Program Evaluation of the Therapeutic Community in a Correctional Setting

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Abstract

Criminal and anti-social behaviors are often intertwined with trauma and chronic substance abuse. Exposure to traumatic experiences is disproportionately present and has the most significant impact on individuals and communities burdened by poverty, violence, social isolation, racism, and exposure to criminal justice systems. The use of criminal sanctions and retributive measures by the criminal justice system without rehabilitation or treatment are the least effective means of reducing future criminal behaviors. Retributive (Punishment) justice and Restorative (Recovery) justice are two models used within the criminal justice system. Restorative justice focuses on offenders taking responsibility and acceptance for their actions to promote rebuilding their morale and social selves. Organizations that use a rehabilitation model often have a separate program and housing unit for inmates and this is called the therapeutic community (TC). In rehabilitation, the therapeutic community is a standard of care across the United States.

Purpose: This scholarly project was to conduct a TC program evaluation with a focus on opportunities to integrate trauma-related and substance abuse issues. The TC program at Albemarle Charlottesville Regional Jail (ACRJ) was implemented in 2000 and paused in March 2020 due to the COVID-19 pandemic. As part of the Post-COVID-19 restart, the TC program is preparing to integrate Medication Assisted Treatment (MAT) for substance abuse recovery. A program evaluation of the TC program was needed before implementing major program changes related to supports for inmates with substance use disorders and trauma-based behaviors.

Methods: Agency Clinical Innovation (ACI) framework was used to examine the worth of the program in terms of effectiveness, efficacy, and appropriateness. An eight-step summative

approach was used to complete a program evaluation of policies, program elements, and the TC environment in the correctional setting.

Results: The major strength of the TC program is a well-established evidenced-based program of cognitive, behavioral, and milieu interventions that are foundational for effective trauma informed and substance abuse recovery interventions. The major limitation was a lack of integrated medication assisted therapy for substance abuse and withdrawal. There are three major recommendations for integration into planned TC program revisions. First, implement a tiered approach that supports early assessment and integration of TC skills for all inmates. Second, integrate evidenced-based medication assisted treatment into the TC for inmates with acute substance abuse treatment needs. Third, implement a tri-annual program evaluation to assess the effectiveness of TC, MAT, and trauma informed approaches to support program effectiveness and efficiency.

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Introduction

In the United States of America, diagnosed and untreated trauma is both a health and social epidemic. Consequently, criminal behaviors are often intertwined with substance abuse and trauma (*U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and QUALITY.*, 2018). The health care community increasingly recognizes that trauma is associated with long-term negative consequences as a serious public health crisis (Menschner & Maul, 2016). Trauma is related to multiple causes and is often created when an inmate is both directly and /or indirectly exposed to an event or experience that involves a real or perceived threat to physical, emotional, and psychological safety. Consequently, trauma is also linked to mental health issues like depression, suicidal tendencies, chronic anxiety, hostility, and impaired ability to relate to others socially. Although, trauma can be seen across all income and demographic groups; imprisoned inmates are mostly young, poor, and have substance abuse problems. Many of these inmates are greatly marginalized and have histories of child abuse. Rates of exposure to trauma are elevated among people with justice involvement and within the correctional system (Chaudhri et al., 2019). The effects of traumatic events place a heavy burden on individuals, families and communities and creates challenges for public institutions and service systems (SAMSHA, 2014).

In most Western Societies, the criminal justice system primarily deals with criminal offenses and punishment. Once a punishment is imposed, justice is considered accomplished. Alternative models for inmates put forward are now commonly referred to as restorative justice (Wenzel, 2008). Restorative justice is in the process of deliberation that places significance on

healing rather than punishing; healing the inmate or offender by rebuilding their moral and social fabric in return heals the community and mends social relationships Wenzel, 2008). Jails and prisons can be peer support environments that help interrupt the cycle of criminal activities.

In recent years, the term "trauma-informed care" (TIC) has been used to describe techniques in which providers in various settings (i.e., social service, education, healthcare, and corrections) can better serve people who have experienced traumatic events (Raja et al., 2015). Trauma-informed care acknowledges the need to understand a patient's life experiences to provide care that is patient-centered, effective, and has the potential to facilitate or improve patient engagement, treatment adherence, and health outcomes (Menschner & Maul, 2016). Trauma-informed care is significant because it takes the whole inmate into account. Also, the framework of trauma-informed care incorporates the reality of how widespread trauma has become, knowledge about different types of traumas, and how trauma can manifest (Greene, 2018).

The terms used for someone incarcerated in a jail or prison are inmate, prisoner, felon, or offender. In the correctional setting, individuals involved with mental health services are not addicts, patients, healthcare consumers, or a client. Inmate, felon, and offender are terms used to define a human being by their involvement with the criminal justice system. This is a social and moral dilemma. Terms like inmates remove humanity and place a greater burden on poor and disenfranchised people. In this context, the person is called an inmate because that is the term used to describe incarcerated individuals at Albemarle-Charlottesville Regional Jail.

In the correctional system, delivery of effective drug treatment and trauma-informed care can be more challenging than in any other setting. Even though incarceration has been recognized as the most optimal time to implement treatment; jails unlike prisons often have rapid

turnover and on average shorter stays. This fact can have a significant impact on treatment options for incarcerated inmates in jails. Additional barriers to effective treatment were negative views of treatment from the staff, security concerns, potential for diversion, institutional philosophy (i.e., belief in abstinence-based treatment), and availability of resources (Belenko et al., 2013).

The correctional environment has additional challenges. Most correctional environments have overcrowded housing units, lights that are on all night, loudspeakers that blare without warning, and privacy that is severely limited. Security staff often must complete tasks that are unavoidable triggers, such as pat-downs, strip searches, frequent disciplinary actions, and restricted movement. These daily tasks previously mentioned are most likely to increase trauma-related behaviors and symptoms that can be difficult for the security staff to manage. To incorporate trauma-recovery principles into the correctional environment requires a clear understanding of criminal justice priorities. Criminal sanctions and authoritative and punitive measures without treatment are the least effective means of reducing future criminal behavior (Miller & Najavits, 2012).

In the United States, the use of pharmacotherapy for opioid addiction dates to the early 20th century (Schwartz et al., 2018). In 1912, the first morphine clinic was opened in Jacksonville, Florida. Afterwards, morphine clinics continued to be established in numerous cities across the country and nearly all were operated by the local health departments. There was one exception with the morphine clinic in New Haven, Connecticut that was run under the guidance of the Police Department from 1918 to 1920. Efforts to eliminate opioid addiction were later discontinued due to stringent enforcement of regulations written by the Treasury Department in support of the Harrison Narcotics Act of 1914 and a ruling by the Supreme Court

in 1919. Essentially, the regulations made the use of any opioid medication for ambulatory maintenance treatment for addiction illegal and this included the implementation of a gradual dose reduction of morphine. In 1923, the last morphine clinic was closed in Shreveport, Louisiana. Convictions and incarcerations under the Harrison Narcotics Act mounted, and federal prisons became overcrowded and unruly with the smuggling of illicit drugs into the prisons. The severity of this situation called for intervention; and in 1935, Congress authorized the opening of special prisons in Lexington, Kentucky, and Fort Worth, Texas. Initially, these prisons were termed narcotic farms with the hopes of treating inmates with their addictions to opioids.

In 1993, the World Health Organization recommended the implementation of opiate maintenance treatment in prisons to help reduce the risk of drug injection and related harms such as the spread of blood-borne diseases (de Andrade et al., 2018). In Medication Assisted Therapy (MAT), the participants receive synthetic opioid medication such as methadone, buprenorphine, and naltrexone. These medications are used to help manage the adverse effects of withdrawal from opioids. Besides the use of biological therapy, it is suggested to include psychological treatment as well. Several psychological treatment options have also been adopted or trialed by prison systems, including motivational interviewing (MI), therapeutic communities, and cognitive behavior therapy (CBT). MI counseling approach seeks to increase inmate motivation and readiness for change. Therapeutic communities accommodate inmates receiving treatment in distinct units away from non-participating inmates. CBT programs for inmates are designed to change thinking patterns that foster criminal behavior and drug abuse. Despite the World Health Organization recommendations and evidence of effective outcomes, very few inmates receive drug or alcohol treatment while in jail or prison (de Andrade et al., 2018).

Clinical interventions for inmates need to be congruent with the primary duties of the correctional staff, public safety, inmate safety in custody, rehabilitation staff, and institutional security. The introduction to trauma-informed principles could play a major role in minimizing triggers, stabilizing offenders, reducing critical incidents, deescalating situations, avoiding restraints, or other measures that may repeat aspects of past abuse. Manual-guided, present-focused approaches to trauma such as Seeking Safety (Miller & Najavits, 2012) have been effective with offenders without causing distress or decompensation that requires attention from prison mental health staff. In addition, by addressing trauma in terms of current impact, symptoms, related problems (e.g., substance abuse and alcohol abuse), building psychoeducation, and increasing safe coping skills, trauma-informed care can help effectively address trauma directly without requiring the inmate to explore distressing memories. Trauma-informed care implemented in a correctional environment is a good fit to ensure physical and emotional safety for the correctional population. Collaboration with stakeholders to change organizational practices to fit trauma-informed principles will help to transform the culture of care in the correctional setting. Feelings of safety and acceptance help initiate positive relationships and increase the likelihood of treatment adherence, trust in the judicial system, and collaboration with outside organizations for the continuum of care after release from custody (Chaudhri et al., 2019).

Therapeutic Community (TC) programs for incarcerated persons are designed to address the behavioral health needs of inmates with minimal use of psychiatric or substance dependence medications. The integration of MAT and behavioral interventions in TC programs is needed to reduce the impact of trauma, the risks of acute withdrawal during incarceration, and post-release overdose. The purpose of this evidence-based review of the literature is to answer the question:

In an adult forensic TC population with a history of substance abuse, what is the best evidence for medication-assisted treatment for opioid and alcohol abuse compared to treatment as usual during incarceration?

Literature Review

A systematic literature review of the academic journal articles published in English between January 2010 and April 2021 was conducted to investigate the present research available about sustainable, evidence-base treatments for opioid and alcohol abuse with the use of biological and non-biological care (e.g., medication-assisted treatment and trauma-informed care), relevant literature on behavioral therapies, medication-assisted treatment, and their efficacy in the forensic setting. Four databases were utilized for this searched: PubMed, Web of Science, Cumulative Index of Nursing and Allied Health Literature (CINAHL), and Cochrane Library.

An advance search was conducted in the PubMed database, utilizing English, full text, Randomized Controlled Trails, Systematic Reviews and Adult 19 – 44 years filters. The keyword string used was (*medication assisted treatment opioid OR alcohol treatment) AND (prison OR incarceration)* and this search resulted in 103 articles initially after changing time frame (2010 to 2021 publication date).

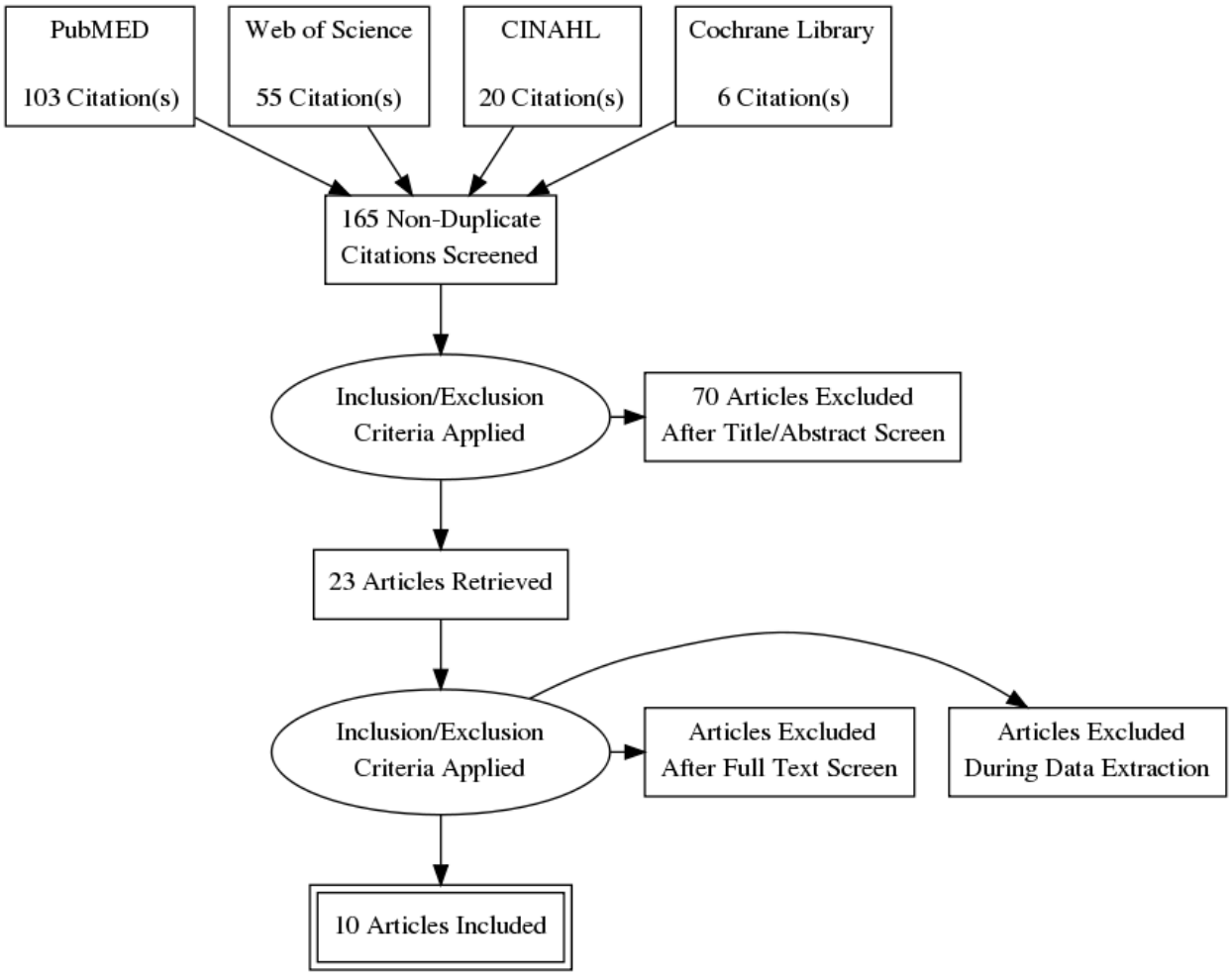
On the Web of Science database, the keyword string *(Medication assisted treatment opioid OR alcohol treatment) AND (prison or incarceration)* was used with a basic topic search. The search resulted in 55 articles initially after narrowing the stated time frame (2010 to 2021 publication date); excluding articles not published in English and refining the search to review articles only.

A stepwise search in CINAHL was performed to investigate the evidenced-based practice question utilizing the Advance Search option. The preset filters were set to edit the results to full text, publication date between January 2010 and April 2021, English and the USA. Medication-assisted *treatment* was searched as a keyword and revealed 262 results. *Opioid abuse treatment* was searched as a keyword to reveal 5 results. *Alcohol abuse treatment* was searched as a keyword along with the MeSH heading option "*Alcoholism"* to reveal 1,996 results. *Jail OR incarceration* was searched as a keyword along with the MeSH heading option "*Correctional Facilities"* to reveal 1,208 results. Searches 1, 2, 3, and 4 were combined with the Boolean operator AND, the fifth search produced 0 results. Searches 2, 3, and 4 were combined with the Boolean operator AND, the sixth search produced 0 results. Searches 1 and 4 were combined with the Boolean operator AND, the seventh search produced 20 results.

A total of 184 articles were collected between the four databases. Zotero bibliography software was utilized to remove duplicates which resulted in a total of 165 articles remaining. Based on a review of the titles and abstracts of the articles, 70 articles were removed due to a lack of relevance to the PICOT question: Anti-social personality disorders / mental health treatment [8]; Tuberculosis/ HIV and Hepatitis [19]; Foreign issues with mental health [5]; Physical health issues [4]; sexual victimization / sexual health [4]; child neglect [1]; arrest/ re-entry [13]; and alcohol and drug abuse only [16]. As a result, 23 articles were retained for analysis. Full-text review completed of retained articles, 10 remained for further analysis. Figure 1 shows the search process, using a Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) flow diagram.

Figure 1

Preferred Reporting items for Systematic Reviews and Meta-Analyses (PRISMA) flow diagram for the integrative process



Literature Review Analysis

The full text of the ten sources retained for analysis was reviewed for the overall level of evidence and emerging themes. The evidence level and quality of the items retained from the search were evaluated using the Johns Hopkins Nursing Evidence-Based Practice Criteria (Dang & Dearholt, 2017). Three randomized controlled trials were reviewed, and all the RCTs yielded level I evidence and high/good (A/B) quality. Two correlations, non-experimental research yield level III evidence, and high/good (A/B) quality. One implementation study yielded level II and

high (A) quality. Five systematic reviews/meta-analyses yield level II &III evidence and high/ good (A/B) quality.

Analysis and Synthesis of Evidence

The highest level of evidence included for analysis was JHNEBP level I, with two studies rating as "A" quality and one rating as "B" good quality. One of the studies evaluated the screening process for risk assessment, and program entry and contribute to the knowledge base for screening intervention referral to treatment (SBIRT) (Prendergast et al., 2017). The other studies evaluated the prison-initiated buprenorphine provided to both male and female inmates with previous heroin dependency and examination of coordination between community correctional agencies and community-based treatment programs (Gordon et al., 2014; Welsh et al., 2015). Five of the studies were systematic reviews, one of the studies reviewed ethical principles in the use of MAT in the correctional settings (Ludwig & Peters, 2014) Two of the studies were literary reviews of treatment efficacy, and one on the delivery of MAT in both prisons and jails (Bright & Martire, 2013; Moore et al., 2019; Schwartz et al., 2018) One study examined the attributes of optimal therapeutic strategies for treating incarcerated women who have a history of substance abuse (Finfgeld-Connett & Johnson, 2011). Two of the studies were correlation studies, an examination for treatment linkages in the criminal justice system, and evaluation of evidence-based best practices and standards of care for pregnant women with opioid use disorder (Belenko et al., 2013; Peeler et al., 2019).

The full-text review identified five themes; 1) The effects of medication-assisted therapy; 2) The effects of non-biological therapy; 3) Screening practices for inmates with substance abuse issues; 4) Transitioning treatment, and 5) Coerced Treatment of Substance abuse (Table 1.)

Table 1

Literature Table

Source	Focus	T1	T2	T3	T4	T5
Belenko, et al. (2013)	Examine treatment linkage points in the criminal justice system	X	X			
Bright & Martire, (2013)	Efficacy of substance abuse treatment					X
Finfgeld-Connett & Johnson, (2011)	Explicate attributes of optimal therapeutic strategies for treating incarcerated women who have a history of substance abuse		X			
Gordon et al., (2014)	Evaluation of prison-initiated buprenorphine provided to male and female inmates in the U.S. previously heroin-dependent prior to incarceration	X			X	
Ludwig & Peters, (2014)	Review of ethical principles to guide the use of MAT in correctional settings	X			X	
Moore, K.E., et al. (2019)	A comprehensive review of the states of the literature on MAT delivered in both prisons and jail settings	X				
Peeler, Fiscella, Terplan, & Surfin, (2019)	Evaluation of evidence-based practice and standards of care for pregnant women with opioid use disorder	X	X			
Prendergast, McCollister, & Warda, U. (2017)	Screening intervention referral to treatment for ETOH and drug abuse.			X		
Schwartz, et al. (2018)	Examine the effectiveness of pharmacotherapy on the reduction of Opioid abuse and criminal activity for adults under community supervision	X			X	
Welsh, et al. (2016)	Examination of coordination between community correctional agencies and community-based treatment programs	X			X	

Themes: T1) The effects of medication-assisted therapy, T2) The effects of non-biological therapy, T3) Screening practices for inmates with substance abuse issues, T4) Transitioning treatment, T5) Coerced Treatment of Substance abuse

The effects of medication-assisted therapy. The first theme was the efficacy of medication-assisted therapy for incarcerated inmates with substance abuse issues. This theme is characterized by any comprehensive treatment plan for substance abuse that includes pharmacologic intervention with a goal of patient recovery with full social function. Moore et al.,

(2019) completed a Meta-Analysis and systematic review of 11 quasi-experimental studies, eight RCTs, and five follow-up studies of these RCTs. They found that rates of opioid abuse in the criminal justice populations are disproportionately elevated compared to the general population. Prisoners in both state and federal correctional facilities report lifetime use of heroin and other opioids. Effective treatment prior to release is critically important for people with opioid use disorder in the criminal justice population. People from this population face an increased risk of death by overdose following release from custody due to loss of tolerance to opioids and the increase in the availability of more potent forms of synthetic opioids (e.g., fentanyl). Correctional facilities that utilize medication-assisted therapy use Methadone as opposed to any other forms of MAT. Existing programs only target populations of inmates who are pregnant or suffer from chronic pain. Consequently, inmates entering the correctional system are often forced to undergo withdrawal from opioids. The initiation of MAT or maintenance of MAT during incarceration may prevent relapse and overdose on opioids post-release and reduce crime and health risk behaviors which are often associated with opioid use disorder.

Pregnant women represent a unique population within correctional facilities. At the end of 2016, nearly 214,000 women were behind bars in the United States, representing more than 30% of the world/s total incarcerated population of women. Women incarcerated in the U.S. have risen by more than 700% between 1980 and 2014 (Peeler et al., 2019). The incarceration of women has increased by more than 50% in contrast to men. Consequently, opioid use by pregnant women has also increased within the general population. In addition, not only are pregnant women effected, but substance use during pregnancy is also associated with higher rates of pregnancy complications including fetal growth restriction, placental abruption, preterm labor, or fetal death (Peeler et al., 2019). Due to this risk, screening for opioid use disorder is of

great importance. Medication-assisted treatment is the evidence-based standard of care in pregnancy; correctional facilities that house women who may have co-occurring opioid use disorder and pregnancy must be prepared to provide MAT. Medication-assisted treatment is typically a long-term process with different interventions that includes support groups, cognitive behavioral therapy, or contingency management, as well as regular monitoring to support an inmate receiving methadone and buprenorphine (Peeler et al., 2019). It is suggested that correctional facilities should invest resources in multifaceted programs for their pregnant patients, as this will have benefits not only for the expectant mothers but also for their newborns (Peeler et al., 2019).

Medication-assisted therapy (MAT) often refers to the core components of treatment for opioid and alcohol abuse; methadone, buprenorphine, and naltrexone (Gordon et al., 2014; Ludwig & Peters, 2014; Moore et al., 2019; Schwartz et al., 2018). One form of Medication-assisted therapy used to treat opioid use disorders is Methadone. Methadone is one of the most widely used forms of MAT, and because it is a full opioid agonist; Methadone effectively reduces opioid abstinence symptoms (e.g., withdrawal and cravings). Also, it reduces abuse of illicit opioids and increases treatment retention. Buprenorphine is another widely used substitution therapy for opioid abuse (Moore et al., 2019; Peeler et al., 2019). Buprenorphine is a partial agonist that is effective in reducing research on naltrexone is minimal, and administration methods have not been approved by the U.S. Food and Drug Administration, naltrexone has been shown to increase treatment retention and reduce abuse of opioids (Moore et al., 2019).

Providing substance use treatment in the correctional setting comes with its challenges, however, there are several empirically supported approaches. Medication-assisted treatment has been identified as one of the most efficacious and well-established interventions in both

detoxification and treatment of substance abuse disorder (Ludwig & Peters, 2014). Despite the effectiveness and support, MAT continues to be underutilized or is unavailable in most U.S. jails or prisons. Instead, utilization of detoxification protocols indicates that correctional policies favor a "drug-free" detoxification and treatment approach (Ludwig & Peters, 2014). "Drug-free" detoxification manages symptoms of withdrawal (e.g., nausea, vomiting, and diarrhea) without the use of opioid-supported treatment. "Drug-free" detoxification and treatment have demonstrated to be less effective than MAT, and in some cases even harmful.

The difference between healthcare standards in the correctional system and detoxification policies is perceived to be a moral and ethical conflict arising from the perception that the use of methadone and buprenorphine is just substituting one addiction for another (Ludwig & Peters, 2014). The medications used in medication-assisted treatments target the neurotransmitters that serve as the physical dependence mechanisms for opioid use disorders; as a result, they diminish withdrawal symptoms and reduce cravings. Also, MAT is an evidence-based practice that refers to the combined use of pharmacotherapies and non-pharmacotherapies (e.g., behavioral therapies) as well as supplementary core services. Medication-assisted treatment, therapeutic communities, contingency management, and motivational interviewing demonstrate efficacy in reducing recidivism, relapse, and risk behaviors (Ludwig & Peters 2014).

The effects of non-biologic treatment. The second theme was non-biological treatment for incarcerated inmates with opioid use disorders. Non-biological treatment is aimed at strengthening coping skills to reduce substance abuse relapse, establish, and enhance trust-based relationships, and promote care that is individualized and just (Finfgeld-Connett & Johnson, 2011). Three articles analyzed the effectiveness of non-biological treatment in correlation with medication-assisted (Belenko et al., 2013; Finfgeld-Connett & Johnson, 2011; Peeler et al.,

2019). There are models to link offenders to treatment and these models have been implemented and tested at every stage of processing in the criminal justice system (Belenko et al., 2013). Immediately after the arrest, a defendant might receive a screening, brief intervention, and referral to treatment, diversion to community treatment under pretrial supervision conditions, or alternative to an incarceration sentence.

Drug treatment courts are available in many jurisdictions; offenders may be diverted prior to trial or placed in drug treatment courts following conviction. After the sentence, the inmate may access treatment in jails, prisons, or while under probation or parole supervision. Treatment mandated as a condition of the inmates' sentence would be considered the latter point of linkage. Depending on the state, treatment at any of these stages could be offered to an inmate through local public health systems, contracted providers, or a brokerage model where services are available by different providers, often through a referral made by a case manager. These service options include outpatient, intensive outpatient, residential and medication-assisted treatment. In-state prisons, typically residential treatment is in a modified therapeutic community (Belenko et al., 2013), TCs are less common in local jails because this population of inmates is often incarcerated for brief periods. In a therapeutic community, inmates are provided an intensive, highly structured pro-social environment where treatment staff and peers interact to influence attitudes, perceptions, and behaviors associated with drug abuse.

Finfgeld-Connett & Johnson (2011) completed a qualitative systematic review of nine qualitative studies of eight prisons and one jail. The study comprised treatment programs for women with substance abuse problems. In therapeutic communities, substance abuse is generally viewed as a complex disorder that involves the whole person. The principles of trauma informed approach that acknowledge adverse childhood events, sexual assault, and gender violence are

foundational to the treatment of incarcerated women. The perception is that substance abuse effects women's values, beliefs, feelings, and attitudes; and often leads to destructive behaviors. Treatment within therapeutic communities tends to be interpersonally driven and participants are housed separately from the general prison environment. In the Finfgeld-Connett & Johnson (2011) review, six programs were labeled as therapeutic communities, and three remaining substance abuse treatment programs included in this systematic analysis tended to use fewer confrontational approaches and were characterized as more woman-centered. In addition to group and peer counseling, one-on-one and family counseling were offered in one program. Another program focused on coping and skills training, and management of past trauma. The third program was based on a feminist framework and utilized empowerment approaches to assist women to explore the social roots of their problems, confronting gender-related issues, and actively shaping their personal growth. Peeler et al., 2019, suggest that evidence-based treatment of opiate use disorder in pregnant women should include associated mental health services such as cognitive behavioral therapy and group session in addition to MAT.

Screening Practices for inmates with substance abuse issues. The third theme was screening practices for inmates with substance abuse issues. This theme is characterized by promoting an intervention that provides a universal low-cost screening to a targeted population using brief, valid and reliable screening instruments (Prendergast et al., 2017). Prendergast et al., (2017), completed a randomized study of 732 inmates from a large urban jail in the Screening, Brief Intervention, and Referral to Treatment (SBIRT) group or control group. SBIRT is an evidence-based practice that has been shown to reduce alcohol and drug use in healthcare, education, and other settings. There is limited information about the effectiveness of this intervention in the prison or jail setting. This intervention was used along with Alcohol,

Smoking, and Substance Involvement Screening Test (ASSIST). The intervention was then used to assess the risk level for drug and alcohol misuse by inmates and provided those identified as having low or medium risk with a brief intervention in jail and referred those with high risk to community treatment following release. To gain knowledge about past and previous drug and alcohol abuse screening would provide appropriate care at the level of risk. Also, it could potentially curtail progression to higher risk levels and reduce risky behaviors while incarcerated.

Transitioning treatment. The fourth theme was the transition of treatments for inmates released back into the community. This theme is characterized by increased access to effective treatment interventions that began during the incarceration and continue in the community for inmates with substance abuse disorders. Gordon et al., 2014, completed a randomized clinical trial of prison-initiated buprenorphine provided to male and female inmates in the U.S. who were previously heroin-dependent prior to incarceration. A total of 211 participants with 3-9 months remaining in prison were randomized to one of four conditions formed by crossing into prison treatment condition (received buprenorphine vs. counseling only) and post-release service setting (at an opioid treatment center vs. a community health center). Outcome measures were: entered prison treatment completed prison treatment, and entered community treatment 10-days post-release. In the United States, incarcerated inmates with pre-incarceration heroin addiction were estimated at 12-15 %; compared to less than 1% of the general population. However, many inmates with heroin addiction histories remain untreated while in prison (Gordon et al., 2014). Consequently, heroin addiction often continues or resumes rapidly following release from custody and contributes to high rates of HIV and hepatitis infection, death by overdose, increased criminal activity, and re-incarceration. Increased access to effective treatment that begins during

incarceration and continues in the community are greatly needed for inmates with heroin addiction histories. The authors reported the results of the clinical trial as encouraging, however, they emphasized that a larger clinical trial of buprenorphine in a different setting with both genders would be useful for further research.

The coordination between community correctional agencies and community-based treatment providers helps to decrease major barriers to the diffusion of medication-assisted treatment (Welsh et al., 2016). The inclusion of medications (e.g., methadone and buprenorphine) in combination with traditional counseling and behavioral therapies help to treat substance use disorders and move toward recovery from trauma. Many inmates with mental health needs and/or substance abuse disorders are under the supervision of community corrections. Treatment services, particularly medication-assisted treatment for opioid and alcohol dependence, are rarely delivered by staff in the correctional system. Typically, treatment services require an inmate to be referred to treatment providers in the community. Implementation of MAT in a community correctional environment focuses on treatment options for drug-involved offenders that include referral to MAT. Medication-assisted treatment is any treatment for a substance abuse disorder that includes a pharmacologic intervention as part of a comprehensive substance abuse treatment plan with the optional goal of patient recovery with full social function. The idea of MAT Implementation in Community Correctional Environment (MATICCE) begins with the assumption that addressing two major barriers to service for this population (Welsh et al., 2016). Staff unfamiliarity with MAT and a lack of inter-organizational linkages hinder transitions in treatment (Welsh et al., 2016). Enhanced staff awareness can result in more frequent and sustainable coordination of services for offenders transitioning between the correctional system and community supervision.

In the United States, inmates involved in the criminal justice system are subjected to different types of supervision in the community (Schwartz et al., 2018). Probation is the most common form of supervision. Probation is proceeded by a court sentence and community supervision is provided by a local, state, or federal probation agency. Parole is another variety of supervision and refers to a conditional release from prison to be able to serve the remainder of their sentence in the community. Generally, probation and parole are considered an alternative to incarceration. Probationers and parolees are often mandated to be drug tested and to attend appointments with supervising officers; a positive drug test or failure to attend appointments with supervising officers can result in incarceration.

The same as in jails and prisons, medication-assisted treatment is underutilized in community corrections (Ludwig & Peters, 2014). In addition, the progress in adopting medication-assisted treatment into community supervision of former inmates is met with several barriers. The major barriers include stigmatizing beliefs on the part of the probationer or parolee, providers, and criminal justice professionals, as well as their knowledge in reference to the effectiveness of medication in reducing illicit opioid use and criminal behavior (Schwartz et al., 2018). Leadership, staff probation, and parole agencies should be the targeted audience to educate about medication-assisted therapy. Education is necessary but not sufficient to initiate change in access to pharmacology for adults under criminal justice supervision (Schwartz et al., 2018).

Coerced treatment of substance abuse. The theme is characterized by coerced treatment for substance abuse that occurs at the intersection of substance abuse treatment and the criminal justice system. Bright & Martire (2013), conducted a literary review of treatment efficacy for inmates with substance abuse disorders. They found that substance use treatment

provided within a context of legal coercion is directed at those inmates whose involvement in the criminal justice system is associated or compounded by illicit drug use. Coerced treatment seeks to divert those from the criminal justice system where there has been minimal criminal activity over and above that associated with substance abuse. However, when offending is more serious or persistent, coercion to treatment aims to attract inmates otherwise unmotivated into substance abuse treatment. The aims are founded on the belief that the provision of substance use treatment constitutes an alternative to traditional punishment and a means to minimize drug-related harms and the likelihood of future offending. Coerced treatment for substance abuse occurs at the intersection of substance abuse treatment and the criminal justice system (Bright & Martire, 2013).

Literature Search Limitations

The major limitations of studies included information associated with longitude studies of the effectiveness of medication-assisted treatment. Many of the authors noted the fact that additional research is needed to gain a better understanding related to the epidemic of substance abuse and how it has a profound effect on the criminal justice system and community supervision. The demographics of correctional populations were usually those who were coming from urban areas. Inmates from different demographic areas would give another perspective of the needs of inmates in the correctional populations and the prevalence of substance abuse disorders among those identified populations.

Clinical/Practice Implications

The need to address trauma is increasingly viewed as an important component of effective behavioral health service delivery (SAMHSA, 2014). The fragmented nature of the Criminal Justice system process presents challenges in implementing integrated treatment that

provides evidence-based assessments and continuity of care (Belenko et al., 2013). Current drug court changes are advocating for a significant change in medication-assisted treatment and behavioral therapies for an inmate within the correctional system. Increasing awareness of medication-assisted treatment, as well as behavioral therapies, could help to change local and state policies that govern how correctional healthcare and community correctional systems address issues for those with substance abuse disorders. Incarceration and involvement with the criminal justice system have proven to be an optimal time to initiate behavior changes to decrease the risk of continued criminal activity and use of illicit drug abuse. Reform to protocols as well as policies for the care of inmates with a history of trauma and substance abuse disorder has to be transformed across all varieties of the correctional system in order to make a sustainable change for this population.

Literature Summary

Substance use disorder and trauma is a significant issue mostly affecting those inmates involved in the correctional system at all levels. Most of these inmates come from underserved and disenfranchised populations. Although evidence exists recommending medication-assisted treatment as well as behavioral therapy, both remain underutilized forms of treatment for inmates in the criminal justice system. The stigma and assumptions surrounding the use of MAT within correctional systems continue to undermine and serve as barriers in reference to implementing medication-assisted treatment into practice. Medication-assisted therapy is an evidence-based practice that demonstrates the effectiveness of this treatment model in a correctional setting. The use of approved medications and behavioral therapies in combination could optimize the effects of drug abuse treatment within the correctional system. By interrupting the cycle of drug abuse and criminal activity; MAT and behavior therapy could potentially change the trajectory of their

lives. Healthcare providers, social workers, and leadership within the correctional system have a responsibility to change policies, refer to treatment, and provide adequate treatment that addresses the needs of inmates with substance use disorder within this population. The overall outcome for this population should be to create better outcomes and promote an overall sense of well-being.

Project Method

After a review of the evidence in the literature, it was determined that drug abuse disorder and the effectiveness of therapeutic communities are closely related. In the correctional setting, a TC provides a supportive environment to assist in maintaining active change for inmates with drug abuse disorders and trauma histories. It is important to identify a treatment model that can successfully incorporate MAT and non-biological measures to manage symptoms during early recovery from trauma and drug abuse disorders. The practice site Albemarle-Charlottesville Regional Jail had a TC from May 2000 to March 2020. Due to the COVID-19 pandemic, TC at Albemarle-Charlottesville Regional Jail was paused in March 2020 because program facilitators were no longer allowed into the jail. Prior to the COVID-19 pandemic, the jail's Superintendent and the Board of Directors identified that one of the goals to improve the care provided to the inmates was to start a MAT program for the inmates within the facility. There is a major barrier to the implementation of a MAT program. Before a MAT program can be implemented a systematic review is required to identify the strengths, limitations, costs, and sustainability of the TC program. The TC used the social environment to create a sense of belonging and a network of support for inmates with SUD, traumatic stress reactions, antisocial attitudes, and criminal behaviors. The TC allowed the inmates to become active participants in their own care and the shared activities of the TC. Traditionally, 18-24 months is recommended for an inmate in TC to benefit from the learning opportunities within the TC social milieu. Specialized court docket programs that target criminal defendants with alcohol and SUD issues made it possible for identified inmates to serve shorter sentences. Shorter sentencing has created a gap in inmates available to participate in TC. A program evaluation was needed to ensure that lessons learned

can be incorporated into the MAT program. The project method for this scholarly project was a program evaluation of the therapeutic community in a correctional setting.

Program evaluation in the Agency for Clinical Innovation (ACI) framework is defined as a systematic process to assess the worth of a program or project in terms of effectiveness, efficacy, and appropriateness (Agency for Clinical Innovation, 2013). ACI refers to programs as projects, Models of Care (MoC), Clinical Pathways and Guidelines, and additional innovations and interventions focused on improving health outcomes. Therapies help patients to modify attitudes and behaviors related to drug use; increase healthy life skills and persevere with other forms of treatment, such as medication (National Institute on Drug Abuse [NIDA], 2019). The ACI has three evaluation types: Formative, before a program begins; Process, for when a program is in progress; and Summative, at the completion or pause in a program. The summative evaluation type was used for this assessment because of the program pause in March 2020 and in preparation for including MAT as a jail program. Thus, the application of the ACI: framework was identified to be appropriate for this scholarly project.

The Agency for Clinical Innovation (2013) framework, consists of eight steps to map out a plan for program evaluation: 1) Establish evaluation team, 2) planning, 3) program logic, 4) evaluation design, 5) data plan, 6) implementation,7) communicating results, and 8) incorporate findings. All ACI evaluations use a program logic to inform the evaluation questions of what should be measured and when.

Step 1) Establish Evaluation Team: The evaluation team requires a mixture of expertise and independence to produce an effective evaluation. Planning, implementation, analysis, and reporting of the evaluation is facilitated by the team. The undertaking of the actual evaluation or

guiding of external evaluators and keeping the steering committee and/or network informed of the progress, risks and results are the responsibility of the team.

Step 2) Planning: Good planning is significant to guide a robust evaluation. Planning includes the development of a communications plan that outlines the stakeholders' engagement and disseminates results and reporting. The program design will outline the remaining steps and identify timeframes, key roles, responsibilities, and oversight of the evaluation.

Step 3) Program Logic: This is a useful tool in helping to facilitate the participation of stakeholders as it encourages discussions about the program to be evaluated and therefore shared understandings and priorities. Program logic documents the connection between the critical components in the evaluation and identifies what aspects are most important. Program logic can help to describe the change process underlying an intervention, program, or policy. In addition, it can document connections between critical components in a project and identify where evaluation is most significant. The program logic tool can vary in relation to the project and complexity but in general, the components include:

Inputs: resources that are used to implement a project. Resources consumed are typically highlighted which include staff, funding, in-kind support, equipment/capital, utilization of health services, etc.

Activities: actions undertaken by the project to achieve the desired goals. These activities would include providing staff training and developing new systems to support new MoCs.

Outputs: immediate results/products from an action. Outputs could include the number of inmates placed appropriately into a MAT program.

Outcomes: the changes that occur showing movement towards the goals and objectives of a project. These are also desired accomplishments or changes and are defined as short, intermediate and long term.

Step 4) Evaluation Design: This is a significant stage of the evaluation process, and it involves defining certain questions that will be used to examine the program objectives and desired outcomes. Question to be asked: What were the components of the program? Where are the appropriate resources available (e.g., learning materials, location, and trained clinicians)? Is there a need for this type of program in the correctional setting (e.g., identified needs of the population)? Review previous documents about the programs utilized. Review of screening processes and methods used to identify inmates who would benefit from the TC. Documentation of Objectives and desired outcomes (e.g., individualized plans of care).

Step 5) Data Plan: An essential element of evaluation used to compare data not only describe the data. Also, it provides information to determine whether the outcomes of a program are better or worse than before the program was implemented. It allows for comparisons of program outcomes at different locations and examines the outcomes.

Step 6) Implementation: The undertaking of the evaluation that involves the development of instruments, data collection, analysis, and interpretation of results. Evaluation tools are used to collect some sources of data.

Step 7) Communicating Results: The communication plan will be established during the planning stage. It is used to define how the results of the evaluation will be communicated. The stakeholders and additional participants will be informed about the progress of the evaluations on a weekly basis.

Step 8) Incorporate Findings: Evaluation results are used to support and contribute to evidence-based decision-making and ultimately influence the future aspects of a program through design, expansion, or discontinuation. To be able to do this effectively, an objective of all evaluations is to use the results to determine the ongoing functions of a program.

Implementation Plan

The implementation plan for a program evaluation in a correctional setting used the eight steps within the ACI framework.

1) Establish Evaluation Team: The evaluation team was created to obtain the expertise of the staff who were involved with the previous TC prior to the COVID-19 pandemic. The evaluation team included The Major (TC/MAT supervision officer), Licensed Clinical Social Worker, and program coordinator(s). The team was created to answer questions about the need for a TC. Evaluation of the screening process used to identify inmates who would benefit from being in a structured environment like a TC.

2) Planning: Planning consisted of identifying key roles, outlining the program design, access to data resources, pre-determine data that is restricted or would need to be embargoed, communication plan, and institutional publication review process. The planning team included The Major, Superintendent, and Licensed Clinical Social Worker. Medium for communication was agreed on (e.g., email or face-to-face meetings).

3) **Program Logic:** Initiation of active involvement from the stakeholders. Program logic was used to assist in illustrating the program and define what should be measured and when it should occur during the evaluation. The components of Program Logic were used for the evaluation to maintain focus on outcomes and provide a clear illustration of the components to assist with determining which aspects need to be evaluated. Input of data from identified sources were evaluated to make a connection to the intended result for the participants of TC. In order to gain an understanding of the usefulness of TC, program logic provided guidance to evaluate TC and provided answers about the outcomes achieved through actions and activities. Interviews with team members were conducted to clarify gaps or discrepancies in the TC documentation.

4) Evaluation Design: The evaluation design built on the steps in the program logic. The design was created by identifying the appropriate questions and data required to examine the relevance of the TC at ACRJ. Specific questions about TC were developed to examine objectives and desired outcomes. Ongoing consultation with stakeholders assured that all perspectives are included and that the evaluation incorporates and measures what is considered important to all. Examination of the program's objectives and the desired outcomes were evaluated.

5) Data Plan: An essential element of evaluation to compare data rather than merely describe the benefits of a program. Data associated with the implementation of TC programs in the correctional setting was reviewed. Available program data was assessed via The Superintendent, The Major, and the Program Coordinator(s). Known data sources included policies, interviews, procedures, jail documents, and the annual state mental health survey. Sources included a review of epidemiological data for engagement of TC. Data for cost analysis of labor, materials, and housing of inmates involved in the TC was obtained. All data with PHI was de-identified before analysis. Goals for components utilized within the TC were evaluated. Therapies used within the TC were identified and evaluated for usefulness in this population (i.e., Seeking Safety, MRT and MATRIX). These therapeutic components were selected for evaluation because of their significance in assisting with change for inmates with alcohol and substance use disorders and traumatic experiences. Interviews included ACRJ and Region Ten stakeholders to discuss the collaboration process for TC participants. Standards of Practice (S.O.P) relevant to TC were reviewed and included jail policies that had a direct impact on the implementation of TC.

The TC used several evidence-based interventions that include Moral Reconation, MATRIX and Seeking Safety. Moral Reconation Therapy (MRT) is grounded in the cognitive

behaviorism framework. This framework is inspired by Lawrence Kohlberg's stages of moral development. The idea behind this framework is to focus on the thinking process that occurs when an inmate is trying to decide whether a behavior is right or wrong (Ferguson & Wormith, 2012). MATRIX is an evidence-based model for criminal justice settings geared towards offender/mandated populations, drug court programs, re-entry programs; prison treatment programs, driving under the influence programs, outpatient programs with offenders, mandated populations, and any program that includes justice-involved inmates (*The Matrix Model | Clare|matrix*, n.d.). Seeking Safety is an evidence-based model with a focused-on trauma and substance abuse. Interventions related to Seeking Safety is based on five central ideas: 1) safety as the priority of this first-stage treatment; 2) integrated treatment of PTSD and substance abuse; 3) a focus on ideals; 4) four content areas: cognitive, behavioral, interpersonal, and case management; and 5) attention to therapist processes (Najavits., 2002).

6) Implementation: The program evaluation was completed in three phases: 1) Collecting existing data from identified resources; 2) Follow-up interviews to clarify gaps in the process of discrepancies in documentation; and 3) synthesis of data and interviews for final understanding.

7) Communicating results: The communication plan with stakeholders and additional participants included the progress of the evaluations every two weeks. The final results were presented to the Major and Licensed Clinical Social Worker, and the Superintendent with a plan to disseminate to the ACRJ Board.

8) Incorporating findings: Evaluation results were used to support and contribute to evidence-based decision making and ultimately influence the future aspects of a program through redesign, expansion, or discontinuation. It was beyond the scope of this project to implement

recommendations. Therefore, the final step of this project was the delivery program evaluations and recommendations.

Therapeutic Community Program Evaluation

Purpose

The purpose of the Therapeutic Community program evaluation is to conduct a systematic evaluation of policies, procedures, reports, and leader experiences associated with the TC; to include therapeutic strategies/competencies in contrast with intended outcomes of the TC for inmates with substance use disorder. The context of TC includes the understanding that substance abuse and addiction are symptoms and combinations of deeply rooted issues related to experiences such as sexual and physical abuse, severe trauma, and mental health and/or personality disorders. Evaluation of TC is to gain insight into the multi-dimensional approach and activities used to address issues and help to reduce relapse and faulty thinking, promote pro-social behaviors, and enable inmates to demonstrate conduct that follows the rules and regulations of the Department of Corrections. The protection of human subjects is important for program evaluation. The University of Virginia IRB for Health Service Research was consulted regarding the need for formal IRB review. This program evaluation was determined to not be subject to IRB review (see Appendix A).

Historical Context

Punishment and Rehabilitation

Incarceration has been identified as an optimal opportunity to provide rehabilitation and initiate services to inmates with significant socioeconomic risks, substance abuse, domestic violence, and mental illness (Wenzel et al., 2008). In collaboration with the Community Service Board – Region Ten ACRJ provided services for incarcerated inmates identified as having mental health issues. In 1993 when drug and alcohol abuse increased as an identified risk within this population, ACRJ and Region Ten established their first TC. ACRJ was selected due to the

CSB – Region Ten's efforts to incorporate jail-based substance abuse treatment with the already existing Main Street substance abuse program.

In 1999, the program was dissolved because non-jail staff had been used. The next year, in June 2000, ACRJ TC was reopened using staff based at ACRJ rather than using a team from outside the jail. The discussion to use jail-based staff was put in place to address issues experienced during the previous TC, such as, lack of trained outside staff and volunteers for selected jail programs and core correctional practices. Adherence to core correctional practices address inappropriate staff conduct and hold staff accountable to the principles put in place at ACRJ. The TC program was designed to be compatible with the Standards of Operation of Therapeutic Communities within the Virginia Department of Corrections. Doing so facilitates networking with other prison-based TCs, halfway house Phase V programs, and community-based peer support groups.

2011 Mini Jail Assessment

In 2011, ACRJ had a Mini Jail Assessment completed by the Carey Group (2011). The Mini Assessment was called Evidence-Based Decision Making in Local Criminal Justice Systems (EBDM). ACRJ could not identify inmates that should be targeted and involved with appropriate mental health and substance abuse programming support. According to ACRJ documents, standard practices for housing inmates were based on informal subjective decision-making. The personal data also considered were criminal charges, prior criminal history, behaviors observed during intake, and past jail terms. ACRJs' objective was to identify appropriate measures to determine which inmates to target within this population and organize housing units based on risk levels to reduce harm from co-mingling inmates of various risk levels. Also, the assessment provided ACRJ with insight into how risk principles guide the

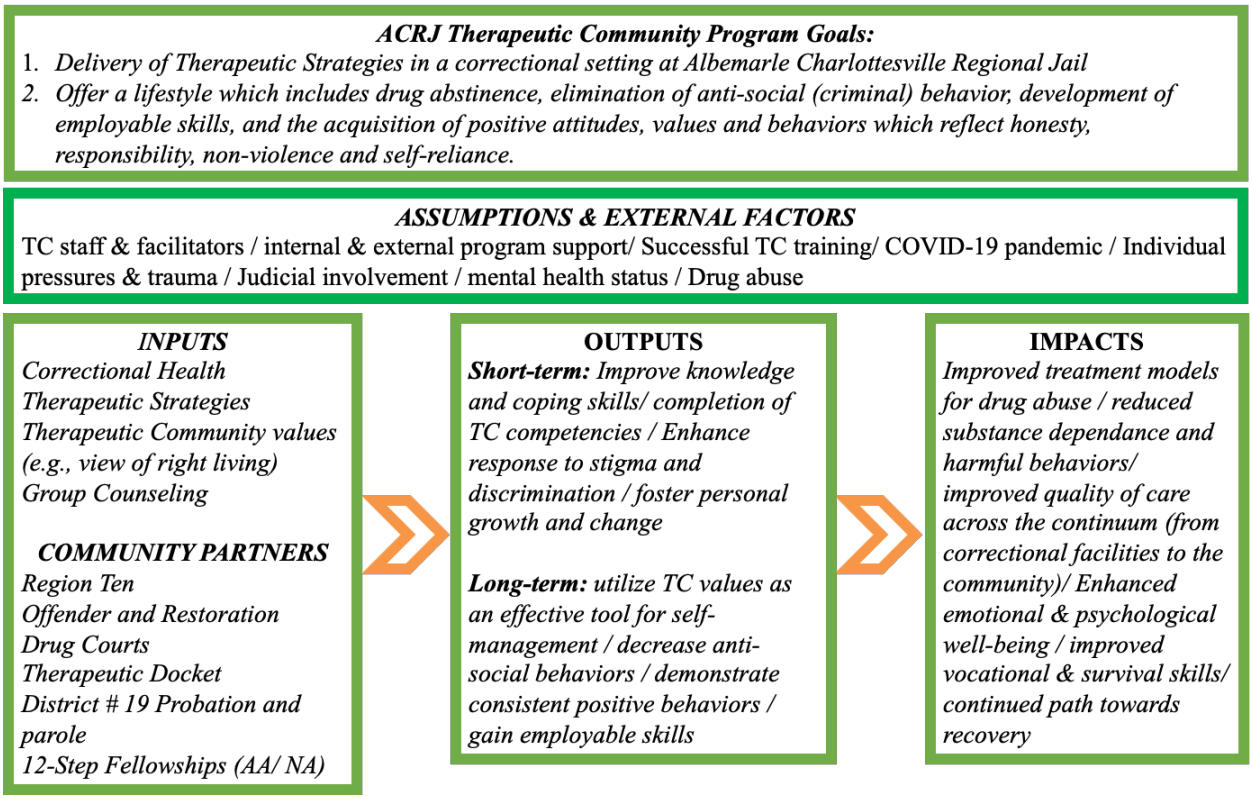
number of hours related to programming to reduce risks within this population. During the EBDM mini-assessment, ACRJ did not have a valid standardized risk instrument to inform decision-making or a database to track offender participation in programming. After the Assessment, ACRJ adapted the Correctional Offender Management Profiling for Alternative Sanction (COMPAS) risk assessment tool in 2013.

Logic Model

The logic model of the TC program (Figure 2.) illustrates the relationship between various program inputs and intended outcomes. A logic model is a visual tool that provides some insight into the thinking behind the program's design. Identified goals, assumptions & external factors, inputs, outputs, and impacts are depicted in the logic model with descriptions and flow of activities from inputs to impacts. The logic model was used to identify and evaluate key TC program elements.

Figure 2

Logic Model of the TC program



Program Goals

There are two main goals of the TC. The first goal is to provide a TC program. The second goal is to provide a range of evidence-based rehabilitation interventions. The TC programs is to help reduce risk factors that promote anti-social attitudes and behaviors. Some of the targeted risk factors include negative peers, anti-social personality traits, and criminal and substance abuse history. TC incorporates a social learning model that uses a variety of highly structured and evidence-based practices and techniques. The components within the model focus on reducing criminogenic risk factors by identifying and addressing faulty thinking, negative attitudes, and behaviors. The continuum of care after incarceration is facilitated through the collaborative relationships between TC facilitators and outside organizations to reinforce new

behaviors learned in TC to reduce the likelihood of recidivism. According to the American Psychiatric Association (APA, 2013), social impairment includes recurrent substance use that can play a major role in the failure to meet obligations at work, school, and home. An inmate may continue substance use despite experiencing persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance use. Also, inmates may lose interest in important social, occupational, or recreational activities and withdraw from the family in relation to substance use.

Assumptions and External Factors

In a 2011 Albemarle-Charlottesville Regional Jail (ACRJ) document to the courts, assumptions about the Therapeutic Community-Lives of Change Under Sober Terms (LOCUST) were explained. It stated that the TC at ACRJ is driven by research and incorporates criminogenic needs within the population. The TC is highly structured and based on cognitive-behavior strategies. The underlying premise of cognitive-behavioral strategies is that thoughts and feelings are the core of behaviors. To change anti-social behaviors. Beliefs about TC were congruent among the stakeholders. As evidenced by the program pause during the COVID-19 pandemic, the TC can be impacted by a variety of social and historical influences that can alter how, and if, the program can continue to provide a rehabilitation environment for inmates.

Inputs:

The incarceration cycle includes arrest, jail, intake, screenings, referrals, and assessments. In addition, there is the court process and decisions, discharge from jail or transfer to another jurisdiction, connection to community services.

TC Community Process

The TC is structured in three phases of change (see Appendix B). Phase I-Orientation (pre-contemplation and contemplation) involves gaining knowledge about TC, adapting to TC terms, culture, processes, and learning rules governing the community. The other TC participants assist the newer member in the practice of new behaviors that reflect the principles and values of the TC. The new TC member will also cooperate with the intake process, complete assessments, participate in motivational programming, and talk about change. TC participants are expected to complete phase I in 30 days. To advance to Phase II, the participant must submit a written petition based on the recommendations from coordinators, security, classification, and clinical staff's experience with the inmate. Then the treatment team will assess readiness to advance to phase II.

Paintings of quotes and affirmations are on all classroom walls where programs are facilitated. These paintings uphold the concepts of the programs and create an atmosphere of acceptance and understanding community that sets them apart from other parts of the jail. Figure 3. is a picture of a painting located at the entrance hall into program block HU-3. The image is of a quote by Robert Frost: Freedom lies in being bold. This can be interpreted to mean that: Freedom lies in being brave enough to take a chance. Brave enough to change your life and free yourself from actions that have negatively impacted your life.

Figure 3

Program Block Entrance.

Photograph by the author with ACRJ Permission

TC members lacking literacy skills are encouraged to ask another TC member for assistance with reading or writing to complete the competency. Contemplation is when there is: a demonstration of the TC regimen, understanding of appropriate behaviors, initial involvement with peer community, assimilation into the community, memorization of TC philosophy and rules, understanding of program activities, taking direction from staff and peers, and a good understanding of the cognitive structure.

Phase II-Resocialization (preparation) is when the TC member becomes familiar with upcoming challenges and recovery issues. Demonstration of ongoing conformity with the structure of the TC, maintaining positive attitudes while fulfilling the responsibilities, and showing loyalty to peers based on right living values are part of phasing up demonstrate mastery of preparation. Figure 4. is a painting reinforcing the fact that there are NO EXCUSES. The inmate has volunteered to be in the TC program. A decision has been made to commit to self-improvement and preparation for integration back into their community as a productive citizen.

Figure 4.

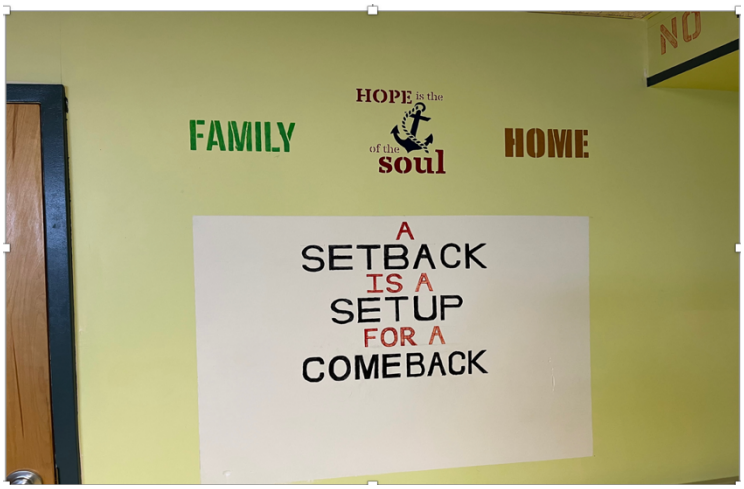
Focusing Statement Above a Classroom Door

Photograph by author with ACRJ Permission

Phase III-Ongoing Recovery (Action) members look at themselves, make decisions about whom they want to be, and take action to become that person. Examination of character defects and learning what would need to be done to maintain recovery. In Phase III, members are expected to serve as role models for the right living to the newer TC members. Figure 5. is a painting on one of the classroom walls stating a setback is a setup for a comeback. The comeback is a TC program term that means getting back on track after a relapse or interruption in the process of recovery. The painting serves as a reminder of what they are looking to achieve by participating in programs. Inmates participating in the TC program should understand that being in jail is a setback, however, the TC program offers what is needed for a great comeback. TC program endorses personal growth and positive behaviors by utilizing TC values to improve self-awareness and coping skills.

Figure 5.

Inmate Affirmations painted on the wall of the classrooms by the inmates



Photograph by author with ACRJ Permission

Phase IV-Reintegration (maintenance) members who complete Phase III may remain in the TC as Phase IV Elders. TC members who meet the eligibility criteria for trustee may apply for a trustee job as TC consultants and thus earn some good time. The term good time is used when an inmate receives a reduction in time to be served from the original sentence. The participant demonstrates leadership, a desire to help others understand the TC, and appropriate transition in the TC. TC members at Phase IV can still be confronted by another member even at this level of progress through the program. Inmates who have obtained trustee status in ACRJ, assist with kitchen duties and overall maintenance of the jail.

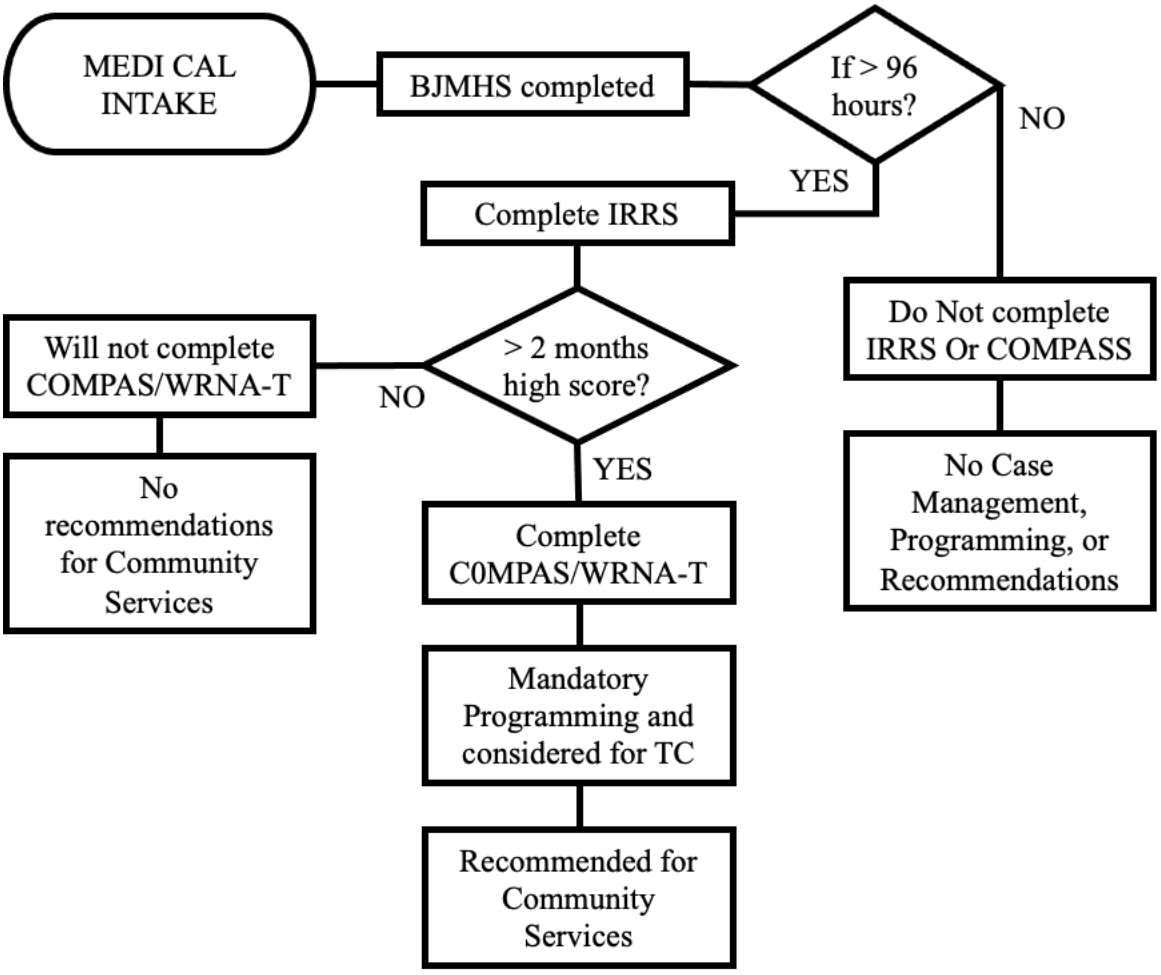
Limitations of TC participants working as jail trustees are their increased contact with inmates in the general population and the probability of criminal opportunities. Strengths are TC participants can demonstrate what they are learned in the TC. In Phase IV, TC participants are considered Elders and should appropriately demonstrate learned skills/competencies completed from Phase I-III. Trustee status is a behavioral rehearsal for real-life obstacles and challenges in

the future. Phase IV TC participants seek out responsibility, act as a positive role model, ability to communicate effectively with others, ability to problem-solve, show humility, meets responsibility under pressure, and appropriately express difficult feelings such as shame or guilt.

Dominant inputs to the ACRJ TC include the Brief Jail Mental Health Screen (BJMHS), Post Orders, Intake Recidivism Risk Screen (IRRS), Correctional Offender Management Profiling Alternative Sanctions (COMPAS), and Women Risk Needs Assessment -Trailer (WRNA-T) screening tools. The initial intake assessment and additional assessments play a significant part in determining an inmate's appropriateness for TC and mandatory programming (Figure 6).

Figure 6

Program Referral Process



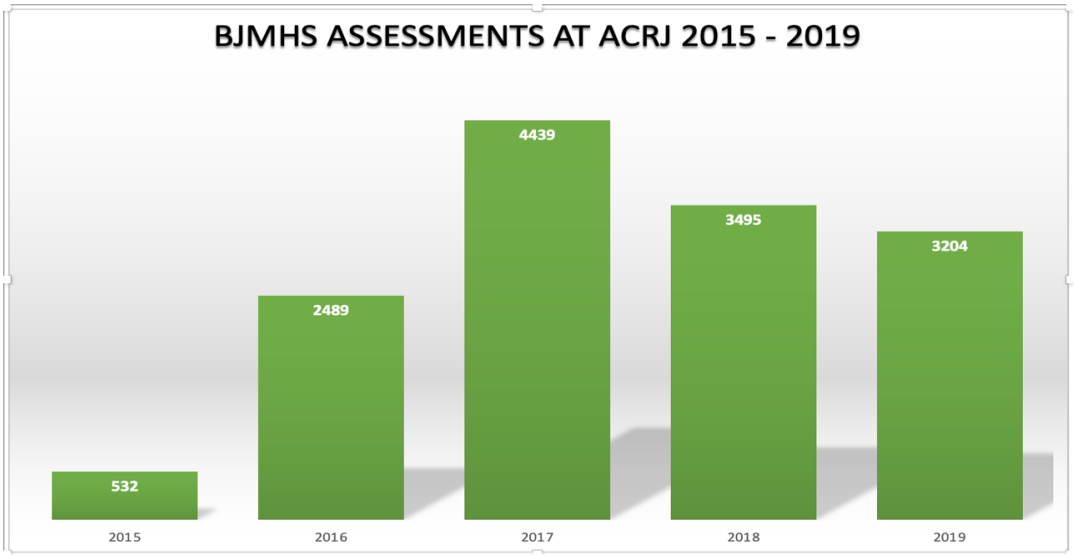
Brief Jail Mental Health Screen (BJMHS)

The Brief Jail Mental Health Screen (BJMHS) is a validated screening tool approved by the Virginia Department of Behavioral and Developmental Services (DBHDS). It is a booking tool utilized to screen incoming inmates to jails and detention centers. The BJMHS was created to identify inmates with the possibility of having a serious mental illness such as schizophrenia, bipolar disorder, or major depressive disorder. As a screening tool, it can determine the possibility of mental health issues; it cannot diagnose that an inmate has a mental illness, has a need for mental health services, or specify the mental illness the inmate has. At ACRJ, BJMHS

is administered by the Correctional clinical staff. The screening tool contains eight yes/no questions that focus on both past and present mental health issues. The information collected during this intake process can be utilized to make referrals to Mental Health services, recommendations for jail housing assignments, and program options. Therefore, correctional clinical staff must provide an initial clearance prior to an inmate meeting with the classification staff. Afterward, the classification staff will conduct the completion of required documents and standards to determine an inmate's appropriateness for transitioning to a general population living unit including TC. The Strengths of BMHJS are that it is an easy-to-use assessment tool and provides enough information to make an initial referral to Mental Health. Limitations lie mostly in user error; clinical staff can overlook making Mental Health referrals during the intake process, prolonging the time between the initial incarceration and assessments made by Mental Health. Figure 7. presents the number of BJMHS assessments completed during intake from 2015 to 2019, prior to COVID-19.

Figure 7.

Numbers of Completed BJMHS Assessments 2015 - 2019



Note: This bar chart displays the number of inmates who received a BJMHS assessment during the years labeled

Post-Orders

The intranet within Albemarle-Charlottesville Regional Jail contains a section named-Post Orders, this section provides step-by-step instruction and explanation about the activities conducted by the classification staff for inmate services. The post-orders are a useful point of reference for new classification staff and other jail employees. This forty-three-page document also provides relevant information about procedures and guidelines for additional screenings, programing, transition, and reentry for inmates incarcerated at ACRJ. The Classification Supervisor or his/her designee will classify all inmates within ninety-six hours of intake into the facility as determined by his/her booking date and time in the New World operating system. Inmates who will not be confined for ninety-six hours will not be classified. This is determined by checking the video court docket, transportation schedule, New World operating system, and confirming with the Records Department. A limitation of post-orders is that it is only available

on the ACRJ intranet system and not available to outside staff and volunteers. Outside staff and volunteers would benefit from post-orders to gain insight into the classification, and jail programming process to coordinate inmate services with jail staff.

Intake Recidivism Risk Screener, COMPAS, and WRNA-T

The IRRS, COMPAS, and WRNA-T are risk assessment and screening tools initiated in sequence after the BJMHS is completed; the inmate remains in custody for more than two months with a high score result during IRRS. The screening tools are utilized to determine program options specific to the identified needs of the inmate. Additional referrals are made for inmates with overt medical or mental health issues presented during intake.

Intake Recidivism Risk Screener (IRRS). The IRRS is a self-reported assessment tool and collects significant information to assess the risk for recidivism and initiate an inmate's participation in TC (see Appendix C) The IRRS requires additional searches of the inmate's criminal background to assure the accuracy of information provided by the inmate. The IRRS is completed by the fifth business day after the initial booking process, the IRRS will be completed on all inmates incarcerated at ACRJ. The IRRS identifies the legal status of the inmate being assessed (i.e., probation violation, pre-trial, or post-trial). The history of criminal arrest records both adult and juvenile are questioned. The four questions asked in the IRRS are: The number of times violated parole; number of times arrested (including incidences as a Juvenile); the age of the first arrest, and job experiences and financial situation before current incarceration. The fourth question refers to job experience and financial situation includes timeframes of 12 months Full-time, 12 months Part-time, 6+ months Full-time and 0 to 6 months PT/FT. If an inmate has his/her classification waived due to Medical, Mental Health, Security, or other reasons.

Once the waiver is lifted, the IRRS will be completed within 5 calendar days. The IRRS also includes running a VCIN/NCIN and DMV record check. The Virginia Criminal Information Network (VCIN) and National Criminal Information Network (NCIN) are utilized to enhance public safety. VCIN is maintained by the Virginia state police and it provides a means of apprehending fugitives that have fled our or another jurisdiction and are located within the city. VCIN/NCIC system also enables the police department to recover stolen property removed from or brought to this jurisdiction. The questions related to an inmate's criminal history will be completed along with the IRRS by referring to the criminal history search and Correctional Assessment and Intervention System (CAIS).

CAIS is a supervision model that integrates both risk and needs assessments in one face-to-face interview. In the event CAIS is unavailable, the case manager will utilize the Virginia Courts Case Information websites. Any information discovered during criminal history research changes to previously answered questions will be revised on the Intake Recidivism Risk Screener and the full assessment. Strengths of the IRRS include identifying the risk to reoffend and candidates for pre-trail release or alternatives to incarceration. Limitations of the IRRS are related to self-report and the time required for record searches. Self-report introduces the bias of offering low and minimum risk inmates early release without further exploring the criminogenic and dynamic risk areas that may require immediate attention to truly impact recidivism (e.g., alcohol/drug problems, attitudes/ orientation, personal emotional). The validation check is labor and time intensive and introduces additional delays to interventions, whether interventions are initiated in the jail or the community depending on the length of stay

Correctional Offender Management Profiling for Alternative Sanctions (COMPAS). COMPAS is a risk assessment tool utilized for the ACRJ male population, completed after the

IRRS (see Appendix D). COMPAS is gender-neutral, facilitates client-focused care plans, aids in determining appropriate program options, and makes specific referrals for programs. Program referrals are based on areas of need as measured by the COMPAS assessment. COMPAS is completed within 15 calendar days, for inmates who score medium or high on the IRRS. An implementation time waiver is permitted if an inmate is experiencing an active mental health crisis or significant behavior issues, or issues with substance abuse or alcohol withdrawal. After the waiver has been lifted, the classification staff is provided an additional fifteen days before COMPAS is initiated. Program referrals are based on areas of need measured by the COMPAS assessments tool. The current charge and criminal history are entered into the assessment prior to the COMPAS interview. Inmates are encouraged to cooperate with the completion of the COMPAS assessments to avoid losing their good time and the ability to participate in any other mandatory programming.

The strength of COMPAS is that it utilized data to identify and address criminogenic needs missed by initial screening tools and risks often related to recidivism. Limitations of COMPAS have some similarities to IRRS because it is also a self-reported assessment tool and relies on additional information from the criminal history. Inmates unwilling to divulge significant information related to substance abuse history, socioeconomic and education status can have a direct impact on informed decisions about jail housing, participation in TC, supervision, and case management in the community settings. The impact of symptoms related to substance and alcohol abuse have proven unpredictable. The provisions for waivers during withdrawal interrupt the timeline from initial booking to treatment delaying entry to TC and mandatory programing. Interventions to mitigate withdrawal symptoms would decrease the use of waivers and promote recovery and support for sobriety.

Women's Risk Needs Assessment-Trailer (WRNA-T). WRNA-T is a risk/need assessment for the adult, female population at ACRJ. WRNA-T has some similarities to COMPAS, they are both utilize to help identify risk, assist in creating client-focused care-plans, aid in determining appropriate program options and both assessments are initiated 15 calendar days after receiving a score of medium or high on the IRRS. The WRNA-T differs in the gender-responsive factors and is designed to supplement existing risk/needs assessments (See Appendix E). The same conditions for a waiver would apply.

The COMPAS/WRNA/T process and timeliness of the assessment is influenced by several factors related to inmate health and judicial status. If the inmate has a scheduled release date within 2 months of the booking date, a full COMPAS/WRNA-T Assessment will not be completed. These inmates will be advised of optional programming available to them on the kiosks in the living units. If an inmate is pending trial without a release date and scores Medium or High on the Intake Recidivism Risk Screener, then a full COMPAS/WRNA-T Assessment will be completed. For all the inmates that score Low on the Intake Recidivism Risk Screener, a full criminal history will be completed through the CAIS to ensure its accuracy. If a full COMPAS/WRNA-T had been completed and an inmate is placed back in custody after being released within 12-months from the date the Case Manager completes that IRRS, a full assessment will not be completed, and the information collected during the previously completed assessment and case plan will be utilized for referrals to programming during the new incarceration period.

The COMPAS/WRNA-T assessment and additional checks are used to develop a case plan by the Classification Manager. For inmates that score out as appropriate for mandatory programming, a case plan is created regardless of the recommended supervision level determined

by the COMPAS/WRNA-T assessment. The case plan and COMPAS/WRNA-T are thoroughly explained to the inmate and used to advise on the programs they are mandated to attend.

Measuring Scale

The Measuring scale used in COMPAS score each inmate with a number range from 1 to 10, with 10 being indicating the highest risk. COMPAS gives a label of low risk for scores 1 to 4 5 to 7 are labeled medium; and 8 to 10 are labeled high. The use of the measuring scale aids significantly in the progression through the programming process. When an inmate scores a Medium or High on the IRRS, a full COMPAS or WRNA-T will be completed. Completing the COMPAS/WRNA-T assessment also provides scores used to refer an inmate for mandatory programming. In COMPAS, questions referring to Substance Abuse uses the following scale, Unlikely 1-2, Probable 3-4, Highly Probable 5-10.

Any male who scores "Highly Probable" on the COMPAS bar chart will be referred for mandatory participation in Substance Abuse Services and become a possible candidate to participate in TC. However, if that inmate has criminal charges of a sexual crime or murder, they are not permitted in TC. Therefore, inmates deemed inappropriate for the TC will be referred to another mandatory program. Also, this will be indicated in the inmate's care plan by Substance Abuse Services. Any female who scores "Highly Probable" on the WRNA-T bar chart will be referred for mandatory programming through Substance Abuse Services. Male or females who score "Probable" can be referred to programming per staff. Mandatory participation in Seeking Safety will be referred for males receiving a score of "Highly Probable and "Probable." Any female whose WRNA-T Needs Scale presents a need for Experience of Abuse as a child or Adult (1 or higher), PTSD (2 or higher), Physical Abuse **(**1 or higher), or Sexual Abuse (1 or higher) will be referred for mandatory programming in Seeking Safety. In COMPAS/WRNA-T, there

are questions about Family Criminality, Socialization Failure, Social Adjustment Problems, Employment Problems, and Vocational/Education. These specific inquires utilize the same numerical and descriptive language to guide referrals for additional programming. Referrals to programs like Anger management (MRT), Parenting Inside Out, and Employment/Financial programs are initiated using the same measurement scales previously mentioned.

Community Partners

Community partnerships facilitate positive choices and opportunities to increase success chances when released. Community partnerships with Offenders Aid and Restoration (OAR) and Region Ten helped reduce and maintain this population's rehabilitation and transitional care objectives. OAR volunteers provided parenting and Anger management groups, and In-house Region Ten staff coordinated transitional care. Court documents about programming depict the significance and length of time for each program offered at ACRJ. State and local re-entry programs are highlighted in this document. Before 2020 and COVID-19, ACRJ documents stated that the re-entry program at ACRJ is broken up into integral steps. Step I focus on classroom and programming, and Step II focuses on access to a transition coordinator for the first forty-five days after release from custody. In addition, 12-Step Fellowship programs like Narcotics and Alcohol Anonymous Support Groups provide a recovery process, and support networks indistinguishably linked together were provided to all participants weekly. In 2015 and 2016, a specific number of participants and completions were not included in the court documents. In 2017, court documents began to include participation enrollment and completion numbers.

Outputs

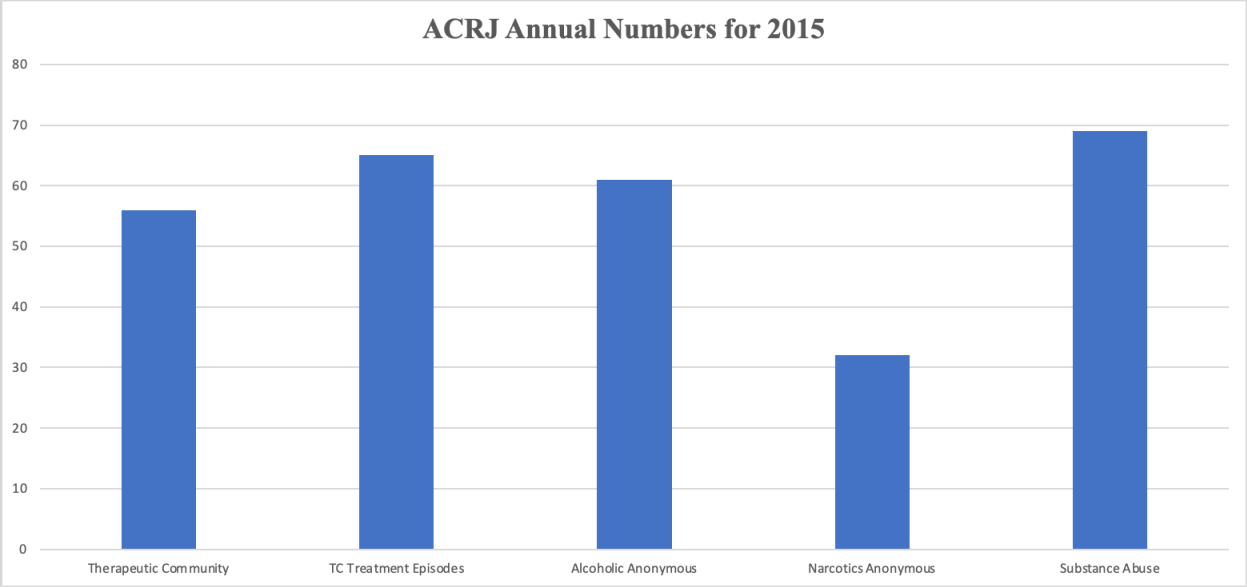
Short and long-term outputs describe activities and results from an action. Coordination of services, service delivery, knowledge sharing and care continuity. Outputs demonstrate movement towards a goal to improve outcomes, delivery of interventions and efficiency.

Short-Term Outputs

In 2013, all services related to substance abuse at ACRJ were combined. Services included TC, Narcotics Anonymous (NA), Alcoholics Anonymous (AA), and substance abuse education (SAE). Furthermore, Matrix, which is an evidence-based substance abuse model was added to the TC agenda as the primary vehicle used for SAE. Subsequently, in 2015, the Substance Abuse Services (SAS) Annual States report, included a variety of psychoeducation components such as communication skills, anger management, conflict resolution, life skills for coping, dysfunctional and functional family dynamics, defense mechanisms, addressing irrational fear, parenting, healthy relationships, and stress management. Process and mindfulness groups are used as a strategy to deal with present issues and identify and address faulty thinking. Peer support was seen as an opportunity to review their process; receive construction feedback, set goals, and identify and address community issues. Sexual Assault Resource Agency (SARA) helps participants deal with sexual trauma and relationship issues. Collaboration with ACRJ mental health department included medication management for identified mental health issues. Transition care such as home planning and coordination of continuum of care. Also, the report includes SAS stats (see Figure 8.). The SAS chart depicts the year's total of inmates who participated in substance abuse treatment and TC. The programs listed in the chart focused on total multidimensional change and offers an aspect of right living in which the goal is lifestyle and foster personal growth.

Figure 8.

Substance Abuse Service Use



Note: The treatment episodes in the chart depict the number of entries into the TC that included repeat participants.

The annual numbers for 2015, did not include female inmates. The women's TC was shut down due to a lack of qualified staff to provide clinical oversight. TC coordinators anticipated restart of the women's TC in 2016, the restart included a partnership with Region Ten to provide 20 hours of clinical and clinical- related case management. However, like the men's TC, the women's TC is to provide an opportunity to receive treatment and re-entry services simultaneously.

Inmates may request entry into TC through the Classification Staff. However, referrals can be made by the court, jail staff, Region Ten staff, family members as well as any concerned persons or agencies. The initial consideration for admission into TC is based on specific screening and admission criteria as well as general impressions from a personal interview with the inmate. Besides meeting the admission criteria, the inmate needs to demonstrate real

motivation to abstain from alcohol and drugs and an overall willingness to change. After all the steps are completed, the final decision for admissions is made by the TC treatment team and Institutional Classification Committee (ICC). Outside of the normal admission process into the TC, TC staff coordinates immediate admissions into TC for Drug Court clients that received sanctions (i.e., for drug use) to minimize interruptions in treatment due to brief episodes of incarceration. However, Inmates returning to the Charlottesville-Albemarle and Nelson County area and expected to be at the jail long enough to obtain some benefit will be the highest priority for admittance to the TC. All other Inmates are considered on a case-by-case basis by TC facilitators and the Institutional Classification Committee.

When inmates are approved for admittance to the TC, they will be expected to fill out an Application for TC form, a Consent to Release Confidential Information form, and a Client Participation Contract. Inmates are encouraged to read all the forms thoroughly and ask questions to clarify anything that they didn't understand. These forms are completed during the Grace period, introduction and orientation, in TC. The inmates are allowed to petition to be included in the TC family during a Developmental meeting. After completion of the TC application and petition to come off the Grace period, the new member will be allowed to change into a blue uniform, signifying participation in the ACRJ TC.

The TC, classification, and security staff understand the commitment to change is not an easy choice to make, and new members require time to adjust to the milieu and TC experience. Even though admission to TC is voluntary, Inmates are encouraged to stay in TC for at least 30 days before making a final decision to resign from TC. Selected inmates are expected to participate in TC until they are released from custody back to community supervision or transferred to the Department of Corrections.

Inmates can be removed from the TC in two ways, resignation, or termination. Inmates who have decided to resign from the TC, are required to follow the written policy for resignation from the TC. An inmate's decision to resign from the TC is announced to the other TC participants and staff. Although, shared belief that it is best to remove a member that no longer desires to participate in the TC, rather than having that inmate act out and disrupt the TC milieu. Inmates will receive feedback on their decision to resign from the other TC participants. TC participants providing feedback on the decision demonstrate responsibility to one another and the community.

When an inmate who has previously resigned from the TC, wishes to return, a new application would need to be submitted 30-days after the resignation date; and the process for admission starts all over again. Previous TC participants aren't given priority over newer inmates who have applied for admission. Inmate's reapplying for admission is encouraged to frequently check in with TC facilitators as a means of demonstrating serious intent about returning.

Once an inmate is a member of the TC, progression through the phases is initiated (see Appendix C). The process is called "phasing-up", which refers to advancing from one phase to the next. The phases use the Transtheoretical Model-Stages of Change: pre-contemplation, contemplation, preparation, action, and maintenance. The five stages of change are integrated into four phases that follow a logical progression to promote good choices and prevent further substance abuse. Skills and competencies build during the progression of phases. Interventions are grounded in cognitive-behavioral and social learning theories that are utilized throughout the process.

TC members must successfully progress through the phases to remain in the TC. Consistent demonstration of new behavior skills is vital in maintaining status and continued

progression through the phases of TC. However, there are incidents where inmates are unable to consistently demonstrate the skill set related to the phase. Consequently, TC members can be returned to the previous phase. The Licensed Clinical Social Worker, TC Coordinator, and Substance Abuse Counselor state that the TC is not always a linear process, sometimes we need them to take a step back and re-learn the skills related to the previous phase. Demotion is seen as a way of giving them another chance to adjust behaviors and progress rather than totally discharging them from the TC (personal communication, February 11, 2022).

Confrontation is a method of addressing behaviors that negatively impact the community. The role of confrontation is to be a learning experience that raises awareness to negative behaviors. To facilitate change LOCUST TC believes there are two elements necessary for a community to be effective, and those elements are structure and accountability. To achieve structure, there are ACRJ, Cardinal, House, and Major rules that are consistently enforced. However, the TC uses confrontation to provide an external source of self-awareness until the critical interpersonal elements are realized and mature. Confrontations between TC members are called “Pull-ups.” Pull-ups can be written or oral. One-on-Ones, relating time, confrontations/encounter groups, feedback sessions and therapeutic reprimands are common confrontation tools used within most TCs. Confrontations are always conducted under staff supervision with a set of guidelines established to ensure the safety of everyone involved.

When a confrontation is initiated, it is assumed that a TC member is willing to confront another member out of the responsible concern and the issue being communicated is what the confronter believes is true. All TC members are encouraged to appreciate the benefits of being confronted by another member, with the understanding, that it is about their behavior and not them as a person. Confrontation feedback points are used to maintain the integrity and focus of

the meeting. When the confrontation is completed, it allows the TC member being confronted to put into action lessons learn from the confrontation. Some of the feedback points are to: identify the behavior being confronted, explain why the behavior was unacceptable, identify the motivation for the behavior, identify how this behavior is part of the old destructive lifestyle, state what will happen if this behavior continues, and what the TC requires of this member.

Confrontations are guided by their own set of rules and feedback points for individuals involved in the confrontation process. During a confrontation, individuals must sit on their hands with feet flat on the floor; no gestures or threats of violence; maintain eye contact with the individual providing feedback; and no rationalizing, justifying, or giving excuses. Other TC members are not allowed to come to the aid of the member being confronted. If they do, this is called red crossing.

Long-Term Outputs

In 2017, the operational manual for the TC was revised by the program's coordinator to include updates and needed revisions for accuracy. The revisions were made using Therapeutic Communities of America (TCA) standards for correctional settings. These standards are specific to the core program elements and best practices. The operational manual is not intended to be a "how-to" manual for TC staff only, but to serve as a point of reference for all ACRJ staff. The manual uses both TC and LOCUST interchangeably and states that the primary objective of the LOCUST-TC is to foster personal growth and change. The TC community is said to be the only treatment approach that teaches good citizenship and community involvement. A combination of counseling, group therapy, and peer pressure to rehabilitate hardcore drug-using inmates and assist them to redirect their lives toward positive goals.

In the LOCUST TC operational manual, the idea of recovery is written as a total change in lifestyle and image. A form of development learning that is cultivated within the very social context or self-help and mutual self-help. The process of lifestyle changes and the image is initiated within the TC and it is up to the individual to use the lessons learned to continue the journey of recovery. The LOCUST TC encompasses the principles of "Right Living", these values are used to guide activities and build the cardinal rules associated with the TC. Right living is described as, truth and honesty of word and deed; living in the here and now; acceptance of the personal responsibility for your destiny; living by a clear moral code; social responsibility (being your brother's keeper); values of hard work and excellence. Gaining the understanding that the inner human being is seen as good, and it is the behavior that is seen as bad.

Colonel Kumer (personal communication, February 9, 2022) stated that at one time the TC remained full and there was a waiting list of individuals that wanted to be a part of the TC. TC lite was created where inmates were housed separately, isolated from the general population, and introduced to the structure of the TC. Inmates who previously graduated from the TC were also isolated to preserve their new skill set for anti-social behaviors. Elder TC participants were also housed separately and were able to share their experiences with the newer TC members. So, inmates never left the program, they would remain in the TC until they were released from jail. Pre-pandemic, ACRJ housed as many as 600 inmates in the general population, and there were many inmates to pull from for the TC. Therapeutic Drug courts and home electronic monitoring allowed inmates to be released sooner and receive resources from outside organizations. A significant decline in the general population directly impacted individuals available for participation in the TC. In March 2020, COVID-19 emerged, and there was a further decline in the general population at ACRJ, with current census down to 290's. Colonel Kumer (personal

communication, February 9, 2022) stated that the decline in the general population presents an issue because, in order to have a resource-intensive program like Medication-Assisted Therapy, we would have to bring up the population numbers at ACRJ. Length of stay is a major issue and impacts opportunities for program improvement.

Impacts

In ACRJ, the position of the Program facilitator is described as an individual that implements programs utilizing an evidence-based curriculum. Besides conducting programming, the Program facilitator is responsible for initiating a safe and effective transition from incarceration back to the community for inmates. In March 2020, TC and additional programming were placed on hold due to COVID-19. Prior to March 2020, ACRJ offered many programs in addition to TC to assist inmates with the transition back into their communities. In 2015, 24 programs were listed in the annual report to the courts. Graduate Equivalency Degree (GED) and Special Education (SPED) classes were listed among the programs offered at ACRJ. Concerns about costs and benefits need to be evaluated when there are multiple programs and strategies that serve a similar goal. The cost for rehabilitation programs and supports are not tracked separately from the daily jail costs. There is no difference between the general population of inmates at ACRJ and those participating in programs or the TC. The cost to house an inmate in first fifteen days during the screening process is $108/day = $1620. If an inmate remains incarcerated for at least a year, it will equal $216,000/year. Hypothetically, every inmate who participated in TC and didn't return to jail would be a cost-saving for ACRJ.

In accordance with 6VAC15-40-60 of the Department of Corrections Minimum Standards for Jails and Lockups, the Albemarle-Charlottesville Regional Jail is required to forward an annual report to the courts concerning services and programs offered. The Annual

Inmate Report is a detailed report prepared by the program coordinator at ACRJ and it covers a period from January 1 to December 31 of the previous year. In addition, the report provides an in-depth description of the programs offered, the number of inmates enrolled in specific programs, the number of program completions, certifications, service referrals, and the number of inmates who obtained official documents while incarcerated (i.e., birth certificates, social security cards, etc.). The number of programs at ACRJ varied from 2015 to 2020, however, an evaluation of the Annual Inmate Report confirmed that TC remained on the roster of programs being offered at the jail until it was placed on hold in March 2020. The continued implementation of TC was most likely in response to the steady incline of substance abuse and addiction within the jail and prison population.

Implications and Recommendations

The TC is an evidenced-based framework where inmates can develop new stress and coping competency or skills. Inmates become mentors or elders for the newer members communication and support skills are mastered. Mentoring and peer support are critically important for addressing trauma events that impact current behavior. Jails are a peer support environment and TC leverages of the environment are consistent with Peplau's (Peterson, 2020) description of the therapeutic milieu. Peplau's interpersonal theory describes four sequential phases of a nurse-client relationship. A specific task and interpersonal skills characterize each phase: 1) pre-interaction, 2) orientation, 3) working, and 4) termination. The phases ensure so that the client can develop meaningful relationships and work towards effective self-management.

Implications

Orientation for new nurses and officers at ACRJ should include information about restorative justice models like the TC to help integrate the principles and values of recovery and change the culture of working practices within the correctional environment. Implications for nursing staff who complete health assessments and initial screenings include: information about MAT and risks and benefits, protocols and procedures for those experiencing intoxication and withdrawal from alcohol and drugs, and motivational interviewing techniques. ACRJ Nursing staff administering opioid agonist treatment medications under the authority of the opioid treatment protocol are appropriately trained. Registered nurses at ACRJ should become Certified Correctional Health Professionals (CCHP-RN) to gain greater insight into complex legal and public health considerations of providing care to incarcerated populations. Correctional health professional certifications help support correctional nursing as a specialty and offer pathways for

continuous improvement, promoting trauma-informed care, and MAT for this population. Prescribing nurse clinicians will receive a Nurse Buprenorphine Wavier Training to administer, dispense and prescribe buprenorphine to the inmates at ACRJ. Wavier training would provide clinicians with an understanding of dosing practices and the efficacy of Buprenorphine.

The Standards for Opioid Treatment Programs in Correctional Facilities from the National Commission of Correctional Healthcare (NCCHC, 2016) will need to be used to establish the Standards of Procedures (SOPs) for medication-assisted treatment at ACRJ. NCCHC standards are linked to specific federal regulations and provide guidance essential for providing appropriate MAT in a correctional setting, achieving, and maintaining NCCHC accreditation. All aspects of the standards for MAT are addressed by written policy and defined procedures. Staff orientation to MAT includes purpose, operations, and how to recognize acute manifestations of intoxication and withdrawal. Policies and procedures are updated or changed as new developments in the field arise.

Implications for MAT involve the revision of ACRJ protocols for medically supervised withdrawal and alcohol and substance use maintenance. Treatment protocols used by clinicians will include treatment plans or algorithms that specify the roles of qualified health care professionals and the course of therapy that meets the inmate's needs. Furthermore, MAT-related training and knowledge about trauma-informed care for ACRJ correctional officers regularly assigned to MAT-TC is necessary to understand MAT and answer general questions about MAT to inmates and staff. For Inmates have completed their sentence at the jail, discharge planning will include coordinated care to arrange the continuum of medicated assisted therapy with a community-based opioid treatment program and necessary follow-up health services that foster medications adherence. In addition, administrative reports will include statistical reports on

MAT-TC to facility administrators, the courts, and community health services to monitor trends in the delivery of services at ACRJ.

Recommendations

The TC at ACRJ has been in existence and operational until the program was paused in March 2000. Since the beginning of the TC, the primary change agent has been the community itself. Moreover, the influence of positive peer pressure within a highly-structured social environment promotes prosocial attitudes and helps to sustain recovery. In the criminal justice system; trauma, substance abuse, and criminality are closely related. Therefore, revision of the TC that includes MAT would serve as a benefit for inmates suffering from exposure to traumatic experiences, faulty thinking, and addiction during incarceration. In addition to MAT, revision of TC and regular program evaluations would ensure that the TC maintains its fidelity and effectiveness.

Program Implementation

Review of the literature identified that medication-assisted therapy alone is not effective enough to combat substance use in a meaningful way. The use of approved medications like Naltrexone, Suboxone, and Methadone has shown a significant reduction in the use of illicit substances; however, long-term recovery needs to address core issues, such as trauma, and use ongoing cognitive strategies for recovery. The TC uses cognitive-behavioral competencies and skills sets to decrease anti-social behaviors to decrease involvement with the criminal justice system, reduce recidivism, and promote recovery from trauma. ACRJ stakeholders understand that punishment alone is not an effective way to change behavior and only removes the individual from the community without emphasizing lessons learned from incarceration; this is called retributive justice. ACRJ TC focuses on an alternative justice model called restorative

justice. Restorative justice focuses on responsibility, acting against past behaviors, and recognizing the need for change.

Length of stay was a recurring barrier throughout the program evaluation. Current drug and therapeutic courts and home electronic monitoring resulted in shorter lengths of stay and a decrease in the general population at ACRJ. Reconsideration of TC modules and concepts is essential to optimize the time an inmate is incarcerated at ACRJ. Reintroduction of select TC modules to the general population would ensure that all inmates have an opportunity to participate in rehabilitation services to reduce anti-social behaviors. Also, utilizing the TC evidence-based modules could provide structure within the correctional setting. The tiered approach would consist of the following:

Tier I. Program modules offered to all inmates incarcerated at ACRJ. Additional assessments can be completed while participating in Tier I TC. Inmates would be able to experience the benefits of TC as well as receive assistance for risks and needs identified during the initial screening process.

Tier II/TC Lite. Preparation for TC. The inmate will also receive early exposure to TC by learning more about the competencies and rules of the TC. Meetings with peers/mentors are initiated during this time. Inmates can use this time to determine if they are ready to be a member of the full TC. Commitment to self-improvement through the community milieu and activities associated with TC.

TC III/Full TC. Inmates who will be incarcerated for a least 12 months and meet the eligibility criteria for the TC. The inmate is a full member of TC and participates in all TC activities. Progression through phases of TC is determined by completing the competencies associated with that phase. Additional assessments are completed to identify specific risks and

needs. Planning for discharge from the jail with community partners are conducted to make sure that a continuum of care is established with outside organizations. Full participation of TC helps the inmate to learn to understand and solve problems for themselves and others. Subsequently, eliminates anti-social behaviors impact of trauma, and reduces the risk of recidivism.

Tier IV. Peer/mentors: These inmates have completed the TC competencies and demonstrate mastery of TC. They will assist the newer members and act as an extension of TC facilitators. Jails and prisons are identified as peer support environments. Peer recovery support emphasizes the valuable role of experiential knowledge. Peers/mentors' unique perspectives and ability to empathize with participants enhance the treatment experience and support for recovery (Reif et al., 2014). Newer TC members benefit when mentors/peers share their TC experiences, and act as role models, and provide positive reinforcement. TC facilitators assure that peers/mentors maintain appropriate boundaries so that newer TC members can take advantage of TC's opportunity.

Medication-Assisted Treatment

Establish an evidenced based MAT intervention that is integrated with the psychosocial approaches used in the TC. MAT increases survival by reducing acute withdrawal risk symptoms and post-release overdose. MAT needs to be available for any inmate who needs acute substance withdrawal support; the MAT screening should not be waived nor delayed until the inmate qualifies for TC. The goal of MAT is to achieve a full recovery and the ability to lead a meaningful life. MAT and cognitive-behavioral strategies increase retention to treatment, promote abstinence from substance abuse and introduce coping skills to maintain recovery and sobriety. Adherent to MAT optimizes their ability to gain and maintain employment and avoid criminal activity often associated with substance abuse.

Evaluation and Sustainability

Correction facility-based substance abuse treatment and trauma-informed care will change based on social trends and clinical evidence. There is a need to conduct systematic and ongoing program process evaluations at least every three years. The program evaluation framework provides an agenda for continued assessment of the TC program that is recommended to be conducted to provide insights into the potential strengths and limitations of the program. The program evaluation process would be improved by including Substance Abuse and Mental Health Services Administration (SAMHSA) guide (SAMSHA, 2014) for evaluating trauma informed approaches within service organizations. Such insights would promote ideas and practices in line with restorative justice in the criminal justice system as well as social regulation, individual-level counseling, and group-level peacekeeping (Wenzel et al., 2008). Future evaluations also need a refined process to evaluate of the cost and benefits of the TC program. Comparisons between TC and standard inmate housing as well as community and court partners collaboration will be needed to evaluate the impact of TC MAT on engagement with post-release substance treatment and recidivism rates.

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Appendices

Appendix A: IRB Determination

FOR IRB-HSR OFFICE USE ONLY

UVA IRB-HSR Study Tracking # 23563

☒ **Project is determined to NOT meet the criteria of Research with Human Subjects or a Clinical Investigation and therefore is not subject to IRB-HSR Review.**

All project team personnel are required to follow all requirements described in this form and follow:

- *Procurement requirements if participants will be compensated for their time*
- *UVA Information Security policies to protect the data: See Appendix B: Privacy Plan.*
-

Pick One

☐ No health information/specimens are to be collected or used for this project

☒ Health information/specimens to be collected or used for this project meet the criteria of Deidentified under HIPAA (No identifiers as noted in Appendix A may be collected/ used.) If data/specimens are from dbGaP, keep Appendix C on file with your project documents and contact School of Medicine Office of Grants and Contracts to obtain an Agreement and a dbGaP Data Request Form/Institutional Certification.

☐ Health information collected meets the criteria of identifiable. Follow the Privacy Plan Appendix B.

☐ Health Information meets the criteria of Limited Dataset. HIPAA Data Use Agreement is required to share data outside of UVA. Complete Appendix E.

☐ Data/Specimens used in this project are coded: Complete Appendix D.

☒ Your project was determined to be non human subject research. If you decide to publish results of this project you must describe the project in the publication as non-human subject research and NOT as human subject research.

IF SENDING OR RECEIVING DATA/SPECIMENS

☒ Provide this signed form to School of Medicine Office of Grants and Contracts and/or Medical Center Procurement if your project has external funding or plans to share data/specimens outside of UVA.

Contact the IRB if anything concerning this project changes that might affect the non-human subject determination.

☐ **Project is determined to be Human Subjects Research or a Clinical Investigation** and must be submitted to the IRB-HSR for review and approval prior to implementation. Please go the Protocol Builder to create your submission.

Name of IRB Staff: Kristin Shelby	***Date:*** 11-18-21

Appendix B: TC Program Inmate Competencies

Updated: 4.7.2017

PHASE I COMPETENCIES-ORIENTATION
(REQUIREMENTS OF PHASE I)

Inmate Name: _____ Date Entered Orientation: _____

The activities required of you in Orientation Phase (Phase I) will help you make a successful transition from general population to the structured environment of the Therapeutic Community. In the Orientation Phase, you will be expected to learn the Philosophy, Rules and begin the processes of the TC Model that will assist you in the practice of new behaviors. In order to advance to Phase II, you must complete all requirements on this form.

A. (Column 1 is for you to check: Column 2 is for the verifier to initial: Column 3 is for the date of completion.)

✓	Initial	Date	Task
			Review and sign Comprehensive Treatment & Release Plan/Checklist/Participation Agreement Date: _____
			Complete the TCU short forms and other assessments as requested and submit to staff.
			Attend all scheduled appointments with referrals. Attend all medical, psychiatric appointments, and take medications as prescribed.
			Begin using the verbal and written pull-up process appropriately
			Identify problems: 1. Associated with substance use 2. Other psychological Addressed in treatment and formulate an individual treatment-Completed phase up
			Learn TC Schedule and demonstrate acceptance of the daily regime.
			Be willing to talk about change as demonstrated by participating in groups and monitoring conversations outside of group time.
			Actively participate as a member of assigned crews/job duties.
			Attend and participate in all groups and complete all assignments in a timely manner
			Complete Orientation Activities • Big Brother/ Sister checklist • Complete 15 minutes relating time with every member of the TC. • Complete structured orientation activities as assigned • Date Completed Orientation Activities: _____
			What have you learned about: • Complete basic substance abuse education and relapse prevention • Present "Who am I" 2-page autobiography to the family in meeting • Present "Why am I back? 2-page paper to the family in meeting (if returning) • Complete and Present Initial Self-Evaluation to the family in meeting
			•
			•
			•
			Participate in all motivational activities as assigned by staff
			Follow all ACRJ rules and regulations as described in the inmate handbook
			Demonstrate TC tools • Writing minimum # of pull-ups daily • Giving verbal and written push-ups daily • Delivering verbal pull ups appropriately • Using proper response to pulls up
			Write a Value / Principle Essay (one page in length) and present in PMDM. Date: _____ Topic: _____
			Study TC Manual and complete oral exam on rules and the structure of the Community.

PHASE II COMPETENCIES-RESOCIALIZATION PRIMARY TREATMENT

(REQUIREMENTS OF PHASE II)

Inmate Name: _____ **Date Entered Phase II:** _____

Special attention is given in this level to addressing individual and collective social deviancy that is expressed and reinforced by thinking patterns, attitudes, feelings and behaviors. Individuals are made aware of their destructive patterns, taught socially productive lifestyles, and challenged to pursue Values of Right Living. In order to advance to Phase III, you must demonstrate your knowledge and practice of Phase II Requirements below. You must fill out a phase up application. Clinical Staff will assess your completion of Phase II Requirements and your readiness to advance to Phase III.

A. (Column 1 is for you to check: Column 2 is for the verifier to initial: Column 3 is for the date of completion.)

	Initial	Date	Task
			Participate in counseling sessions as requested. Follow treatment plan as developed with TC Counselor.
			Attend all scheduled appointments with all referrals. Attend all medical, psychiatric appointments, and take medication as scheduled.
			Continue to attend, participate in and complete assignments for all assigned meetings/groups
			Demonstrate appropriate use of confrontation tools by confronting negative behaviors of peers and completing learning experiences assigned to address behaviors. ☐ Give and receive verbal and written pull-ups on a regular basis without dialoging and giving proper response. ☐ Comply with assigned consequences and learn to view consequences as learning experiences.
			Demonstrate acceptance of TC values in confrontation, outreach to others, showing responsible concern and investing in personal growth. Recognize and understand the importance of confronting out of responsible concern and not out of vindictiveness (tit for tat). Learn to view confrontation as caring concern. Show empathy for others.
			Participate in a minimum of two confrontation groups or as otherwise requested and give feedback in each of these sessions. **Dates: 1.**_____ **2.**_____
			Provide community members affirmations in the form of push ups
			Complete your aftercare plan with Region 10 staff or if going to DOC, sign release of information for ACRJ to provide treatment information to treatment providers.
			Complete an "Initial Self Evaluation" and present it to the family in a house meeting. Turn into Staff (if not completed in Phase I) **Date:** _____
			Demonstrate loyalty to and fellowship with your peers.
			Regularly interact with other members of the Community.
			Read the "Thinking Errors" module from the education manual, and complete an "Initial Second Step". Present in a house meeting. **Date:** _____
			Fulfill responsibilities of position in the TC Structure. → Demonstrate willingness / acceptance of role, duties, and responsibilities in the Structure Board. → Demonstrate Positive Role Modeling → Exhibit job competency within assigned role(s). › Accept increased responsibility and accountability when structure changes occur → Ask for and accept direction from peers
			→
			→
			→
			→
			Participate in joyful activities. Participate in fun activities on the unit such as Community Building Activities, Motivational Activities, Fun Days, etc.
			Read the first section of the NA Basic Text or the AA Big Book (up to personal stories) and/or Stage II Recovery by Earnie Larson. Be prepared to answer questions on the concepts found in these books and how they apply to you in your recovery.
			Complete Application for Phase Change and turn into staff.
			Give an ACRJ Officer Review of Inmate Progress form to an Officer who knows you and ask him to complete the form and forward to staff. **Date:**_____
			Demonstrate an understanding of the Community Values and Principles. Write an essay on a community value or principle. Essay must be at least 1 page in length; Submit to staff for review. Present at PMDM **Date:** _____

			Identifies oneself as a community member.
			Write an essay on how you know you have moved from being an observer to a participant in the community and submit to staff for review. Essay must be at least one page in length. Demonstrate some separation from the street, drug, and prison cultures and codes by not using the associated slang language. Demonstrate identification as a TC member by using TC vernacular, (lingo). **Date:** _____
			Practices honesty, demonstrate integrity, practice setting healthy boundaries (i.e. practicing refusal skills)
			Demonstrate a level of commitment to the TC program.
			→ Act as if. Understand and comply with the program, participating fully in daily activities.
			Follow directions. Comply with learning experiences and adhere to rules. Understands the importance of rules.
			→ Displays a general knowledge of the TC approach.
			Set an example for others.
			→ Continuously show improvement in giving and receiving confrontation.
			Delaying gratification and not acting impulsively.
			→ Begin to demonstrate problem-solving skills.
			> Demonstrate recognition of the importance and purpose of the lines of communication to process issues and concerns.
			→ Demonstrate recognition of the importance of confronting negative behaviors not only for that member's sake but also for the health of the community.
			> Identify life problems and recognize behaviors that have had a negative impact on your life.
			→ Demonstrate the ability to recognize, identify, and begin to communicate feelings.
			→ Identify and recognize what self-esteem is and begin to assess own personal level of self-worth and confidence.
			Follow all ACRJ Rules.
			Present a summary of all the required areas of progress in Phase II on this sheet and turn into Staff.

B. What areas have you recognized that you need help with?

C. How do you see yourself fitting into the TC Community?

D. What benefits do you see from following the TC Process and adopting right living skills?

ONGOING TREATMENT PHASE COMPETENCIES

(REQUIREMENTS OF PHASE III)

Inmate Name: _____ **Inmate Number:** _____ **Date Entered Phase III :** _____

During this level, the TC Community provides treatment in the effort to engage members in recovery. In order to advance to Phase IV, you must petition, in writing, the TC Staff (Clinical and Security) requesting to advance. Based on recommendations from a phase review panel that will include Elders, Correctional Staff, and Clinical Staff's experience with you, Clinical Staff as a whole will assess your readiness to advance to Phase IV.

A. (Column 1 is for you to check: Column 2 is for the verifier to initial: Column 3 is for the date of completion.)

✓	Initial	Date	Task
			Participate in counseling sessions as requested by staff. Continue following treatment plan as developed with TC Counselor.
			Attend all scheduled appointments with referrals. Attend all medical, psychiatric appointments, and take medications as prescribed.
			Continue to attend, participate in, and complete assignments for all assigned meetings / groups, which include but are not limited to the following: AMDM, PMDM, Community Building Activities, Learning Experiences, etc. (Complete Didactic classes, if applicable). • Facilitate at least one (1) independent group (LE that you received **Name of group:** _____ **Date:** _____
			Demonstrate acceptance of TC Values in confrontation, outreach to others, showing responsible concern and investing in personal growth.
			> Demonstrate how the TC process works by consistently being open to giving and receiving pull-ups, without dialogue, and by participating appropriately in confrontation groups Continue elaborating at AMDM and PMDM. > Consistently confront out of responsible concern and not be motivated by vindictiveness (tit for tat). ➢ Consistently uses affirmations in the form of push ups, both verbal and written
			Participate in joyful activities. Actively participate in fun activities on the unit such as Community Building Activities, Motivational Activities and Fun Days, Talents shows, etc.
			Demonstrate loyalty to and fellowship with your peers.
			➢ Fulfill responsibilities of position in the TC Structure. Ask for and accept direction from peers.
			Demonstrate an understanding of the Community Values and Principles. Write an essay (at least 1 page in length) on a Value and Principle, including personal experiences of how you have demonstrated the value and principle. **Submit to staff for review. Present at PMDM Date:** _____
			Demonstrate a level of commitment to the TC program. Key attitudes that reflect the acceptance of the program, commitment to working on oneself in the program, and value for the role model attributes of honesty and responsibility.
			➢ Demonstrate the key attitudes listed above by adaptability to job/structure board changes, room changes, acceptance of staff as rational authority, and ability to contain negative thoughts and emotions.
			Identify oneself as a Community Member; participates actively in all TC groups and activities. Demonstrates a leadership role in these activities.
			Write an essay (at least one page in length) on how you have moved from participant to member status in the program and submit to staff for review. **Date:** _____
			➢ Demonstrate behaviors consistent with Right Living Skills.
			Display a general knowledge of the TC approach. Present a seminar on one of the TC tools at the LE Presentations group. **Date:** _____ **Tool:** _____

			Set an example for others.
			➢ Accepts full responsibility for your behavior, problems, and solutions.
			➢ Consistently provide and respond to confrontation appropriately.
			➢ Demonstrates being trustworthy and dependable.
			➢ Demonstrates healthy risk taking by talking about personal and sensitive issues in group.
			➢ Uses groups appropriately.
			Demonstrates mentoring to new comers. Serve as Big Brother if assigned.
			➢ Continues to develop emotional skills. Identify specific emotional problems and be able to utilize feedback. Demonstrates emotional control.
			Demonstrates delayed gratification and not acting impulsively.
			Demonstrates consistent problem solving skills and refusal skills.
			Demonstrates setting healthy boundaries.
			➢ When experiencing volatile/uncomfortable feeling/ urges ask for feedback from peers and staff. Can identify feelings.
			➢ Consistently follow lines of communication to process issues / concerns.
			➢ Confront individuals to benefit the individuals and to protect the health of the community.
			➢ Learn how to solve problems and how to apply new problem solving skills to your life.
			Follow all ACRJ rules. Any institutional infractions will be reviewed.
			Turn into Staff a summary of progress in Level III and request permission to advance to Phase IV by filling out the phase up application.

B. How do you show concern for the community?

C. How are you addressing the personal problems you have identified?

D. How do you view confrontation now as compared to when you first arrived in TC?

REINTEGRATION PHASE IV STATUS REVIEW CRITERIA

Inmate Name: _____ Inmate Number: _____ Date Entered Phase III: _____

Precipitating factors and contributing disorders and conditions are also addressed in the TC environment by members and Staff. Some offenders are referred to specialists within the correctional center and surrounding community. In order to advance to Level IV, you must petition, in writing, the TC Staff (Clinical and Security) requesting to advance. Based on recommendations from a phase review panel that will include Elders, Correctional Staff, and Clinical Staff's experience with you, Clinical Staff as a whole will assess your readiness to advance to Phase IV.

A. (Column 1 is for you to check: Column 2 is for the verifier to initial: Column 3 is for the date of completion.)

✓	Initial	Date	Task
			Participate in counseling sessions as requested by staff. Comply with treatment plan as developed with TC Counselor.
			Attend all scheduled appointments with referrals. Attend all medical, psychiatric appointments, and take medication as prescribed.
			Continue to attend, participate in, and complete assignments for all assigned meetings / groups, which include, but are not limited to the following: AMDM, PMDM, Community Building Activities, Learning Experiences, etc. (Complete Didactic classes, if applicable). ➢ Facilitate at least (2) independent groups: ➢ **(topic): _____ Date: _____;** **(topic): _____ Date: _____**
			Seek and assume responsibility as assigned within the structure.
			Volunteer to facilitate groups and Family Meetings Facilitate One on One Encounter Groups Will be cycled in and out of positions to benefit the Community. Placement on the structure board will be determined by staff.
			Serve as a Big Brother for a new member on a rotating basis.
			Demonstrate appropriate responses to confrontation under increased stress.
			Demonstrate the ability to trust the process.
			Phase IV members should use their time wisely and avoid isolation from the community.
			Continue utilizing the lines of communication during increasing interactions with staff.
			Demonstrate increased self-control and acceptance of right living skills.
			1. Demonstrates leadership within the community by: a. Makes proposals for activities or to improve the program b. Seeks out responsibility c. Demonstrates belief in the program concept and philosophy d. Can handle frustration and stress appropriately without acting out e. Acts as a positive role model/leads by positive example f. Does not argue and complain when told to do a task g. Demonstrates pride in personal appearance h. Demonstrates the ability to communicate effectively with others i. Facilitates groups/ activities in the community j. Demonstrates the ability to handle increased personal autonomy Members in this Phase may be assigned Elder status as recognition of their maturity, growth, and leadership skills. With this status, additional privileges may be granted. Elders should be able to demonstrate the ability to interact directly with staff on issues related to the "pulse of the community" – issues affecting the viability of the community as a whole. This does not include personal or individual member's issues.

			Participate in motivational and fun activities such as Community Building Activity, Motivational Activities, Fun Days, Talents Shows, etc.
			Utilize group as a vehicle for corrective learning and practicing more effective coping and problem solving skills. Display leadership and may co-facilitate groups with staff upon request.
			Role model effective interaction and communication and appropriate expression of feelings.
			Focus more on issues related to the health of the community versus needs of individuals.
			Demonstrate openness to direction/suggestions from peers and able to provide effective leadership through healthy communication.
			Demonstrate internalization of community values by: ➢ Does the right thing when no one is looking. ➢ Does things for the community without the expectation of reward or external acknowledgement. ➢ Gains self-worth from a job well done.
			Continue to utilize problem solving skills and assisting others with problem solving and decision-making skills.
			Shows initiative in job functions. Goes above and beyond expectations.
			Follow all ACRJ rules.
			Present to Coordinators a summary of progress in Phase IV and submit paperwork in a manner consistent with status review timelines every 30 days.

B. Give two examples that demonstrate how you have internalized the values and principles of the community and how you have mattered.

C. What does "trust the process" mean to you and how do you demonstrate acceptance of that?

D. Give two examples of how you have demonstrated the principle "you have to give it away to keep it."

Appendix C: Inmate Recidivism Risk Screen (IRRS)

ASSESSMENT - OFFICIAL RECORDS

Name: _____ **Screening Date:** _____
Inmate/OAR Number: _____ **DOB:** _____
Gender: _____ **Ethnicity:** _____
Scale Set: Intake Recidivism Risk Screener
Screener Name: _____
Agency: _____

Screening Information

Legal Status: _____

OFFICIAL RECORDS

Criminal History

Exclude the current case for these questions.

1. How many times has this person been arrested before as an adult or juvenile (criminal arrests only)?

_____

Include the current case for the following question(s).

2. What was the age of this person when he or she was first arrested as an adult or juvenile (criminal arrests only)?

_____

Non-Compliance

Include the current case for these questions.

3. How many times has this person violated his or her parole?

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5+

INTERVIEW

Vocation (Work)

Please think of your past work experiences, job experiences, and financial situation in the period of time before your current incarceration.

4. In the 12 months before this incarceration, how much time did you work or attend school?

○ 12 Months Full-time ○ 12 Months Part-time ○ 6+ Months Full-time ○ 0 to 6 Months PT/FT

Appendix D: Correctional Offender Management Profiling for Alternative Sanction (COMPAS)

ASSESSMENT - OFFICIAL RECORDS

Name: _____ **Screening Date:** _____
Inmate/OAR Number: _____ **DOB:** _____
Gender: _____ **Ethnicity:** _____
Scale Set: Full Assessment
Screener Name: _____
Agency: _____

Screening Information

Legal Status: _____

OFFICIAL RECORDS

Current Charges

If the person is being assessed for a probation/parole violation or revocation as the result of a technical violation, check the current offense(s) in the current offenses table for which they were under supervision and reference the original offense(s) when answering current charges questions. If revoked or violated for a nontechnical violation (i.e., a new offense), check the offense(s) in the current offenses table, and count the offense(s) for which they were under supervision as prior history.

If the person was returned to prison as the result of a technical violation, check the current offense(s) in the current offenses table for which they were under supervision. If returned for a nontechnical violation (i.e. a new offense), check the offense(s) in the current offenses table, and count the offense(s) for which they were under supervision as prior history.

☐ Homicide	☐ Weapons	☐ Assault	☐ Arson
☐ Robbery	☐ Burglary	☐ Property/Larceny	☐ Fraud
☐ Drug Trafficking/Sales	☐ Drug Possession/Use	☐ DUI/OUIL	☐ Other
☐ Sex Offense with Force	☐ Sex Offense w/o Force		

1. Do any current offenses involve family violence?
   ○ No ○ Yes
2. Which offense category represents the most serious current offense?
   ○ Misdemeanor ○ Non-violent Felony ○ Violent Felony
3. Was this person on probation or parole at the time of the current offense?
   ○ Probation ○ Parole ○ Both ○ Neither
4. Based on the screener's observations, is this person a suspected or admitted gang member?
   ○ No ○ Yes

Criminal History

Exclude the current case for these questions.

5. How many times has this person been arrested before as an adult or juvenile (criminal arrests only)?

_____

6. How many prior juvenile felony offense arrests?
○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5+

7. How many prior juvenile violent felony offense arrests?
○ 0 ○ 1 ○ 2+

8. How many prior commitments to a juvenile institution?
○ 0 ○ 1 ○ 2+

Note to Screener: The following Criminal History Summary questions require you to add up the total number of specific types of offenses in the person's criminal history. Count an offense type if it was among the charges or counts within an arrest event. Exclude the current case for the following questions.

---

9. How many times has this person been arrested for a felony property offense that included an element of violence as an adult?
○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5+

10. How many prior murder/voluntary manslaughter offense arrests as an adult?
○ 0 ○ 1 ○ 2 ○ 3+

11. How many prior felony assault offense arrests (not murder, sex, or domestic violence) as an adult?
○ 0 ○ 1 ○ 2 ○ 3+

12. How many prior misdemeanor assault offense arrests (not sex or domestic violence) as an adult?
○ 0 ○ 1 ○ 2 ○ 3+

13. How many prior family violence offense arrests as an adult?
○ 0 ○ 1 ○ 2 ○ 3+

14. How many prior sex offense arrests (with force) as an adult?
○ 0 ○ 1 ○ 2 ○ 3+

15. How many prior weapons offense arrests as an adult?
○ 0 ○ 1 ○ 2 ○ 3+

16. How many prior drug trafficking/sales offense arrests as an adult?
○ 0 ○ 1 ○ 2 ○ 3+

17. How many prior drug possession/use offense arrests as an adult?
○ 0 ○ 1 ○ 2 ○ 3+

18. How many times has this person been sentenced to jail for 30 days or more as an adult?
○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5+

19. How many times has this person been sentenced (new commitment) to state or federal prison as an adult?
○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5+

20. How many times has this person been sentenced to probation as an adult?
○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5+

Include the current case for the following question(s).

21. Has this person, while incarcerated in jail or prison, ever received serious or administrative disciplinary infractions for fighting/threatening other inmates or staff?
○ No ○ Yes

22. What was the age of this person when he or she was first arrested as an adult or juvenile (criminal arrests only)?
_____

Non-Compliance

Include the current case for these questions.

23. How many times has this person violated his or her parole?
○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5+

24. How many times has this person been returned to custody while on parole?
○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5+

25. How many times has this person had a new charge/arrest while on probation?
○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5+

26. How many times has this person's probation been violated or revoked?
○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5+

INTERVIEW

Family Criminality

The next few questions are about the family or caretakers that mainly raised you when growing up.

27. Which of the following best describes who principally raised you?

- ○ Both Natural Parents
- ○ Natural Mother Only
- ○ Natural Father Only
- ○ Relative(s)
- ○ Adoptive Parent(s)
- ○ Foster Parent(s)
- ○ Other arrangement

28. If you lived with both parents and they later separated, how old were you at the time?

○ Less than 5 ○ 5 to 10 ○ 11 to 14 ○ 15 or older ○ Does Not Apply

29. Were any of the following people ever arrested, to your knowledge?

Father/father figure	○ No ○ Yes	
Mother/mother figure	○ No ○ Yes	
Any siblings	○ No ○ Yes	
Wife/husband/partner others	○ No ○ Yes	

30. Did a parent or parent figure who raised you ever have a drug or alcohol problem?

○ No ○ Yes

31. Was one of your parents (or parent figure who raised you) ever sent to jail or prison?

○ No ○ Yes

Peers

Please think of your friends and the people you hung out with before your most recent arrest/incarceration.

32. In the last couple of years before this incarceration, how many of your friends/acquaintances had ever been arrested?

○ None ○ Few ○ Half ○ Most

33. In the last couple of years before this incarceration, how many of your friends/acquaintances served time in jail or prison?

○ None ○ Few ○ Half ○ Most

34. In the last couple of years before this incarceration, how many of your friends/acquaintances were gang members?

○ None ○ Few ○ Half ○ Most

35. In the last couple of years before this incarceration, how many of your friends/acquaintances were taking illegal drugs regularly (more than a couple times a month)?
○ None ○ Few ○ Half ○ Most

36. Have you ever been a gang member?
○ No ○ Yes

37. In the last couple of years before this incarceration, were you a gang member?
○ No ○ Yes

Substance Abuse

What were your usual habits in using alcohol and drugs in the period before this recent arrest/incarceration?

38. Do you think your current/past legal problems are partly because of alcohol or drugs?
○ No ○ Yes

39. Were you using alcohol or under the influence when arrested for your current offense?
○ No ○ Yes

40. Were you using drugs or under the influence when arrested for your current offense?
○ No ○ Yes

41. Are you currently in formal treatment for alcohol or drugs such as counseling, outpatient, inpatient, residential?
○ No ○ Yes

42. Have you ever been in formal treatment for alcohol such as counseling, outpatient, inpatient, residential?
○ No ○ Yes

43. Have you ever been in formal treatment for drugs such as counseling, outpatient, inpatient, residential?
○ No ○ Yes

44. Do you think you would benefit from getting treatment for alcohol?
○ No ○ Yes

45. Do you think you would benefit from getting treatment for drugs?
○ No ○ Yes

46. Did you use heroin, cocaine, crack or methamphetamines as a juvenile?
○ No ○ Yes

Residence/Stability

47. In the 12 months before this incarceration, how often did you have contact with your family?
○ No family ○ Never ○ Less than once/month ○ Once per week ○ Daily

48. In the last 12 months before this incarceration, how often did you move?
○ Never ○ 1 ○ 2 ○ 3 ○ 4 ○ 5+

49. Did you have a regular living situation prior to your current incarceration (an address where you usually stayed and could be reached)?
○ No ○ Yes

50. How long had you been living at your last address prior to this incarceration?
○ 0-5 mo. ○ 6-11 mo. ○ 1-3 yrs. ○ 4-5 yrs. ○ 6+ yrs.

51. Did you have a verifiable phone number where you could be reached (cell or landline)?
○ No ○ Yes

52. Could you provide a verifiable residential address?
○ No ○ Yes

53. How long had you been living in that community or neighborhood (before this current incarceration)?
○ 0-2 mo. ○ 3-5 mo. ○ 6-11 mo. ○ 1+ yrs.

54. In the 12 months before this incarceration, did you live with family—natural parents, primary person who raised you, blood relative, spouse, children or boy/girl friend if living together for more than 1 year?
○ No ○ Yes

55. Did you live with friends (prior to this incarceration)?
○ No ○ Yes

56. Were you living alone (prior to this incarceration)?
○ No ○ Yes

Social Environment

Think of the neighborhood where you lived during the time before your current offense.

57. In the neighborhood you lived in before this incarceration, was there much crime?
○ No ○ Yes

58. In the neighborhood you lived in before this incarceration, did some of your friends or family feel they needed to carry a weapon to protect themselves?
○ No ○ Yes

59. In the neighborhood you lived in before this incarceration, had some of your friends or family been crime victims?
○ No ○ Yes

60. In the neighborhood you lived in before this incarceration, did some of the people feel they needed to carry a weapon for protection?
○ No ○ Yes

61. In the neighborhood you lived in before this incarceration, was it easy to get drugs?
○ No ○ Yes

62. In the neighborhood you lived in before this incarceration, were there gangs?
○ No ○ Yes

Education

Think of your school experiences when you were growing up.

63. Did you complete your high school diploma or GED?
○ No ○ Yes

64. What was your final grade completed in school?

_____

65. What were your usual grades in high school?
○ A ○ B ○ C ○ D ○ E/F ○ Did Not Attend

66. Were you ever suspended or expelled from school?
○ No ○ Yes

67. Did you fail or repeat a grade level?
○ No ○ Yes

68. How often did you have conflicts with teachers at school?
○ Never ○ Sometimes ○ Often

69. How often did you skip classes while in school?
○ Never ○ Sometimes ○ Often

70. How strongly do you agree or disagree with the following: I always behaved myself in school?
○ Strongly Disagree ○ Disagree ○ Not Sure ○ Agree ○ Strongly Agree

71. How often did you get in fights while at school?
○ Never ○ Sometimes ○ Often

72. What is your current level of education?
○ Less than high school
○ GED
○ High school
○ Some college or vocational
○ College degree

73. What is the highest grade level that you completed?

_____

Vocation (Work)

Please think of your past work experiences, job experiences, and financial situation in the period of time before your current incarceration.

74. Did you have a job prior to this incarceration?
○ No ○ Yes

75. Do you currently have a skill, trade or profession at which you usually find work?
○ No ○ Yes

76. Could you verify your employer or school (if attending) prior to this incarceration?
○ No ○ Yes

77. In the 12 months before this incarceration, how much time did you work or attend school?
○ 12 Months Full-time ○ 12 Months Part-time ○ 6+ Months Full-time ○ 0 to 6 Months PT/FT

78. Have you ever been fired from a job?
○ No ○ Yes

79. About how many times have you been fired from a job?
_____

80. Right now, do you feel you need more training in a new job or career skill?
○ No ○ Yes

81. Right now, if you were to get (or have) a good job how would you rate your chance of being successful?
○ Good ○ Fair ○ Poor

82. Thinking of your financial situation prior to this incarceration, how often did you have conflicts with friends/family over money?
○ Often ○ Sometimes ○ Never

83. Thinking of your financial situation prior to this incarceration, how hard was it for you to find a job ABOVE minimum wage compared to others?
○ Easier ○ Same ○ Harder ○ Much Harder

84. Thinking of your financial situation prior to this incarceration, how often did you have barely enough money to get by?
○ Often ○ Sometimes ○ Never

85. Thinking of your financial situation prior to this incarceration, did anyone accuse you of not paying child support?
○ No ○ Yes

86. Thinking of your financial situation prior to this incarceration, how often did you have trouble paying bills?
○ Often ○ Sometimes ○ Never

87. Thinking of your financial situation prior to this incarceration, did you only get jobs that paid only minimum wage?
○ Often ○ Sometimes ○ Never

88. Thinking of your financial situation prior to this incarceration, how often did you worry about financial survival?
○ Often ○ Sometimes ○ Never

89. Could you verify the employer at the time you were arrested on the charges that resulted in your current incarceration?
○ No ○ Yes

90. How much have you worked in the last 12 months?
○ 12 Months Full-time ○ 12 Months Part-time ○ 6+ Months Full-time ○ 0 to 6 Months PT/FT

91. I have found a type of job or career that I like.
○ Mostly Disagree ○ Uncertain Don't Know ○ Mostly Agree

92. How difficult will it be for you to keep a job once you have found one?
○ Not Difficult ○ Somewhat Difficult ○ Very Difficult

93. Have you completed a vocational training course?
○ No ○ Yes

Leisure/Recreation

Thinking of your leisure time in the past few (3-6) months before this incarceration, how often did you have the following feelings?

94. In your leisure time prior to this incarceration, how often did you feel bored?
○ Never ○ Several times/mo ○ Several times/wk ○ Daily

95. In your leisure time prior to this incarceration, how often did you feel you had nothing to do in your spare time?
○ Never ○ Several times/mo ○ Several times/wk ○ Daily

96. In your leisure time prior to this incarceration how much would you agree or disagree with the following - You felt unhappy at times?
○ Strongly Disagree ○ Disagree ○ Not Sure ○ Agree ○ Strongly Agree

97. In your leisure time prior to this incarceration, did you feel discouraged at times?
○ Strongly Disagree ○ Disagree ○ Not Sure ○ Agree ○ Strongly Agree

98. In your leisure time prior to this incarceration how much would you agree or disagree with the following - You were often restless and bored?
○ Strongly Disagree ○ Disagree ○ Not Sure ○ Agree ○ Strongly Agree

99. In your leisure time prior to this incarceration, did you often become bored with your usual activities?
○ No ○ Yes ○ Unsure

100. In your leisure time prior to this incarceration, did you feel that the things you did were boring or dull?
○ No ○ Yes ○ Unsure

101. In your leisure time prior to this incarceration, was it difficult for you to keep your mind on one thing for a long time?
○ No ○ Yes ○ Unsure

SELF-REPORT

NAME: _____ **DATE:** _____

Think of your social situation with friends, family, and other people in the past few (3-6) months. Did you have many friends or were you more of a loner? How much do you agree or disagree with these statements?

102. "I had friends who helped me when I had problems."
Strongly Disagree Disagree Not Sure Agree Strongly Agree

103. "I felt lonely."
Strongly Disagree Disagree Not Sure Agree Strongly Agree

104. "I had friends who enjoyed doing things with me."
Strongly Disagree Disagree Not Sure Agree Strongly Agree

105. "No one really knew me very well."
Strongly Disagree Disagree Not Sure Agree Strongly Agree

106. "I felt very close to some of my friends."
Strongly Disagree Disagree Not Sure Agree Strongly Agree

107. "I have often felt left out of things."
Strongly Disagree Disagree Not Sure Agree Strongly Agree

108. "I could find people to socialize with when I wanted."
Strongly Disagree Disagree Not Sure Agree Strongly Agree

109. "I had a best friend I could talk with about everything."
Strongly Disagree Disagree Not Sure Agree Strongly Agree

110. "I have never felt sad about things in my life."
Strongly Disagree Disagree Not Sure Agree Strongly Agree

The next few statements are about what you are like as a person, what your thoughts are, and how other people see you. There are no 'right or wrong' answers. Just indicate how much you agree or disagree with each statement.

111. "I am seen by others as cold and unfeeling."
Strongly Disagree Disagree Not Sure Agree Strongly Agree

112. "I always practice what I preach."
Strongly Disagree Disagree Not Sure Agree Strongly Agree

113. "The trouble with getting close to people is that they start making demands on you."
Strongly Disagree Disagree Not Sure Agree Strongly Agree

114. "I have the ability to "sweet talk" people to get what I want."
Strongly Disagree Disagree Not Sure Agree Strongly Agree

115. "I have played sick to get out of something."
Strongly Disagree Disagree Not Sure Agree Strongly Agree

116. "I'm really good at talking my way out of problems."
Strongly Disagree Disagree Not Sure Agree Strongly Agree

117. "I have gotten involved in things I later wished I could have gotten out of."
Strongly Disagree Disagree Not Sure Agree Strongly Agree

118. "I feel bad if I break a promise I have made to someone."
Strongly Disagree Disagree Not Sure Agree Strongly Agree

119. "To get ahead in life, you can't concern yourself with the needs and wants of others."
Strongly Disagree Disagree Not Sure Agree Strongly Agree

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120. "Some people see me as a violent person."
Strongly Disagree Disagree Not Sure Agree Strongly Agree

121. "I get into trouble because I do things without thinking."
Strongly Disagree Disagree Not Sure Agree Strongly Agree

122. "I never lose my temper."
Strongly Disagree Disagree Not Sure Agree Strongly Agree

123. "If people make me angry or lose my temper, I can be dangerous."
Strongly Disagree Disagree Not Sure Agree Strongly Agree

124. "In my lifetime, I have never strongly disliked anyone."
Strongly Disagree Disagree Not Sure Agree Strongly Agree

125. "I have a short temper and can get angry quickly."
Strongly Disagree Disagree Not Sure Agree Strongly Agree

The next statements are about your feelings and beliefs about various things. Again, there are no 'right or wrong' answers. Just indicate how much you agree or disagree with each statement.

126. A hungry person has a right to steal.
Strongly Disagree Disagree Not Sure Agree Strongly Agree

127. The reason people get into trouble with the law is that they have no chance to get a decent job.
Strongly Disagree Disagree Not Sure Agree Strongly Agree

128. When people do minor offenses or use drugs they don't hurt anyone except themselves.
Strongly Disagree Disagree Not Sure Agree Strongly Agree

129. If someone insults my friends, family or group they are asking for trouble.
Strongly Disagree Disagree Not Sure Agree Strongly Agree

130. When things are stolen from rich people they won't miss the stuff because insurance will cover the loss.
Strongly Disagree Disagree Not Sure Agree Strongly Agree

131. I have felt very angry at someone or at something.
○ Strongly Disagree ○ Disagree ○ Not Sure ○ Agree ○ Strongly Agree

132. Some people must be treated roughly or beaten up just to send them a clear message.
○ Strongly Disagree ○ Disagree ○ Not Sure ○ Agree ○ Strongly Agree

133. I won't hesitate to hit or threaten people if they have done something to hurt my friends or family.
○ Strongly Disagree ○ Disagree ○ Not Sure ○ Agree ○ Strongly Agree

134. The law doesn't help average people.
○ Strongly Disagree ○ Disagree ○ Not Sure ○ Agree ○ Strongly Agree

135. Many people get into trouble or use drugs because society has given them no education, jobs or future.
○ Strongly Disagree ○ Disagree ○ Not Sure ○ Agree ○ Strongly Agree

136. Some people don't deserve any respect and should be treated like dirt.
○ Strongly Disagree ○ Disagree ○ Not Sure ○ Agree ○ Strongly Agree

Appendix E: Women Risk Needs Assessment -Trailer (WRNA-T)

OFFICIAL RECORDS

Documentation

Directions: Staff completing this form should (a) interview the client, and (b) consult appropriate official records prior to completing the interview. Criminal history, current offense, and other agency reports should be consulted in order to verify and corroborate the client's answers to questions asked during the interview. Below, please check all of the official sources of information consulted prior to beginning this interview. In most instances the client's perceptions are preferred; however, if there is a clear discrepancy between the client's version and the recorded version, certain items may be overridden (based upon official record) to increase a client's risk or need. It is imperative that interviewers ask the client the entire question before proceeding to override the item. Please see the scoring manual for further information on overrides and scoring.

IN THE COURSE OF COMPLETING THIS INTERVIEW, THE FOLLOWING DOCUMENTS WERE READ (check all that apply):

- ☐ Police Report(s)
- ☐ Prosecutor's Documents
- ☐ Pre-sentence Reports
- ☐ Assessments, including substance abuse assessments
- ☐ Treatment Reports
- ☐ Criminal History
- ☐ Client probation, parole, and institutional files
- ☐ Classification File
- ☐ Earlier Interviews
- ☐ Other

If other, specify

_____

Some of the following items (e.g., current conviction charge) can be completed without input from the client. In these cases, the interviewer should simply transfer information from the client's record to this document. However, most items will require questions of the clients. In those cases, the questions are provided in this document. Interviewers are requested to ask all questions in their entirety, except for questions that are not applicable.

INTERVIEW

Employment/Financial

SCORING: EMPLOYMENT/FINANCIAL SCALE – These questions must be asked directly of the offender

130. Prior to your incarceration, were you employed?
- ○ Fulltime
- ○ Part time or unable to work because of child/family care, poor health/student, etc.
- ○ Unemployed, but able to work

131. During the 3 years before your offense, did you have any difficulties finding and keeping a job?
○ No ○ Yes

132. Did you own or lease an automobile?
○ No ○ Yes

133. Did you have a checking account?
○ No ○ Yes

134. Did you have a savings account?
○ No ○ Yes

135. Were you (or you and your significant other) able to pay your bills without financial help from family or friends?
○ No ○ Yes

136. During your adult life, have you ever been homeless or lived in a shelter?
○ No ○ Yes

Case Management Notes:

137. Do you worry about whether you will be able to make ends meet once you are released?
○ No ○ Some ○ A lot

138. Will you be the sole provider of your children upon your release?
○ No ○ Yes ○ N/A

139. Do your children have medical insurance?
○ No ○ Yes ○ N/A

140. Did you have medical insurance prior to your most recent incarceration?
○ No ○ Yes

141. Did you make less than $10,000 per year?
○ No ○ Yes

142. Were you receiving public assistance?
○ No ○ Yes

143. Did you live in public housing?
○ No ○ Yes

144. Did you receive food stamps?
○ No ○ Yes

145. Prior to coming here did you have any recent problems like eviction, bankruptcy, calls from collection agencies, cut-off utilities, problems with getting child support payments, repossession of property... things like that?
○ No ○ Yes

146. Do you live in a household where at least one member has full-time, year-round employment?
○ No ○ Yes

Notes (Employment/Financial):

_____

Anger / Hostility

Now we are going to move on to some questions about how you feel. We'll talk about things like anger, depression, and other mental health issues that are common to many women.

SCORING: ANGER/HOSTILITY SCALE – These questions must be asked directly of the client. If there is evidence of violent offenses in the client's background, and the client does not relate to anger, create discrepancy. For example, "what was going on for you when that assaultive incident was committed?" Avoid interrogations, however.

147. Would you describe yourself as having a strong temper?
○ No ○ Yes

148. Do you have trouble controlling your temper when you get upset?
○ No ○ Yes

149. Were you angry or upset when you committed the present offense?
○ No ○ Yes

150. Within the past 3 years, have you ever hit/hurt anyone, including family members, when you were upset (exclude self-defense)?
○ No ○ Yes

151. Have these events ever resulted in involvement with child and family services or law enforcement?
○ No ○ Yes

152. Within the past 6 months have you had any times when you think you got too aggressive when something made you angry?
○ No ○ Yes

Case Management Notes:

153. Have you taken any classes or programs to help you manage your anger?
○ No ○ Yes

Notes (Anger/Hostility):

_____

Mental Health

SCORING: HISTORY OF MENTAL ILLNESS SCALE – These questions must be asked directly of the client.

154. Have you ever seen a mental health counselor/therapist, psychologist, or psychiatrist for help with a problem? (Do not count prison intake interviews.)
○ No ○ Yes

155. Have you ever taken any prescribed medication to help you feel better emotionally?
○ No ○ Yes

156. Have you ever been diagnosed with mental illness?
○ No ○ Yes

157. Have you ever attempted suicide?
○ No ○ Yes

158. Have you ever seen things or heard voices that were not really present?
○ No ○ Yes

159. Have you ever been hospitalized or placed in a mental health unit for any of these or other types of mental health problems?
○ No ○ Yes

Notes (History of Mental Illness):

_____

Abuse / Trauma

I am going to ask you some questions about whether or not you have been physically or sexually abused as a child or an adult. There are only four questions in this section, and if the questions are too difficult to answer, we will just move on to the next section. Please understand that the types of experiences that we would consider to be abusive include hitting, slapping, pushing, kicking, and threatening to hurt you.

SCORING: ABUSE/TRAUMA SCALES – These questions must be asked directly of the client.

☐ Move on to the next section.

160. Have you ever experienced physical abuse as an adult?
○ No ○ Yes

161. Have you ever experienced physical abuse as a child?
○ No ○ Yes

162. Have you ever experienced sexual abuse as an adult?
○ No ○ Yes

163. Have you ever experienced sexual abuse as a child?
○ No ○ Yes

SCORING: PTSD SCALE – These questions must be asked directly of the client.

In your life have you ever had any experience that was so frightening, horrible, or upsetting that IN THE PAST MONTH you (check any that apply):

164. Have had nightmares about it OR thought about it when you did not want to.
○ No ○ Yes

165. Tried hard not to think about it OR went out of your way to avoid situations that reminded you of it.
○ No ○ Yes

166. Were constantly on guard, watchful, or easily startled.
○ No ○ Yes

167. Felt numb or detached from others, activities or your surroundings.
○ No ○ Yes

Case Management Notes:

168. Are you currently being stalked or emotionally abused (humiliated, threatened, harshly ridiculed) by someone close to you? If yes, follow agency policy.
○ No ○ Yes

Notes (Abuse/Trauma):

_____

Significant Other / Spouse

In the next couple of sections we are going to ask you some questions about your relationships with significant others, your children, and your immediate family. First let's talk about your relationships with significant others.

SCORING: RELATIONSHIP STABILITY SCALE – These questions must be asked directly of the client.

169. Are you currently involved with a significant other?
○ No ○ Yes

170. If yes, how long have you been involved with this person?
○ No significant other

○ 0-24 months

○ 25 months to 10 yrs

○ 10 yrs+

171. Are you married (include common-law and domestic partnerships)?
○ No ○ Yes

Notes (Relationship Stability):

_____

Parental Involvement

Now, let's talk about your children.

SCORING: PARENTAL INVOLVEMENT SCALE – These questions must be asked directly of the client.

172. Do you have any children who are 18 or younger?
○ No ○ Yes

173. Do you expect to have shared or full custody of your children upon release?
○ No ○ Yes

174. Do you maintain at least monthly contact with any children by letter, telephone, or visits?
○ No ○ Yes

175. Are you involved in important decisions regarding your children (e.g., school-related, health, outside activities)?
○ No ○ Yes

176. Do you feel prepared to be a good parent?
○ No ○ Yes

Case Management Notes:

177. Are you a single parent?
○ No ○ Yes

178. Have you ever been investigated for abuse/neglect of a child (e.g., by police, children services, school)?
○ No ○ Yes

179. Are you having any difficulty obtaining or maintaining custody of your children?
○ No ○ Yes

Notes (Parenting):

_____

Family of Origin

In this last section we are going to talk about your family. Here we only want to focus on your close biological or adoptive family members.

SCORING: FAMILY OF ORIGIN SCALES – These questions must be asked directly of the client.

180. How is your relationship with your parents (parent figures) and/or siblings (check the row that best applies)?

- ○ Good, just minor conflicts
- ○ Conflictual some of the time (mixed)
- ○ Conflictual most of the time
- ○ Family, but no contact
- ○ Family deceased

181. Do you maintain at least monthly contact with any family members?

○ No ○ Yes

182. Does your family currently refuse to communicate with you because they are angry with you?

○ No ○ Yes

183. Does your family tend to be critical of you when they communicate with you?

○ No ○ Yes

184. Does your family encourage you to participate in programs, classes, or treatment sessions that might help you to avoid trouble in the future (e.g., or come to terms with substance abuse, etc.)?

○ No ○ Yes

185. Have any close family members ever been in trouble with the law or had problems with substance abuse or domestic violence?

○ No ○ Yes

186. Did you receive visits from your family during this prison term?

○ No ○ Yes

187. Has your family offered to help you get established after you are released?

○ No ○ Yes

Notes (Family of Origin):

SELF-REPORT

Significant Other / Relationship

The following questionnaire asks about issues that have a special interest to women such as relationships, self-confidence, abuse, and parenting. These questions are designed to help us find appropriate programming for you as you complete this period of supervision. Please answer them as honestly as you can.

RELATIONSHIP SCALES : The next questions ask you about your relationships with your significant others. In answering these questions please think of your most recent intimate relationship(s). This may include boyfriends/girlfriends, significant others, romantic partners, spouses, etc.

188. In general, would you describe these relationships as supportive and satisfying?
○ No ○ Yes

189. Do you get into relationships that are painful for you? Or is your present relationship a painful one?
○ No ○ Yes

190. Have significant others loved and appreciated you for who you are?
○ Often ○ Sometimes ○ Seldom/Never

191. Do you find yourself more likely to get in trouble with the law when you are in a relationship than when you are not in a relationship?
○ Often ○ Sometimes ○ Seldom/Never

192. Do you tend to get so focused on your partner that you neglect other relationships and responsibilities?
○ Often ○ Sometimes ○ Seldom/Never

193. Have partner(s) been able to convince you to get involved in criminal behavior?
○ Often ○ Sometimes ○ Seldom/Never

194. Do you feel okay about yourself when you are not in a relationship? Or if in a relationship: Would you feel okay about yourself if you were not in a relationship?
○ No ○ Yes

Self Efficacy

SHERER SELF-EFFICACY SCALE : Please check the response that best describes you.

195. When you make plans, are you fairly certain that you can make them work?
○ Often ○ Sometimes ○ Seldom/Never

196. Do you have problems getting down to work when you should?
○ Often ○ Sometimes ○ Seldom/Never

197. Are you pretty persistent --- like if you can't do a job the first time, do you keep trying until you can?
○ Often ○ Sometimes ○ Seldom/Never

198. When you set important goals for yourself, do you have trouble achieving them?
○ Often ○ Sometimes ○ Seldom/Never

199. Do you give up on things before completing them?
○ Often ○ Sometimes ○ Seldom/Never

200. Do you avoid facing difficulties?
○ Often ○ Sometimes ○ Seldom/Never

201. When something looks complicated, do you avoid trying to do it?
○ Often ○ Sometimes ○ Seldom/Never

202. When you have something unpleasant to do, do you stick to it until you finish it?
○ Often ○ Sometimes ○ Seldom/Never

203. When you decide to do something, do you go right to work on it?
○ Often ○ Sometimes ○ Seldom/Never

204. When you try to learn something new, do you tend to give up if you are not initially successful?
○ Often ○ Sometimes ○ Seldom/Never

205. When unexpected problems occur, do you handle them well?
○ Often ○ Sometimes ○ Seldom/Never

206. Do you avoid trying to learn new things when they look too difficult?
○ Often ○ Sometimes ○ Seldom/Never

207. Does failure just make you try harder?
○ Often ○ Sometimes ○ Seldom/Never

208. Do you feel insecure about your ability to do things?
○ Often ○ Sometimes ○ Seldom/Never

209. Can you depend on yourself?
○ Often ○ Sometimes ○ Seldom/Never

210. Do you give up easily?
○ Often ○ Sometimes ○ Seldom/Never

211. Do you feel capable of dealing with most problems that come up in life?
○ Often ○ Sometimes ○ Seldom/Never