Evaluation of Intensive Substance Abuse Treatment in Local Jails

Report to the Committee Studying Treatment Options for Offenders with Mental Illness or Substance Abuse Disorders (SJR 97/HJR 142, 2002)

November 25, 2002

Written public comments may be submitted to Nancy Roberts by December 20, 2002, at the following address: Division of Legislative Services, General Assembly Building, 910 Capitol Street, Richmond, Virginia, 23219 (e-mail nroberts@leg.state.va.us or fax 804-371-0169). If you have questions, please call Nancy Roberts at (804) 786-3591.

An Evaluation of Therapeutic Communities in Local Jails

Report of the Department of Mental Health, Mental Retardation and Substance Abuse Services

Item 329O. of the 2002 Appropriation Act

James M. Reinhard, M.D., Commissioner

September 30, 2002

Acknowledgments

Many thanks to the staff at the Virginia Beach Community Services Board "Phases" program, and the Fairfax-Fall Church Community Services Board "True Freedom" program for their time in assisting us with this study, and for the difficult and excellent work they are doing every day. Thanks are also due to the inmates participating in these programs who generously shared their time, thoughts and feelings with us. We also wish to extend appreciation to Sheriff Paul J. Lanteigne of Virginia Beach, and Sheriff Stan G. Barry of Fairfax County, and their staffs, for their assistance with this study.

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Study Language

Item 329 O. of the 2002 Appropriation Act requires the Department of Mental Health, Mental Retardation and Substance Abuse Services to "conduct an evaluation of therapeutic communities in local jails" and report the results to the Chairmen of the House Appropriations and Senate Finance Committees.

Goal

The goal of the Department's evaluation is to provide the members of the Committee with information about the status of jail-based therapeutic communities in Virginia jails by (1) conducting brief visits of two currently operating jail-based therapeutic communities (TCs) to collect qualitative information and provide a context for further study, and (2) designing an evaluation study that would be based on objective outcome data.

Context for the Study

In 1995, the Commonwealth of Virginia received grant funding from the U.S. Department of Justice to expand the availability of substance abuse therapeutic community programs in prisons. Because the Commonwealth had already established one of the largest prison based therapeutic communities in the world (Indian Creek), the Commonwealth was allowed to use these funds to establish pilot substance abuse treatment programs in six local jails. These grant funds, allocated to the Department of Mental Health, Mental Retardation and Substance Abuse Services, and administered by the Department of Criminal Justice Services, terminated in 2000. A thorough evaluation of these programs has been documented by Taxman and Bouffard (Residential Substance Abuse Treatment (RSAT) in Jail: Comparison of Six Sites in Virginia, May 2000.) In 2000, at the conclusion of the pilot phase, the General Assembly allocated special funds (Intensified Drug Enforcement Jurisdictions Assistance Fund - IDEA) for the original six programs. However, IDEA funding for these programs ($700,000) was eliminated in the SFY 2003 budget. The Department was able to allocate federal funds from the Substance Abuse Prevention and Treatment Block Grant to maintain three of the six programs and maintain reduced services at the remaining programs.

To respond to this study mandate, staff at the Department of Mental Health, Mental Retardation and Substance Abuse Services selected two of the remaining programs for review. One of these programs represents a "pure" replication of the jail-based therapeutic community model. The other program was selected because it provides services to a hard to serve population -- those with co-occurring mental health and substance abuse disorders.

Methods

As indicated by the goal statement, completion of this study involves two complementary methods. The first method involves collecting qualitative evaluative information at identified sites to develop a context for a second study that will use quantitative, more objective approaches to measure the outcomes of treatment in these programs. This approach provides a method of collecting information about the structure and process of the treatment program, as well as information about the perceptions of the participants. In addition, this information is useful in developing the second part of the study.

The next phase will identify objective indicators of positive treatment outcomes, based on review of scientific research literature, and the establishment of the technical means and administrative processes to collect this information about inmates who have participated in the program. This method will use objective data from several sources and will measure the impact of treatment on participants at a specific point in time after release from custody.

To begin the study, staff at Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services identified two jail-based substance abuse treatment programs that had originally been funded by the RSAT funds, contacted the community-services board (CSB) staff responsible for providing treatment and requested permission to include them in this study. After reviewing both the national literature and state-based literature, and talking with key informants at the state level, staff developed a structured interview format designed to stimulate discussion with persons in critical roles at the local level, principally (1) inmates participating in the program; (2) CSB staff providing clinical services in the program; and (3) key members of the sheriff's department who interact with the program. CSB staff served as the conduit and "hosts" for the visit. The content of the structured interview was shared with CSB staff prior to the visit to assist them in the selection of participants for Department staff to interview. In some cases, either because of time limitations of the visits and personal interest on the part of the subject, copies of the interview questions were circulated to collect written responses. This report relies heavily on input from the inmates and clinical staffs for content. The information gathered from the respective sheriffs' staffs was useful in helping the researchers understand the context in which the treatment programs operate. Summaries of the interviews are not included in this report because this study focuses on clinical issues. They are available from the Department on request.

During these site visits, DMHMRSAS staff also began the process of identifying likely data sources and administrative relationships and processes for collecting objective information about the impact of the program on the inmates over time. A plan for collecting this information is included in the last section of the report.

All who participated in interviews were told that DMHMRSAS staff were conducting a study at the request of the General Assembly to determine whether or not the TC model of jail-based services was effective. Although no one asked for or was offered anonymity, all who spoke were very candid, and the identities of the specific

inmates who spoke with interviewers are protected by federal and state statute because they are considered "patients." In the interest of protecting the candor of staff, this report does not identify them by name.

Budget reductions in FY 2003 resulted in closure of three TC programs, although all CSBs are maintaining some level of substance abuse treatment services in jails. Department staff selected the Virginia Beach CSB jail-based TC as the major facility for this study because it is well established and provides services to a pool of inmates large enough to provide useful data. The other program selected for inclusion in the study is that operated by the Fairfax-Falls Church CSB. This jail-based program was selected because of its unique focus on providing substance abuse treatment services using a TC framework to inmates who have been diagnosed with a serious mental illness in addition to a substance abuse disorder. While visiting the Fairfax County Jail, Department staff learned that a program for persons with only substance abuse disorders has continued to operate in the jail, as well. In addition, the Middle Peninsula-Northern Neck CSB continues to operate a jail-based therapeutic community. The Department may include information from these sites, as well, in its quantitative study of jail-based TCs, and will share the results with the members of the General Assembly.

Overview of Virginia Beach Jail-Based Therapeutic Community

Two DMHMRSAS staff visited the Virginia Beach CSB program on July 29, 2002. The program provides services to about 60 men annually. Most spend between four and seven months working their way through the four program levels. The jail-based portion of the visit was with a group meeting of men in the unit of the program that includes inmates who are both new program participants and those who are finishing the program. Department staff also interviewed staff from the Virginia Beach Community Services Board who are directly involved in providing services in the Therapeutic Community program at the jail. Finally, Department staff visited a group comprised of individuals who had successfully participated in the jail-based therapeutic community and were now residing in the community. The following discussion summarizes the findings resulting from this visit.

Program Structure

Admission to the program is both voluntary and by court order on a first come, first serve basis. Capacity is restrained by the limit of 48 physical beds (3 sections with X 16 beds per block), although occasionally, when the overall population of the jail is very crowded, inmates are admitted to the program before an actual "bed" is available. The inmate then sleeps on a mattress on the floor, mirroring conditions in the rest of the jail. There is usually a waiting list of about 3 weeks. Interested inmates contact CSB jail staff through the same system they use to express interest in General Equivalency Diploma (GED) or religious groups. Once CSB staff interview an inmate and determine that the inmate is appropriate for the program, the CSB staff places the inmate's name on a list for the jail staff to move the inmate to the cellblock for the first phase, on a space available basis. Once the inmate is actually in the program, staff conduct objective

assessments of readiness for treatment, using the University of Rhode Island Change Assessment (URICA), and clinical issues, using the Addiction Severity Index (ASI). A treatment plan is developed using the information from these assessments.

The Virginia Beach CSB Jail-Based TC consists of four phases: Phase I is an orientation; Phases II and III are "treatment" phases; Phase IV is for men who have successfully completed treatment and are either awaiting transfer to the state Department of Corrections or some other entity, or who will soon be released back to the community. Counselors are assigned to a specific pod, and are generally present from 8:30 a.m. –5:00 p.m., with a break for lunch, five days a week. In the evenings and on weekends, the inmate participants run the therapeutic aspects of program. The CSB maintains offices for the counselors in a nearby building that is off the government complex site. The same CSB staff who provide services to the jail program also conduct weekly group sessions with graduates of the jail-based TC who are residing in the community.

Men in Phases I and IV live together as a community on a daily basis, an arrangement that allows for more experienced (and successful) members of the TC to mentor new members. Phases II and III each are assigned their own distinct "pods." Within the context of the jail environment, inmates earn certain privileges (and responsibilities) as they are promoted from phase to phase. Privileges might include "time off" from the program, being allowed to take off the orange jump suit (worn over street clothes) in group, extra television time, or a choice in assignments.

The time not spent in group is strictly scheduled and monitored by the inmates in the designated roles. For instance, a strict television schedule permits increased recreational viewing as an inmate progresses through phases, but watching local and national news is required at every level. Staff are available for one-to-one counseling as needed, but the lack of access to any private space (e.g., having to conduct the entire program within the confines of the cellblock) limits the frequency and utility of these services. In addition, the TC model is a group focused model that is effective primarily because of the emphasis it places on learning to be a part of a community by learning to trust other community members. Inmates have access to ancillary services through the jail staff.

The backbone of the therapeutic community is the hierarchy of roles assigned to the residents, or in the case of jail-based programs, inmates. These roles are designed to provide concrete opportunities, closely monitored by staff, for inmates to learn and practice the skills (and attitudes) necessary for successful participation in any community. They also help to relieve the staff of some of the practical tasks necessary for this type of treatment to be effective so that they can focus on the clinical and therapeutic issues that brought the inmates to the jail and spurred them to participate in the TC. It is important to note that the structure imposed by participation in the TC is much more regimented than that of the rest of the jail facility. Inmate participants support the concept of community inherent in the TC model when the staff are not present (evenings and weekends). There are eight principal roles for each jail-block operating in the TC:

Coordinator – reports directly to the staff responsible for the particular "pod" housing the phase group and provides management of the cellblock, reporting critical issues to staff and leading the community by identifying community issues and concerns and documenting them in a daily log.

Expeditor - reports to the Coordinator; responsible for maintaining the daily schedule (established by staff) with a minimum of confusion. Examples include announcing the start of a group session ten minutes and again five minutes before starting, keeping track of the time during the session, and notifying members when the session has only five minutes left. Also keeps a log of "bookings" (infractions of TC rules), including the nature of the booking and the consequence, tracks deadlines for consequences and schedules the "booked" inmate with the Facilitator. The logbook is reviewed weekly by staff.

Facilitator - Also reports to the Coordinator; responsible for leading all groups, with limited exceptions. (Staff provide clinical services as a part of two of these daily (Monday through Friday) groups.

Secretary – maintains and organizes all books and materials that are the property of the program (as opposed to personal property of a group member); assures that all members have access to appropriate reading material for the program as well as access to the newspaper, when one is available; maintains a logbook (catalog) of materials in the cell block and who has checked them out; forwards logbook to staff for review, upon request.

Orientation Clerk - Reports to the Coordinator and insures that new members are oriented to the program by providing each new member with a "walking partner," a list of program topics and schedule for covering them (syllabus), a list of rules and other helpful material. Also maintains a block status board showing general status in progress, and a logbook reflecting the entries of the status board, which is available for staff review upon request. Meets daily with Coordinator to discuss progress of new members.

Supply Clerk – Reports to the Coordinator and monitors supplies and materials, assuring that supplies and materials are adequate to meet the needs of the members, but not excessive to the extent that it might create a real or perceived security issue.

Creative Energy Honcho - Reports to the Coordinator and maintains posters, games and materials (construction paper, tape, markers) used for block recreation activities that support the therapeutic goals of the program; protects materials from misuse, including personal entertainment unrelated to the program. Also maintains a written inventory and records all games and activities conducted in the block in a logbook, which is made available to staff at their request.

Physical Fitness Leader – Reports to the Coordinator and is responsible for planning, subject to staff approval, and conducting a daily physical exercise program that can be conducted in the block.

Staff assign inmates to particular roles by considering inmate learning and clinical goals and the capacity to successfully address the assigned role as demonstrated in participation in the community and performance in previous roles. The roles are hierarchical and carry with them some level of respect by other inmates in the program. Roles are reassigned periodically, as natural openings occur due to an inmate moving to the next phase of treatment, or as inmate learning needs change.

Program Content

In Virginia Beach, program content is highly dependent on the staff assigned to a particular block. There is not a standard "curriculum" of topics. Theoretical approaches vary from the cognitive-behavioral model currently favored by many professionals treating substance abuse disorders in a variety of treatment settings, to a more structured focus and reliance on the 12 step model utilized by self-help groups such as Alcoholics Anonymous (although the 12 step model was part of every pod). In addition, inmates attend AA meetings every weekday evening. Currently no NA (Narcotics Anonymous) meeting is available because the jail prohibits entry by felons, and many recovering narcotics addicts are convicted felons. Because inmates move from pod to pod as they progress through treatment, they are exposed to every counselor and approach.

Like all TCs, the program is strictly governed by a schedule, but this one is integrated, by necessity, into the daily operating schedule of the jail, including cell inspections. A written schedule designates daily times for community meetings, quiet time, creative energy, therapy groups (two per day), a time to complete reading and written assignments related to group work, presentations, the required television news period, community meetings (which focus on how well the community is functioning, what inmates need to do to improve its functioning) and meetings of self help groups (Alcoholics Anonymous and Narcotics Anonymous). These events occur during the week. During the weekend, when staff are not present, the roles and responsibilities assigned to specific inmates become critical. On weekends Community Meetings occur, coordinators meet with those reporting to them, inmates read and study program materials, Creative Energy activities are conducted, and inmates participate in scheduled organized religious and spiritual activities.

Staff Qualifications

Clinical staff are very carefully selected for this assignment and must qualify with a combination of experience and education. Obviously, they have to be comfortable working in a locked environment in a law enforcement context. In addition, staff must meet certain qualifications established by the Sheriff. For instance, applicants with poor credit ratings are considered poor security risks. All of the counselors interviewed were experienced working in this environment. All clearly demonstrated a sound

understanding of the program model and the clinical issues the inmates present. All demonstrated sound theoretical knowledge of substance abuse treatment.

Interview with Inmates

As previously indicated, DMHMRSAS staff met with 23 male inmates in the orientation phase and the terminal phase of the program. These inmates live together in the same pod with the senior inmates providing "walking partner" function and general mentoring for inmates who have recently joined the TC. The inmates seemed very pleased to have their input included in the study and were characteristically polite while simultaneously forthright in their responses. The schedule allowed a discussion of only about 90 minutes, and the inmates participated enthusiastically. In order to facilitate inmate participation in the discussion, copies of the discussion guide were distributed at the beginning of the meeting. Many recorded their answers, unsolicited, and this information is used to support the impressions of the researchers. The following summarizes the content of the discussion with the inmates, using the discussion guide.

1. How were you selected to participate in the program?

The overwhelming majority of inmates self-referred into the program. A few had requested assistance from the sentencing judge who had court-ordered participation.

2. How long have you been in the program?

Members of this group were either members of the orientation phase or were finishing the program. Time of participation ranged from one week to 7 months.

During the discussion, the range was easy to discern. One young adult male was finishing his jail term and the program and was grappling with the difficult life choices he would face upon discharge regarding his marriage, which had not supported his sobriety in the past, coupled with desiring a stronger presence in the life of his young children. The resolute calmness that accompanied his presentation indicated the significant impact of this program on his ability to identify problems that he would have ignored previously. In contrast, a new resident, middle-aged, had been recently incarcerated for the first time because of multiple offenses involving relatively petty crimes; he was having great difficulty acknowledging his responsibility for being in jail.

3. How would you describe this program?

The inmate response to this question clearly indicated the "confrontational" nature of the program, indicating close monitoring of behavior and group participation, congruence between words and behaviors; responses to "pull-ups" (a written record submitted by one inmate to log the inappropriate behavior of another; a common tool used in TCs to encourage members to be aware of each others' behaviors without generating unsupervised conflict); the growing awareness and insight that criminal behavior and drug use are connected; learning methods of addressing problems without

drug or alcohol use that includes learning new ways of thinking about oneself and others; and learning new behavioral responses. Some of the responses were particularly poignant:

- "This program opens your eyes to things forgotten; its people can help me if I am willing to accept (sic)";
- "It is a very good program and prepares me for the outside. I cannot wait for the time I can put it all to use and stay clean";
- "Tough program; really made me think about myself and why I'm here and keep coming back";
- "This program is a (sic) excellent way to learn the tools needed to stay clean on the outside. And it makes you get in touch with your feelings so you realize what you have been doing wrong. And how to deal with them without using".

Inmates also described the process of this particular block (with both "new" and senior members) to include the assignment of a "shadow" (mentor); receiving an overview of the 12 steps of the self-help programs (AA and NA).

4. List three ways this program has helped you.

The responses of the senior inmates to this item revealed the impact of the cognitive-behavioral approach, with a strong emphasis on "how-to":

Look at myself
Look at my behaviors
Look at my thinking
Understand my behavior
Identify risks
See "danger signs" (for relapse)
Take criticism
Appreciate others
Deal with issues that caused me to use
Stay clean
Obey rules and laws
Show feelings to another person so I can get help
Recognize [when] my thinking is distorted
How to look at issues I need to address
Keep priorities straight
Make better decisions
Talk about problems
Ask for help
Stay clean.

5. If you could change one thing about this program, what would it be?

Most responses to this item indicated a desire to increase treatment capacity (size of the program) and increase access to CSB staff for group and individual counseling.

6. If you learned that this program was going to change, what is the one thing that you would say NOT to change?

Inmate responses to this question clearly underscored the importance of daily interaction with the CSB staff for counseling. Having the program provided to them while in jail was also very important. Other responses addressed the inclusion of the 12-Step self-help principles, and keeping the program open to those seeking treatment voluntarily.

7. Where will you go and what will you do when you leave here?

Responses to this question reflected hopefulness and optimism focusing on "staying clean" and living a legitimate lifestyle. Members mentioned returning to live with family, living in a supportive environment (such as a halfway house) and engaging in treatment, working, and participating in self-help groups.

Interview with Transition Clients

DMHMRSAS staff also met with the weekly Transition Group, consisting of eight men, facilitated by CSB staff to provide support to people who had participated in the jail-based TC and who are now living in the community. Using an adapted version of the same discussion guide, these individuals responded as follows:

1. How is this particular phase (aftercare) of the program helping you?

Responses clearly indicated that the former inmates consider the support received through this part of the program to be crucial in helping them maintain sobriety.

Other responses reference:

- the structure and security offered by continuing to meet with a counselor already known from the jail-based TC
- underscoring the sense of community instilled in the TC expressed by "looking out for each other",
- "keeping it (the learning from the TC) fresh"
- the comfort of knowing that "everybody's going through the same 'stuff'"
- "helping me keep my priorities straight."

2. How would you describe this phase of the program?

This question solicited additional information about how this phase is helpful: "Helps me work my recovery program so that the message doesn't leave [me]"; "helps me analyze what I learned and get acclimated";

3. List three ways this program has helped you.

As in the jail-based part of the program, responses to this question clearly indicated the impact of the cognitive-behavioral approach:

"I learned tools to help me stay sober; I got perspective on errors in thinking and learned how other people thought about me"

"I couldn't have done this on blind faith. I learned about 'high' thinking (e.g., thinking as an addict thinks) and how to change it. I learned how to deal with adversity -- what I was doing wrong, why I was doing it and how to fix it, but I needed knowledge to do this."

" It (the program) retrained my thinking without 'medicating' myself."

"The program gave me knowledge -- showed me a way to live; I learned I can't do this (stay sober) by myself -- I need support to keep my thinking on track; I learned how to ask for help from my AA sponsor while I was in jail."

"I learned self-control, and not to prejudge others, to really listen to them."

4. If you learned that this program was going to change, what is the one thing that you would say NOT to change?

Again, just as in the jail-based portion of the program, the importance of daily contact with the counselors was judged as critical to the program's success. Learning and understanding the 12 Steps (principles of AA and NA) was also cited as a key component. Other individuals cited the fact that the program is in jail, adding to its intensity, as a key component. Finally, the program structure focusing so much time on group treatment was listed as a key positive feature.

Summary of Virginia Beach Program

1. This program is very faithful to the therapeutic community model: participants live and work together, serving to increase the intensity of the treatment; hierarchical roles are assigned to participants to assist in the process of learning responsibility to the larger community and to address specific behavioral and clinical issues; these roles support the functioning of the community so that the staff are able to focus on clinical issues and strategies; the treatment is "phased" in levels; participants play an active role in addressing each other's clinical issues.

2. The program capacity is limited not only by physical space, but also by availability of resources to support staff. Several inmates commented that they appreciated the small

size of the groups, believing that this enhanced the feeling of trust and community building and facilitated their willingness to "open up" in groups and to each other. The resulting openness supported the accountability that is a keystone to successful therapeutic community treatment in any setting.

3. Other than the model of the therapeutic community, there is no official curriculum or therapeutic approach. However, several therapists are knowledgeable and skilled at using the cognitive-behavioral approach, and the effects of this are apparent in the inmate's discussion of the program and its impact on them.

4. The program has a strong aftercare component that plays a valuable role in supporting the individuals once they return to the community.

Overview of the Fairfax County (Fairfax-Falls Church CSB) Jail-Based Dual Diagnosis Program

The same two DMHMRSAS staff visited the Fairfax County Jail on August 8, 2002 to collect information about its program for dually-diagnosed (substance abuse disorder and serious mental illness) inmates. This very small program provides jail-based services as many as a dozen men, all of whom live together on the same group of cellblocks. Although this program does not utilize all of the concepts of the therapeutic community, it is included because it addresses the treatment needs of a very difficult population in a jail-based setting, and does utilize principles of residential services.

Treatment principles associated with the therapeutic community are generally considered to be inappropriate for this population. The program structure inherent in the therapeutic community requires a high level of interpersonal interaction that is thought to be too stringent for persons with serious mental illness. The symptoms of many types of serious mental illness, including visual, tactile or auditory hallucinations, extreme mood swings, feeling disassociated from one's body, can be ameliorated with medication, but they are not completely eliminated. This program certainly requires appropriate interpersonal interaction, but the type of highly interactive (even confrontational) interactions that would occur in a typical therapeutic community for persons with severe addictive disorders, would not be helpful, and, in fact, could be destructive for these more fragile individuals. The programmatic content of this program, however, is highly defined. Also based on cognitive-behavioral therapy, this program uses an established curriculum and accompanying workbook to support the therapeutic work with the inmates who participate in the program. Other than a coordinator, appointed by staff, there are no hierarchical participant roles in this program.

Program Structure and Content

Admission to the program is voluntary and is a collaborative process involving assessment of eligibility and approval for admission by True Freedom staff and the Inmate Classification Section operated by the Fairfax County Jail Sheriff's Department.

Individuals request, are referred, or are court ordered for treatment. When there is room in the group of cellblocks assigned to the program, the inmate is transferred. Only four inmates share a cellblock in this program, due to the nature of the mental illnesses they are experiencing. The Fairfax-Falls Church Community Services Board, which also operates several other programs in the jail facility, operates this program, True Freedom. Staff have offices in the jail building, and the jail facility has designated space for groups, so inmates are able to leave the cellblock to participate in the program.

The program is divided into five phases and lasts about 25 weeks. In the first phase the inmate is integrated into the group process and the specific treatment needs are identified. The main focus is on clinical assessment, including the Addiction Severity Index and a self-assessment of mental health symptoms. In addition, the inmate is required to describe himself, focusing on values, beliefs, long and short-term goals, and other characteristics, without reference to mental illness or addiction. Phase Two focuses on development of the treatment plan, with additional structured exercises to provide the individual and clinician with information about the inmate's history. The information gathering process provides additional insight into the nature of the co-occurring disorders and invaluable clinical information in formulating accurate diagnoses. In addition, an introduction to the Twelve Steps is provided with the initiation of the First Step ("recognizing that your life has become unmanageable and that you need help") of traditional self-help programs. Phase Three explores the impact of the inmates co-occurring disorders on the individual and others. Another symptom inventory is administered to monitor stability and assess any changes. Additional structured exercises are initiated to assist the inmate in focusing on core issues and specifics of personal history, clinical issues, and cause-and-effect" relationships. Inmates begin to establish intermediate and long-term goals. The fourth phase requires the development of Emergency High Risk and Relapse Prevention Plans with additional structured exercises to help the inmate identify issues in his social and family system, identify relapse issues, and provide opportunities for skill building in goal setting. The final phase repeats the symptom inventory and self-assessment of values, beliefs, goals and other personal characteristics. The focus of this phase involves planning for integration into society and the transition into a community-based recovery focused support system. In addition, the inmates complete a Satisfaction Survey and Program Critique, which becomes and invaluable tool for program evaluation and improvement.

In addition to the assignments described above, the program relies heavily on daily groups that focus on assigned topics for discussion. These topics provide an opportunity for the inmate to learn objectively about aspects of recovery from mental illness and addiction by addressing a significant variety of topics, including:

- Fundamentals of mental illness and addiction (8 weeks)
- Personal identity issues (2 weeks)
- Recognizing and managing emotions, including anger (3 weeks)
- Communicating effectively (2 weeks)
- Relationships, including family, social, impact of addiction, parenting, domestic violence, forgiveness, rebuilding (5 weeks)

- Relapse prevention for addiction and mental illness (5 weeks)

  Groups meet daily, and a medication group with a psychiatrist is conducted monthly to provide the inmates an opportunity to learn about the medications they are taking to address the symptoms of their mental disorders.

  Inmates are given a workbook upon acceptance into the program with detailed information about the program structure, schedule, topics, homework assignments, and expectations. Each inmate actively participates in the development of his own detailed treatment plan.

Staff Qualifications

There are three clinical staff providing most of the clinical support to this program. Both have extensive experience working with persons who have both mental illness and substance abuse disorders. Both have master's level training. At the time of this interview they had been working in the jail setting for 3 months. They are jointly supervised by the community services board's Alcohol and Drug Services and Forensic Unit.

Interview with Inmates

All the inmates had referred themselves to the program. Length of stay ranged from 1 week to 6.5 months.

1. List three ways the program has helped you.

DMHMRSAS staff were extremely impressed with how articulately the inmates discussed their mental illnesses in conjunction with their addictive disorders. The information was highly reflective of the cognitive behavioral approach. Inmates were very specific about treatment goals. Those nearing release to the community had clear and realistic goals for maintaining recovery from mental illness and addiction. Almost to a person, the inmates expressed newly found knowledge about the importance of continuing to take medication (lack of medication compliance is the major reason for recurring symptoms of mental illness) and maintaining sobriety, as well as insight about how the two disorders interact and must be carefully managed. For some inmates, participation in the True Freedom program was the first time they had ever successfully managed the symptoms of their mental illness, much less their addiction. Other answers include:

- medication information and compliance,
- education about that inmate's specific type of mental illness
- the interaction between addiction and mental illness
- helped stabilize the inmate's mental illness
- reduced shame about mental illness
- helped integrate "12 Steps" of AA/NA with mental illness recovery

- provided tools to cope with mental illness
- improved compliance with medication for mental illness
- helped set long range goals
- helped stop ruminating (and reduced other symptoms of mental illness)
- healthy ways of coping
- listening to others
- improved self-respect -- no need to be ashamed of mental illness

2. If you could change one thing about this program, what would it be?

- More education about mental illness and addiction.

- More one-to-one time with the psychiatrist

- More one-to-one time with the counselors

- More access to VCR tapes for the program

3. If you learned that this program was going to change, what is the one thing that you would say NOT to change?

- Keep the True Freedom (program) block
- Don't make the cell blocks bigger (only four men share a block)
- Don't increase the ratio of staff to inmates

4. Where will you go and what will you do when you leave the program?

This question is particularly important for this very vulnerable group. As with discharge from state mental health facilities, appropriate discharge planning and follow-up can make a critical difference with the success of the program. In addition, the researchers were interested in identifying what type of outcomes would be realistic for this group in the second phase of the study. Those nearing the end of the program who were being released to the community were entering residential programs specifically designed to address either mental illness, addiction or both. One man looked forward to returning to his wife and children and planned to initiate family therapy to help improve his wife's understanding of his mental illness and addiction issues. One man, who would be transferred to the Department of Corrections, had received permission to stay in the program until his transfer occurred.

The researchers were also interested in learning about the inmates' prior experiences with treatment, since treatment programs for co-occurring disorders are relatively rare, even in the community. Generally, this was a first exposure to dual diagnosis treatment. Several had experienced previous treatment for mental illness in either outpatient settings or at state mental health facilities.

Summary of Fairfax County Program

This program provides services to men and women with both serious mental illness and addiction disorders, and is specifically tailored to meet their needs. The program is very dependent on the clinical staff for day-to-day operation and uses a curriculum format based on principles cognitive-behavioral therapy to help the inmates learn about mental illness and addiction, and a variety of related topics and skills designed to improve stability and sobriety. The inmates were very open about their mental illness diagnoses and the medications they use to control symptoms. All of the inmates who were eligible to be released back to the community in the near future had specific plans about developing and utilizing appropriate treatment and support.

Evaluation of Outcomes for SA Consumers treated in Jail Based Therapeutic Communities

In order to provide a quantitative assessment of the impact of the selected jail-based substance abuse programs, information about inmates who participated in the study and who have been released to the community will need to be collected an analyzed. The following plan presents a description of the specific questions that are helpful in determining treatment effectiveness and a process for collecting and analyzing that information.

The following questions will be answered by the study:

1. What percent of clients reduced their frequency of use of a primary or secondary drug from intake to follow-up?
2. What percent of consumers report being employed?
3. What percent of consumers report wages post discharge?
4. What percent of consumers commit a crime again?
5. What percent of consumers report a decrease in arrests?
6. What is the cost of providing SA treatment in the jails?
7. What cost savings are realized as a result of SA treatment being provided in jails?

Time-line

Data Collection	6 months
Analysis & Report Writing	6 months

This evaluation will use existing data, so that no additional data collection effort will be necessary for this study. Demographic data is collected on all consumers at both programs, and most of the data is stored electronically either at the jail or the CSB. Whenever possible, an attempt will be made to retrieve data electronically. In the case that data cannot be retrieved electronically, a researcher will visit the CSBs and input all the required data elements from the case files into a structured database that will be used for outcome evaluation purposes. The data provided by the programs will be used to link records with already existing data from the following other state agencies:

1) Department of Motor Vehicles (DMV)- This will help answer questions 5 and 6.
2) Virginia Employment Commission (VEC)- This will help answer questions 2 and 3.
3) Virginia Department of Health (VDH) – Death records will be used to account for some of the inmates that cannot be located.
4) State Compensation Board (Local Inmate DS). This data resource will help answer questions 5 and 6.

One other dataset, Virginia Health Information (VHI), which represents information that is collected from all hospitals in Virginia, will be explored for linking and possible information about utilization of other healthcare resources.

For the purposes of an evaluation study, data that can provide information about inmate behaviors after release from jail is essential. Obtaining this information can be accomplished easily through the use of administrative databases. For example, data on employment from Virginia Employment Commission can be used to calculate employment outcomes since release. In addition, the use of secondary administrative data is much less costly than primary data collection.

Because the consumers (inmates) in this situation are in a controlled environment where opportunities for drug use are minimal or limited, calculating an outcome of reduction in drug use is not as useful at discharge as a calculation after the inmate's release would be. Given that one of the primary goals of participation in a TC program is reduction in frequency of use, this data is essential. Information about frequency of use of drugs is not available from any administrative data source. In order to capture this information, follow-up interviews are necessary.

The study will collect data from inmates at six-months and one-year interval after their release into the community, using telephone interviews. Collecting follow-up data on substance abuse consumers is the most challenging part of any study. At best this process yields a follow-up rate of 50%, given experience with other similar studies. Using these two methods (administrative datasets and follow-up interviews) will provide follow-up data on almost 70% of the consumers. There may still be a few consumers that cannot be located in the state datasets or contacted for follow-up because they have left the state, or are not in any of the datasets, or they are serving a longer sentence than the time period for this study allows.

The following elements will be in the database:

1. First two letters of the first name
2. First two letter of the last name
3. SSN
4. Date of birth
5. Gender
6. Race
7. Ethnicity
8. Education

9. Diagnosis
10. Referral Source
11. Legal Status
12. Crime that resulted in incarceration
14. Date of admission to the jail
15. Date of admission to the program
16. Date of program completion*
17. Discharge Status*
18. Living Arrangement*
19. Residential Status*
20. Employment Status*
21. Income*
22. Number of days of paid work*
23. Number of arrests in the last 6 months*
24. Primary Drug Type
25. Secondary Drug Type
26. Frequency of Use of Primary Drug*
27. Frequency of Use of Secondary Drug*
28. ASI Composite score evaluation if available*

Budget

Therapeutic Community Evaluation Study

Personnel	Job Title	Effort	Annual Cost	Funds
Current staff	Evaluation Manager	0.25	20,840	20,840
Current staff	Manager	0.10	7,680	7,680
To be hired	Consultant	1 month	8,000	8,000
To be hired	Research Assistant	6 months	15,000	15,000
Supplies				
General Supplies				500
Contractual				
Follow-up interviews				20,000
Cost of getting administrative data				5,000
TOTAL DIRECT COSTS				**77,020**

* These elements will be collected at discharge and then at 6-month and one-year follow-up intervals.