THERAPEUTIC COMMUNITIES IN CORRECTIONAL SETTINGS

The Prison Based TC Standards Development Project

Final Report of Phase II

Executive Office of the President
Office of National Drug Control Policy
Barry R. McCaffrey, Director

December, 1999

FOREWORD

Scholars, policy makers, and practitioners from around the country joined ONDCP and the Departments of Justice and Health and Human Services in March of 1998, to address key policy questions regarding drug treatment and the justice system. This consensus meeting took stock of existing knowledge, probing scientific research and clinical experience to determine what is known with reasonable confidence. The participants found that quite a bit is known, but also found that what is being done is often not consistent with what is known. To help rectify this situation, ONDCP has taken a number of steps.

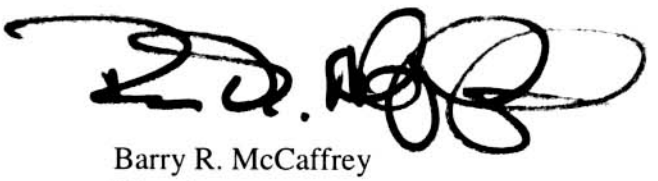
- A comprehensive statement of policy that reflects the state of established knowledge has been crafted and circulated, first among Federal agencies and then among major stakeholder organizations. In concert with the Departments of Justice and Health and Human Services, ONDCP will convene a National Assembly on Drugs, Alcohol Abuse, and the Criminal Offender in December of 1999, where local, state, and Federal stakeholders will be challenged to seek consensus on sound national policy and identify short- and long-term actions required for its implementation.

- The Breaking the Cycle initiative -- a fully integrated program of testing, swift and certain sanctions, treatment and continued monitoring, and relapse prevention – has been expanded from one to four sites, three for adults and one for juveniles.

- The Drug-Free Prison Zone Demonstration Project was established and is demonstrating, in eight states and selected Federal prisons, a program of regular inmate drug testing, the use of advanced technologies for drug detection, interventions including drug treatment, and training of correctional and other institutional staff.

- The field testing of Operating Standards for Prison-Based Therapeutic Communities (TCs) has been conducted by Therapeutic Communities of America (TCA), with ONDCP support.

This document is the result of that field testing effort. TCA is to be commended for this groundbreaking contribution and for bringing a new level of discipline to the discussion of drug treatment. This comprehensive set of operating standards for prison-based TCs -- over 120 standards across 11 program domains – has now been validated in operational prison settings. It provides a blueprint for state and local leaders who want to do it right. The standards will eventually be put into a format appropriate for use by national accrediting organizations. In the interim, TCA's continuing leadership will be needed to provide expert guidance for their proper application. Well done TCA. We look forward to continuing progress, step by step.



Barry R. McCaffrey
Director

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November 1, 1999

Prepared for

The White House Office of National Drug Control Policy (ONDCP)

by

The Criminal Justice Committee of Therapeutic Communities of America*

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I. Overview of the Standards Development Project

Therapeutic Communities of America, (TCA), through its criminal justice task force has launched a project to develop minimum standards for operating modified therapeutic community (TC) programs in prison settings. The project consists of three continuous phases: Phase I, Phase II, and Phase III. Phase I activities, supported by the Ohio Department of Alcohol and Drug Addiction Services (ODADAS), developed an initial draft of standards and outlined procedures for assessing compliance with standards. Phase II activities, supported by *The White House Office of National Drug Control Policy (ONDCP),* were a field validation of the assessment procedures (i.e. the review protocol) to inform a final revision of standards. Phase III, the final phase of the project, will translate the TC standards into a format appropriate for accreditation of modified TC programs in correctional settings.

Phase I of the project yielded a draft of the standards and a preliminary field standards assessment protocol (see TCA, Phase I Project Report, 1997). Phase II of the project has been successfully completed. The present report summarizes the work scope, conclusions, and recommendations of the Phase II working committee. It includes the *Revised Prison TC Standards* based upon the activities of Phase II.

II. Introduction to the Standards Development Project

In recent years, a variety of TC-oriented program models have been adapted for incarcerated substance abusers in prison settings. This development has been fostered by overcrowded prisons, the influx of drug offenders, and the documented success of an early TC prison model in reducing recidivism to crime and relapse to drug use.

Modifications of the TC model for prisons are shaped by the unique features of the correctional institution, e.g., its focus on security, its goal of early release, its limited physical and social space, and the prison culture itself. Nevertheless, experience and research shows that peer-managed communities for social learning can be successfully established for the substance abusers who enter these prison-based programs. A prominent feature of modified prison models is the mutual involvement of correctional officers and prison administrators and mental health and TC treatment professionals. For participants who leave these prison TCs, models for continuance of recovery have recently been established outside the walls in TC-oriented halfway houses.

The Need for Standards

The diversity of programs within the TC modality in general and within the correctional system in particular underscores the need for standards that treatment programs in correctional settings have labeled themselves TCs. Whether these are valid or even similar TC models is often unclear. In addition to these broad issues, there are pragmatic reasons for developing standards for TC prison programs, which include: maintaining quality assurance and best practices in TCs; guiding staff training; and evaluating the effectiveness and cost benefit of TC treatment in prison.

Also, explicit program standards are essential criteria for formal accreditation and licensure efforts.

III. Phase II: Major Aims and Scope of Work

The primary aim of Phase II was to complete a field validation of the standards review protocol. There were two key objectives in this phase: (a) to assess and improve the comprehensiveness and clarity of the standards themselves and (b) to assess the utility of the standards review protocol. The field evaluation trial was conducted at eight modified TC prison programs selected from prison institutions in

different regions of the country. An expert in TC prison programming conducted the trial at each site utilizing the existing field review protocol (i.e., formerly the "*SEEQ-Criminal Justice Version Reviewer Worksheet;*" see Appendix B).

The Phase II project began Oct. 1, 1998. Table 1 summarizes the key tasks, activities, and deliverables in this period.

Table 1	Key Tasks, Activities, and Deliverables for Phase II of the Standards Development project
	1. Planning: 2 full days; full working committee. 2. Selection of 4–6 prison TC sites for field review 3. Selection of 4 field reviewers 4. Orientation for field reviewers 5. Development of a protocol for the site visit 6. Conducting the field reviews at each site 7. Development of reports from the field reviewers 8. Analysis of the field reports by the project coordinator 9. Development of the executive summary report 10. Review and approval of revisions to the field protocol and the prison standards by the full working committee. 11. Review of Executive Summary report by ONDCP 12. Completion of the Full Phase II Report

Four field reviewers were selected whose experience with TC programming ranged from 12–20 years. The criteria for site selection provided a reasonable first test of the *general validity* of the review protocol and the standards themselves. A total of eight different modified prison TC programs were selected from prison systems in California, Florida, New York, and Ohio. Table 2 lists the field reviewers and prison sites selected for field review.

Some of the programs were housed in the same prison complex. However, each site visit to the prison was limited to two days to complete. Typical reviewer activities during the site

visits included examination of records, interviews with staff at all levels, interviews with residents, observation of meetings and groups, and observation of the physical environment.

Table 2.	Field Reviewers and Sites Selected for Phase II of the Standards Development project
Reviewers	•Allan Bernhardt, M.A., MSW •David Kressel, Ph.D. •Robert L. Neri, LMHC, CAP •Nelson Tiburcio, M.A.
Selected Prison Sites	
1. Florida	• Lowells Men's Unit Therapeutic Community Program capacity= 210 beds operational for 10 years at Marion Correctional Institution • ZephyrHills Correctional Institutional Therapeutic Community for dually disordered operational for 3 years under the Florida Dep't of Corrections number of beds = 70 gender = men
2. California	• KEY SAP Men's Program at the California Rehabilitation Center (CRC) operational for 7 years capacity = 200 beds •Walden House Women's Program at the California Rehabilitation Center (CRC) operational for 4 years capacity = 294 beds (96 at the time of field reviewer visit)
3. Ohio	• OASIS Men's Therapeutic Community at Pickaway Correctional Institution (Orient, OH) operational for 7 years capacity = 150 beds • Tapestry Women's Therapeutic Community at the Ohio Reformatory for Women (Marysville, OH) operational for 9 years capacity = 92
4. New York	• Stay'n Out Men's TC facility at Arthur Kill Prison operational for 23 years capacity =143 beds • Stay'n Out Women's TC facility at Bayview Prison operational for 23 years capacity = 40 beds

IV. Report of the Field Review: Main Findings and Recommendations

This section summarizes in bullet form the main findings and recommendations drawn from both the quantitative and qualitative reports of the site reviews. The findings and recommendations presented address the two main aims of Phase II: (1) to assess the utility of a field review protocol and (2) to assess the utility of and revise the Prison Based TC Standards.

A. Utility of the Review Protocol and Process:

Overall, the review protocol was relevant and useful and the review process was feasible and comprehensive. The existing Field Review Protocol (formerly the "Reviewer Worksheet for Criminal Justice TC programs [SEEQ]") is appropriate and useful for assessing whether programs meet the TC standards. However, later versions of this protocol must correspond more closely to the final revisions in the standards themselves. The specific recommendations for revision of the field review protocol and process are noted:

- The Field Review Protocol should include more quality assurance measures of accreditation such as staff education, adequacy to the facility, etc.
- Criteria for weighting the subsections of the standards must be developed to capture the variance within programs in meeting different areas of the standards.
- The field reviewers must be highly experienced in the TC and in the use of the review protocol. Moreover, there must be *experiential parity* across reviewers who are evaluating different program sites to assure comparability in the quality of accreditation process based upon the review protocol.
- The elements of the review process (e.g. participant observation, assessment of files, interviews with key personnel and residents etc.) are appropriate to assess program compliance with standards. However, the *time* required to complete an

adequate field review must be expanded to at least two days per program rather than two days per prison.

- The field reviewer must be *positively perceived* by the correctional and clinical staff and the residents as nonintrusive, neutral, and helpful to the program. Such perceptions facilitate voluntary and honest disclosures concerning program elements and culture.
- Some *additional components of the process* that must be included are attending a staff meeting, assessing whether clinical records are used in the treatment process, and reviewing the staff training program.

Preparation prior to the prison site visit is essential to maximize the efficiency of the field review process. A preparation checklist for program site visits was developed and successfully implemented during phase II. This preparation checklist should be standardized and included in later revisions of the field review protocol.

The Field Review Protocol utilized in Phase II is contained in Appendix A. This document will be revised to include the recommendations from the field review as part of the phase III activities of the project. As with the standards themselves, the Field Review Protocol will be refined through its general use in the field.

B. Utility and Revision of the Prison-Based TC Standards

Overall, the standards were comprehensive, clear, and relevant to assessing the validity of modified TC programming in prisons. The specific recommendations which were considered for revision of the standards are noted.

- The term *community member* should replace the terms *brother* and *sister* to provide a generic concept of the roles of the residents in prison TCs.
- Items must be included which *assess capability* of the program to meet standards, i.e. limits of the prison setting, standards for programs with and without aftercare capability, and standards for integrating all prison personnel in the TC program.

- Items must be included that reflect the TC treatment goals of eliminating *criminal and antisocial* behavior and thinking in prison TC admissions.
- Questioning staff concerning their recovery history challenges American Disability Association guidelines.
- Standards should be added that address problems, needs, and issues of special populations.
- Some of the standards are *abstract* and leave room for interpretation and thereby reviewer differences. Items in each area should provide concrete examples of the TC perspective and approach.
- Standards should include items requiring routine random observation of TC activities, such as meetings and groups by staff to reliably assess quality assurance. Site visits provide a single sample (often biased) of the quality of the activities. The random observations (analogous to random urine screens) should be conducted at some frequency and recorded in the file with date, activity, and overall rating of the activity.
- Field reviews for purposes of accreditation of the programs based upon these standards require reviewers with special expertise in TC programming, prison treatment, and program quality assurance assessment.
- Accreditation based upon the review protocol must consider factors influencing the program's *capacity to comply* with the standards. Such factors include the age of the program start up (e.g., early stage, experienced), institutional restrictions (e.g., degree of isolation of the program from the general population in prisons, prison referral pathways, and classification criteria), limits of funding resources, and the presence of appropriate aftercare services. Overall the standards should include items that assess the minimal requirements to support the capability of the program.
- Compliance with the TC prisons standards should be appropriately assessed in terms of particular client characteristics and special needs (e.g., MICAs, females, juveniles, sex offenders). Funding and training resources must be available to improve the program's capability to address these special needs.

V. The Revised Prison TC Standards: Conclusion, Clarifications, and Caveats

The Revised TC Prison Standards are contained in Appendix B. These reflect the conclusions and recommendations of the Phase II project as modified and approved by the TCA Criminal Justice Committee. TCA recommends dissemination of Prison TC Standards as general information to the field. Periodic refinement and revision of these standards will be informed through their general implementation in the field as guidelines for program accreditation, staff training, and staff certification.

The TCA standards represent the core elements and *best practices* of the therapeutic community treatment approach modified as TC treatment in correctional settings. Based upon theoretical writings, research, and clinical experience (see for example De Leon, 1995, 1997, in press; Lipton, 1997), the standards were developed to provide quality assurance of *therapeutic community programming* in the prison settings. They should be distinguished from standards required for prison institutions in general or health care components within prison institutions. For example, the standards for functional areas such as safety, security, and order are more appropriately included in institutional-wide evaluations (see for example, *Performance Standards for Adult Community Residential Standards* (4th ed.), American Correctional Association, 1999). TC programs in prisons must comply with basic institutional regulations and standards. However, accreditation of TC-oriented programs within prison settings signifies compliance with minimum standards for implementing the essential elements and *best practices* of the TC treatment model and method.

Specific Caveats

Interpretative guidelines for these standards are under development as part of the TCA standards project. Until these are available, implementation of these standards for accreditation and other uses should be guided by the following considerations.

- These national standards are *minimum* criteria for assuring appropriate implementation of prison based TC oriented programs. Their efficacy as guidelines for accreditation or quality assurance criteria depends upon use of the standards in their entirety. Modifications in the form of deletions, additions, word changes, and selective omissions of particular sections could undermine the integrity, validity, and utility of the standards.

- These national standards can guide the development of standards that are specific to states or other jurisdictions. TCA can assist states in the appropriate adaptations of the national standards to meet local conditions.

- Accreditation of prison TC programs based upon these national standards should be conducted by qualified agencies or bodies, e.g., the American Correctional Association (ACA), to assure their appropriate use in the accreditation process.

- The present standards represent generic guidelines for prison-based TCs. However, compliance with these standards should be appropriately assessed in terms of the particular characteristics and special needs of the participants in prison-based TC programs (e.g., MICAs, females, juveniles, sex offenders). Funding and training resources must be available to improve the program's capability to address these special needs.

- Accreditation based upon these standards must consider factors influencing the program's *capacity to comply* with the standards. Such factors include the age of the program start up (e.g., early stage, experienced), institutional restrictions (e.g., degree of isolation of the program from

the general population in prisons, prison referral pathways, and classification criteria), limits of funding resources, and the presence of appropriate aftercare services.

•These national standards reflect the essential elements and best practices of the TC approach. Thus, they can be utilized for initiatives in staff training, credentialling and licensure. TC training should include a curriculum, expert faculty, and teaching format that appropriately reflect scope and intent of the standards.

VI. Summary Of Phase II and Plans

Phase II of the Standards Development Project has been successfully completed. The field reviews at all sites have been conducted and the data have been analyzed. The Phase II results validated the standards themselves and the review protocol. Recommendations based upon the field review guided the final revision of both the standards and the protocol. The TCA Criminal Justice Committee has recommended dissemination of the TCA National Prison TC standards guided by considerations and caveats that assure their appropriate implementation. The final and third phase of the standards development project is to translate the TCA standards into the format that can be utilized by the *American Correctional Association (ACA)* for program accreditation. A brief outline of Phase III is attached as Appendix C.

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Appendices

A

Field Review Protocol for Assessing Compliance with TCA Standards

The (SEEQ)*: Criminal Justice Version

Therapeutic Community Model Standards

Field Review Protocol*

*** Much of the material in this document is based upon the Therapeutic Community Scale of Essential Elements Questionnaire (SEEQ, Melnick and De Leon 1993), and adaptations made by Allen I. Bernhardt. The SEEQ is based upon theoretical writings on the therapeutic community model and method (e.g., De Leon 1995). No part of this material may be reproduced in any form of printing or by any other means, electronic or mechanical, including, but not limited to photocopying, audiovisual recording and transmission, portrayal or duplication in any information storage and retrieval system without express permission from the authors of the SEEQ, and publishers, Center for Therapeutic Community Research, at NDRI, Inc. , New York, NY.**

Therapeutic Community Model Standards

This instrument is intended for internal use as a working document only, and not for distribution. Scoring is based upon reviewer's subjective interpretation of observed behavior (on-site) and objective data obtained from the provider.

Scoring Guide
0 = Program lacks this element or fails to meet this standard.
1 = Program has this element, but does not successfully engage this standard.
2 = Program has element but needs more work before meeting this standard.
3 = Program has element and is working reasonably well. Standard is met.
4 = Program has element and is working very well. Additional work is not needed in this area.
N/A = not applicable, or appropriate

STANDARDS

SECTION I – TC PERSPECTIVE

The TC Perspective includes a four-view way of looking at the problem of substance abuse, and its treatment. It is a social model which views addiction as a disorder of the whole person. Within this view, substance abuse is a symptom and the actual physical addiction is secondary to the need for total treatment of the individual. Treatment is seen as a process of experiential learning including direct confrontation of the individual's values, behaviors and attitudes. It takes place in a highly defined community with firm boundaries and expectations.

1.0 View of the Addictive Disorders

1.1 The program's written philosophy of addiction is consistent with the TC perspective. ____

1.2 In language, actions and attitude, the community clearly and consistently demonstrates adherence to the TC Perspective. ____

Comments:

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2.0 View of the Addict

2.1 Residents and staff clearly acknowledge and identify common personality and behavioral problems shared by all substance abusers. ____

2.2 The prevailing attitude in the community is a sense that the individual needs to make major, conscious life changes, rather than that the person is "sick" and in need of care. ____

Comments:

3.0 View of Recovery

3.1 Abstinence is seen as a prerequisite to recovery, as evidence by a drug-free environment. ____

3.2 Recovery is discussed as an on-going process; continuing after treatment. ____

3.3 Residents and staff clearly identify elements of the TC Perspective (e.g. Right Living) as keys to true recovery, including global self-changes. ____

Comments:

4.0 View of Right Living[1]

4.1 The program openly displays and promotes prosocial values, including: honesty, self-responsibility, work ethic, community responsibility, etc. ____

4.2 A common theme of all interactions in the community reflects a commitment to clearly defined values of Right Living. ____

Comments:

SECTION I SUMMARY: ____

Comments:

[1] "Right Living" refers to an understanding that particular lifestyle and behavioral choices lead to physical and mental health, and a positive and prosocial outlook on life overall.

Section II – The Agency: Treatment Approach and Structure

The agency provides the structure, resources and framework for the treatment approach, which needs to support the TC Perspective. Lines of authority, agency policies and procedures, rules and regulations and practices should help to define the therapeutic community.

5.0 Agency Organization

5.1 The program maintains positive and supportive relationships with all stakeholders sufficient to maintain the integrity and autonomy of the therapeutic community process. ____

5.2 The program has financial resources sufficient to maintain the integrity and autonomy of the therapeutic community process. ____

5.3 The program maintains written administrative policies and procedures that are known to the staff, and are updated at least annually. ____

5.4 The program has established "cardinal" rules (no sex, violence, substance use, etc.) which, if violated, may result in termination of client's participation in the program. ____

5.5 There is a minimum planned duration of treatment which is based upon research and is related to the target population, with actual length varying by individual treatment plans. ____

5.6 The entire staff (clinical, admin., support, etc.) meets and communicates regularly in order to address clinical issues and to assess the functioning of the TC process. ____

Comments:

6.0 Agency Approach to Treatment

6.1 The primary approach to treatment is the "community-as-healer", versus individual focus. ____

6.2 Treatment activities emphasize experiential learning (direct and vicarious); "doing" rather than "getting" therapy. ____

6.3 Residents are accountable to each other and the community on a continuous basis, fostering a strong sense of responsibility for self and others. ____

6.4 Treatment emphasizes the development of behavioral alternatives to substance use. ____

6.5 All elements of the multidimensional program are linked through the community process, which takes precedence over specific treatments. ____

6.6 The program reflects inclusion and respect for all, regardless of cultural background, gender, age, ethnicity, sexual preference and medical status (e.g. HIV). ____

Comments:

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7. 0 Staff Roles and Functions

7.1 The clinical staff includes substance abusers in recovery, preferably with thorough knowledge of TC theory and method. ____

7.2 The locus of programmatic control is shared between staff and residents, however, the staff maintains ultimate authority, and applies it in a rational manner. ____

7.3 Throughout interactions, the staff tends to redirect individual members to the community healing process. ____

Comments:

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8.0 Members' Roles and Functions

8.1 There is a clearly defined stratification of members which establishes increasing levels of responsibility and clinical status. ____

8.2 Senior residents take a responsible role in relation to junior residents, including roles such as: Running house meetings, orientation of new members, and other peer and house management functions. ____

8.3 Interpersonal relationships are reflective of appropriate boundaries as represented by the brother/sister model. ____

Comments:

9.0 Health/Mental Care

[N*ote: services in this section may be provided outside the actual TC, perhaps by other providers – particularly in the case of correctional programs. Scoring takes this into account.]*

9.1 The treatment provider works in conjunction with the host institution to allow for the provision of initial and regular physical exams, with appropriate labwork and provides for the ongoing medical care of residents, as indicated. ____

9.2 The program provides health education training in both prevention and control of threatening diseases. ____

9.3 The treatment provider works in conjunction with the host institution to allow for the provision of appropriate mental health screening and treatment, according to the target population's needs. ____

9.4 The treatment provider works in conjunction with the host institution to allow for the integration of health/mental health services with appropriate modifications to the clinical program to accommodate special needs. ____

Comments:

SECTION II SUMMARY: _____

Comments:

SECTION III – COMMUNITY AS THERAPEUTIC AGENT

The primary therapeutic agent in the TC is the whole milieu, best defined as "community-as-healer." The process depends upon a solid structure that provides a surrogate family and community, with distinct values and mores. Key to the process is direct, honest and immediate feedback or "mirroring," which gives external control and definition to the individual in a way that provides "social order."

10.0 Peers as Gate Keepers

10.1 The prevailing mode of interaction is positive peer pressure, including confrontation and supportive feedback aimed at changing behavior and attitudes. ____

10.2 Negative behaviors and attitudes are confronted immediately and directly by peers, and this practice is seen as acceptable by the community, reinforced by it, and acts to neutralize "jailhouse" attitudes. ____

10.3 The program culture fosters the development of personal relationships to facilitate individual change. ____

10.4 Peers are given the opportunity for input regarding behavioral sanctions to be imposed by staff. ____

Comments:

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11. 0 Mutual Help

11.1 Much of the actual help received by members is through informal interactions between members in the course of daily activities. ____

11.2 Therapeutic groups are held regularly, and allow members to help each other in their treatment goals. ____

Comments:

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12.0 Enhancement of Community Belonging

12.1 There are regular points of interaction between staff and residents that indicate a shared mission and experience, e.g., recreational activities, special events such as program anniversaries and holiday celebrations. ____

12.2 There are regularly held meetings and seminars, which serve to motivate, educate and coordinate members; and general meetings ad hoc to address negative behaviors, including the entire house ____

12.3 Residents participate in activities to mark significant program milestones (e.g. movement between program phases, scholastic achievement). attainment of treatment goals. ____

12.4 Residents and staff work together to solve community problems; residents have meaningful input into program planning. ____

Comments:

13.0 Contact with Outside Community [for Aftercare units]

13.1 Contact with individuals outside the TC is limited, and closely monitored by the program. ____

13.2 Residents earn unsupervised contact with people outside the TC through clinical progress. ____

Comments:

14.0 Community/Clinical Management: Privileges

14.1 There are clearly defined privileges that are earned based upon clinical progress, including status advancement. ____

14.2 Actual choices of privileges are supportive of recovery, self-enhancement, positive behavior, and values of right living. ____

Comments:

15.0 Community/Clinical Management: Sanctions

15.1 There are clearly defined behavioral norms that govern resident behavior. ____

15.2 Sanctions for violation of rules are well defined, and known by all residents; including learning experiences. ____

Comments:

16.0 Community/Clinical Management: Surveillance

16.1 The treatment provider, in conjunction with the host institution, will allow for the conducting of regular and random urine screening, including testing for probable cause, using a reliable system. ____

16.2 There is a well-documented system (e.g., sign-in/sign-out logs) that keeps continuous track of the whereabouts of all residents. ____

16.3 The program screens belongings and conducts "room runs" in order to minimize the presence of contraband and drugs. ____

Comments:

SECTION III SUMMARY: _____

Comments:

SECTION IV – EDUCATIONAL AND WORK ACTIVITIES

The TC is structured as an educational experience, teaching right living and responsibility in addition to independent living skills. The structure of job functions has as a secondary goal the maximization of employability. In addition, the TC should provide formal educational assessment and instruction to support high school completion.

17.0 Formal Educational Elements

[*Educational and vocational elements may be provided off-site, and by another provider, particularly in corrections program. Scoring will account for this.*]

17.1 The program supports and encourages resident participation in available educational assessment and instructional services on-site. ____

17.2 The program supports and encourages resident participation in available vocational training, including actual job preparation. ____

17.3 The program includes seminars that enhance independent living skills and contains a learning lab to assist participants in such areas as GED preparation, English as a Second Language, and other tutoring. ____

Comments:

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18.0 Therapeutic-Educational Elements

18.1 A major focus of member learning is on the development of affective skills, including the ability to identify and express feelings in an appropriate manner. ____

18.2 Conflict resolution and decision making skills are emphasized in the clinical program. ____

18.3 The program includes formal and informal training in relapse prevention. ____

Comments:

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19.0 Work as Therapy

19.1 There is a clearly defined hierarchical structure of levels of resident job functions. ____

19.2 Members perform all possible house chores, e.g. cleaning, maintenance, etc. ____

19.3 Work is used to fully support the clinical program goals and to reinforce the sense of community and individual self-esteem. ____

19.4 A key clinical focus of job functions is to improve the participant's ability both to give direction to subordinates and to take direction from superiors. ____

Comments:

SECTION IV SUMMARY: ____

Comments:

SECTION V – FORMAL THERAPEUTIC ELEMENTS

In addition to the 24-hour per day therapeutic process of the TC, group counseling (especially encounter) is the primary therapeutic element. Individual and family counseling are adjunctive and serve to enhance the TC process. Substance abuse counseling is relatively informal and includes role modeling and mentoring by ex-addict staff, as well as personal sharing.

20.0 General Therapeutic Techniques

20.1 Confrontation focuses on negative behavior and attitudes, not on the individual. ____

20.2 Members are encouraged to "act as if" as a means of developing a positive attitude. ____

20.3 In the balance, peer feedback occurs more frequently than staff counseling. ____

20.4 The program prohibits public humiliation, physical punishment, and the withholding of sleep, food, water, and the use of the toilet. ____

Comments:

21.0 Groups as Therapeutic Agents

21.1 The program uses groups as a primary clinical intervention, including: encounters, probes, marathons, tutorials, etc. ____

Comments:

22.0 Counseling Techniques

22.1 Counselors' interactions with residents contain a high degree of positive role modeling. ____

22.2 Staff counseling techniques include didactics, personal sharing and redirecting members to the peer/community process. ____

22.3 Staff counselors meet individually with residents on a regular basis no less than twice monthly. ____

Comments:

23.0 Role of the Family

23.1 Where applicable, family services are provided as determined by individual treatment plans. ____

23.2 Where appropriate, the family is utilized as a therapeutic or behavior management agent. ____

Comments:

SECTION V SUMMARY: _____

Comments:

SECTION VI – PROCESS

The program is segmented into distinct phases that enable residents to gauge their progress, and to generate personal motivation to continue treatment to completion. The stages of treatment generally reflect classic therapeutic process, but allow more formal transition and rites of passage, a corrective experience in the rehabilitation of addicts.

24.0 Stages of Treatment

24.1 The program is designed in 3 main stages, each with clearly defined goals, activities, and member expectations. ____

Comments:

25.0 Introductory Period

25.1 Activities of the orientation/induction period are clearly aimed at assimilating the new resident into the community. ____

25.2 A complete psychosocial assessment is completed in writing within 10 days of admission. ____

Comments:

26.0 Primary Treatment Stage

26.1 Major goals of primary treatment include full incorporation into the community process, focus on abstinence and psychological growth. ____

26.2 This phase emphasizes full use of the positive reinforcement of privilege and status level systems. ____

26.3 Members develop job readiness skills, strengths in interpersonal relationships in the workplace and resolve authority relationship problems in order to improve employability. ____

Comments:

27.0 Community Re-entry Period

27.1 The major clinical focus of re-entry is on preparation for transition to living in the community, family reintegration and development of an aftercare plan. ____

27.2 Re-entry/aftercare plans include a clear list of personal objectives such as: employment and/or education/training, support network, family reintegration, living arrangements, transportation, savings, and continuing treatment as indicated. ____

27.3 The program provides for continuity of care via referral to appropriate service providers. ____

Comments:

SECTION VI SUMMARY: _____

Comments:

SECTION VII - ADMINISTRATION

Therapeutic communities are now impacted by significant external forces that require accountability. Administrative activities need to continuously interface with local, state and federal agencies, and other funding and regulatory entities. Matching the demands of these with the unique characteristics of the therapeutic community necessitates proactive approaches from administrative units.

28.0 Quality Assurance

28.1 The agency has a written plan and conducts identifiable quality assurance activities, and documents same. _____

28.2 The quality assurance oversight body is situated in a manner that insures corrective action takes place in a timely fashion _____

28.3 Each resident has a written treatment plan, which is reviewed and updated regularly. _____

28.4 The program demonstrates its commitment to documenting the effectiveness of treatment through the maintenance of record-keeping systems that will facilitate analysis of program performance, and through its willingness to participate in evaluation studies and criminal justice system follow-up. _____

28.5 There is an ongoing effort to support each resident's staying in treatment as long as necessary. _____

29.0 Staff Training

29.1 The agency is committed to ongoing enhancement of the TC through assessment of training needs, provision of relevant staff training and regular communication with other TC's. _____

29.2 There is documentation of attendance at all required staff trainings, and evidence of an ongoing schedule of activities. _____

30.0 Physical Plant

30.1 The facility is clean, safe and adequate in space to meet the needs of the population. _____

30.2 The facility meets all applicable fire/safety and building codes, and local, state and federal regulations, including licensing. _____

31.0 Client Records

31.1 The agency maintains clinical records in a manner that meets regulatory requirements, but also facilitates clinical work. _____

31.2 Confidentiality is clearly maintained in the handling of all client-identifying materials. _____

SECTION VII SUMMARY: _____

Comments:

SECTION VIII – CORRECTIONS PROGRAMS

While most of the key elements of corrections-based TC's are common to all TC's, some unique characteristics are essential in the appropriate application of the model to the environment of prisons.

32.0 Corrections-Based TC Standards

32.1	The political/fiscal environment enables the TC to maintain its integrity, while insuring safe integration into the prison population.	____
32.2	The TC program operates within a distinct space, separate from the main prison population.	____
32.3	In the balance, the environment is supportive of identification with the TC culture.	____
32.4	The area in which the TC is housed is clean and well-maintained.	____
32.5	Where permissible, the TC staff includes ex-inmates who provide appropriate role modeling.	____
32.6	The program length-of-stay is adequate to provide necessary rehabilitation and preparation for re-entry.	____
32.7	Program participants agree to be subject to sanctions for infractions of program rules that may involve the loss of program status or privileges.	____

SECTION VIII SUMMARY: _____

Comments:

OVERALL SUMMARY

SECTION I _____

SECTION II _____

SECTION III _____

SECTION IV _____

SECTION V _____

SECTION VI _____

SECTION VII _____

SECTION VIII (Corrections only) _____

Comments:

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Sugarman, B. (1986). Structure, variations, and context: A sociological review of therapeutic community. In G. De Leon & J.T. Ziegenfuss, Jr. (Eds.), *Therapeutic communities for Addictions.* Springfield, IL: Charles C. Thomas Publishers.

B

Revised TCA Standards for TCs in Correctional Settings

Revised TCA Standards for TCs in Correctional Settings

Standards Domains

A. Theoretical Basis

B. General Clinical Guidelines

C. Administration

D. Staffing

E. Facility/Environment

F. TC Program Elements

G. TC Process

H. Stages of Treatment

I. Community and Clinical Management

J. Intake Screening and Assessment

K. Community-Based Aftercare

INTRODUCTION

This chapter presents a provisional list of standards for TC programs in prisons. The standards are organized into 11 domains. For each domain, there is a general standard reflecting an essential element or overarching principle of the TC approach. This is followed by a general rationale or intent of the standard and the list of specific indicators, or performance measures, of the general standard.

A. THEORETICAL BASIS

T. It is essential that programs operating as TCs have a solid grounding in the existing professional literature which describes the TC (history), theory and treatment model

General Rationale/Intent

The TC Perspective consists of four broad views which guide its approach to the treatment of substance abuse and related problems: the view that substance abuse and criminality are symptoms of a disorder of the whole person, the view of the person which consists of the social and psychological characteristics which must be changed, a view of "right living." the morals and values requirements which sustain recovery, and a view of recovery from addiction as a developmental learning process. These views define the unique, characteristic manner in which the therapeutic community approach differs from other forms of treatment.

Standards

T1. The program has a package of written orientation materials that includes a statement of program philosophy that is consistent with the TC perspective.

T2. The program openly displays TC slogans and teachings and promotes prosocial values of 'right living,' including: truth, honesty, self-responsibility, work ethic, community responsibility, responsible concern for peers, etc.

T3. The program handbook or manual should provide an explicit and comprehensive section on the TC perspective on the substance abuse disorder. Substance abuse and criminality are seen as symptomatic behavioral problems that are secondary to the disorder of the whole person.

T4. The prevailing attitude in the community is a sense that the participant needs to make major, conscious life changes, rather than that the person is 'sick' and in need of care.

T5. Participants and staff clearly acknowledge and identify common personality and behavioral traits shared by all (incarcerated substance abusers).

T6. Abstinence is seen as a prerequisite to recovery, as evidenced by a substance-free environment.

T7. Recovery is discussed as an on-going process, continuing after treatment.

T8. TC prison programs have a clearly defined, written glossary of program terminology based upon general TC and program-specific sources that is given to participants upon entry, as well as to clinical and security staff at onset of employment.

B. GENERAL CLINICAL PRINCIPLES

CP. It is essential that program participants identify with the TC and feel a sense of belonging in order to change their patterns of criminality and substance use. There must be a continuous (i.e., 24-hour) atmosphere of constructive confrontation and feedback to individuals and the community as a whole, in order to raise personal awareness of the individual's behavior and attitudes.

General Rationale/Intent

The TC approach to substance abuse treatment is a psychosocial, experiential learning process which utilizes the influence of positive peer pressure within a highly structured social environment. The primary therapeutic change agent is the community itself, including staff and program participants together as members of a "family." The culture is defined by a mutual self-help attitude where community members confront each other's negative behavior and attitudes and establish an open, trusting and safe environment where personal disclosure is encouraged, and the prison culture of the general population is rejected. Participants need to view staff as role models and rational authorities rather than as custodians or treatment providers

Standards

CP1. The primary approach to treatment is "community-as-method."

CP2. The prevailing moral imperative is "I am my brother's keeper" as opposed to the prison culture attitude.

CP3. Both TC staff and security staff are seen as members of the community, with different roles and responsibilities.

CP4. Participants are aware of each other's treatment goals and objectives and help others to achieve personal growth toward their goals.

CP5. Treatment activities emphasize experiential learning (direct and vicarious); "doing" rather than "getting" therapy.

CP6. Participants are accountable to each other and the community on a continuous basis, fostering a strong sense of responsibility for self and others.

CP7. The locus of control is shared between staff and program participants. However, the staff maintains ultimate authority, and applies it in a rational manner.

CP8. A major focus of participant learning is on the development of affective skills, including the ability to identify and express feelings in a prosocial manner.

CP9. The counselor's interactions with program participants are both formal and informal (e.g., role modeling).

CP10. Staff counseling techniques include didactic, personal sharing and redirecting members to the peer-community process.

CP11. Program participants are strongly encouraged to self-disclose personal issues and observations about the community, in keeping with prison and TC guidelines.

CP12. Participants maintain strict confidentiality between the program and the general prison population .

CP13. Positive feedback such as encouragement is provided more frequently than negative feedback.

C. ADMINISTRATION

AD. It is necessary that key administrative and management staff who interface with the contracting agency have a full understanding of the TC, and function synergistically in order to maximize the effectiveness of the program.

General Rationale/Intent

In a TC, all staff, including administrative and support staff, are part of the community and therefore need to fully support the principles and practices of the TC process. In an in-prison TC, the contracting agency responsible for the program operation is usually not located at the site, except where the corrections agency is the sponsor. It is assumed that the agency is accountable to the public funding agency in terms of administrative requirements, including any licensing standards. It is also assumed that the facility is certified through other standards for correctional facility operations. There are general administrative standards which are specific to, or have a significant impact on, the TC program.

Standards

AD1. The agency maintains written administrative policies and procedures that are known to the staff, and are updated at least annually.

A2. The agency has a written quality assurance plan that insures corrective action takes place in a timely fashion.

AD3. The program reflects inclusion and respect for all, regardless of cultural background, gender, age, race, sexual orientation, criminal history and medical status (e.g., HIV).

AD4. The program prohibits practices that are demeaning to a program participant or that otherwise conflict with minimum standards of correctional care.

AD5. Each participant has a written treatment plan which is reviewed and updated periodically in accordance with the planned duration of treatment and phases of the program.

AD6. The agency is committed to documenting the effectiveness of treatment through identification of, and collection of data on, relevant outcome indicators.

AD7. The agency maintains clinical records in a manner which meets regulatory requirements, but also facilitates clinical work.

AD8. Confidentiality is strictly maintained in the handling of all client-identifying materials (reference: federal regulations, 42 CFR, part 2).

AD9. The facility is properly licensed, accredited and/or certified as may be required by appropriate state agencies.

AD10. The program has sufficient financial support and resources to enable it to maintain the integrity and autonomy of the therapeutic community process while insuring safe integration into the prison population.

AD11. The program has written "cardinal" rules (no sex, violence, substance use, etc.) which, if violated, may result in termination.

AD12. The program length-of-stay is adequate to provide necessary rehabilitation and preparation for re-entry, but not beyond the point of diminishing returns, as is optimal indicated by research (9-12 months or 12-18 months etc.).

AD13. There is an ongoing effort to support each participant's staying in treatment long enough to have the desired effect.

AD14. There is a written policy and procedure that insures that program participants may leave the program voluntarily.

AD15. The entire staff meets and communicates regularly in order to address clinical issues and to assess the functioning of the TC process.

AD16. TC management meets regularly with the warden/superintendent and senior Corrections staff to insure proper communication.

AD17. The TC provider and Corrections officials (e.g., warden) negotiate the following:

•allowing program participants to express feelings openly, and loudly, if necessary

•shared locus of control between staff and program participants

•procedures for program participants' involvement in disciplinary handling of other program participants

•maximizing the number of TC program hours per day (operating 7 days per week when feasible)

•allowing informal/formal staff-program participants interactions that might be considered "fraternization" in the prison setting.

•written monitoring protocol about systematic accountability to prevent staff/participant-clinical boundary problems.

•allowing program participants to perform maintenance and cleaning of the program space--broaden scope of program TC work readiness job functions.

•clarifying the criteria for selecting client candidates who are appropriate for the program

•establishing referral procedures in order to maximize utilization of program slots and to achieve optimal outcomes

AD18. Efforts are made to insure that TC members maintain the respect of general prison population (e.g., by competing in sports, etc.).

AD19. An incident reporting protocol that distinguishes which incidents/member behaviors are directly addressed by the program and how they are reported and managed by clinical and prison security staff.

AD20. The warden and senior correctional staff permit access to the program by interested outside parties.

AD21. The warden/superintendent and senior correctional staff understand the program and support its objectives.

AD22. Clinical records of program participants are not merged with their general prison file, but are fully protected by confidentiality regulations.

D. STAFFING

S. It is essential that the entire staff function in a manner that is consistent with the philosophy and practice of the TC.

General Rationale/Intent

Ideally, the majority of clinical staff should be graduates of a TC. In any case, there should be a mixture of recovering and non-recovering staff, including graduate-level professionals and ex-program participants, who complement each other in a unified way. There needs to be full support for the integrity of the TC at all levels within the funding and sponsoring agencies, including administration. In order to insure that the TC maintains its effectiveness, there must be initial and ongoing TC-specific training. Security and TC staffs need to be sensitive to each others' needs and approaches.

Standards

S1. The clinical staff includes recovering addicts and/or ex-offenders, preferably graduates from a TC, who act as positive recovering role models.

S2. Staff who are not in personal recovery are fully initiated and integrated into the TC concept and act as role models.

S3. At least one key management or senior supervisory staff person is a TC graduate, where this provision is feasible under state regulations.

S4. There is a TC staff orientation program consisting of at least 30 hours of didactic and experiential (e.g., immersion) training required for all employees, and an ongoing schedule of in-service and TC-specific training activities.

S5. Key administration officials from the contract agency and from the public agency and institution receive a minimum of 15 hours of TC-specific training, including both didactic and experiential.

S6. Clinical staff are appropriately certified as may be required by state regulations, and all staff are encouraged to obtain TCA certification.

S7. TC and security staff receive cross-training, i.e., TC staff receive security training from the public agency and security staff receive TC-specific training through a qualified provider.

S8. All clinical staff receive at least 2 hours of individual and 6 hours of group clinical supervision per month.

E. FACILITY/ENVIRONMENT

FE. The environment should support the primary identification of program participants with the TC culture in contrast with the prison culture.

General Rationale/Intent

The atmosphere within the TC facility should be one of safety, identification and caring. Participants should be enabled to take full responsibility for the TC space, maintaining it with a sense of ownership, pride and quality. Participants should be allowed to clean and maintain the facility as much as possible, including painting, decorating and repairing. It is important that the physical space reflect the care and concern which program participants in the TC demonstrate toward each other. When something is broken, it should be fixed immediately.

Standards

FE1. To the extent possible the program should be a self-contained environment within the larger prison setting. The treatment program is situated in special housing and space and there is minimal mixing of the treatment participants with the population in the recreational yard or at mealtimes.

FE2. The facility meets all applicable fire/safety and building codes, and local, state and federal regulations, including licensing requirements, as may be required.

FE3. The facility is clean, safe and adequate in space to meet the needs of the TC program.

FE4. Throughout the TC space, there are highly visible signs, slogans and symbols indicating a common philosophy, purpose and identification.

FE5. Larger TC programs are subdivided into units no larger than [50-75].

F. TC PROGRAM ELEMENTS

TC. All TC program components are structured to address the common socialization and psychological needs of program participants.

General Rationale/Intent

Every element and activity in the TC has multiple purposes, including: community building, education, increasing self awareness and self esteem, developing employment and independent living skills and improving interpersonal skills. Participant interactions are maximized through the emphasis on group activities. Participants may lead many of the activities under staff supervision.

Standards

TC1. There is a hierarchical stratification of program participants which establishes levels of responsibility and status by job functions. A TC organizational chart and structure board is posted in the main area of the program, managed by peers under staff supervision.

TC2. Participants perform all possible house chores, e.g., cleaning, maintenance, clerical, expediting, etc.

TC3. Work is used to support the program goals and to reinforce the sense of community and individual self-esteem.

TC4. A key clinical focus of job functions is development of appropriate attitudes and values concerning work, and skills for resolving interpersonal conflict, especially those involving authority relationships.

TC5. The program uses groups as a primary clinical intervention, including: encounters, probes, marathons, tutorials, etc.

TC6. Therapeutic peer groups and topical theme groups are held at least weekly, allowing program participants to help each other toward their individual treatment goals.

TC7. Staff counselors meet individually with program participants on at least a twice-monthly basis.

TC8. There are daily points of interaction between staff and program participants that indicate a shared mission and experience, (e.g., meals, recreational activities, holiday observances)

TC9. There are daily morning meetings which serve to motivate and energize program participants.

TC10. Meetings are held daily in which community business either is or can be transacted.

TC11. General meetings occur ad hoc to address negative behaviors, extraordinary positive behaviors, incidents or attitudes, and include the entire house.

TC12. Program participants and staff engage in meaningful program rituals, traditions and rites of passage.

TC13. The program includes daily, participant-led seminars which enhance independent living skills.

TC14. Conflict resolution, anger management and decisionmaking skills are taught throughout the clinical program.

TC15. The program provides formal relapse prevention training.

TC16. The program integrates health/mental health services with appropriate modifications to the clinical program to accommodate special needs.

TC17. The program provides appropriate educational assessment and instructional services on site.

TC18. The program provides health education training in both prevention and control of threatening diseases.

TC19. The program provides appropriate vocational training, including job preparation.

G. TC PROCESS

TP. The process of change in the TC unfolds as an interaction between the individual and the community. Socialization and personal growth occurs when individuals meet the community expectations of participation in all program activities and all social roles.

General Rationale/Intent

The TC is run primarily by positive peer pressure and group process. Participants check each other's behavior and attitudes on a continuous basis. Through constant interaction, the TC population provides feedback and confrontation aimed at raising personal awareness, particularly of the effects of one's behavior on others. This leads to increased community responsibility and accountability.

Standards

TP1. To strengthen trust in the program, the staff guide program participants to use the community process.

TP2. Senior program participants take a responsible role in relation to junior program participants, including roles such as: running house meetings, orientation of new program participants, and other peer and house management functions.

TP3. The program culture fosters the development of interpersonal relationships to facilitate individual change.

TP4. Program participants are viewed as brothers/sisters, and interpersonal relationships of a romantic or sexual nature are considered taboo.

TP5. Much of the actual help received by program participants is through informal interactions between program participants in the course of daily activities.

TP6. Peer feedback occurs more frequently than staff counseling.

TP7. The prevailing mode of interaction is positive peer pressure, including confrontation and supportive feedback aimed at changing negative behavior and attitudes.

TP8. Participants and staff work together to solve community problems; program participants have meaningful input into program planning.

TP9. Participants are encouraged to "act as if" as a means of developing a positive attitude.

TP10. The program allows some contact with the general prison population (e.g., mess, recreation) so program participants can test their clinical progress outside the boundaries of the program space.

H. STAGES OF TREATMENT

ST. The protocol prescribes at least three major program stages: induction, primary treatment, and re-entry. These are structured in order to facilitate a developmental process of change.

General Rationale/Intent

Meeting the goals and objectives of the prescribed program stages facilitates internalized learning until the individual actually incorporates a new identity which is consistent with the principles of right living. Moving through the stages of compliance, conformity, commitment and integration, the individual's motivation changes from external to internal. In prison TC programs, re-entry is modified,

depending upon the circumstances of the jurisdiction. Ideally, there is a separate living space for re-entry program participants until they are released to a community-based program.

Standards

ST1. The program is designed in three main stages, each with clearly defined written goals, activities and participant expectations.

ST2. Activities of the orientation/induction stage are aimed at assimilating the new participant into the community.

ST3. Orientation program participants may receive lesser consequences in order to assist them in adjusting to, and engaging in, the TC process. This phase has more of a psychoeducational focus.

ST4. There are written criteria for testing program participants for passage into the primary treatment stage--which is celebrated as a rite of passage.

ST5. Major goals of primary treatment include full incorporation into the community process, focus on abstinence and psychological growth.

ST6. The primary treatment stage emphasizes full use of the positive reinforcement of privilege and status level systems.

ST7. Participants develop good work habits and values and job readiness skills, strengths in interpersonal relationships in the workplace and resolve authority relationship problems in order to improve employability.

ST8. The major clinical focus of re-entry is preparation for transition to independent living outside the TC, through education and life skills training, followed by employment.

ST9. Re-entry program participants develop a commitment to continued treatment and support systems in the community, as well as concrete plans to obtain these.

ST10. Re-entry program participants are fully oriented to 12-Step recovery support groups (e.g., NA, AA), relapse prevention technology and alternative support groups.

ST11. The provider agency maintains qualified service agreements with a network of community-based aftercare resources.

ST12. The program maintains positive relations with community corrections and justice agencies responsible for follow-up treatment and aftercare services in the community.

ST13. The program initiates joint discharge planning with parole and/or other community supervision staff at least 90-120 days prior to a participant's release date.

I. COMMUNITY TC AND CLINICAL MANAGEMENT

CM. The psychological and physical safety of the community is the responsibility of both program participants and staff.

General Rationale/Intent

Management of participant behavior requires full participation by all program participants. The behavior modification system includes a balance of negative and positive rewards which are applied in a consistent, predictable, immediate and rational manner. Senior program participants are involved as a team in confronting individuals and investigating incidents in order to determine responsibility. Participants are expected to engage in continuous checking of each other's behavior and attitudes.

Standards

CM1. There are written behavioral norms which govern participant behavior.

CM2. Graduated sanctions for violation of rules are well defined, and known by all program participants.

CM3. Participants are involved in handing out behavioral consequences and earned privileges to the extent possible, under staff supervision.

CM4. There are clearly defined privileges, e.g., status advancement, more desirable living space, which are earned based upon clinical progress.

CM5. Choices of privileges are supportive of the principles of recovery and "right living."

CM6. Negative behaviors and attitudes are confronted immediately and directly by peers. This practice is seen as acceptable to the community, is reinforced by it, and acts to neutralize prison culture attitudes.

CM7. Critical feedback is directed at negative behavior and attitudes, not at the individual's character.

CM8. Participants enter into treatment contracts which include contingencies for behavioral consequences (e.g., lesser housing, less desirable job, etc.).

CM9. The program requests urine drug testing of program participants, conducts tests on staff for probable cause, and requests the results of all urine drug screens conducted.

CM10. There is a system of regular house-runs which keeps continuous track of the whereabouts of all program participants.

CM11. In conjunction with correctional staff, the program screens belongings and conducts "dorm runs" in order to minimize the presence of contraband and drugs.

CM12. Supervisory staff regularly conduct random observations of the main clinical activities (analogous to random urine screens) to sustain quality. These are recorded in the file with date, activity, and overall rating of the activity.

J. INTAKE SCREENING AND ASSESSMENT

SA. It is essential to assess the primary problem area of program participants admitted to the program. This includes obtaining a history of substance abuse and related criminal activity, other offenses and mental health. In addition, the program should have an ongoing mental health screening capability.

General Rationale/Intent

The TC approach has been adapted for a wide variety of social and psychological problems in addition to substance abuse. However, certain subgroups of substance abuser may not be suitable for the socialization and psychological demands of community life. For example, program participants who are actively violent or severely mentally ill pose threats to the safety, or make excessive management demands upon, the peer community.

Standards

SA1. The program has written eligibility criteria agreed upon by the sponsoring agency and corrections officials to identify participants most likely to benefit from the program.

SA2. Residents conduct outreach activities within the general prison population.

SA3. There is a standardized admission screening and assessment format, which may include interviews with senior program participants.

SA4. Mental health screening is conducted by qualified staff.

SA5. The program has the authority to reject inappropriate and unmotivated applicants.

SA6. Staff conduct a thorough biopsychosocial assessment within 10 days of admission, which includes identification of the program participant's strengths and weaknesses.

K. COMMUNITY-BASED AFTERCARE

AC. There must be appropriate community-based aftercare of at least 6 months duration after release from prison TC programs.

General Rationale/Intent

Research clearly demonstrates the importance of aftercare programs to maintain the positive gains made in the prison TC. Ideally, these programs include a TC-oriented residential setting which enables the former participant to transition back into the community successfully. However, other forms of aftercare with documented effectiveness may be appropriate for some prison TC graduates.

Standards

AC1. Minimally, each participant has a written aftercare plan co-authored by staff and program participant, which includes community treatment and support group participation.

AC2. Where available, program participants are referred to a community residential facility for a minimum of 6 months duration.

AC3. Urine surveillance is available for at least the first 3 months of aftercare.

AC4. Whenever possible, family counseling is provided as part of the aftercare plan.

AC5. Participants sign a release form to allow for follow-up by the sponsoring agency.

AC6. The prison TC has a written agreement with the specific community agency to which the participant would be referred.

C

Phase III: Brief Overview of Aim and Workscope

Phase III of the project and subsequent efforts will focus upon adapting these standards into formats that facilitate a general accreditation process for TCs in correctional settings. The plan for this phase consists of the establishing a collaborative liaison with the *ACA* to guide the adaptation of these standards into its appropriate format. When funded, Phase III will require approximately four months to complete. Some of the main tasks of this phase are listed in Table 3.

Table 3.	**Main Tasks for Phase III**
	• Planning meetings with the collaborative team. • Reviews of standards—related material in ACA formats to provide a framework for translation. • Selection of an appropriate format for correctional settings • Revision of the current prison based standards into correctional formats • Revision of the current for field protocol for assessing standards into correctional formats. • Field Testing of the ACA version of the standards format in several sites • Review and approval of the and revisions of the ACA standards and assessment versions • Final Products: Reformulation of Standards into the ACA Format

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