.

Table 3: Cost Analysis of the Phoenix House Program

Phoenix House	\$ (2000 Dollars)
Total Accounting Cost	1,813,437
Annual Accounting Cost per Client	2,536
Weekly Accounting Cost per Client	49
Accounting Cost per Treatment Episode	1,751

Table 4: Cost Analysis of the Walden House Program

Walden House	\$ (2000 Dollars)
Total Accounting Cost	1,916,663
Annual Accounting Cost per Client	2,611
Weekly Accounting Cost per Client	50
Accounting Cost per Treatment Episode	1,312

Ideally, to estimate the economic impact of treatment programs, cost data should be compared with outcome data to assess the cost-effectiveness or costs and benefits of these programs. Cost-effectiveness analysis dictates the selection of one primary outcome to express program effectiveness. Benefit-cost analysis is a more complicated analysis that entails the selection of a set of program outcomes that must be expressed in monetary terms in order to directly compare the outcome costs with program costs. Our intention was to perform a cost-

effectiveness analysis of the SATF programs to assess the impact of treatment on reducing recidivism by examining the number of days reincarcerated over follow-up. Initial analyses of the follow-up data revealed that both treatment participants and inmates that received no in-prison treatment had the same number of reincarceration days. Thus, with no difference in “effectiveness” between study participants, a cost-effectiveness analysis was not possible. Future evaluations of these programs over longer timelines are planned to examine the benefits of in-prison treatment on increasing post-release productivity, reducing criminal activity and health services utilization, and improving prison management issues.

V. Conclusions and Recommendations

The purpose of this evaluation was to assess the impact of the two TC programs at the SATF with regard to during- and post-prison measures. In addition to measuring impact and outcomes, an evaluation should result in specific recommendations for further improvements—both for SATF and for the other prison-based programs comprising this initiative. In this final section, we summarize the overall conclusions regarding the effectiveness of the SATF and offer a set of targeted recommendations based on the data collected over the 5-year evaluation period.

Overall, the SATF-SAP appeared to have had a positive impact on in-prison behaviors and prison management. Relative to untreated inmates, SATF-SAP inmates had fewer disciplinaries (and were less likely to have committed violent infractions) and, according to random drug test data, levels of drug and alcohol use were extremely low. Likewise, there was a positive trend over time for SATF-SAP parolees to accept an aftercare referral. The rate of appeals filed, however, did not differ between treated and untreated inmates at the SATF.

In contrast, post-release recidivism rates did not differ between the SATF-SAP and comparison subjects in the outcome study. The likelihood of being returned to custody (for any reason) did not differ significantly by treatment condition, nor did the two groups differ in the type of first re-offense. However, there was a trend for the SATF-SAP subjects to be less likely than the comparison subjects to be returned to custody for a drug-related offense. In addition, there appeared to be a trend for those who spent at least 6 months at the SATF-SAP to have better post-release outcomes than those who spent 5 months or less in treatment. This effect remained even after controlling for discharge status.

One of the problematic aspects of the SATF-SAP concerned aftercare attendance. Although an increasing proportion of SATF-SAP participants accepted some kind of aftercare referral over time, only about 11% received 3 or more months of treatment in the community. While these subjects had lower recidivism rates than other SATF-SAP parolees, this small group is unlikely to represent the entire SATF-SAP population. Hence, using existing data, it is not possible to predict how the other SATF-SAP parolees would have performed had they entered aftercare and remained in aftercare for a sufficient period of time. Such an analysis would be possible if aftercare participation were mandatory or if aftercare volunteers could be randomly assigned to aftercare treatment or a no-treatment condition.

However, because the majority of studies that evaluate correctional drug abuse treatment programs report separate findings for aftercare subgroups, a similar analysis was included here to facilitate comparisons with other studies using this design. SATF participants who received at least 3 months of aftercare (n=38) were significantly less likely to have been returned to custody

than those who did not (n=358; 31.5% versus 55.6%, respectively, or about a 43% reduction in recidivism risk). By comparison, the relative reductions in recidivism reported in the Key-Crest study was 58%; and for Amity, 87%. Nevertheless, it is important to keep in mind that treatment dollars are still being expended on those who *do not* enter and remain in aftercare. Thus, it appears that some of the prior studies in this field—whether by implication or inference—may have inflated expectations for the majority by emphasizing the results of a self-selected few.

Several aspects of the evaluation and the program itself should be taken into account when interpreting the results summarized in this report. The current evaluation tested the effectiveness of the SATF-SAP using a matched comparison group design with a large sample and using a conservative analytic approach. Unlike many previous studies of correctional treatment that assessed 12-month outcomes, our evaluation of the SATF-SAP found that the treatment and comparison groups did not have significantly different return-to-custody rates. At least for the period during which the outcome study cohort was recruited (June 1999-June 2000), the SATF-SAP did not impact recidivism, the outcome of greatest interest to CDC (although further analyses may reveal positive outcomes in other areas, e.g., employment).

The treatment model used at the SATF-SAP—the therapeutic community—was not new. It has a 30-year or more history with favorable outcomes reported for both community- and prison-based programs. Nor was this model new in California—the Amity program at R. J. Donovan Correctional Facility had been in operation since 1990 and had showed a positive impact on recidivism at 12 months. Indeed, the legislation authorizing the SATF cited the Amity program as the model to be followed. But several features of the Amity program were not followed, including the voluntary nature of the program, the size of the program, the nature of continuing care, and the use of peer mentors.

All participants in Amity volunteer to be in the program; by contrast, a large percentage of the SATF participants are involuntary (although all those in the study agreed to participate in the study). Amity is a 200-bed program, whereas each of the SATF providers serve up to 739 inmates.¹⁴ The community care for Amity graduates was provided by the same organization, was located at a single program located near the prison, and was residential; by contrast, the continuing care arrangements for SATF were quite different, involving multiple providers, residential and outpatient modalities, and programs located throughout the state. Whereas peer mentors were used at the Amity program, peer mentors were not used during the early stages of the SATF activation. The Amity program was implemented in an established prison; the SATF-SAPs were implemented concurrently with the activation of the institution. Finally, in light of the importance of aftercare, it should be noted that for 10 months the SATF-SAPs shared one institutional parole agent (who was responsible for developing post-release treatment placements).

It may be that, despite adopting an empirically supported treatment modality, the structure of the SATF is not conducive to effective treatment. Another possibility is that SATF

¹⁴ The physical structure of the SATF makes it difficult to determine the size of the treatment facilities from a functional perspective. Although both facilities have a capacity of 739, programming occurs at the cluster level, with each cluster housing (up to) 66 residents. However, even in these smaller settings, group sizes often exceed the recommended size of 3-15 participants. As a general rule, the effectiveness of therapeutic groups decreases when their size precludes face-to-face interaction among all members (Barker, Wahlers, & Watson, 1995).

was evaluated too early and the program had yet to achieve maturity when the outcome study cohort was recruited. The recruitment and retention of qualified treatment provider staff personnel was a difficult challenge for both Walden House and Phoenix House during the initial phases of program development. For example, staff turnover rates for the period July 1999–June 2000 were 67% for Phoenix House and 41% for Walden House. These high levels of staff turnover coincided with the period of inmate recruitment for the outcome study, and anecdotal data from our focus groups with inmates, treatment staff, and custody staff indicated that these high levels of treatment staff turnover had a negative effect on program functioning. Additionally, Walden House replaced both its program director and clinical director in November of 1999 (nearly mid-point in the outcome study recruitment). Because of the high turnover rates, middle managers at the SATF-SAPs were often inadequately prepared to train and supervise counseling staff, particularly new hires.

The institutional staff was also subject to high levels of turnover and redeployment. The first SATF warden was relieved of duty in December of 1999. This resulted in a series of “acting” or “interim” wardens until the second permanent warden was appointed in August of 2000. Program Directors of Walden House and Phoenix House expressed concerns that the interim wardens were reluctant to authorize major program changes or initiatives, deferring those decisions to the eventual “permanent” warden. In addition, three different chief deputy wardens and five associate wardens directed the SATF-SAP in its first two years of operation. In January of 2000, over 70% of the custody staffs in both treatment facilities were changed due to the redeployment mandated under the “post and bid” process. Also, during the outcome study recruitment period, the Walden House facility changed its custody captain once and the Phoenix House facility changed its custody captain four times. Anecdotal data obtained from focus groups with treatment and custody staff during this period (see Fourth Annual Report) indicated that high levels of turnover among treatment and custody staff hindered the formation of strong working relationships, diluted the effects of cross training, and undermined the consistency of the program.

Possibly a large, mainly involuntary, TC program with a diffuse continuing care component can work (i.e., reduce recidivism), but the program would likely require 4-5 years to develop a strong therapeutic culture, establish an experienced and stable workforce, and achieve the needed support from the prison administration and line staff. A proposed yearly cohort study under review at OSAP is intended to test this “maturation” hypothesis.

Maturation, however, can only occur if the SATF programs and CDC address issues that have hampered its effectiveness thus far. In our fifth annual report to the legislature on the SATF program (Anglin et al., 2002; see also Farabee et al., 1999), we made several recommendations that we believe deserve to be revisited here. These include:

Reduce program size. Although we are not aware of any controlled studies of the effects of a substance abuse program’s size on post-release outcomes, our own observations, combined with feedback from SATF-SAP treatment staff, indicate that the size of the SATF-SAP may have hampered the development of a true therapeutic community culture. This is not to say that such a culture cannot and will not ultimately be established; rather, it appears that this process is occurring more slowly than would be the case in a smaller program. In developing future programs, one possible strategy to expedite the development of a TC culture would be to limit admissions during a program’s first year to inmates who volunteer for treatment. Once the milieu

is established, however, issues such as program size and the presence of involuntary inmates may prove more tractable.

Develop programs in less-remote areas. New prisons often provide economic salvation for impoverished rural communities (Schlosser, 1998). This fact, combined with the lower cost of land, has prompted the widespread development of prisons in remote areas. As a result, a number of operational challenges have arisen for prison-based substance abuse programs—most notably, locating and hiring local individuals with prior training and/or experience in the treatment modality being offered. As noted in earlier reports, limited human resources and high turnover rates for drug abuse treatment counselors have made staffing a perennial concern for SATF-SAP providers.

Ideally, future programs requiring a large number of staff should be located near a metropolitan area where there is an adequate labor pool. However, if this is not possible, an alternative approach to overcome the barriers associated with recruiting staff in remote areas would be to offer sufficient wages to induce counselors to move to and stay in the area where the prison is located. Wages for substance abuse counselors are traditionally low—a problem commonly cited to account for the substantial staff turnover in community-based programs (Gustafson, 1991). Given the relocation issues and the stressful working conditions of prison-based treatment programs, prison-based providers should be allowed to allocate more of their budgets for staff wages than they would for a similar program based in the community.

Decrease the number of involuntary participants. Much of the growth in criminal justice treatment (both in California and nationally) is based on the widely accepted dictum that involuntary substance abuse clients tend to do as well as, or better than, voluntary clients (Leukefeld & Tims, 1988; Simpson & Friend, 1988). However, as discussed above, these studies were based on community-based treatment samples. As we have seen in the present outcome study, those admitted to the SATF-SAP with little or no desire for treatment were substantially more likely than those who wanted treatment to have been returned to custody within 12 months. Based on these findings, we offer four recommendations:

- ***Target volunteers.*** Ideally, the majority of clients referred to prison-based programs (and particularly new programs) should be inmates with at least a modicum of a desire to change their behavior through the assistance of a treatment program. Thus, motivation for treatment should be a consideration for prison-based treatment referral and admission.
- ***Enhance motivation.*** A number of studies have demonstrated the importance of the early phases of treatment as they relate to client motivation for change and willingness to engage in the treatment process. In community-based treatment, increasing the number of individual counseling sessions during the first month of treatment has been shown to significantly improve client retention (De Leon, 1991). Given the higher proportions of involuntary clients in correctional treatment programs, the initial phase of treatment should emphasize problem recognition and willingness to change before introducing the tools to do so. Both Walden House and Phoenix House have established Induction Units for this purpose.
- ***Offer incentives.*** Overcoming inmates' reasons for not entering treatment probably requires that programs not only remove disincentives, but also incorporate incentives that would be meaningful inducements for their target population. Coercion alone is not sufficient to promote engagement in treatment. In Gendreau's (1996) review of effective correctional

programs, positive reinforcers outnumbered punishers by at least four to one. Possible incentives for treatment participation could include improved living quarters and enhanced vocational or employment opportunities. The Federal Bureau of Prisons incorporated a number of incentives to increase enrollment in their residential drug programs. These included financial achievement awards contingent on program performance, increased privileges such as preferred living quarters, and the opportunity to earn up to a 1-year reduction in their statutory release dates (Pelissier et al., 2000).

- *Allow for non-sanctioned removal.* Focus groups conducted with SATF-SAP inmates and staff over the past 5 years have revealed that many SATF-SAP inmates who do not wish to participate in treatment must commit a serious infraction in order to be removed. As a result, there is anecdotal evidence that some inmates willingly act out in order to be removed from the program. Alternatively, because infractions can also result in additional prison time, some involuntary SATF participants remain in the program (though disengaged from the treatment process) simply because the consequences of removal are too severe. Providing a mechanism for removing recalcitrant inmates from the SATF-SAP after a 2- or 3-month trial period would likely reduce the levels of disruption to treatment activities.

Mandate aftercare. As we have seen in the present study, aftercare attendance appears to be associated with lower rates of recidivism. Previous studies of prison treatment indicate that low rates of aftercare attendance and/or retention can seriously diminish the impact of prison-based treatment. One solution to this problem would be to conduct a pilot study in which aftercare is mandated for all those who receive substance abuse treatment while in prison. However, if this is not possible, an alternative would be to offer incentives for participation in community-based treatment after release. An example of this would be to offer inmates early release from prison with residential aftercare required as a condition of parole. This condition should also stipulate frequent, random urine testing and close parole supervision. Another possible incentive would be to offer court-ordered classes (e.g., spousal abuse, victim awareness) as part of the aftercare treatment programs. In both cases, however, it should be noted that community supervision functions primarily to hold clients in treatment until intrinsic motivational and engagement factors can be sufficiently addressed in the community treatment program.

The analyses conducted as part of the 12-month outcome study provide support for three additional recommendations:

Pay greater attention to alcohol. As described in Section III F, alcohol was the most commonly cited problem substance at the time of the baseline and the 12-month follow-up interviews; it was also by far the most commonly reported substance to be used first following release from the SATF. In light of recent evidence that nearly 40% of state prisoners were under the influence of alcohol during their most recent offense (Martin, 2001), the rather vague restrictions concerning alcohol use while on parole (i.e., “not in excess”) may need to be revisited. In addition, both in-prison and community-based programs should give alcohol at least as much attention as illicit drugs in their treatment protocols.

Compare SATF-SAP outcomes across yearly cohorts. Because the SATF-SAP has continued to develop since we selected the subjects for the initial outcome study (June 1999-June 2000), and because the programs have received greater support from the prison administration, it is possible that those receiving treatment at the SATF-SAP in later years may show improved

outcomes. To examine this, matched cohorts from 1998, 2001, 2002, and 2003 should be identified and compared with regard to recidivism rates and survival curves. This proposed analysis is currently under review by OSAP officials.

Base policy decisions on evaluation of the full CDC treatment initiative. Over the past decade, the number of prison-based TC programs grew from three programs totaling 500 beds in 1996 to 32 programs totaling 7,650 beds in 2002. UCLA-ISAP is conducting process and/or outcome evaluations at 17 of these programs. Because these programs vary in size, the population served, and the organization providing the treatment services, we believe that broad policy decisions regarding these programs should be postponed until the evaluation results for the entire CDC treatment initiative are available (est. June 2004).

In summary, results of UCLA-ISAP's five-year evaluation of the SATF-SAP suggest that there were some benefits of treatment with regard to inmates' in-prison behaviors (e.g., reduced levels of infractions, lower rates of drug use, and lower levels of absenteeism among correctional staff; see Prendergast et al., 2001), which may have led to some cost savings in prison management. However, our evaluation did not reveal any significant differences in recidivism between the SATF-SAP participants and the matched comparison group from Avenal State Prison. Plans to conduct further analyses to determine actual in-prison cost savings, as well as a recidivism study of subsequent SATF-SAP release cohorts, are currently under review by OSAP officials.

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Appendices

- A. Rates of Disciplinaries Filed by Quarter
- B. Percentages of SATF-SAP Parolees Receiving a Continuing Care Referral
- C. Rates of Inmate Appeals Filed by Quarter
- D. Changes in Self-Reported Substance Use
- E. Cost Analysis for SATF Treatment Providers

**Appendix A:
Rates of Disciplinary Filed by Quarter**

**Appendix B:
Percentages of SATF-SAP Parolees Receiving a Continuing Care Referral**

**Appendix C:
Rates of Inmate Appeals Filed by Quarter**

**Appendix D:
Changes in Self-Reported Substance Use**

**Appendix E:
Cost Analysis of SATF Treatment Providers**