1601

ALCOHOL, DRUGS AND CRIME: AN INTERIM REPORT ON NEW YORK STATE'S INTERAGENCY INITIATIVE

FEBRUARY, 1987

VERA INSTITUTE OF JUSTICE
377 BROADWAY
NEW YORK, NEW YORK 10013

TABLE OF CONTENTS

Section		Page
I	INTRODUCTION	1
II	DEPARTMENT OF CORRECTIONAL SERVICES	7
	Legislative Mandates	7
	Program Overview	8
	Content of the Lincoln Program	12
	Space and Staffing Status, and Timing	17
III	DIVISION OF PAROLE	20
	Legislative Mandates	20
	Program Overview	21
	Training Overview	25
	Staffing Status and Timing	26
IV	VERA INSTITUTE OF JUSTICE	31
	Legislative Mandates	31
	Research Objectives and Design	34
	Implementing the Research	37
	Data Collection and Data Elements	42
	Process Analysis	48
V	EVALUATIVE SUMMARY: PROGRAMMATIC AND INTERAGENCY ISSUES	51
	DOCS	52
	Parole	54
	Interagency Issues: DOCS and Parole	57
	Interagency Issues: DSAS and DAAA	63

APPENDICES

APPENDIX A: Legislative Problem Document

APPENDIX B: Proposed DOCS Plans for the Lincoln Pilot

APPENDIX C: Consent Forms

APPENDIX D: Preliminary Process Analysis Results: A History of ASATs and Description of Three Feeder Sites

I: INTRODUCTION

In early 1986, Assemblyman Melvin Miller proposed a 1.3 million dollar addition to the New York State budget to finance a comprehensive alcohol/drug abuse program for inmates and parolees. The budget bill provided resources for the State Department of Correctional Services (DOCS) and the State Divisions of Parole, Substance Abuse Services (DSAS), and Alcoholism and Alcohol Abuse (DAAA) to enhance existing services and create new ones, and allocated funds for the Vera Institute of Justice so that it could monitor and support implementation of the State initiative and design an evaluation to test the impact of these services. The legislative initiative aimed to provide purpose, coherence, and leadership to the State's efforts to address programmatically a chronically neglected criminal justice and crime control issue -- the relationship between alcohol, drug abuse and crime.

Alcohol, drug abuse and criminal behavior are linked. A 1983 survey by the U.S. Department of Justice underscores the association:

--54% of all inmates convicted of violent crimes were drinking prior to the offense; 25% had used drugs.

--62% of those convicted of assault had been drinking prior to the offense; 22% had used drugs.

--68% of those convicted of manslaughter had been drinking prior to the offense; 19% had used drugs.

--48% of those convicted of robbery had been drinking prior to the offense; 31% had used drugs.

This strong association prompts two questions: Can the provision of services to alcohol- and drug-abusing offenders reduce their subsequent criminal activity? If so, what kinds of services can lead to this result? The State interagency initiative presents an opportunity not only to expand services for alcohol/drug-abusing offenders but also to begin to answer these questions.

The special allocation by the legislature is grounded in the hypothesis that recidivism among alcohol- and drug-abusing ex-offenders can best be reduced by a comprehensive program designed to increase their sobriety after release -- a program providing a continuum of services, including in-prison treatment, pre-release planning (including assessment of post-release needs), appropriate referral to community-based treatment, and follow-up of those treatment referrals (including further linkage to needed services). The State initiative addresses some of the large gaps in this envisioned treatment continuum, building on the best of what is already in place.

The legislation envisioned a service continuum for chemically dependent offenders beginning with their identification by DOCS at classification and then continuing with transfer to a

DOCS facility where treatment would be provided to identified inmates. Following successful completion of treatment, they would be prepared for release at a new alcohol/drug abuse pilot program (to be housed at the Lincoln Correctional Facility in Manhattan), their post-release treatment needs would be assessed and they would be referred to appropriate community-based treatment programs which they could attend upon release. A paramount goal of the effort was to forge long-sought but unrealized collaborations among Parole, DSAS and DAAA -- working relationships viewed by the initiative's framers as prerequisites to the development of post-release treatment services that reach parolees and that are responsive to their special needs.

A total of 700,000 dollars was appropriated for the initiative's start-up period of six months, one-half of which was targeted for DOCS to extend its existing Alcohol and Substance Abuse Treatment (ASAT) model to more prisons, to enhance ASATs in place, and to establish a new pilot community preparation ASAT specifically designed to treat soon-to-be-released alcohol/drug abusers. The 350,000 dollar balance was allocated to the Division of Parole to fund, in part, the development (with DAAA and DSAS) of an interagency assessment and referral service designed to seek continuity of treatment for releasees by linking them with community-based treatment providers. Parole's allocation also included funds for a joint DSAS/DAAA training function and for a 12-month contract with the Vera Institute to provide

technical assistance to the various State agencies and to monitor and evaluate the entire initiative.

This document is Vera's record of the activities set in motion by the legislative initiative. We need to open with a reservation: Despite the encouragement and cooperation of all parties, understanding and describing an interagency State initiative from the outside is not easy. While this report tends to highlight some unresolved issues and, here and there, underscores matters that seem to us to be causes for further concern, we are on balance encouraged by the scope and character of the participating agencies' achievements in the first nine months of this initiative, and we mean to convey that generally encouraged view of the prospects for their efforts.

What follows, then, is documentation and analysis of where the initiative stands and where it appears headed. Briefly, DOCS seems poised for implementation; the agency is completing its hiring for the classification facilities, for the new and existing ASATs, and for the Lincoln pilot program. Pathways to Lincoln have been established, and a 37-bed unit has been designated at the facility for the pilot's use. Parole is hiring up for its pre- and post-release functions; it has established where and how the assessment and referral team is to work; and it has taken a leadership role in efforts to forge the interagency collaborations that are vital to the initiative's ultimate effectiveness. DSAS has committed counselors and important technical resources

toward Parole's pilot efforts. DAAA, however, has chosen to take a different approach, one which departs from the role envisioned for it by the legislative framers of the initiative.

In addition to its provision of ongoing technical assistance and its efforts to help coordinate and to monitor the agencies' efforts (a product of which is this report), Vera has developed and is ready to put into place a research design intended to produce a reliable base of information that will address public policy questions relating to the effectiveness and efficiency of treatment and to recidivism.

Organization of the Text. The middle three sections of this report provide a detailed status report on the initiative. Organized by agency and ordered as they appear along the envisioned service continuum (with DSAS and DAAA activities specified in the Parole section), each of these sections begins with an account of the agencies' roles as specified by the Legislature. Instead of the legislation itself (which was quite brief), a paper prepared by Assemblyman Miller's staff entitled the "Problem" document (shown in Appendix A) served as the source for discussion of these legislative mandates. In the DOCS and Parole sections, this discussion is followed by a report on planning and implementation activities relating to the particular programs for which the agency is responsible. The DOCS and Parole sections end with an update of their staffing status, and specifies target dates for program implementation. The section on Vera's work

focuses on the plans it has developed for formal evaluation of the pilot programs, and on the activities it has undertaken in implementing these plans. The last section of this report addresses various issues that, in our view, need attention and resolution. This section is divided into discussions of agency-specific issues, on the one hand, and issues arising from interagency activities on the other.

II: DEPARTMENT OF CORRECTIONAL SERVICES

Legislative Mandates

The legislation recognized DOCS's ASAT programs as a "noble beginning" in the provision of services for inmates in need of alcoholism and drug treatment. From this starting point, the legislation proposed "to expand the availability of existing ASAT programs and to establish a longitudinal/chemical dependency program based on the ASAT model." The expansion plans provided for additional staff at DOCS classification facilities to enhance the identification process; staff for new ASATs at two correctional facilities for female inmates; additional staff at ten extant ASAT programs; and the creation of a new position to assist the coordinator in Albany responsible for system-wide ASAT programming.

The initiation of an in-prison service continuum for drug and alcohol abusing offenders envisioned in the legislation was to center around the establishment of two pilot programs -- a "treatment program" and a "pre-release" ASAT. The legislative document describes the former as a new, residential ASAT,[1] with a

---

[1]Programs deemed "residential" by DOCS are those in which participants are housed in a distinct unit set aside for the ASAT (e.g, an entire floor or building), separate from the facility's general inmate population. The great majority of ASATs are non-

relatively large staff (in comparison to other ASATs) for the program, to achieve "smaller counselor to inmate staffing ratios." The legislation clearly indicates that the pre-release ASAT is to be the linchpin (on the DOCS side) of the new service continuum. The creation of such a program was targeted for the Lincoln pre-release facility in Manhattan, tailored for individuals who are "within the release milieu." The pilot ASAT was to take advantage of the participants' proximity to the release community, and their imminent release date. Specific benefits would include the opportunity for "more intensive family/inmate reorientation" with easier family access, "more constant and direct" contact with the field parole officers who would be supervising participants upon release, and participation in community-based programs prior to release. The legislation called for a program of four weeks duration put together as a residential 37-bed unit at the Lincoln facility.

Program Overview

Expansion of ASATs in the DOCS System. DOCS has planned for (and is now implementing) considerably more expansion than was specified in the legislative proposal. In addition to the establishment of two ASATs for female offenders,[2] new programs

---

residential, with participants living in dormitories or cellblocks as part of the general population, and attending the program by going to the offices or rooms reserved for the program and its staff.

[2]Albion and Parkside.

will be put in place at six other facilities.[3] Additional staff is planned for five non-residential programs[4] and two residential ASATs.[5] Instead of placing additional staff at ten facilities (as specified by the document which underlies the budget bill), DOCS is adding staff at seven facilities, and starting five new programs. As a result of this expansion, DOCS will have ASATs in 27 of its 51 facilities; while not reaching all the nearly 19,000 inmates who are judged by current DOCS screening practices to be alcohol and/or drug abusers, the initiative's allocations will make treatment programs available to many more of these individuals, and has the potential to raise the quality of that programming across the system.

Plans have also gone ahead for enhancing identification efforts by the placement of additional staff at the two DOCS adult male classification facilities.[6] The new staff will administer the Michigan Alcoholism Screening Test (MAST) to all inmates entering the DOCS system, in addition to working in the existing ASAT programs at these sites. The expanded staffing should permit much more systematic administration of the MAST than has been the case up to now, with the intent of identifying

---

[3]Greene, Sullivan, Washington, Fulton, Camp Monterey and Camp Pharsalia.

[4]Arthur Kill, Eastern, Fishkill, Hudson, and Edgecomb.

[5]Mt. McGregor and Collins.

[6]Downstate and Wende.

and targeting individuals who would benefit from placement in a facility with an ASAT program.

The Lincoln Pilot Program. DOCS has merged the treatment and pre-release purposes described in the legislative proposal into one program by developing a plan for a twelve-week residential pilot program for 37 inmates to be known as the Lincoln Community Preparation ASAT Program. Designed to build upon the positive effects of treatment obtained previously, inmates who have recently successfully completed at least three months of attendance in an ASAT at one of a select group of "feeder" facilities will be considered eligible for the Lincoln program. Details concerning the choice of the feeder sites and further participant selection criteria are discussed below in the Identification and Transfer section.

The length of stay at this Lincoln program varies from the four-week term noted in the legislative documents. DOCS has argued that a 90-day program (a period viewed as a conventional minimal intervention term among many recovering alcoholics and treatment practitioners) offers advantages over a shorter program. One benefit concerns the ability to motivate clients participating in the program. By virtue of the Parole Board scheduling system, all participants in a four-week pre-release treatment program would have already met with their Board and been given an "open" or release date. A twelve-week program requires the selection of participants who have not yet won their release date and who must still successfully meet with a Parole

Board; DOCS believes inmates in that circumstance are more likely to get involved in the program, at least partially as a means of enhancing their chances for Parole. Inmates with four weeks to release date, on the other hand, are likely to be thinking about nothing other than getting out, and are regarded as very difficult to engage in treatment.

Another benefit of the longer length of stay identified by DOCS is the opportunity for participants to take full advantage of pre-release services currently offered at Lincoln. The pre-release services to be incorporated into the pilot include exposure to the range of ex-offender services in the community (e.g., vocational programs like Vera's Vocational Development and Neighborhood Work Programs, brokered at Lincoln by the South Forty program), and assistance in planning an inmate's reintegration into the family and social structure to which he will return. This pre-release programming will build upon similar community preparation efforts in drug and alcohol areas, which will include Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) groups led by community members, and Al-Anon and counseling sessions that will involve the participant's family. Thus, where ASAT programs in other facilities are geared to maintaining sobriety and developing coping skills while incarcerated, the focus of the pilot community preparation ASAT at Lincoln is to help men prepare to acheive these goals in the community.

Content of the Lincoln Program

All inmates who participate in the Lincoln pilot will have successfully attended (as measured by DOCS) an ASAT program in another correctional facility. According to DOCS officials, maintaining and strengthening the effects of this prior treatment will be an overriding principle in the Lincoln curriculum. Alcohol and drug treatment are viewed by these managers and planners as a constant, life-long process, characterized by repetition and reinforcement of lessons previously learned. Thus, the Lincoln program is designed to continue much of the educational content found in ASAT programs throughout DOCS facilities. Films, audio tapes, lectures and seminars led by program counselors and outside specialists will be used to present the educational curriculum, and participants will be expected to do homework assignments to promote the internalizing of this material. The proposed content of the Lincoln curriculum is outlined in a DOCS planning document, specifying the "12 Week ASAT Cycle." This outline (Appendix B) indicates the variety of topics to be covered, ranging from an array of health issues associated with drug and alcohol abuse (e.g., drug pharmacology, fetal alcohol syndrome, and AIDS), to motivational films designed to promote sobriety.

This document, as well as a tentative program schedule outlining participants' weekly activities (also shown in Appendix B) reflects a dual emphasis on educational and psychological

curricula. Each week of the Lincoln ASAT cycle has been assigned a "theme" and will also focus on one of the Twelve Steps of Alcoholics Anonymous (AA) and Narcotics Anonymous (NA). In contrast to the video, lecture and seminar contents, these themes and the AA/NA steps are of a psychological nature, ranging from "honesty and self-control" to "family and faith."

The weekly schedule also reflects the community preparation components which have been incorporated into the standard ASAT programming. In this regard, the Lincoln program (as proposed) will stress active participation in AA and NA groups and involvement of the inmate's family in the recovery process. The men in the pilot project will have four or five mandatory AA/NA meetings per week. Almost all of these groups will be led by AA/NA members from the nearby community; using leaders from outside the prison, DOCS hopes to encourage inmates to plan for AA/NA participation in the communities in which they intend to reside upon release.[7]

As many as seven weekly Al-Anon meetings are also scheduled. These groups, as well as four "family counseling" sessions that have been scheduled weekly, are the focus of the program's

---

[7]To similarly facilitate this goal, DOCS is currently developing with AA a statewide "networking correspondence program." Inmates being released from prisons throughout the State who wish to participate will be provided with the name of an AA member in their community of release who is willing not only to correspond with the inmate, but also to become a temporary AA sponsor when that inmate is released. For inmates being released to the New York metropolitan area, DOCS has a list of over 700 AA members who have indicated a willingness to participate in the program.

efforts to engage the inmate's family in his treatment regimen. The Al-Anon and family counseling sessions have been scheduled for weekday evenings and weekends to encourage attendance by spouses and other family members. How successful these efforts will be, and what procedures promote actual family involvement at Lincoln, are especially difficult to predict; nevertheless, the effort is an important innovation worth observing.

Details regarding the integration of Lincoln's pre-release programming into the pilot have not yet been determined. Lincoln offers a standard three-week pre-release program for its general population (all of whom have "open dates" and are released, on average, five weeks after coming to Lincoln); this program is presently being reviewed and upgraded by the coordinator of pre-release programs in Albany and by Lincoln's administration. Once plans for the revised pre-release activities are finalized and made known to the ASAT pilot's planners, pre-release components will be incorporated into the pilot. At this point, DOCS has decided to structure the last three weeks of the pilot participants' stay in half-day modules to permit scheduling of the pre-release programs.

Also in an early planning phase is the determination of Parole's involvement in the program and the extent of its contact with pilot participants while at Lincoln. As discussed fully in the Parole section of this report, Parole will be running its own pilot service focusing on assessment and referral for post-release treatment in the community. Largely an expansion of its

current ACCESS program, the staff will provide these services to the Lincoln pilot participants, but also to non-pilot parolees who have already been released, perhaps for some time, who need specialized assistance. DOCS and Parole have agreed that the content of the Parole/ACCESS effort at Lincoln will be release planning, but the shape and timing of this effort is still under discussion.

Identification of Participants and Transfer into the Lincoln Pilot. As noted above, potential participants must have recently successfully completed at least three months in an ASAT program. Another criterion, specific to Lincoln's security classification in the DOCS system, is that the participant cannot have been approved (or did not apply) for temporary release status. Lincoln's classification as a facility for men will also exclude females from the pilot.

Additionally, efforts will be made to identify "re-apps" for participation -- that is, inmates who have been turned down by the Parole Board at a prior hearing. These individuals are preferable for the pilot because they are much more likely to be released upon a subsequent hearing than are "initials," or those who are meeting the Board for the first time. This greater chance for release is important: The central community preparation dimension of the pilot program presumes participants will be released to the community in the near future. For the same reason, inmates who already have a mandated or conditional release date (and will not meet with the Board) will also be targeted for the program.

Thus, potential Lincoln pilot participants will be identified by the ASAT staff at each feeder site four to five months before their eligibility release date (the date they are eligible for release *if* the Board grants them Parole) or conditional release date. Inmates identified for the pilot will be told that they can participate in the project, and informed about the Lincoln program, Parole's role in post-release programming, and Vera's research plans. If they elect enrollment in the program, they will be transferred to Lincoln within twelve to fourteen weeks before their eligibility or conditional release date.

DOCS has arranged for the majority of Lincoln's 37 pilot beds to be filled by men from the Mt. McGregor, Sing Sing/Tappan, and Woodbourne Correctional Facility ASATs. Vera has been provided with data from Woodbourne on "re-apps" and men with conditional release dates who meet the criteria described above, distributed by number of months to release date. The number of eligible men from Woodbourne is small (four to six per month); although the data are still being prepared at the other two sites, DOCS believes those numbers will be fairly consistent with Woodbourne's (allowing for difference in program size). To increase the number of eligibles, some "initials" will take part in the project, and DOCS and Vera are considering the designation of other ASATs as feeders; these potential sites include Arthur Kill, Mid-Orange, Otisville and Taconic.

Space and Staffing Status, and Timing

Lincoln Space. A thirty-seven bed unit at Lincoln has been specified by DOCS as the location for the residential pilot program. The program will occupy the entire sixth floor of the facility which includes individual residential rooms, offices, and a common space which can be used for group meetings. On two other floors, additional office and treatment space has been set aside for the staff of the new ASAT and for an institutional parole officer who will assist in the pre-release processing of the pilot inmates. Space has been identified for Parole staff who will be coming into the facility on a part-time basis, and Vera research staff have been provided desk space and a great deal of help in locating files, gaining access to inmates, and preparing to conduct research activities on-site (as described in Section IV below).

Staff and Staff Training. The legislative proposal identified 32 new FTE positions to staff the enriched ASAT program it envisions. The creation of these positions was complex because Civil Service judged DOCS plans for these positions to require the establishment of new State titles. After prolonged negotiations, Civil Service authorized a new ASAT Corrections Counselor sub-group which will rate a GS19, and a new title for Alcohol Rehabilitation Assistants (currently GS11) who will now be referred to as ASAT Program Assistants, rated at GS14.

A total of 31 positions have been approved for DOCS by Civil Service. DOCS has engaged in the posting, interviewing and hiring process since late December, and expects to have all the new staff members in place by February 28. The new staff to be utilized for ASAT expansion will include:

--at each of the two adult male classification sites, one GS14 employee to enhance the identification process;

--at each of the two new ASAT programs for female offenders, 1.5 FTE ASAT Program Assistants and a .5 FTE Stenographer;

--at each of the four new ASAT programs for male offenders, one ASAT Program Assistant;

--at each of the two new ASATs at the Camp facilities, a .5 FTE ASAT Program Assistant;

--at each of the five expanded existing ASATs, one ASAT Program Assistant;

--at each of the two expanded residential ASATs, two ASAT Counselors, two ASAT Program Assistants, and a Stenographer;

--an assistant to the Director of Alcohol and Substance Abuse Programs in Albany.

The new staff for the Lincoln Community Preparation ASAT will include four counselors (two ASAT Counselors and and two ASAT Program Assistants) and a Stenographer. DOCS still intends to appoint a GS21 Program Supervisor (as the program's director), but this is the one position of the 32 originally described in the legislation to which Civil Service has not yet agreed. DOCS hopes to have this position approved and filled in the near future, but in any case does not view the absence of Civil Service approval as anything but temporary.

DOCS considers training a necessary component of ASAT staff development, and has indicated plans for training Lincoln personnel. During the week or two anticipated between staff placement at Lincoln and arrival of the first program participants, a full orientation is planned. That orientation will include discussions of treatment issues, introduction to Parole and the Parole process, introduction to Vera and the research component, and lessons in the actual mechanics of the Lincoln pilot project (including information gathering and documentation). Fellowship Center, a non-profit agency serving offenders with alcohol problems which maintains contractual training agreements with DOCS, will be responsible for much of the treatment issues training.

Placement of Program Participants. In early January, DOCS sent memos to the feeder site Deputy Superintendents, detailing the process by which Lincoln participants were to be selected and prepared for transfer. In response to this initial call for participants, DOCS now expects that the first pilot participants will enter Lincoln in late February. By the middle of March all 37 slots in the program should be full; this necessitates an increment of 10-15 participants a week, and is in line with the respective capacities of DOCS and Parole staff to process new transfers (who must still go to a Parole hearing).

III: DIVISION OF PAROLE

Legislative Mandates

The legislative initiative assigns a broad range of tasks to the Division of Parole. Chief among these is the provision of services to the Lincoln pilot participants (essentially to complete the continuum of services begun at entry to prison with the inmate's classification), and an assessment and referral service for "the new parolee, releasee or parolee who is in danger of technically violating" because of alcohol or drug abuse. These post-release services, as well as a training program for treatment providers and parole officers, were to be developed and implemented in a long-sought but previously unrealized collaboration with the State DSAS and DAAA. These services are in addition to those routinely performed by Parole (e.g., referral for appropriate employment and/or job training) which will, of course, continue to be offered to inmates and parolees receiving the enriched Lincoln pilot services.[1]

---

[1]Parole is also designated by the legislative mandate to contract with the Vera Institute to support, monitor and evaluate the initiative.

<u>Program Overview</u>

As a vehicle by which to develop pilot services, Parole has chosen to expand its existing ACCESS program, an assessment and referral service for parolees with drug problems begun in the spring of 1986. Jointly developed and staffed by DSAS and Parole, the current program operates in Parole's 40th Street office. Parolees are referred to an ACCESS counselor by their field parole officers who have judged them to be in special need of the substance abuse expertise (and/or treatment contacts) ACCESS was created to provide.

Under the current State initiative, Parole is re-organizing and expanding ACCESS to serve both the Lincoln pilot participants and a greater number of other releasees under parole supervision. For the first time, ACCESS will provide assessment and referral services for alcohol-abusing offenders as it has up to now offered to drug abusers. These services (both alcohol- and drug-related) will be provided to the pilot participants during their last few weeks at Lincoln, in final preparation for their release. To accomplish these goals, ACCESS, in accordance with the legislative initiative, will have an expanded staff, which will operate in the New York Parole office (covering Manhattan and Brooklyn) and in the Bronx office, as well as at Lincoln.

<u>The Lincoln program.</u> As indicated in the DOCS section, Lincoln pilot participants will be identified at select feeder ASATs, and then transferred to Lincoln. Parole is planning for their institutional parole officer (IPO) at the feeder facility

to meet initially with a targeted participant; the IPO will describe Parole's role in the Lincoln program, and will begin to prepare a Parole transfer summary for the man's move to Lincoln. At Lincoln, Parole plans for its project coordinator and/or the Lincoln IPO to meet each participant at an intake interview and then for the Parole/ACCESS staff to: assess the participant's progress during the pre-release program; determine his post-release treatment needs; identify appropriate services in the community to meet those needs; and make post-release treatment referrals. As part of case management, the coordinator and ACCESS staff will meet regularly with ASAT staff working with the inmate. After release, ACCESS counseling staff will confirm the participant's entry into treatment, and monitor his attendance through quarterly reports prepared by the service provider.

The expanded project staff will include a project coordinator recruited and employed by Parole who will oversee the program and four counselors who will be responsible for the provision of assessment and referral services to Lincoln participants and parolees. Two of the counselors will be specialists in drug treatment (DSAS employees subcontracted by Parole) and two will be trained as alcoholism treatment specialists (originally intended to be hired from DAAA, these staff will be specially selected and trained parole officers). Parole intends for the four counselors to be divided into two teams comprised of a drug and alcohol specialist. These teams, as well as the coordinator, will split their time between the Lincoln site and the two Parole offices.

As part of the Lincoln pilot service, Parole also intends for the field parole officer who will ultimately supervise the participant on his release to meet him at Lincoln near the end of his stay. Parole has indicated that the field parole officer will assist the ACCESS counselor in making a referral to post-release treatment (if possible), or at least be aware of that referral. Other than this collaborative pre-release referral at Lincoln, the duties of the field parole officers vis-a-vis pilot participants remain those of conventional parole supervision. While post-release monitoring of the releasee's follow-up of a referral can be part of these routine duties (if a parole officer can afford the time, he or she may contact a treatment agency to get feedback on a parolee's participation) ACCESS counseling staff will provide formal, written follow-up of referral outcomes.

ACCESS for the Parolee. In addition to working with pilot participants, ACCESS staff will also provide expanded assessment and referral services to the general parole population in the New York and Bronx Parole offices. Up to now, ACCESS has operated out of the New York office only, with part-time DSAS counselors providing drug treatment referral services only on weekday mornings (a time of day during which parolees are difficult to reach). The program will now have five full-time staff members (a coordinator and four counselors, as specified above) providing both drug- and alcohol-related services out of two Parole offices.

In these offices the program will continue to accept referrals from parole officers,[2] evaluate treatment requirements for referred parolees and try to secure their placement in appropriate community treatment programs. ACCESS follow-up services will consist of confirming a parolee's initial appearance and requesting quarterly treatment summary reports from providers at the referral site. Now performed by parole aides, these compliance duties will be taken on by the ACCESS staff in the expanded program.

While the responsibilities of the expanded ACCESS are essentially the same as those performed by the "old" ACCESS, for the new program, Parole and DSAS have intensified their efforts to forge important contacts with treatment providers. DSAS's Director has personally requested assistance on the part of providers in Brooklyn, the Bronx and Manhattan, and received assurances from particular programs that outpatient treatment slots will be made available for ACCESS clients. The two ACCESS counselors presently on staff (see below) have visited these sites, and according to their supervisor, are making explicit arrangements with individual provider staff who will assist in handling ACCESS cases.[3]

---

[2]To increase appropriate use of the program, Parole is developing means for identifying recent Bronx and Manhattan parolees who leave prison with special Parole conditions related to drug/alcohol use or treatment. The field officers in charge of these cases will be contacted and encouraged to use ACCESS for the identified parolee.

[3]It is questionable whether such arrangements will be forged with alcoholism treatment providers by the alcoholism counselors in the expanded ACCESS (who will not be DAAA employees and have not yet been hired). This issue is discussed in the last section of this report.

Training Overview

Parole has arranged with DSAS and DAAA to provide training to 150 field parole officers, and to community-based drug- and alcohol-abuse treatment providers as outlined in the legislative initiative. The philosophy behind such training is similar to that which drives the pilot services noted above: Obtaining appropriate services depends on good communications between parole officers and providers, and the special needs of the drug- and/or alcohol-abusing parolee must be understood, and understood in similar frames of reference by both parties. Specifically, parole officers must learn how to assess the needs of these parolees and how to evaluate treatment options in ways likely to afford a match between parolee and provider. Providers in the community must have a feel for how parolees differ from other clients, how Parole operates, and the special demands made on individuals under Parole supervision.

Additionally, Parole plans to use DSAS and DAAA to provide specialized training to various staff working on the initiative. One such group is the "treatment team" at Lincoln. As envisioned by Parole, that team consists of all the individuals who will be working with Lincoln pilot participants: the Lincoln ASAT staff, the Parole project coordinator, the new ACCESS counseling staff and the institutional parole officer at Lincoln. The focus of

that training would be to foster communication across conventional turf and to seek to develop a "team approach." While not yet in writing, DSAS, DAAA and DOCS have expressed interest in this training. Additionally, DAAA has agreed to Parole's request that DAAA assist in the training of the two parole officers it is hiring as ACCESS alcoholism specialists. Vera has also agreed to broker its experience with local alcoholism treatment providers to assist these counselors, and where possible, help establish arrangements for future treatment slots.

Staffing Status and Timing

Programs. The legislation provides Parole with the following new positions:

1 GS21 Parole Project Counselor

2 GS18 Substance Abuse Counselors

2 GS14 Alcoholism Counselors

1 GS5 Stenographer

The legislation indicated that Parole was to subcontract the counseling positions to DSAS and DAAA. Such an arrangement has been made with DSAS which decided to recruit two Substance Abuse Counselors at GS21, and assume the differential costs. DAAA, however, declined such a collaborative role. Vera's understanding of DAAA's position regarding delivery of these services is described in a later section of this report.

The two newly hired DSAS counselors began a five-week training and planning period in late December. During that period, they spent time in the New York Parole office, at DSAS's own training facility, with other DSAS personnel who work in court-related treatment programs, and visiting treatment sites. They are now ready to begin work at Lincoln and at the Parole offices.

In light of DAAA's unwillingness to provide direct service personnel (a determination detailed in the Summary/Issues section of this report), Parole decided to expand its own staff by creating the two Alcoholism Counselor positions. Parole is recruiting parole officers for these positions (GS19) who are conversant with alcoholism treatment and plans to hire them by late February. DAAA has agreed to provide intensive training to these two individuals with emphasis on assessment procedures and knowledge of community-based providers.

Parole hired the Parole Project Coordinator at a GS22 in late December. He is presently based in the Bronx Parole office and has been working in a planning role. The Stenographer also came on staff in late December, and is being trained in ACCESS duties in the Bronx office. In addition to these pilot staff, Parole will be bringing in new personnel at Lincoln to prepare pilot participants for Board hearings; these include an IPO (who has been placed) and a Stenographer (who has not).

Once the alcoholism counselors are hired and team assignments of the new Parole/ACCESS staff are determined, complete

field services will be available, likely by mid-March. ACCESS services for parolees with drug problems (provided by the two DSAS counselors already on staff) will begin in the Bronx and Manhattan offices in early-mid February. It is less clear when the full staff will begin work at Lincoln; considerable progress is still needed to coordinate Parole/ACCESS responsibilities with those of the DOCS ASAT staff. The first participants of the 12-week Lincoln pilot ASAT will enter that program in late February, so by March final agreements and procedures must be in place at Lincoln for the ACCESS team to begin work. Additionally, it has to be determined how the coordinator and the two counseling teams will ultimately divide their time between Lincoln and the Parole offices.

Parole has been internally publicizing the expanded ACCESS, and expects to have a written description of the service ready for this purpose in early February. This description will be circulated to area supervisors, for dissemination to field staff. Parole also plans to make a formal presentation on ACCESS to the Board of Parole in March, with the intention of effectively integrating ACCESS in the Board's formal decision-making process.

Training. Meetings held during the fall between DSAS, DAAA and Parole planners led to a decision that the training of the two targeted groups (the parole officers and the providers) would be handled, in the main, in separate efforts by DSAS and DAAA. It was decided that DAAA and DSAS would each be responsible for two of the planned five days of training, and work together on

one of those days. More recent discussions between these agencies suggest that a more coordinated effort will be attempted which would be consistent with the spirit of the legislative initiative. (Vera's views on the desirability of an integrated approach are taken up in the "Issues" section below.)

DAAA, borrowing from an earlier effort with probation officers, has presented Parole with a proposal and curriculum for their work with parole officers on this initiative. Tentatively accepted by Parole, DAAA's plan included a focus group workshop that they held in mid-January with eight field parole officers.[4] A DSAS training specialist also attended the workshop. DSAS has not yet submitted to Parole plans for its training, although it has expressed its intentions to do so. DAAA and DSAS planners are reportedly talking with one another about ways of dividing training content, and making that content consistent across presentations by the two agencies. Parole expects to work with both agencies to incorporate parts of its own training curriculum used with officers.

It is anticipated that the parole officer training will begin in mid-March. Parole has arranged for the sessions to be held at a space available to them at John Jay College, and has met with regional administrators about training plans and

---

[4]Held at Vera's offices, the focus group was useful in identifying areas in which parole officers need training with regard to drug- and/or alcohol-abusing parolees. DAAA is preparing a document describing the results of the meeting, and its plans for incorporating those results in its training efforts.

procedures for identifying the individual officers who will attend the training. Plans call for four groups of trainees to attend one day a week for five weeks; approximately 100 parole officers will be in training by the end of the State fiscal year. At least another fifty officers will be trained subsequent to this first wave of participants. While some discussion of training for providers has occurred, no plans have yet been made in this regard.

IV: VERA INSTITUTE OF JUSTICE

Legislative Mandates

The Vera Institute is specified by the legislative document as playing a dual role in the State initiative. One of these is a coordinating and technical assistance mission, centering on the development of interagency collaboration in the planning and implementation of the pilot services. Vera developed close working ties to specific individuals in each agency who were charged with project design and implementation and has furnished assistance to them as they conceptualized and designed program initiatives. The Institute has and will continue to provide suggestions and assessment during implementation of those activities.

In the next year of the initiative, Vera's technical assistance effort will focus on development of linkages between program initiatives undertaken by State agencies and services performed by voluntary providers of community-based alcoholism treatment and those performed by other agencies designed to meet needs of ex-offenders. Technical assistance will also take the form of feedback based on results of Vera's evaluation effort (described below); interim findings will be described and interpreted on a regular basis to the State agencies involved in the

initiative so as to increase the effectiveness of the pilot services.

Vera's other role is to monitor the implementation effort, and evaluate the success of the pilot services put in place. DOCS and Parole officials have made it evident that they place primary value on Vera's responsibility in this regard, indicating that they view Vera as an independent evaluator whose assessment of the pilot programs' impacts will be critical in measuring the ultimate success of the effort. While sharing that perception of its role as program evaluator, Vera takes a larger view with regard to its research involvement in the initiative. Specifically, because prior research suggests a linkage between alcohol/drug abuse and criminal behavior, we believe that the State initiative presents an opportunity to answer central questions prompted by that association: Can the improved provision of services to alcohol- and drug-abusing offenders reduce their subsequent criminal activity? If so, what kinds of services can lead to this result?

It is in this context that Vera has developed a research strategy designed to compare the relative impacts of a range of services offered to New York State inmates and parolees. Plans for this design and its implementation are discussed in this section. Two other substantive monitoring/evaluation tasks are also addressed below. One is a process analysis of the pre- and post-release pilot programs implemented by DOCS and Parole which will be used to both describe these programs and interpret out-

comes experienced by participants. The second is Vera's plans with regard to following participants in the pilot program. This work will go beyond the collection of routine outcome data (e.g., criminal recidivism, severity of alcohol/drug abuse) and include tracking releasees' experiences with a range of community-based treatments.

Research Plans and Research Implementation. The research plans presented in this section are the result of considerable prior planning, information gathering and pilot testing; thus, for example, they are more "set in stone" than Vera's plans six months ago. Nevertheless, they must be regarded as tentative and may differ from those which are implemented for several reasons. First, the plans are in part dependent on the actions of other actors over which Vera has no control (e.g., DOCS's graduating and releasing to the community, on the average, 37 pilot participants every three months). They are also in part based on certain assumptions that can only be tested through actual research implementation (e.g., there are enough inmates coming through Lincoln who meet criteria to establish a sufficient comparison sample). In addition to these general provisos (which are largely endemic to any research endeavor), the plans described here are entirely dependent upon two other things occurring. One of these is that adequate funding becomes available for the activities necessary to carry out these plans. Second, Vera and Parole have not reached agreement on necessary assurances providing for the routine protection of the confiden-

tiality of subject data gathered post-release. Such an agreement (which has been reached between Vera and DOCS) will need to be embodied in a contract between Vera and Parole before any such data are collected.

Research Objectives and Design

It is Vera's intention to address the central public policy questions noted above by comparing the efficacy of the new pilot services to the efficacy of those programs presently in place. Specifically, the research is designed to compare the post-release outcomes of three groups of inmates, all of whom have been identified as having alcohol and/or drug abuse problems. These include (1) inmates who participate in DOCS's Alcohol and Substance Abuse Treatment programs (ASATs) and attend the special Lincoln pre-release and post-release pilot program implemented under this initiative; (2) inmates who successfully participate in non-Lincoln ASAT programs only; and (3) inmates who receive no alcohol and substance abuse treatment while in prison.[1]

Outcome data will be collected for purposes of testing whether pilot participation (plus ASAT) or participation in

---

[1]For purposes of efficiency, men in groups 2 and 3 will be chosen from Lincoln's general inmate ("CPOD") population. Given this constraint, it is possible that the pool of subjects will not be large enough to permit the kind of clear delineation between groups 2 and 3 stated. (Vera is presently collecting data at Lincoln in this regard.) If so, use of the two separate comparison groups will be dropped and we will use one comparison group; these subjects will be assessed along a continuum of "degree of ASAT attendance."

traditional ASAT alone is associated with greater success during the first year after release from prison. Individuals receiving these two forms of treatment will be compared to the no-treatment group to see if, after release, they...

...show fewer rearrests and convictions, and spend less time incarcerated;

...have fewer drug- and alcohol-related relapses, and in general evidence less severe drug and alcohol problems;

...show more attendance in community-based treatment programs for drug and alcohol abusers, and are more likely to complete these programs successfully;

...are more integrated within their family structure, and report greater satisfaction with their family and social lives;

...are more residentially and vocationally stable;

...have fewer medical and mental health problems, and are less likely to need care for these problems.

These and related outcome data will be collected from various sources (listed below), with the primary source being interviews with pilot program participants conducted at two and twelve months after release. Results of the two-month interview should permit a detailed picture of the early reintegration process to emerge (including alcohol and drug problems) during what is generally regarded as the most stressful time for a releasee. Tracking releasees for a full twelve months will, however, provide a longer time period for assessing conclusions about the impact of different treatment modalities.[2]

---

[2]If research resources permit more extensive analyses of outcome data and if the samples are large enough, interviewing at these two points in time (and obtaining data covering the period between interviews) will allow us to examine rather fully the reintegration process, and how different outcomes relate to each other (e.g.,

In addition to outcome data, considerable background information will be collected on each subject prior to his release from DOCS. Besides being an important source of descriptive information, these background data will be essential for analyzing effects of treatment. Previous studies have shown that individuals' criminal histories, severity of dependence, treatment histories, social stability, etc., are related to the outcomes we will be measuring. (It is recognized that the best predictor of criminal behavior is prior criminal behavior; a parallel finding exists in alcoholism research -- the best predictor of treatment outcome is the severity of the drinking problem before treatment.) Such "pre-treatment" data will be analyzed to determine if program participation has an impact above and beyond those factors. These data will also be essential for determining whether certain treatments were more effective with certain types of individuals (e.g., the additional pilot treatment is most successful with individuals whose families are not intact, or who have a poor employment history). Rather than generating simplistic conclusions -- such as that the program does or doesn't work -- the research is designed to provide the kind of specific findings that are most useful for policy makers, namely, what works best for whom.

---

whether criminal behavior precedes or follows a period of alcohol or drug abuse).

Implementing the Research

The research strategy outlined above (and described in detail below) was the result of a series of meetings Vera held with DOCS and Parole officials, informed by Vera staff's prior knowledge of the link between alcohol, drugs and crime, and the effectiveness of treatment for alcohol and drug problems. Both State agencies indicated considerable interest in having their program efforts monitored and evaluated by an outside agency.

Subsequent to these initial meetings, Vera began investigating current programs run by these agencies, visiting ASATs and the Lincoln site, and holding meetings with parole officers, their supervisors, and ACCESS planners and staff. In addition to ongoing design planning, technical research tasks have centered on the development and pilot testing of data collection instruments (including assessment and adaptation of previously developed and standardized measures); surveying extant information collected by DOCS (investigation of Parole data will be done in February); developing and testing procedures for identifying and tracking comparison subjects; assisting DOCS in establishing criteria and procedures for identifying Lincoln participants and tracking them in the research; hiring and training Vera research staff in data collection; and finalizing arrangements with DOCS staff for the collection of these data. Vera has had an on-site researcher at Lincoln since early November performing many of these duties. Vera will be ready to begin intake with Lincoln pilot participants whenever that program starts (DOCS thinks it

will be late February), and intake of comparison subjects will begin at approximately the same time.

Intake into the Research Samples. All subjects will enter the research at the Lincoln Correctional Facility located in upper Manhattan. The "experimental group" (group 1) will consist of all individuals who attend the pilot community preparation ASAT and are provided Parole's new referral and assessment service. As noted above in the DOCS section of this report, most (if not all)[3] of these participants will be inmates who have successfully attended the Woodbourne, Sing Sing/Tappan and Mt. McGregor ASAT programs. Each feeder site represents a unique treatment approach within the ASAT model, and has been selected to permit a comparison of the programs' effectiveness (see the Process Analysis discussion below). Inmates in the experimental group will be told at the feeder site about Vera's research role and, as part of their agreement to attend the Lincoln pilot, will assent to be interviewed by a Vera staff member near the end of his stay in the program.

Since Vera staff will also be observing, interviewing and informally interacting with participants and staff, Vera's site researcher will be introduced to each participant when he first comes to Lincoln. To ensure the validity of information obtained

---

[3]It will be recalled from the DOCS section that it has not been determined if these three feeder sites can provide enough eligible pilot participants to fill the 37 treatment beds. If necessary, other ASAT feeders (Arthur Kill, Mid-Orange, Otisville or Taconic) will be used.

by Vera, the site researcher will use this initial meeting to build rapport with the inmate; Vera's research role (and its independence from DOCS and Parole) will be explained further to the participant, and any questions the inmate might have will be answered.

The 37-bed pilot unit at Lincoln will be unique to that institution; the remainder of the approximately 200-bed facility is devoted to inmates who have already been granted an "open date" for release by the Parole Board, and typically stay for no longer than five weeks. This "CPOD" (Community Preparation -- Open Date) population at Lincoln will serve as a pool for "comparison group" subjects. Based on information prepared by Parole, Vera will initially screen out as ineligible for the research men who are not reporting to the Bronx and Manhattan Parole offices upon release (where Vera expects to collect follow-up data). All CPOD inmates who will be reporting to these offices will be given a standardized alcoholism assessment instrument and asked about their drug abuse history. If, on the basis of his scores on these indices, the inmate meets pre-determined criteria for alcohol and/or drug abuse, he will be asked about his prior ASAT experience. Individuals who have recently completed an ASAT (or successfully attended for a minimum of three months) will be eligible for the ASAT-only group (group 2) and those who did not attend an ASAT will be eligible

for the no-treatment group (group 3).[4] If the potential pools are large enough (more than 15 per month, which we estimate to be the most Vera staff at Lincoln can handle), the subjects will be selected randomly from each pool for inclusion in the samples.

Once a comparison subject has been identified as eligible and assigned to a study group, he will be informed of Vera's research, told that we would like him to participate in an interview just prior to his release from Lincoln and in two interviews (2 and 12 months) after his release, and asked for his consent to participate in the study (see the "Consent Protocol" in Appendix C). Before obtaining his consent, the inmate will be told about the research and given an overview of the intake interview. He will also be told that his participation is entirely voluntary and that he can drop out of the study at any time; that his decision whether or not to participate will have no bearing on his release date or his status with Parole; that whatever he tells Vera about the information Vera is collecting will be kept confidential;[5] and that he is assured of anonymity in any research reports. He will also be told that he will be paid at least $10 for each of the two follow-up interviews Vera

---

[4]Vera is presently in the process of piloting these instruments with CPOD inmates at Lincoln, and testing criteria for assignment to comparison groups. By mid-February, we expect to have sufficient information to permit final decisions regarding these criteria.

[5]As noted in the introduction to this section, Vera and Parole have not yet reached agreement on assurances for the confidentiality of follow-up data. Such an agreement must be reached before any such data will be gathered.

will be conducting after his release. If he chooses to participate he will be asked to sign a consent form (also in Appendix C).

The same consent procedures will be utilized with experimental subjects, with one exception. Because these inmates have consented to be interviewed at Lincoln as part of their agreement to participate in the pilot program, it will only be necessary to obtain their consent to take part in the follow-up interviews. Otherwise, the same consent protocol will be used with these subjects, and they will be asked to sign a consent form like that signed by comparison subjects (which does not, however, make reference to the Lincoln intake interview).

<u>Tracking Subjects for Follow-up.</u> Arrangements are being made with Parole to follow subjects after their release from Lincoln. Each subject's field parole officer will be informed of Vera's research procedures while the subject is still at Lincoln. A week or so before a follow-up interview is to take place, this parole officer will be contacted by Vera staff, and arrangements will be made for a Vera interviewer to be introduced to the subject at his next weekly meeting with the parole officer. The subject will be reminded of his agreement to participate in the study, and told that he will be given a stipend if he is still willing to take part in the approximately hour-long follow-up interview. If necessary, these interviews will be conducted in

the Parole office, although we are presently investigating the possibility of conducting them at a nearby, neutral site.[6]

Scheduling. DOCS's program plans call for 37 Lincoln participants to complete the pilot program (and thus enter the research as experimental subjects) every 12 weeks. If available, the research design calls for from 12 to 15 comparison subjects from each of groups 2 and 3 to enter the research monthly. If, as was noted in the DOCS section of this report, Lincoln participants begin in late February, an adequate experimental sample of 148 subjects will have entered the research by March of 1988. A similar schedule is proposed for comparison samples, which calls for each of two samples of 144 subjects[7] to have entered the research by February of 1988. The proposed schedule calls for the two-month follow-up database to be complete by May of 1988, and the twelve-month follow-ups to be finished in March of 1989.

Data Collection and Data Elements

Intake data. Vera has developed and is presently pilot testing at Lincoln the instruments that will be used at research

[6]Vera has project offices within two blocks of the 40th Street Parole office which will likely be utilized for subjects who report here. We will attempt to make similar, nearby arrangements for cases who report to the Bronx Parole office.

[7]Standard methods for estimating adequacy of sample sizes (a "power analysis" which, in this case, was specified for statistical tests of variance proportions) have suggested that samples of this size are an efficient choice for meeting the goals of the research. These analyses were done with an anticipated attrition rate of 20%.

intake. On the basis of our review of approximately 40 institutional files of DOCS inmates and pilot interviews with about the same number, an Intake Data Collection Form (IDCF) has been designed (a copy of the form is available upon request). The Vera site researcher will initially transcribe information from the inmate's DOCS file onto the IDCF, and then use the interview with the inmate to corroborate file data and obtain information not available from the file. During and after the interview, responses will be coded on the IDCF (where possible -- about one-fifth of the items are open-ended), which can be directly keypunched (or entered on-line) for computer processing.

Information that will be collected on the IDCF include:

--demographic data, such as age, race/ethnicity, marital status;

--residential and employment history, such as number of moves in year prior to incarceration, length and type of longest job held, number of weeks unemployed in year prior to incarceration;

--sources of income and total income in year prior to incarceration;

--relevant familial, social and psychological information, such as familial criminality and alcohol/drug problems, self-reported recreational and "free time" activities, self-reported satisfaction with relations with spouse/girlfriend, parents, children;

--medical and mental health data, such as type and status of insurance held, number of prior hospitalizations, ongoing medical disorders, prior psychiatric hospitalizations and medication;

--data relating to the present incarceration and parole status, such as length of this incarceration, number of disciplinary actions, participation in vocational and educational programs, length of parole and parole conditions;

--post-prison plans and expectations, including residential and vocational plans, and plans for familial and social reintegration.

To the extent that it is available, ASAT participation information will also be collected on the IDCF. Vera is concerned about the quality of these data, as DOCS has not yet developed systematic means for measuring degree of participation in the array of programs that presently exist. Fortunately, pilot group feeder sites appear to have better documentation than most ASATs, which will be useful for this group. As part of this initiative, DOCS is presently preparing (with Vera's assistance) documentation for system-wide use, but these are not likely to be useful to the research until the middle of 1987. Until then, we will look carefully through counselor notes in institutional files and probe the area of ASAT participation in the inmate interview.

Extensive information relating to prior alcohol and drug abuse will also be collected on the IDCF. A standardized alcoholism severity assessment instrument, the Alcohol Dependence Scale (ADS), will be used in combination with data on prior treatment history and self-reported problems due to drinking (arguments with family, spouse, trouble on the job, etc.) to measure the severity of the inmate's alcohol problem. A widely used instrument with proven psychometric qualities, the 25-item

ADS is a valid and reliable index of alcohol dependence.[8] In addition to using this instrument with all research subjects, Vera will be utilizing the ADS for screening comparison subjects, so it will be given to all CPOD inmates coming through Lincoln (which now total well over 100 men a month). This will provide, we think, a valuable source for estimating the prevalence of alcohol abuse in the DOCS inmate population.[9] Degree of prior drug problem will be assessed by asking subjects about their level of usage of various drugs and when they last used these drugs, and by obtaining their drug treatment history.

Any history of arrests relating to drugs and alcohol will also be assessed. A series of questions will probe the man's experience with regard to the connection between his use of alcohol/drugs and criminal behavior (and/or violence). Criminal

---

[8]This is in contrast to the popular Michigan Alcoholism Screening Test (MAST) which, in Vera's judgment, mixes items addressing different aspects of alcohol problems and is only useful as a screening device. Since the MAST is used by DOCS at classification (on ostensibly all inmates, although at least a third of the cases we have seen don't have MAST results recorded in their DOCS file), it will be possible to compare the results of the two scales. The best source on the ADS is the Alcohol Dependence Scale User's Guide, by H.A. Skinner and J.L. Horn (1984), available from the Addiction Research Foundation, Toronto.

[9]Up to now, prevalence estimates have been based on MAST data collected at classification. In addition to the drawbacks of the MAST mentioned above -- again, in Vera's judgment -- the validity of responses given to DOCS personnel at intake is open to question. This is because a common ingredient of inmate folklore is that if you admit to law enforcement agents that you have drinking and drug problems, you will receive better treatment and your culpability will be reduced. We expect this rationale to be attenuated when the inmate is near release and when he is responding to research questions put to him by Vera staff under conditions of confidentiality.

history data will not be collected on the IDCF (from files or interviews). These data will be obtained from NYSID RAP sheets, and are likely to be collected only during follow-up, so as to capture both pre-treatment criminal history, and post-release outcome results.

Outcome data and post-release treatment experience. Post-release data collection planning has been driven by two concerns. One of these is to obtain outcome results, such as was noted in the Research Objectives section above (e.g., criminal recidivism, alcohol and drug relapses). We are also interested, however, in tracking the releasee's experience with a range of community-based treatments -- even if he does not actually participate in such treatment. A number of officials have hypothesized that, even if "the best" in-prison treatment and referral services were put in place, community-based programs are unavailable to this population, because the programs are too full (meaning also that there are not enough of them), and/or because parolees cannot afford them or are undesirable for other reasons. Therefore, in addition to questions relating to participation in treatment, subjects will be asked if they had considered obtaining services of any kind in the community (and why or why not), and what their experiences were in trying to obtain specific services. In this way barriers to receiving treatment (e.g., lack of insurance, no available bed space) will be identified. The role of the field parole officer in the releasee's use of services will also be explored in these interviews, and in interviews with supervising parole officers.

These questions have been incorporated with others relating to outcome in a draft Follow-up Data Collection Form (FU-DCF). This instrument, which resembles the IDCF in form and content, will serve as the basis for follow-up interviews conducted 2 and 12 months after release. In addition to these interview data, Vera anticipates interviewing parole officers and using Parole files as an alternate source for some of the outcome data. Community-based providers will be also be tapped to provide information on subjects' attendance in treatment programs. If a subject has indicated his participation in a program, the program will be approached and asked to release to Vera information concerning the outcome of the man's participation. Subjects will be asked to sign a separate release/consent form at their first post-release interview, which can be readily copied and sent to providers with a solicitation of cooperation. This technique, combined with follow-up phone calls when necessary, has proven successful in similar data collection efforts previously done by Vera.

Most of the outcome data collected in the FU-DCF follows from that obtained pre-release. The alcohol and drug abuse assessment instruments used in the pre-release interview will be repeated to track changes in drinking and drug problems. Community reintegration information will be assessed through questions relating to residential, employment, and familial stability and satisfaction. In addition to information about the releasee's experience with various programs (alcohol, drug, ex-offender,

educational, vocational), data relating to medical and mental health problems and treatment will be obtained. Subjects will also be queried about their post-release criminal behavior, but recidivism outcomes will be primarily measured by the use of RAP sheets.

Process Analysis

In addition to these subject-specific data, considerable information regarding the implementation of treatment at Lincoln and Parole's assessment and referral effort will be recorded and assessed. The sources for this process analysis can include information gathered during technical assistance efforts provided to DOCS and Parole by Vera and other agencies, data obtained in interviews with on-site program staff, and observations of staff-participant interaction. Vera will have a full-time site researcher working at Lincoln, who, through formal and informal discussion with staff and participants, will develop systematic descriptive materials on the program at this site. In addition to pilot staff, structured interviews will be done with Lincoln administrators and other personnel who are familiar with the program (e.g., corrections counselors, other officers). Parole personnel who work at Lincoln, as well as field parole officers and administrators familiar with the pilot ACCESS services will be interviewed regarding this program.

Observations of and interviews with staff and participants at other ASATs, and with parolees and field parole officers will

also be included as part of the process data. In particular, extensive descriptive summaries of the program at the Lincoln feeder sites will be prepared, as a basis for comparing the "new, improved" pilot version to the existing services.[10] A preliminary descriptive summary of these programs, along with an introduction to the development of the ASAT model in the DOCS system has been completed (based on information gathered in two visits to Woodbourne, one to Sing Sing/Tappan and numerous discussions with DOCS administrators). A draft of this summary is shown in Appendix D.

While this summary will be updated as Vera staff becomes increasingly familiar with these programs, in its present form it provides a basis for a comparison of the feeder sites. One notes from the descriptions, for example, that the Woodbourne program -- which was the first ASAT site and serves as the prototype for system-wide ASAT programming -- is based on the disease model of alcoholism, allies itself with the Alcoholics Anonymous (AA) approach, and sets abstinence as the critical pre-requisite to recovery. Philosophically, Mt. McGregor is similar, but its unique residential structure (all participants live and are "treated" together in a building separate from the rest of Mt.

---

[10]We had originally planned to provide a similar analysis of the existing (pre-initiative) ACCESS, but found the program to be too small and short-lived to merit an analysis. Vera has and will continue to hold structured interviews with parole officers and their supervisors to assess the process by which they usually handle parolees with alcohol and drug problems (without the assistance of ACCESS).

McGregor's inmates) fosters the sense of a treatment community where inmates are intimately involved in the day-to-day operations of the unit. The Sing Sing/Tappan ASAT, which has more staff than either of the other two sites, evolved from a drug-treatment program funded by DSAS, and continues to be relatively independent and drug treatment-oriented, adhering less to an AA-based program model.

V: EVALUATIVE SUMMARY: PROGRAMMATIC AND INTERAGENCY ISSUES

The previous three sections of this report describe the progress made by each of the agencies involved in this initiative during its first half-year. Those descriptions provide clear evidence that much has been accomplished, but much has yet to be done. To some extent, the next steps for these agencies are self-evident and ought to proceed smoothly, building upon the groundwork already completed and described above in discussions of status and timing. This section reviews more difficult (or at least unresolved) issues which Vera believes need attention if they are not to turn up later as barriers to implementation. In the course of monitoring the State initiative, these issues have arisen as such because they have not yet been adequately addressed by the agencies, or because they have so far resisted focused efforts to resolve them. In either case, we have attempted to suggest a way out, or at least the initial steps on the way to their resolution.

The first part of this section addresses concerns specific to DOCS's and Parole's efforts, and focuses on particular aspects of their pilot programs. The balance of the section is devoted to a discussion of issues that cross over agency boundaries. We

address problems encountered by DOCS and Parole in coordinating their efforts with the pilot participants at Lincoln, and barriers to implementing an internally consistent continuum of services. The role that DAAA and DSAS have come to play with regard to the latter issue -- the character of the treatment service itself -- is also considered.

DOCS

Involvement of the Feeder Sites. Vera met with staff at the Woodbourne and Sing Sing/Tappan ASATs (which, along with Mt. McGregor will be sending inmates to the Lincoln pilot) and discussed various areas of potential difficulty with them. (A meeting at Mt. McGregor will occur in February.) An issue which arose in these meetings was the potential for differences in treatment philosophy to influence the degree of enthusiasm of these ASAT staff for the Lincoln pilot. Specifically, Woodbourne staff, whose treatment model focuses on abstinence as the first step to recovery and the concept of addiction as a disease (an approach most associated with Alcoholics Anonymous), welcome the development of the Lincoln ASAT. In contrast, the Sing Sing/Tappan staff, whose program derived from a DSAS drug-free treatment model that operated at Sing Sing in the late Seventies, expressed less confidence in the effectiveness of the pilot effort. Although they were clearly willing to cooperate in the initiative, the Sing Sing program is historically unconnected to DOCS central ASAT administration in Albany (unlike Woodbourne).

The program's staff (now employees of DOCS but previously of DSAS) were most invested in delivering their own services, and were candidly pessimistic about new pilot programs.

It is evident at this point in their development that it is premature to regard DOCS's ASATs as reflecting a uniform, fully developed treatment model. Rather, they serve as a structural starting point within a prison, assuming varying forms that are distinctly associated with each facility and program staff. It has not been determined which of these program variations is most effective; thus, ASAT sites with rather different "personalities" have been intentionally chosen as feeders to the Lincoln pilot facility in order to provide comparisons that may be useful in Vera's research effort.

Fortunately, further discussions with Sing Sing/Tappan and Woodbourne staff have suggested that these programs' approaches to actual treatment may vary less than their stated conceptual differences. However, we believe that a greater sense of confidence in and, to some extent, "ownership" of the Lincoln program by the feeder sites is needed to increase the effectiveness of the pilot effort. Joint meetings of the ASAT site managers appear necessary to discuss perceived differences and their implications. While the staffs need not embrace one another's treatment philosophies in an absolute sense, some basic goals must be agreed upon if the pilot program is to be described to candidates by individuals who share a belief that the project can have an impact. At the very least, all men coming to Lincoln

must know what the treatment philosophy and expectations there will be.

Parole

The ACCESS Model as a Basis for the Post-release Pilot. Although the legislative document specifies the ACCESS program as offering the "skeleton" for the development of post-release pilot services under the leadership of Parole, Vera has concerns about the adequacy of this model as a foundation for dealing with problems faced by drug- and alcohol-abusing parolees upon their release from prison. In our view, ACCESS will only be effective to the extent that it offers the sort of assertive intervention necessary to complete the continuum of services envisioned by the initiative.

Staffed by part-time workers who did their best in borrowed space under an informal agreement between DSAS and Parole, the "old" ACCESS was commendable for providing something extra when no resources were provided to do so.[1] Our impressions, however -- drawn from visits with senior and staff parole officers, their parole area supervisors, and DSAS personnel -- were that the initial effort was more valuable as a policy initiative than it

[1]Because Parole and DSAS are presently in the midst of mounting the expanded ACCESS effort, we distinguish here between the "old" ACCESS that worked out of the 40th Street Parole office and was manned part-time, and a "new," expanded ACCESS that will have five full-time staff members and work out of both the Manhattan and Bronx offices.

was in the provision of services. Reportedly, large numbers of parolees missed their appointment with the ACCESS counselor (Vera was told it was unrealistic to expect many parolees to arrive at appointments made for them before noon), and many that showed up did so only to please their supervising parole officer -- they were frequently not referred, or did not make it into treatment once referred.

With the additional staff and visibility that will come to ACCESS as a result of the legislation, the "new" program will serve considerably more parolees, and will seek to refer Lincoln pilot participants to appropriate services. Most important, however, in Vera's view, is the apparent attention being paid to linkage with treatment providers. The new ACCESS counselors' early efforts to make arrangements with providers for their clients is critical. The pilot will only work if, when a releasee or parolee must quickly obtain needed services, those contacts pay off. It will also be essential to get the field parole officer assigned to a Lincoln participant involved in the case before his release, when a referral decision is made. Finally, follow-up on referred clients must also be implemented as planned; within a reasonable time after referral, ACCESS should know about the status of that referral.

Vera is alert to these issues for several reasons. One is the Institute's early interest in linkage services, which we have identified as the vital missing ingredient in treatment for the

offender population.[2] The knowledge that DAAA will not be directly involved in the alcohol-related efforts of the new ACCESS also raises concerns. Addressed more fully in the "Interagency" discussion in the last part of this section, we wonder if parole officers, no matter how motivated, can be specially selected and trained to do assessment, referral, and follow-up adequately. Perhaps most critically (without the leverage DAAA staff would have had), will they be able to make the necessary arrangements with providers for the treatment access essential for a successful linkage?

Finally, Parole's allocation of the resources provided to it in the initiative to a dual effort is of concern to Vera. Our reading of the initiative underscores the vision of a continuum of services, piloted for a specified target group, carefully implemented, monitored and evaluated. Parole's intention to split the time of the new ACCESS staff between Lincoln participants and general population parolees has the potential, in our view, to diffuse services for the Lincoln group (clearly the target group). The effectiveness of a continuum of services cannot be tested if Parole does not adequately commit its ACCESS staff and its field representatives to these men.

---

[2]Vera's interest in this area was initiated by members of its Board in 1983, and was eventually expressed in the form of a proposal to New York City's alcoholism agency, first submitted in 1985, to perform such services. This proposal and its status is described more fully in the final part of this section.

In a sense, the potential for a diffusion of resources is built into the legislation which, while focused on the target group and its service continuum, clearly specifies the goal of serving general population parolees. Parole is understandably committed to regularizing ACCESS services in its NYC offices, where the unmet needs of alcohol- and drug-abusing parolees (and their supervising parole officers' frustration in attempting to deal with those needs), are constantly in evidence. Parole is responsible for over 19,000 parolees in the NYC area, many of whom have Board-mandated conditions of alcohol and drug treatment.

Nevertheless, if ACCESS services to its two client groups (linkage for Lincoln participants and assessment/referral for general parolees) are as successful as hoped -- and present staffing plans are not modified -- priorities will have to be established. The only sensible resolution to this eventuality, of course, would be a provision for expansion of Parole resources to provide both these needed services.

Interagency Issues: DOCS and Parole

Parole's Contact with Lincoln Participants. The ability of Parole to adequately implement its piece of the pre-release program at the Lincoln facility depends on the forging of good working relationships with DOCS's ASAT staff. Since neither agency has completed its hiring of program staff, communication has so far been limited to individuals responsible for program planning

and supervision. Understanding has been reached, at that level, on the distinct roles of the two staffs, with ASAT providing in-prison counseling and initial assessment of inmate needs, and with Parole responsible for formal pre-release assessment and for making and managing the post-release referral.

Differences have arisen, however, over these agencies' views of the degree and timing of Parole's contact with ASAT staff and the participant. DOCS, citing an institutional need to "get to know the participant first" and the potential for the inmates to get conflicting messages, views Parole/ACCESS as minimally involved during the inmate's first eight weeks in the program. In contrast, Parole has expressed its desire to utilize an "integrated treatment team" approach from the beginning of an inmate's stay at Lincoln; this team, in Parole's view, includes its Parole and ACCESS staff, and ASAT personnel. Over the last few weeks the agencies appear to have reached an agreement whereby Parole staff (the coordinator and IPO as distinguished from ACCESS counselors) will have access to Lincoln participants early in their stay. ACCESS counselors would begin case conferencing with ASAT staff during the middle month of the man's stay at Lincoln and would work intensively with him during his last four weeks.

This agreement must be regarded as tentative in as much as it emerged while this report was being drafted, and may be prematurely articulated here. Such an agreement seems a sensible compromise, although the "treatment" role of the IPO and the

coordinator are unclear. Vera suspects progress on this matter is contingent on further discussion between ASAT and ACCESS counselors (and actual case experiences), once these persons are on staff.

Community-based Providers at Lincoln. A related area that requires further action concerns the inmates' contact with community-based treatment programs. With the placement of the pilot at Lincoln (which is not designated as a facility that provides temporary release arrangements), it will not be possible to arrange for inmates to visit any post-release treatment sites to which they may be referred.[3] On the presumption that familiarization with community providers is an essential part of any program stressing release preparation, and noting that neither agency had specified plans in this regard, Vera asked DOCS and Parole what could be done about bringing providers into Lincoln.

DOCS stated its view that post-release planning is Parole's domain and that it is Parole's responsibility to arrange for pilot participants to become familar with community-based services; they would encourage Parole to make those arrangements and would cooperate in making men available to providers. Until recently Parole was unaware of DOCS's position on this matter and, perhaps presuming that DOCS would address this need as part

---

[3]To one extent or another, all parties involved in the initiative wish it were otherwise. Legislative documents, in fact, mention the desirability of participants' initial attendance in treatment outside of Lincoln.

of its enhanced curriculum at Lincoln, had not made plans in this regard.

Once it was brought to their attention, however, Parole officials did recognize the importance of bringing community-based providers -- such as outpatient drug and alcohol programs -- into Lincoln to meet with participants. They have indicated a willingness to initiate plans to do so, taking advantage of the contacts ACCESS staff is presently establishing with providers. In Vera's view, these efforts would ideally include arranging a pre-release screening interview between the inmate and staff from the facility to which he has been referred by ACCESS. The interview could conclude with a guarantee for a treatment slot and an appointment, set for a time just after his release date. Since Lincoln participants will have some time between formal completion of the program and actual release, this screening interview could be arranged for a time during this period.

Treatment Consistency in the Continuum. Differences that matter exist between the DOCS ASAT model and ACCESS's history and use of treatment providers. The ASAT program, while identified as a "chemical dependency program" and welcoming participants who identify themselves as primary drug abusers, has largely been built on the principles of AA; abstinence as the focus of recovery and belief in the medical, or disease, concept of alcoholism is at the core of its treatment approach. ACCESS, on the other hand, is a service designed jointly by DSAS and Parole, and has been staffed from its inception by counselors most

familiar with drug-free therapeutic communities (TCs). In conversations with practitioners, Vera has heard widely divergent opinions regarding the potential for these approaches to produce conflict. Many AA-oriented counselors view TCs as not abstinence-based and thus believe these programs have the potential to yield disastrous effects with individuals who have had AA or NA treatment. Others suggest that the models have converged in recent years, and offer no practical inconsistencies.

In conversations with DOCS and DSAS personnel, Vera has attempted to identify the implications of these different approaches for the success of the pilot continuum's implementation. Administrators of the present ACCESS program view their approach as consistent with the ASAT chemical dependency model, and do not foresee problems making referrals to providers who (in their view) can naturally build upon prior ASAT treatment. One conversation we had with an ACCESS counselor suggests the need for vigilance, however; he saw NA (the drug-oriented companion group to AA) as offering limited benefit, and he had little experience or inclination to make referrals to programs that were not TCs.[4]

In any case, it is clear that AA and TC approaches have important symbolic and historical differences, and we think it is

---

[4]Similar observations have been made by Parole planners. They have noted that many drug counselors hold the notion that individuals with prior drug histories who are presently "clean" don't need treatment. Vera would echo Parole's concern that these men do need supportive and preventive counseling -- such as that available in NA and outpatient group meetings.

important to create enough opportunities for discussion of this topic to sensitize both the planners and counselors involved in the provision of ASAT and ACCESS services. All counselors engaged in the initiative must work closely together to assure that a uniform treatment approach will be in place for Lincoln participants. Specifically, an agreement regarding referral practices and options for Lincoln participants should be forged by these parties to assure continuity and consistency of treatment.

From a broader view, it will be interesting to observe the evolution of this discussion among ASAT and ACCESS staff, and the treatment model which ultimately arises from this interaction. A number of intriguing ingredients have the potential to come together: a model (ASAT) which has its roots in the treatment philosophy of AA, but has purposefully moved to a "chemical dependency" approach; counselors (ACCESS) with backgrounds in drug abuse who assert "their" treatment models are now abstinence-based; and a treatment population whose increasing polyabuse makes boundaries between distinct and discrete treatment approaches artificial. With a collaborative attitude on the part of the actors -- a commitment to meeting the needs of the client, rather than espousing a particular rhetoric or a bureaucratic mandate -- the pilot continuum could evolve into an unusually progressive, responsive and effective treatment model.

Interagency Issues: DSAS and DAAA

The framers of the legislative initiative view the forging of interagency linkages -- among DSAS, DAAA, Parole, and to a lesser extent, DOCS -- as a prerequisite to the development of efficient and effective alcoholism and drug abuse services for inmates and parolees. From documents supporting the legislation, organizational linkages have been discussed "but never created in a comprehensive way." It is clear that the program development effort for drug- and alcohol-abusing parolees is seen by the legislative sponsor as creating the bonds that have been sought but unrealized.

DAAA and DSAS hold the principal statutory authority and responsibility to serve their respective target population. That authority originates at the State level, and to the extent services are carried out at any other level of governance, those activities are delegated by DSAS and DAAA. Each of these agencies is an autonomous Executive Department with agency heads reporting to the Governor's office. Each agency regulates and licenses treatment providers, disburses State tax dollars, and provides direct service itself as well as contracting out for treatment resources. The agencies are presumptive experts in treatment as well as prevention, and each possesses a staff capacity dedicated to training and to research.

The inclusion of DSAS and DAAA in a major program development effort to meet the needs of alcohol- and drug-abusing

prisoners and newly released parolees is more than commonsensical. Each of the agencies has some history of working with the offender population; while DAAA's experience in this regard is not yet broad-based, DSAS has an extensive history of attempting to integrate its efforts into the criminal justice system. DSAS has long had staff in DOCS facilities, and has worked closely with Parole, most recently in developing the ACCESS program which is serving as a basis for its involvement in the current initiative.

Staffing Parole's Pilot Program. The first of two program collaborations envisioned in the initiative for DAAA and DSAS was participation in the design and staffing of Parole's post-release program. Specifically, Parole was to subcontract with these agencies, each of which would provide two counseling staff (expert in their respective specialties) for this effort. Parole's decision to utilize its ACCESS program as a basis for the pilot cemented DSAS's role in this instance, as DSAS was jointly responsible (with Parole) for the development and staffing of this assessment and referral service. As noted in an earlier description of the expanded ACCESS, DSAS has hired and is presently training two counselors as specified in the initiative. Moreover, consistent with the intent of the initiative, DSAS has exploited the leverage available to it as the State drug abuse treatment authority to establish arrangements with local providers to accept ACCESS clients in outpatient drug treatment programs.

DAAA has declined to participate in the direct service collaboration framed by the initiative. As described earlier in this report, Parole plans to fill the two slots set aside for the DAAA counselors with two parole officers who will be selected in light of background and training that accredit them to perform assessment and referral duties. The DAAA decision is not an easy one to chronicle; we describe it here with some reservation if only because it has not so far been put in writing to Parole, the agency responsible to contract with DAAA. As the determination was first heard, it was simple: DAAA reported that it was not in, and didn't want to get in, the business of direct service. Most of those involved in developing the initiative -- Parole, a representative of the legislature who sponsored the initiative, DSAS, and Vera -- had similar reactions to DAAA's position. Because DAAA operates a substantial level of direct services through its Alcoholism Treatment Centers (the ATCs provide various services, including inpatient treatment), the position was unclear. It seemed, from the outside, that DAAA had a ready and available mechanism to use to respond to the initiative; namely, detailing two staff positions to the Parole referral team from a NYC-based ATC. Using such a method would be no small advantage in a bureaucratic, civil service environment where establishing new positions for new programs is difficult indeed.

DAAA's initial "no direct service" position gave rise to a request by the Parole Chairman to meet with the DAAA Director. After an exchange of correspondence in which the Parole Chairman

urged the DAAA Director to alter his position, and after a meeting the two held seeking an agreement on how to proceed, the DAAA position became more complex than simply that it would not provide direct service. DAAA indicated that linkage services to community-based treatment for any members of the criminal justice population were specifically provided for -- in form, function, and financing -- within DAAA's formal planning documents (its Guidelines for Development of Alcoholism and Alcohol Abuse Programs). As specified in that manual, such linking services are to be provided only by the local governmental unit (typically the county); where furnished by that unit, the services became eligible for 50% financing by State DAAA.

DAAA indicated it was willing to work outside of these guidelines in a limited way. Because the money for the two counselor positions was earmarked by the legislature (and not DAAA "State purposes" money, to which the guidelines applied), DAAA was willing to channel the funds to the local NYC alcoholism agency, who -- at the option of the City agency -- could contract with a local provider. It was at this point that Parole decided to use a strategy within its own control, namely bringing two specially selected and trained parole officers onto the expanded ACCESS staff.[5]

---

[5]In an effort to provide needed services and to enhance resources available to ACCESS, Vera filed an application with the City DMH to mount alcoholism linkage services in concert with Parole and DSAS. The City supported the application, but the State DAAA turned down the proposal, citing its guidelines concerning State purposes funds. Vera met with City and DAAA representatives in late January to review the proposal, and was encouraged by DAAA's willingness to try to find a way to fund this needed service through an extension of services currently offered by a certified provider.

The net loss of substituting parole officers for the DAAA counselors is not likely to be measurable, but one issue stands out. The active presence of DAAA within the Parole assessment and referral service was viewed by the framers of the initiative as an emblem of interagency collaboration and more specifically as providing an important source of leverage with which to gain access to community-based alcoholism treatment providers who have not been eager to find room for offenders or parolees. These providers are largely licensed under mental hygiene law by DAAA, and almost all of them are subsidized by State dollars allocated by DAAA. That circumstance would make a DAAA employee (or an employee of the local government unit that funds alcoholism treatment agencies) much more likely to get the attention of a provider than are parole officers, no matter how well-trained.

Training of Parole Officers and Community-based Providers. In addition to involvement in Parole's pilot service, the initiative specified that DAAA and DSAS, again as subcontractors to Parole, were to develop and provide an integrated training effort for parole officers and community-based treatment providers. As noted above, initial discussions between planners for these three agencies led to a decision to offer largely separate drug- and alcohol-related training, to be conducted at different times by DSAS and DAAA, respectively. More recent planning efforts indicate there will be coordination of content, even if the trainers for the two agencies will not appear together except for one of the five days of training. Given the poly-abuse nature of many

(probably most) parolees' problems, and the increasing tendency for treatment models to merge, maintaining rigid distinctions between drug and alcohol problems seems, in Vera's view, potentially counter-productive. We would support increasing attempts to merge these training efforts to allow trainees to explore the differences and similarities between primary-drug and primary-alcohol abusers, and most critically, strategies for dealing with the increasing number of parolees who are poly-abusers.

Interagency Solutions. Trying to ensure integrated training and seeking to establish the ACCESS collaborations detailed earlier have been difficult jobs and seem to reflect, at least in part, a larger interagency issue. The principal barrier to realizing the initiative's collaborative intent can be viewed as political, as a measure of boundaries arising from the administrative separateness of DSAS and DAAA. It is Vera's understanding that many States do not have autonomous agencies that separately fund, regulate, and plan drug and alcohol treatment services. The fact that these public governance functions are separate in New York leads to an emphasis on the differences between financing and running services for drug and alcohol abusers, and makes it difficult to blend treatment resources when the needs of an individual suggest that it is right to do so.

As an historical footnote, that difficulty may in some respects be an unintended result of the 1978 reorganization of New York's Department of Mental Hygiene into four separate and autonomous executive agencies: the Office of Mental Health

(OMH), the Office of Mental Retardation and Developmental Disabilities (OMRDD), DSAS, and DAAA. Concern over the treatment needs of certain populations were at the root of arguments mounted at the time against that reorganization; it was frequently asserted that separating the Department would result in groups of individuals with multiple or cross-over disabilities whose service needs would go unmet. It is worth noting here that those concerns gave rise in the reorganization legislation to the creation of the Inter-Office Coordinating Council, (IOCC), an organizational entity designed to eliminate potential gaps in service for the multi-disabled and to ensure that services across the four disability areas would be comprehensively developed and implemented. While a full analysis of the subject is not possible here, it would seem that a fully developed and operational IOCC could make appropriate collaborations among the four constituent agencies much more likely than now appears to be the case.

In any event, the artificial quality of separating plans and services for individuals who abuse drugs from those developed for individuals who abuse alcohol is perhaps most readily apparent in the ex-offender population that the State initiative seeks to serve.

APPENDIX A:

Legislative Problem Document

(The budgetary recommendations contained here were reduced by the Division of Budget to reflect a six-month start-up term)

PROBLEM

The abuse of drugs and alcohol by inmates is often the primary cause of initial incarceration. Subsequent incarcerations for parole violations and new convictions are often rooted in that abuse.

This is of little surprise to those familiar with the criminal justice field, specifically with corrections. What is surprising (perhaps shocking) is the huge scope of the chemical abuse problem. According to the United States Department of Justice, 43% of inmates in state prisons had been drinking at the time of arrest and 83% indicated that alcohol was involved in the crime.

In New York State the situation is no less alarming. The New York State Department of Correctional Services (DOCS), using the Michigan Alcohol Screening Test (MAST), indicates that of the 11,000 inmates screened annually, fully 32% are clearly alcoholic and that 23% strongly suggest alcohol addiction. Additionally, 60% of all inmates admit to use of illegal drugs prior to commitment.

Such percentages, if generalized to the entire prison population, show that 11,000 inmates clearly need alcoholism treatment and an additional 8,000 are in need of some form of alcoholism/drug intervention. It is important to remember that this means significantly more than half of those in DOCS custody are suffering from an addiction which, if not treated, will make their successful re-entrance into society, much more difficult, if not impossible. It will also enhance their chances of recidivating.

In 1975 the Alcohol and Substance Abuse Treatment Program (ASAT) was created at the Woodbourne Correctional facility in response to the aforementioned need. Since then, ASAT has blossomed into a loose network of similar treatment programs utilizing the Alcoholics Anonymous format and educational tapes dealing with chemical addiction. Today, ASAT treats 3,000 inmates per year in 18 DOCS facilities at a total annual cost of $931,000.[1] Alternative treatment models are operating in at least two[1] other correctional facilities.

Though nearly all these programs operate with skeletal staffs, high inmate to counselor ratios and limited coordination with Parole Officers, studies of two of these programs indicate inmate recidivism was reduced by approximately 5%.

The program is a noble beginning. However, there can be no question that the Governor's goal of providing "appropriate services to inmate sub-populations...with a history of drug and/or alcohol abuse" has not been adequately met. The proposal which follows builds on the best of what is in place today, enhances it and will provide thorough monitoring of the proposed pilot components. The creation of linkages between DSAS, Parole and DAAA have long been discussed but never created in a comprehensive way. This program would help to create the bonds that have been sought and not realized.

Finally, a report to the Executive and Legislature will follow.

PROPOSAL

We propose to expand the availability of existing ASAT programs and to establish a longitudinal/chemical dependency program based on the ASAT model with several modifications.

1. The Identification Process:

At classification, all inmates are supposed to be given the Michigan Alcohol Screening Test which tests for both alcohol and substance abuse. Many are not. If the test administrator is absent then the screening is not done, or may not be done with the same degree of thoroughness. Obviously, an inmate who is a chronic alcoholic or drug addict would benefit from the prison treatment program which he may otherwise be excluded from without a tested showing of need.

NEED: Two grade 14 employees to assure and expedite the use of MAST. One will be placed at Wende, the other at Downstate.

COST: 45,300

2. The Treatment Program:

Send a target group to a DOCS medium security facility that has a new pilot treatment program in place. This will serve to expand the net of treatment through New York's prisons and affect those inmates nearer to release.

The program should be residential in its set up. Inmate participants should have space specifically set aside for those in treatment. Also, the program itself should be geared specifically towards the addicted inmate and not just the addict. To accomplish this, it would be necessary to create several new inmate specific treatment tapes. The

goal will be smaller counselor to inmate staffing ratios, resulting in closer supervision and more enhanced program services.

NEED: 1 Substance Abuse Project Counselor II
Grade 21; $34,000

2 Substance Abuse Project Counselors I
Grade 18; $52,000

2 Alcoholism Counselors.
Grade 14; $42,000

1 Stenographer; $12,000

COST: $140,000

For the female offender we offer the following new projects:

ALBION	
2 ASAT - CAC SG-14 @ $22,650	$45,000
1 Stenographer SG-5	$12,400
	$57,400
PARKSIDE	
1 ASAT - CAC SG-14	$22,650
COST: FEMALE TOTAL	$80,050

The need for more programming is so great that in addition to a pilot program, we also recommend the enrichening of staffing at the following non-residential facilities by 1 Alcohol Rehabilitation Counselor apiece ($22,650):

ARTHURKILL	MID-ORANGE
EASTERN	OTISVILLE
FISHKILL	TACONIC
HUDSON	WOODBOURNE

COST: $181,200

We also recommend the expansion of the residential programs at MT.McGREGOR and COLLINS by including for each:

1 ASAT Project Counselor SG-19	$29,680
3 ASAT - CAC SG-14 ($22,650)	$67,950
1 Stenographer SG-5	$12,400
SUB-TOTAL	$110,030
OTPS	$2,970

TOTAL PER UNIT	$113,000
TOTAL RESIDENTIAL	$226,000

Upon preparation of the inmate specific treatment tape, it will be made available to other ASAT programs operating within the corrections system.

NEED: Tapes
COST: $200

3. Program Coordinator:

We recommend the creation of an additional position to aid the Assistant Director for Alcohol and Substance Abuse Programs in coordinating ASAT programs throughout DOCS. This would help to oversee the transfer of ASAT participants and ensure their continued smooth drug/alcoholism treatment through DOCS facilities.

4. Pre-release:

Send targeted group to the Lincoln pre-release center where a more intensive family/inmate reorientation would take place. Lincoln is an ideal location for several reasons. First, its location in Manhattan would place inmates within the release milieu and would make family access much easier. Second, initial contact with the Parole Officer would be more constant and direct. They could participate in their first AA/NA meeting in the area of release, before release occurred. Third, DOCS could set aside an entire floor to house 37 inmates. They would participate in a final intensive residential treatment program for their 4 week stay at Lincoln, immediately prior to their release.

NEED: 2 Alcoholism Counselors
Grade 14

COST: $45,300

5. Parole:

Parole will coordinate with Division of Substance Abuse Services (DSAS) and Division of Alcoholism and Alcohol Abuse (DAAA) to assist them in their performance of the pre-release function for this targeted population.

Parole will network within the community for appropriate employment; DSAS and DAAA counselors will assess, evaluate and recommend appropriate treatment (both residential and outpatient), depending on need, for the new parolee, releasee or parolee who is in danger of technically violating. The skeleton of this concept is already in place with Parole/DSAS's ACCESS program and DAAA's Albany and Erie Satellite/Parole Units.

We suggest that monies be appropriated to the Division of Parole, who will subcontract with both DSAS and DAAA for these stated purposes.

NEED:

2 Grade 14 Alcoholism Counselors	$45,000
2 Grade 18 Substance Abuse Counselors	$52,000
1 Grade 21 Parole Project Counselor	$34,000
1 Stenographer	$ 12,000

COST: $143,000

6. Training:

We must provide training of treatment providers and parole officers to be sensitive to the problems faced by the addicted inmate, or ex-offender. There are a number of qualified groups/state agencies who can and should be involved, including DOCS, Parole, DSAS, DAAA, the Fellowship Center and the Legal Action Center.

NEED: Sensitization program for alcohol and substance abuse treatment providers and 150 parole officers.

COST: $150,000

7. Coordinating, Monitoring, Reporting:

An organization, like The Vera Institute of Justice, will provide technical assistance throughout the development of the pilot program and will then evaluate its effectiveness. A report will be presented, with recommendations regarding the usefulness of such an approach and procedures for system-wide implementation.

NEED: Organization with appropriate expertise

COST: $250,000

GRAND TOTAL: $1,311,050

Breakdown:

DOCS	$768,050
Parole	$293,000
Study	$250,000

APPENDIX B:

Proposed DOCS Plans for Lincoln Pilot

12 WEEK ASAT CYCLE

1. Social Responsibility

   Step #1 - AA/NA
   Patience and Love
   Video - "Third Avenue"
   "Shotgun"
   "Dead Wrong-the John Evans Story"
   "Junior Rios Story"
   "Teach Life - Leo Buscaglia"
   Lecture - Pharmacology of Drugs
   Seminars - Chemical Dependency as a Disease

2. Respect and Reality

   Step #2 - AA/NA
   Video - "Black History A Walk Through Time"
   "Silence of the Heart: Teenage Suicide"
   "Chemical Society"
   "Pleasure Drugs - The Great American High"
   Lecture - Cell structure, body tissue and drugs
   Seminar - Nutrition: The Effect of Alcohol on Health

3. Honesty and Self Control

   Step #3 - AA/NA
   The effects of alcohol and drugs on the bod
   Video - "Ups and Downs"
   "Straight Talk - Parts I and II
   "Alcohol in the Human Body
   Lecture - Liver, Kidneys, Nervous System
   Seminar - AIDS

4. Forgiveness and Trust

   Step #4 - AA/NA
   Video - "Victims for Victims"
   "Youth in Prison"
   "Addictive Personality"
   Lecture - Brain and Nervous System
   Seminar - Changing Attitudes re: Law & Orde

5. Promptness and Positive Thinking

Step #5 - AA/NA
Narcotic Addiction - Opiates
Video - "The Methadone Story"
"Heroin Epidemic"
"Kyber Connection"
"Narcotic File - Parts 1-3"
Lecture - Opiates
Seminar - Heart Disease and Smoking

6. Generosity and Clear Thinking

Step #6 - AA/NA
Central Nervous System Depressants
Video - "Narcotic File - Part IV"
"The P.C.P. Story"
"Drug Profiles"
"Drug Facts Everyone Should Know"
"The Family Trap"
Lecture - Opiates, Barbiturates, Depressant
Seminar - Drugs on the Job

7. Pattern and Habit

Step #7 - AA/NA
Marijuana
Video - "Marijuana Facts"
"Myths and Decision"
"Corronado Mob"
"Its My Hobby"
"Driving and You"
Lecture - Marijuana
Seminar - Jealousy

8. Negative Thinking and Jealousy

Step #8 - AA/NA
Commonly Abused Drugs
Video - "Angel Dusted"
"Angel Death"
"The Seekers"
"Insight into Insanity"
"Self-Awareness"
Lecture - PCP, Inhalants and Speed
Seminar - Employability

9. Insincerity and Humility

Step #9 - AA/NA
Cocaine .
Video - "Bolivian Cocaine"
"Cocaine Connection"
"Private Hill: Cocaine Addiction"
"Sports Pros and Drugs"
Lecture - Cocaine and the Body
Seminar - Child Abuse

10. Family and Faith

Step #10 - AA/NA
Alcohol
Video - "Alcohol - A Way Out"
"Alcohol, Drugs or Alternatives"
"Alcohol and the Human Body"
"America on the Rocks"
"Bottle and the Throttle"
Lecture - Alcohol
Seminar - Fetal Alcohol Syndrome

11. Attitude and Self Control

Step #11 - AA/NA
The Disease of Alcoholism
Video - "Disease Concept"
"Chalk Talk: Parts I - II"
"Breakthrough - Case #7201"
Lecture - Alcoholism
Seminar - Alcoholics Anonymous

12. Others and the Future

Step #12 - AA/NA
Drunk Driving
Video - "Highball Highway"
"M.A.D.D."
"Good Morning America - Drunk Drivir
"License to Kill"
Lecture - There is a Solution
Seminar - Drunk Driving

R. McDermott/slg
August 12, 1986

DRAFT PROPOSAL FOR LINCOLN ASAT "PILOT" PROJECT WEEKLY SCHEDULE - R. McDermott 8/14/86

	MON	TUES	WED	THURS	FRI	SAT	SUN
MORNING	Unit Clean-Up Orientation Weekly Theme Weekly Schedule Assignments Video	Unit Clean-Up Family Meeting Collect Home-work Film/Video Small Groups	Unit Clean-Up Family Meeting Collect Home-work Seminar Session Small Groups	Unit Clean-Up Family Meeting Collect Home-work Film/Video Small Groups	Unit Clean-Up Family Meetig Collect Home-work Group Presenta-tion Review Evaluation Homework Assignment	Unit Clean-Up Visits Family Counseling	Unit Clean-Up Visits Family Counseling
AFTERNOON	Group Discussion Theme Lecture Homework Assignment * Recreation	Film/Video Groups Individual Homework Assignment * Recreation	Film/Video Groups Individual Homework Assignment * Recreation	Small Group Presentation Preparation Homework Assignment * Recreation	Leisure Time Projects * Recreation	AL-ANON Film/Video	AL-ANON Film/Video
EVENING	AA/NA AL-ANON Family Counseling	AA/NA AL-ANON Family Counseling	AA/NA AL-ANON Family Counseling	AA/NA AL-ANON Family Counseling	CONCERN NIGHT	AA/NA	AA/NA

*In addition to group assignments, each participant will complete two individual assignments each week.

DRAFT PROPOSAL FOR LINCOLN ASAT "PILOT" PROJECT WEEKLY SCHEDULE - R. McDermott 8/14/86

APPENDIX C:

Consent Documents

<u>Proposed Consent Protocol</u>

My name is ______________________________. I work for the Vera Institute of Justice. You may have heard of us or our service programs for ex-offenders such as Neighborhood Work Project and Vocational Development Program. We also started Wildcat Service Corporation. I don't work for that part of Vera; I'm with the research department. We evaluate how effectively different programs work for inmates, ex-offenders, etc. I'm here at Lincoln working on a research project that is studying and evaluating the effectiveness of drug and alcoholism treatment offered to inmates while they are in prison and while they are being prepared for release. We are interested in finding out how men who have had different kinds of treatment (or no treatment) make out when they go back into the community. We're studying these programs to see if one program or any combination of programs has better success helping released men stay clean and sober and out of trouble. We would like you to participate in our study. In order to compare different types of treatment, we need to collect a lot of information about people, such as you, who were in those treatment programs and people who did not participate in them. We need to know, for example, some personal things about your age, race, employment and educational history, and about your family background, your drug, alcohol and criminal history. While a lot of that information is found in your DOCS

file, and DOCS has agreed to give us access to those files (and Parole will allow us to do the same), we would like your consent to interview you so we can verify some of the data we have found and get some more detailed information. We want you to understand that agreeing to participate in our research is entirely voluntary, and your decision will have no effect on your open date or your status with Parole. Before you make your decision -- which we hope will be to participate -- let me tell you more about our research.

If you agree to participate, you will be interviewed by me or another Vera researcher shortly before are released from Lincoln. We would also like you to agree to participate in the research after you leave. If you do, we would like to meet with you over the next year on two separate occasions to ask you about how you are doing and what has been happening to you since your release. We will be interested to know about your drug and alcohol use and about any new arrests or parole violations. These interviews are strictly confidential. Although the two interviews will be arranged through your Parole Officer, he/she will not be present at them nor will he/she know anything you tell us. We will pay you at least $10 each time we interview you.

We will also be interested in knowing about the outcomes of any treatment you go to after your release. We will need your consent, then, to obtain information from any treatment facilities -- like drug and alcohol programs or employment programs -- about your participation in those programs. We will be asking these programs to tell us about your status in the program -- whether you entered, completed or left early and why.

If you choose to participate, all the information we collect about you from interviews with you and from any records about you we use will be kept strictly confidential, and it will be used for research purposes only. We will never identify you by name in anything we write about this research and will take your name off all information forms we collect and store in locked cabinets at the Vera Institute. Vera will refuse any request from any law enforcement agency for access to this information. If you agree to participate, you may change your mind and withdraw at any time without penalty.

To summarize: If you decide to participate, you will be interviewed 3 more times -- once here at Lincoln and twice after release. You'll be paid at least $10 each for those last two meetings. We will also review your DOCS files and your Parole files and summaries prepared for us by treatment or service programs in the community.

For consent form:

"Do you have any questions? [Show him the consent form]

If you are willing to be in the study I need you to sign this. It has in writing the same things I have just explained to you [encourage him to look it over if he is so inclined]. Remember that if you do sign, you can still change your mind at any point and drop out of the study."

Consent to Participate in Vera Institute of Justice Research and to Release Treatment Summary Data

A researcher from the Vera Institute of Justice,

____________________________, has informed me as follows:

1. Vera is studying the community adjustment of drug/alcohol abusing men who have served time in a New York State Correctional Facility. It will be studying both men who have participated in different treatment programs and those who have not.

2. The purpose of the study is to evaluate various DOCS and DOP treatment programs and how they help men make healthy adjustments to returning to their homes and communities. The study seeks to determine which program (or combination of programs) is the most effective in helping men stay straight and sober on the street and from returning to the criminal justice system. I and other clients of these programs will probably not derive any personal benefit from the research, but the study may provide a basis for improving services in the future in and out of correctional facilities.

3. If I participate, I will be interviewed by a researcher near the end of my stay at Lincoln and I will be interviewed twice more within the year following my release to Parole. The Vera Institute of Justice will also collect information from any treatment or community service program in which I participate.

4. I will be paid at least $10 for each of the two interviews I participate in <u>after release</u>. The researcher will be interested in knowing about my living arrangements, my drug/alcohol treatment, my employment and about any new arrests or involvements with the criminal justice system. The two interviews will be arranged through my Parole Officer but he/she will not be present nor will he/she be involved in any way. Vera will refuse any request from the Division of Parole for access to any information they collect on me.

5. Any information which is collected, either from my files at Lincoln (to which The Vera Institute of Justice has been given access by DOCS) or from interviews at Lincoln or on the street, is to be held in strict confidence. Any request for access to this information from any law enforcement agency will be refused by the Vera Institute. This information will be used for study purposes only, and I will never be identified by name in research reports.

6. If I have any questions about the research or my rights as a research subject, the researcher who is interviewing me will answer them.

7. I may discontinue participation in the research at any time, without penalty. Discontinuation will not affect my open date or my status on Parole. By the same token, participation will in no way enhance my status in either of those areas.

8. The research will gather information from my DOCS file at Lincoln (and from the ASAT at Lincoln if I am involved) about my drug/alcohol history, my criminal record, my treatment history, and other information about me. It will also collect information about any treatment or services I may receive in the year following my release from Lincoln. I hearby authorize treatment and service programs to disclose such information to the Vera researchers. I can withdraw this authorization at any time.

9. After considering the foregoing, I hearby consent to participate in the Vera research described above.

_________________________ _____________________________
Date Signed Signature

As the Research Assistant on the Alcohol/Drug Abusing Offender Project of The Vera Institute of Justice, I have informed

______________________________ of the nature and purposes of the research project. He has been given a copy of this Consent Form and has signed it in my presence.

_________________________ _____________________________
Date Signed Signature

Vera Institute of Justice
Consent to Release Treatment/Service Summary Data

Before entering this treatment program, I agreed to participate in a study being conducted by The Vera Institute of Justice. At that time a Vera researcher informed me of the purpose and potential benefits of the research. I was also informed about the types of information that would be collected from and about me, how the information would be used and its confidentiality protected.

At that time I agreed that the research could collect information about me and my treatment. I now authorize the researchers to collect information about any treatment or service I may receive within the first year following my release to Parole. The information they will collect will include: the name of the program or service component, dates of treatment or service, and the degree of my participation (including completion or non-completion) in the program. I hereby authorize each of these institutions to disclose such information to the Vera researchers. I can withdraw this authorization at any time.

All information I give to the researchers or that the researchers collect about me from any source will be used for study purposes only and will be kept confidential. Vera will refuse any request to turn this information over to my Parole Officer, or anyone else associated with the Division of Parole. I will never be identified by name in any research reports.

______________________________ ______________________________
Date Signed Signature

As the Research Assistant on the Alcohol/Drug Abusing Offender Project of The Vera Institute of Justice, I have informed _____________________ of the nature and purposes of the research project. He has been given a copy of this Consent Form and has signed it in my presence.

______________________________ ______________________________
Date Signed Signature

APPENDIX D:

Preliminary Process Analysis Results

PRELIMINARY PROCESS RESULTS:
A HISTORY OF ASATs AND DESCRIPTION OF THREE FEEDER SITES[1]

History of Substance Abuse Programs in DOCS

Prior to the development of the Alcoholism and Substance Abuse Treatment (ASAT) model in the late 1970s, programs for alcohol-abusing inmates in State prisons were run largely by volunteers from outside Alcoholics Anonymous (AA) groups. Because they were entirely voluntary, the programs' success depended on the commitment of visiting AA leaders and the willingness of correctional facility administration to provide access to inmates. There were also voluntary drug-based programs in correctional facilities run by organizations such as Reality House. Corrections-based drug treatment programs administered by the State Division of Substance Abuse Services (DSAS, and its forerunners, NACC and DACC, described below) began in 1966.

Evolution of Drug Programs. Chartered by the State in that year, the Narcotics Addiction Control Commission (NACC), was originally responsible for administering correctional facility programs for "certified narcotics addicts." At the height of NACC's operation in the late Sixties, the agency had 22 facili-

[1]This report is preliminary in the sense that it is based on the limited information Vera has been able to gather in the early stages of this effort. We expect to make considerable additions (and perhaps changes) to these process results upon further investigation of these programs.

ties and was responsible for thousands of inmates, some of whom received drug abuse treatment within a DOCS facility, but most of whom were housed and treated within NACC's own facilities. In the 1969-1970 State fiscal year, the legislature reduced the operating budget for this programming and closed many of the programs located within DOCS's facilities. Over next few years all of the DACC programs (NACC had by then been re-named the Drug Abuse Control Commission) were phased out, and by 1975 DOCS had assumed the administration of the remaining programs, in some cases placing DACC staff on their own payroll. In 1978-79, DSAS received funding to develop some drug abuse programs within DOCS facilities, however, this development effort was soon abandoned, and in 1980-81, DOCS absorbed any DSAS staff still working in their facilities. In a few facilities, former DSAS employees continued to operate drug programs until 1983, when these programs were formally merged into DOCS's expanding ASAT network.[2]

A number of drug programs currently operate within the DOCS system, but with the exception of the Stay'n Out program at the Arthur Kill and Bayview Correctional Facilities, these are

---

[2]As might be expected, the three current ASATs that grew out of the DSAS efforts still exhibit some residual effects of their drug treatment/therapeutic community history. In some cases, staff at such facilities may be somewhat less committed to the alcoholism-as-a-disease model and the belief that AA/NA are primary treatment tools, both of which are cornerstones of the ASAT model.

inmate-run and loosely structured. Stay'n Out is operated by a private, non-profit organization, the New York Therapeutic Communities, Inc., through direct funding from DOCS. Stay'n Out inmates, who are housed in a separate unit at Arthur Kill, attend individual and group counseling, and engage in encounter groups, rap sessions and peer counseling. Based on a therapeutic community (TC) model, participants are encouraged to build mutual trust within the group and break down self-defeating and anti-authority behavior patterns. In the TC, peer pressure becomes the single greatest influence on program participants, with confrontational and encounter groups encouraging modification of behavior.

History of the ASAT Model. In 1975 a counselor at the Woodbourne facility, Patrick Minucci, and the late Buford Peterson of the Fellowship Center in New York City (a private, non-profit organization dedicated to serving alcohol-abusing offenders), initiated the development of an in-prison treatment model specifically designed for chemically dependent offenders. Calling it the ASAT program, Minucci implemented the model at Woodbourne, where the program's popularity increased to the point that, at any one time, as many as one-third of the facility's inmates have been active participants.[3] In 1978 a full-time

---

[3]On the basis of his efforts at Woodbourne, Mr. Minucci authored the Alcoholism, Substance Abuse Treatment Program Manual (referred to here as the ASAT manual) in 1981.

counselor/program assistant was added to the Woodbourne unit, and in 1980, programs based on the Woodbourne ASAT model were instituted in six DOCS facilities. ASATs went through another expansion in 1983, when the model became operational -- with considerable variation specific to individual facilities -- in 18 DOCS facilities. As a result of the new initiative, ASATs are expected to exist in 27 facilities.

Historically, DOCS's ASAT model is based on the medical, or disease, model of alcoholism, which views alcoholism as a progressive disease characterized by an increasing tolerance of the effects of alcohol, and ultimately assuming the form of a physical dependence on alcohol. To fight this disease, intensive use of Alcoholics Anonymous (AA) is viewed as an essential treatment tool. AA attendance is mandatory at most ASATs and total abstinence from both alcohol and other mood-altering drugs is the "foundation step of the recovery process."

Despite the alcohol-related nature of the philosophy underlying the ASAT model, Minucci and Peterson recognized the widespread problem of drug abuse, especially poly-abuse among inmates, and welcomed self-identified drug abusers into their program. Based on the central principle of abstinence -- regardless of one's primary substance of abuse -- the ASAT model has come to be DOCS's system-wide treatment program for chemically dependent inmates.

Described below are the three ASAT facilities (at Woodbourne, Sing Sing/Tappan & Mt. McGregor Correctional Facilities) designated as feeders for the Lincoln pilot program. The Woodbourne program, described first, serves as the prototype for all ASAT programming in the DOCS system, although each program has its own history and "personality," and is structurally specific to the facility in which it operates. Sing Sing/Tappan and Mt. McGregor are perhaps the clearest examples of these site-specific variations, and have been selected to participate in the pilot to permit exploration of these differences. As described below, in the case of Sing Sing/Tappan these are primarily differences of content and orientation (drug vs. alcohol), while at Mt. McGregor, the program is unique due to its structure and treatment modality (residential treatment community vs. scheduled program attendance).

WOODBOURNE CORRECTIONAL FACILITY ASAT

The Setting. Woodbourne is a medium security facility housing approximately 860 men. The Deputy Superintendent for Programs describes Woodbourne as a "program facility," indicating that all incoming inmates are directed into some programmatic module.[4] While recommendations for programs are made by correc-

---

[4]DOCS structures its programming into three half-day modules -- morning, afternoon and evening.

tions counselors assigned to assess inmate needs, the inmate usually makes the final choices himself. Woodbourne offers an academic component with program options ranging from basic education to college level courses, and a vocational education unit with various trade choices. These include work assignments in any of a number of Support Services (which support the operation of the facility as well as offer training) such as barbering, painting/glazing, laundering, grounds squad, library assignments, etc. Other program options include music and recreation modules.

Structurally, there are two ways in which an inmate can participate in the Woodbourne ASAT. As part of participation in an educational program, inmates may attend ASAT during one of their class periods. Otherwise, inmates can choose to attend the program on a "call out" basis, from an educational or vocational module, for an hour of ASAT programming several times a week.

Program Staff. Under the Deputy Superintendent for Programs and within the Guidance & Counseling Department, the ASAT is under the supervision of a Senior Corrections Counselor who is responsible for all counseling at the institution. This person supervises a Corrections Counselor who serves as the ASAT Coordinator. The coordinator is directly responsible for the program activities and supervises three Alcohol Rehabilitation

Assistants (ARAs).[5] According to the ASAT manual, the ARAs are "involved in almost every aspect of the inmate's alcoholism treatment program." At present, only two of these three counselors are working, because the third is on extended medical leave. This staff shortage has resulted in a larger caseload for each counselor, decreasing the time they have available for direct client counseling.

While it is not an absolute requirement, Woodbourne has preferred to hire recovering alcoholics for the ARA slots, and all of the present ARAs meet that criterion. While the hiring process takes into account many factors and ARAs have varying backgrounds and skills, ARAs who are recovering alcoholics must have used AA as their primary source of recovery and continue to use it as a treatment resource in their personal lives.

Under the direction of the ARAs, the ASAT is further assisted by inmate staff assistants who are primarily responsible for performing clerical duties, providing tutoring services to active ASAT participants, and helping with equipment maintenance. Woodbourne has fourteen such slots, nine of which are filled at the present time. It is anticipated that when the third ARA returns or is replaced, these additional slots will be filled.

---

[5]These titles will change as a result of the new initiative, although the staffing will essentially remain the same.

<u>Program Structure & Content.</u> There are three principle ways an inmate may enter the Woodbourne ASAT: the program may be recommended by a corrections counselor or Parole staff; the inmate may hear of it and self-refer; or he may be assigned participation as a result of some institutional infraction. (These are basically the same means for entrance at other facilities throughout the DOCS system.) Once referred, inmates are interviewed and assessed by ASAT staff.

All new participants at Woodbourne must first complete a core curriculum, known at Woodbourne as the "tape program." This program unit is centered around an audio tape library (divided into a set of 27 basic tapes and optional advanced tapes discussed below) which serves as the program's primary source of educational content. Typically, a participant will take four months to finish the core curriculum (the 27 tapes), after which he receives a Certificate of Completion. After completing the tape program, inmates continue in ASAT through participation in individual and group counseling (at the inmate's request) and in mandatory AA meetings. At present, there are 50-75 inmates enrolled in the the core curriculum, and approximately 200 men participating in the post-tape, group and AA program.

The cassette tapes in the ASAT library relate to the disease and treatment of chemical dependency. An inmate listens to each cassette individually in a predetermined order (beginning with

the now well-known "Chalk Talk" by Father Joseph Martin), eventually to cover the basic issues presented by chemical dependency.[6] Accompanying each tape is a written study guide which includes a series of questions that must be answered correctly before the inmate can move on to the next tape. Since participants listen to these tapes on an individual basis, they can stop at any time to review missed or misunderstood material. Study guides are turned in as the tapes are completed and are reviewed by ASAT counseling staff. The inmate then gets written feedback (not a score or grade), focusing on the staff member's assessment of the inmate's understanding of the material.

Group sessions, AA and individual counseling sessions are available to participants who are in the core curriculum, and to graduates of the tape program. Twice-a-week AA attendance is mandatory for a man to stay in the ASAT, and more frequent AA attendance and participation in small group sessions are also encouraged. Counseling sessions in the Woodbourne ASAT take various forms. Individual sessions with an ARA are generally used to help the inmate integrate the information from the tapes into his own value system, and become less frequent after completion of the tapes. A range of group sessions are available to

---

[6]A full description of each tape can be found in the ASAT Manual.

ASAT participants, including values clarification, Rational Emotive Therapy, family counseling, Spanish-speaking, primary-drug and primary-alcohol groups, etc.

The fact that AA meetings are mandatory indicates the extent to which AA's Twelve Steps have been fully integrated into the Woodbourne ASAT. Each inmate is required to attend two meetings a week, and anyone who fails to meet this requirement is initially warned and then dropped from the program's active roster. There are a variety of AA groups from which to choose, including Open meetings, Step meetings, and meetings for the cross-addicted. These groups are led either by persons from the community or by staff ARAs.

There is a disciplined approach to counseling at Woodbourne, reflected, for example in the staffs' clear expectations regarding minimal AA attendance. Attendance is taken at all group meetings and considered very important. While accepting the role of denial in chemical dependency, Woodbourne staff is sensitive to manipulative behavior, and inmates who are just "doing their time" in the program; they frequently "call" individuals on their lack of perceived involvement and insist on a commitment to full participation. Woodbourne also has relatively sophisticated monitoring procedures where inmate participation is tracked and assessed on a regular basis and incorporated into their permanent DOCS file as well as Parole reports.

SING SING/TAPPAN CORRECTIONAL FACILITY ASAT

The Setting. Sing Sing and Tappan are two adjacent but distinct facilities under the direction of a single Superintendent. Sing Sing, which houses approximately 1700 inmates, is a maximum security facility, while Tappan has about 500 inmates and is medium security. Some administrative staff is common to both facilities while other personnel, such as counselors, are assigned to one or the other. Staff can move freely between the two different prisons, but there is little inmate interaction across facilities.

Programming varies in the two facilities as a result of the differences in security-based restrictions and in the inmate population. At Sing Sing, all inmates attending programs must be "called out" from their cellblock for structured periods of time. Additionally, the Sing Sing facility has substantial numbers of transient inmates (TIs), such as men requiring treatment in Sing Sing's extensive medical or psychiatric units. TIs, who stay for shorter, more variable lengths of time than general confinement (GC) inmates, are considered to be temporarily assigned to Sing Sing, and thus are less formally "programmed" and somewhat more difficult to involve in programs. The ASAT at Sing Sing, then, must be flexible in responding to the needs of these inmates, as well as to GCs. Tappan, which has only GC inmates and fewer

restrictions on inmate movement, can offer more intensive, long-term programming. Both facilities, however, in part because of their sheer size (Sing Sing/Tappan has the largest inmate census in the State), offer extensive programming options for all inmates.

Program Staff. Under the Sing Sing/Tappan Deputy Superintendent for Programs, a Substance Abuse Project Director administers both the Sing Sing and Tappan programs. While moving between the two programs, the director's office is at Tappan, so his second-in-command, a Substance Abuse Project Counselor II, has specific responsibility for the Sing Sing ASAT. The ASAT staff size at both facilities is as large as any in DOCS's ASAT system. In addition to its directors, the Sing Sing program is staffed by two Substance Abuse Project Counselors I, a Substance Abuse Vocational Specialist and an Alcohol Rehabilitation Assistant. Tappan's staff includes three Substance Abuse Project Counselors, a Substance Abuse Vocational Specialist and an Alcohol Rehabilitation Assistant.[7] Tappan has approximately six inmate staff assistants who help with the program either as

---

[7]At Sing Sing, staffing under the new State initiative will include three ASAT Corrections Counselors and an ASAT Program Assistant; at Tappan, staff will include four ASAT Corrections Counselors and an ASAT Program Assistant. The administrative personnel will not change.

clerks or in other capacities; Sing Sing has no inmate assistants at this time.

As mentioned in the ASAT history section above, the Sing Sing/Tappan program derived from a DSAS effort in the late Seventies, and both the ASAT director and the Sing Sing program supervisor have been with the program since that time. The program and its leadership reflect these drug-oriented roots. Both administrators question the effectiveness of AA/NA as a primary treatment tool, and believe that counseling such as that provided in the therapeutic community model is more supportive than that observed in AA groups.[8] As is obvious from the above description, the staff is weighted toward substance abuse personnel. Of a joint staff of eleven, only two are designated alcohol counselors. There is no institutional emphasis on hiring recovering alcoholics or addicts and, at present, there are none on staff.

Treatment Structure & Content. Inmates enter the Sing Sing and Tappan programs in much the same way as they do at Woodbourne, with the exception of transient inmates, who are not

---

[8]The administrators do, however, consider their program consistent with the ASAT chemical dependency approach. This consistency is reflected in a document prepared by the program: "It is our philosophy that alcohol is a drug and must be dealt with alongside other drugs of abuse. We will do what we can to breakdown the traditional rifts between alcohol and 'substance abuse' treatment."

provided with quite the same structured routes available to GC inmates. Inmates must apply to enter, are screened and attend six orientation sessions during which time they continue to be assessed and are introduced to the programs. After successfully completing the orientation, inmates sign a Notice of Acceptance and become full participants.

While the content of the Sing Sing and Tappan programs are similar, considerable structural differences between the programs reflect their distinct treatment approaches. In response to the special needs of transient and general confinement inmates, the ASAT at Sing Sing includes a 6-8 week program for TIs, along with a standard one-year program for GC inmates. The latter program presently has approximately 100 participants, while the numbers in the short-term TI program fluctuate. Both programs operate in offices on the first floor of the hospital building, to which participants are "called out" from vocational or educational programs to participate in ASAT sessions. In contrast, the Tappan program occupies two entire floors of a building where participants are both housed and engage in program activity. The 62 participants on each floor of the program (124 total) are described by staff as forming a "treatment community."

Participants in both the Sing Sing programs and the Tappan program attend five half-day sessions every week. Treatment is developed on a very individual basis, and can include the follow-

ing components: individual and group counseling; substance abuse/alcohol education classes; urinalysis (during screening and quarterly thereafter); attendance at in-prison group sessions led by outside groups such as Reality House (a community-based, drug-free treatment provider) and AA (its counterpart for drug abuse, NA, is currently being considered); and family counseling. A program of twenty tapes, edited from the full Woodbourne tape library, is required of all Tappan ASAT participants. Attendance is taken at all of the programs and considered very important. If a participant has unexcused absences any two half-days in a calendar month, he may be dropped from the program.

Bilingual counseling for Spanish-speaking inmates is offered, however these inmates are also required by the program to take ESL classes. Sing Sing/Tappan staff place considerable emphasis on "treating the whole person," and integrate vocational and educational assessment and counseling into their alcohol- and drug-related efforts. According to one Tappan counselor, there is no reason for an inmate to leave the ASAT without a high school education or some realistic vocational preparation if he has no work experience. Staff members similarly stress that pre-release preparation is important for continuing treatment in the community. In their view, treatment in prison offers a beginning, but its value is critically enhanced through the development of a realistic post-release plan. This principle is

formally incorporated into the last 90 days of the year-long program, which specifically center on pre-release programming.

MT. McGREGOR CORRECTIONAL FACILITY ASAT[9]

The Setting. Mt. McGregor is a medium security facility with a total inmate population of 460 men; additionally, there are approximately 300 inmates in an adjacent minimum security camp. Because men in the minimum facility work during the day and are away from the facility at this time, the ASAT staff (with participation from outside AA/NA leaders) run an evening program for these men. The description below concerns the residential ASAT housed at the medium security facility.

Program Staff. At present, the Mt. McGregor ASAT is under the direct supervision of Father Peter Young, an Albany priest who serves as Mt. McGregor's Chaplain. Father Young holds the director position as a volunteer, and is assisted by a single Alcohol Rehabilitation Assistant.[10] Most program activity is

---

[9]As noted in the text of this report, current Vera staff have not yet visited the Mt. McGregor ASAT. Thus, the present description is less complete than the Woodbourne and Sing Sing/Tappan descriptions (though all three must be regarded as preliminary).

[10]This staffing will change dramatically as a result of new positions provided as part of the State initiative. In contrast to its present administration, the Mt. McGregor ASAT will be conforming to the structure in use at other facilities, under the direction of the Deputy Superintendent for Programs, and supervised by a Senior Corrections Counselor at the facility. This director will be assisted by two Corrections Counselors-ASAT, three ASAT Program Assistants and a Stenographer. Father Young will remain as an advisor.

thus handled by (approximately) 24 inmate "coordinators" -- men who have completed the program but are still Mt. McGregor inmates. The Mt. McGregor ASAT has also developed a considerable support network of outside speakers (from AA and NA groups, local providers, DSAS and DAAA) who contribute their time to the program.

Much like Pat Minucci at Woodbourne, Father Young has nurtured and developed the Mt. McGregor program since its inception, and seen it grow in popularity and reputation. The program is unique in that it is housed in a separate building at the facility, operating as very much its own treatment community, apart from the general DOCS population at Mt. McGregor.

Treatment Structure & Content. In contrast to the ASAT programs described above, the primary means for entry into the Mt. McGregor program is self-referral; most inmates at Mt. McGregor's ASAT request admittance to the program. An inmate who wishes to enter the program must fill out a "contact slip," which leads to a screening interview with a staff counselor. In addition to self-referrals, inmates may be assigned to the ASAT by DOCS staff, or in some cases the Parole Board may make participation a requirement.

Because of the program's limited residential space, inmates accepted for participation (almost none are screened out) are initially put on a waiting list and attend a series of orienta-

tion sessions. As space becomes available, participants are moved to the self-contained living unit where, for 90 days, they are immersed in alcohol/drug abuse treatment. During those 90 days, the men attend lectures and video tape presentations (the program has an extensive video library) and can take part in the audio tape program described earlier. Attendance in AA and/or NA meetings is central to the program, and inmates participate in group and individual counseling sessions as needed. At present, approximately 75 inmates participate in the 90-day residential phase of the program.

Upon completion of this program phase, many of the participants stay on and join the staff as inmate coordinators. Those who don't are moved to an aftercare living unit (which occupies a floor of another building) where drug/alcohol treatment continues, incorporated into a regular vocational or academic schedule. Men may stay in this after-care unit for as long as is considered appropriate by the administrator or counselor, which may be as long as the remainder of their stay at Mt. McGregor. As was the case in the 90-day program, the after-care unit provides men with a therapeutic living environment, with easy access to AA and other counseling, while allowing them to participate in activities with the general population. If certain work assignments require that an individual live in general population living quarters, he is still welcome to

participate in the after-care unit's activities. There are presently approximately 35 men in the ASAT's after-care program.[11]

In Mt. McGregor's unique treatment community structure, inmate staff coordinators -- and participants themselves -- are much more involved in the actual "delivery" of treatment than they are in other facilities. Each participant is given specific assignments related to the operation of the living unit, and the group is collectively responsible for seeing that these and the program's "Cardinal Rules and Regulations" (presented to each program entrant at orientation) are carried out. The re-socialization process is also enforced through the use of a program vocabulary designed to focus attention on destructive behavior patterns. Participants learn, for example, that an "indictment" is "a verbal attack on anyone that you may be displeased with, because of wrong doing or lack of doing." A man might be indicted because he was observed "dribbling" ("going around talking or gossiping about the feelings you have for someone else"), or "taking us on a trip" ("avoiding the main issue"). Staff describe the program environment as confronta-

---

[11]This program caseload will be considerably expanded as a result of staff additions coming from the State initiative. A total of 168 beds have been assigned to the new program, the great majority of which are likely to go to participants in the 90-day program.

tional, but fundamentally supportive and positive; any criticism of a fellow inmate must be "de-personalized," focused on behavior and not on the individual himself.

Despite their obvious differences in structure and approach, the educational and program content of the Mt. McGregor program appears to be most similar to that of the Woodbourne program: addiction-as-disease, abstinence, and the Twelve Steps of AA and NA are at the heart of the program. Staff stress that, despite the unique sense of community in the program, it is more aligned with traditional models of alcoholism treatment than to the therapeutic community model used in many drug treatment programs. Certain aspects of the therapeutic community model have been adapted for use, but the AA/NA self-help model best characterizes Mt. McGregor's approach to treatment. Additionally, much program activity, both of the 90-day program and the after-care unit, is directed towards preparation for life on the outside and the appropriate use of AA/NA.