

Implementation Evaluation

**of the Arizona Department of Corrections'
Co-Occurring Services Pilot Project**

October 2007



Center for
Applied Behavioral
Health Policy

ARIZONA STATE UNIVERSITY

Suggested Citation:

Center for Applied Behavioral Health Policy (2007). *Implementation Evaluation of the Arizona Department of Corrections' Co-Occurring Services Pilot Project*. Phoenix, AZ: Arizona State University.



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Implementation Evaluation of the Arizona Department of Corrections' Co-Occurring Services Pilot Project

Prepared for
Governor's Office for Children, Youth and Families,
Division for Substance Abuse Policy
Phoenix, Arizona
Contract No.: CG-ISA-06-6272-00
October 15, 2007

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Acknowledgements

This report was prepared by the Center for Applied Behavioral Health Policy (CABHP), Arizona State University. This project was supported by the Arizona Governor's Office for Children, Youth and Families - Division for Substance Abuse Policy, and funded through a grant awarded by the U.S. Department of Health and Human Services (DHHS), Substance Abuse and Mental Health Services Administration (SAMHSA).

Alice Stader, Pat Beauchamp and Michael S. Shafer were responsible for the content, analysis, and writing of the report. Thanks to Matthew Roy and Brian Arthur for contributing to the report.

The authors also wish to thank the staff of the Division of Substance Abuse Policy and of the Arizona Department of Corrections for their ongoing cooperation and assistance with this project. In particular, we would like to thank Enid Osborne, Terry Maloney, Dan Haley and Dan McDonald for their assistance. Finally, we thank the program participants for their patience during the course of the many observations and interviews conducted as part of this evaluation.

This report was funded through a contract with the Governor's Office for Children, Youth and Families. Points of view represented in this report are those of the authors, and do not necessarily represent the official position or policies of the Governor's Office for Children, Youth and Families or the Arizona Department of Corrections.

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Executive Summary

Against a backdrop of growing awareness of the issues associated with a significant increase in the number of prisoners in prison systems diagnosed with co-occurring mental health and substance use issues, the State of Arizona Governor's Office successfully competed for a Substance Abuse and Mental Health Services Administration (SAMHSA) Co-Occurring State Incentive Grant (COSIG).

As part of that grant, the state proposed to implement a Services Pilot Project to focus on providing in-prison treatment and post-release aftercare services to inmates diagnosed as co-occurring. This unique program is the only SAMHSA COSIG grant-funded program focusing specifically on the criminal justice system. The Arizona Department of Corrections (ADC) operates the program at the State Prison Complex in Tucson. The Center for Applied Behavioral Health Policy (CABHP), in addition to coordinating the overall project, is tasked with evaluating the Services Pilot Project. This report is the first in a series, which will assess the formative and summative results of the project.

The COSIG Services Pilot Project was designed to develop and implement an integrated program of co-occurring pre- and post-release services for 40 adult male inmates of the Arizona Department of Corrections. The primary goal of the project is to increase opportunities for successful re-entry into the community. The pilot project is also designed to reduce recidivism and increase treatment opportunities by providing a structured process for developing and implementing a formalized approach to serving persons with co-occurring disorders.

Research Questions

Over the last 18 months, data were collected for this evaluation largely based on a series of interviews with participants and staff, observations, records reviews, and informal group sessions. The formative evaluation is designed to answer the following set of questions:

- Is the pilot being implemented as designed?
- If not, what is the observed variance in the implementation from the original program design?
- As implemented, does the pilot provide promise of achieving the re-entry outcomes for which it was originally designed?

Based on a thematic analysis of the data from various sources, a number of observations and conclusions were made in several areas, including:

- **Participant Selection:** Due to a number of factors, the initial selection process took a year to complete and participants had difficulty establishing trust as new members joined the cohort throughout the year. Yet, this staggered approach to filling program beds may have ameliorated some problems associated with understaffing during implementation.
- **Program Curriculum:** The program curriculum helped the participants understand their diagnoses and how to deal with them. The curriculum may merit review and revision based on first-year experience incorporating staff and participant feedback.
- **The Therapeutic Community Model:** Although not considered part of the original core process, elements of the Therapeutic Community Model were introduced and were found to enhance the treatment program.
- **Staff-Participant Relationships:** Program participants and staff forged a strong relationship, engendering an atmosphere of trust vital to the success of the program.
- **Staff Turnover:** Significant staff turnover and long term vacancies hurt the program. New staff had to regain the trust of participants and staffing shortages interfered with program implementation.
- **Aftercare Services:** Despite staff shortages, aftercare services contributed to program success. It is unclear if the level of service can be maintained over time without addressing understaffing, because existing staff continued to deliver aftercare services.
- **Acquisition of Services:** Obtaining and paying for services and vendors posed a challenge to program success. Several post-release participants had to change residence due to non-payment of rent. Only the program manager could make purchases with the agency credit card.

The program curriculum helped the participants understand their diagnoses and how to deal with them.

Introduction

Needs Statement

Each year, more than 600,000 prisoners leave state and federal prisons to re-enter the community. Many face barriers to sustained, successful reintegration.

While some may live with family after release, many may not, and housing options are limited. Limited education and work experience and the stigma of being an ex-offender make finding work difficult (Travis, Solomon & Waul, 2007). Many ex-offenders (68%) also exhibited symptoms of substance dependence/abuse in the year prior to imprisonment. Over half of all prisoners in state and federal prisons suffer from some mental health problem and many of those suffer from co-occurring substance abuse and mental health diagnoses (James & Glaze, 2006).

Co-occurring disorders pose a unique challenge to incarceration and successful reintegration. Roger Peters (2004), in an introduction to a special issue of *Behavioral Sciences and the Law* focusing on co-occurring disorders stated:

...co-occurring disorders are often undetected in justice settings, and as a result frequently lead to relapse, recidivism, and the preventable use of scarce community treatment resources, such as crisis stabilization units, hospital beds, and jail beds (p. 427).

Though estimates vary greatly, it is clear that co-occurring disorders pose an escalating challenge to the prison system. Edens, Peters & Hill estimated in 1997 that 3-11% of the prison population suffer from co-occurring disorders. More recently, the Bureau of Justice Statistics estimated that over 40% of prisoners in state prisons had both a mental health problem and substance dependence or abuse (James & Glaze, 2006).

Ex-offenders with co-occurring disorders return to prison at a greater rate and sooner than ex-offenders not diagnosed as co-occurring (Messina, Burdon, Hago-pian, & Prendergast, 2004). Provision of treatment services within the prison system, followed by transitional aftercare services, can reduce the rate of recidivism and relapse.

Knight, Sampson & Hiller (1999) reported a study where prisoners who received nine months of treatment followed by six months of community-based aftercare

returned to prison at half the rate of the comparison group. In a similar study, Butzin, Martin & Inciardi (2002) reported that inmates who received in-prison and aftercare treatment showed similar, positive outcomes. In a review of 20 programs across the U.S., Peters, LaVasseur & Chandler (2004) found that in-prison programming and aftercare reduced the level of subsequent criminal activity.

Against this backdrop, the State of Arizona Governor's Office successfully competed for a Substance Abuse and Mental Health Services Agency (SAMHSA) Co-Occurring State Incentive Grant (COSIG). As part of that grant, the state proposed implementing a Services Pilot Project focused on providing in-prison treatment and aftercare services to inmates diagnosed as co-occurring. The unique program is the only SAMHSA COSIG grant-funded program to focus specifically on the criminal justice system.

The Arizona Department of Corrections (ADC) operates the program at Arizona State Prison Complex-Tucson. The Center for Applied Behavioral Health Policy (CABHP) serves as the Coordination Center for the overall project and evaluates the Services Pilot Project. This report is the first in a series that will assess the formative and summative results of the project.

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Program Design

The Pilot Project was designed to develop and implement an integrated program of pre- and post-release services to 40 adult male Arizona inmates diagnosed with co-occurring disorders. The primary goal of the project is to promote successful re-entry into the community and reduce recidivism by increasing treatment opportunities and providing a structured process to develop and implement a formalized approach to serving inmates with co-occurring disorders.

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The following elements comprise the core processes to serve the participating inmates.

1. **Co-Occurring Integrated Clinical Team:** Program participants are supported by an integrated clinical team consisting of: a licensed substance abuse counselor, a licensed mental health professional, a case manager, correctional officer III(s), and parole/probation officer(s). The team provides assessments, treatment planning, transitional release planning, service delivery, referral, and program coordination.
2. **Co-Occurring Informed Assessment:** Staff employ a variety of diagnostic tools, including the Addiction Severity Index (ASI), the Brief Psychiatric Rating Scale (BPRS) and the SOCRATES (an assessment of willingness to change). Participants are assessed at entry (within 30 days of program entry), within 30 days of release, and at 6-months post release.
3. **Individualized Transitional Release Planning:** An Individualized Transitional Release Plan (ITRP), based on assessments, helps each inmate establish measurable performance objectives and identifies resource needs after his release and re-entry into the community. The ITRP is completed within 90-days of program entry.
4. **Co-Occurring Case Management:** Case managers provide a comprehensive and continuous integrated care system of care to participants starting 12 months prior to discharge and continuing up to 6 months post-release. Case manager caseloads should not exceed 1:40, with caseloads reflecting a mix of pre- and post-release inmates. All inmates should have, at minimum, one face-to-face contact with their case manager per month during the residential phase of the program.
5. **Pre-Release Residential Co-Occurring Treatment Services:** Inmates receive co-occurring recovery treatment and education services for at least 12-months prior to release. These services follow a manualized approach based on *Working with Offenders Who Have Co-Occurring Mental and Addictive Disorders: A Treatment Curriculum for Corrections-Based Programming*, authored by Roger Peters, Ph.D. and colleagues (Moore, Wagner, Peters & Hills, 2004).
6. **Co-Occurring Subsidized Housing:** If needed, participants are provided

subsidized housing for up to 180 days after release at a residence that meets ADC standards and is approved by the case manager and parole/probation officer(s).

7. **Re-Entry Services:** ADC case managers provide referral and enrollment assistance services to help participants get community-based services, as identified in their ITRPs. Inmates continue follow-up contact with case managers for up to 6-months post-release.
8. **Alumni/Relapse Prevention Group:** Participants who successfully complete the program are encouraged to attend monthly alumni meetings. Co-facilitated by a former inmate with co-occurring disorders, alumni meetings provide recently released inmates with a social support network to aide in their community re-entry adjustment and to help maintain abstinence and mental health stability.

Although not identified as a core process in the original design, elements of the Therapeutic Community model were incorporated into the program. According to Ottenberg (2001):

“A therapeutic community is a drug-free environment in which people with addictive (and other) problems live together in an organized and structured way in order to promote change and make possible a drug-free life in the outside society. The therapeutic community forms a miniature society in which residents, and staff in the role of facilitators, fulfill distinctive roles and adhere to clear rules, all designed to promote the transitional process of the residents.”

Curriculum Design

Treatment is separated into four phases and includes a total of 192 modules, which are facilitated by the treatment staff in a group setting.

- Phase I provides a focus on engagement, assessment and identification of treatment needs.
- Phase II focuses on intensive development of coping skills and a wide range of psychosocial skills.
- Phase III continues work on skill development and focuses on building interpersonal, family and social relationships in anticipation of release.
- Phase IV focuses on post-release planning and transition services.

Participant Selection

The Pilot Project was originally designed as an experimental, randomized trial. Based on ADC program selection criteria, inmate-participants must:

- Qualify for housing in a medium security prison yard (Security level 3).
- Receive a Mental Health Care score of 3.¹
- Receive a Drug/Alcohol Treatment Needs score of 3 or higher.²
- Be scheduled for release into either Maricopa or Pima County, the sites of the two case managers.
- Not have any detainers on record at the time program entry that would preclude participation in outside services.
- Have 12-18 months remaining on their sentence at the time of selection.

Originally, CABHP was to randomly assign identified inmates to either the treatment group or a control group. Due to difficulties filling the treatment group (which are discussed later), changes were made in February 2007 to: lower the Drug/Alcohol Treatment Needs Score to 2 or higher; place all identified inmates into the treatment group; and accept volunteers into the program.

1. ADC defines MH-3 as Moderate Need—Inmate requires placement in an institution (e.g., Perryville, Phoenix, Florence, Eyman, or Tucson) that has regular, full-time psychological and psychiatric staffing and services; Inmate has a recognized need for (a) psychiatric medication and or psychiatric monitoring and/or (b) psychological counseling or therapy, or (c) there exists significant potential need for (a) or (b) above.

2. ADC defines A/D 3 as follows: In the three (3) years preceding the current incarceration, substance abuse has contributed to irresponsible behavior or lifestyle in employment, education, WBE training, interpersonal relationships, health, general well being and criminal activity. The inmate may or may not have been under the influence of alcohol/drugs at the time of the instant offense. The offense was not committed to get money to purchase alcohol/drugs. The PSI/POR and/or inmate self-report identify a substance abuse problem.

Staffing

According to the original program parameters, a full staff compliment should consist of the following:

- 1 full-time program coordinator
- 1 full-time and 1 half-time psychologist, later changed to 1 half-time psychologist and 1 half-time nurse
- 2 full-time re-entry case managers
- 2 full-time Licensed Independent Substance Abuse Counselors (LISACs)

Case manager case load should not exceed 40 clients, including those in prison and those released to the community. Initially, the program was limited to 40 in-prison participants. In early 2007, ADC chose to increase the program to 60 in-prison participants. No corresponding change in staffing was proposed.

The Community Treatment Team (CTT), consisting of the case manager, the in-prison clinical team, community-based treatment providers, the parole officer and other interested staff, was formed to meet with program staff and participants to discuss program needs, barriers and support for inmates being released.

Methodology

This report details the CABHP evaluation of the implementation phase of the COSIG Services Pilot Project and provides a qualitative assessment designed to answer the following research questions:

- Is the pilot being implemented as designed?
- If not, what is the observed variance of the implementation from the original program design?
- As implemented, does the pilot promise to achieve the re-entry outcomes for which it was originally designed?

The report is based on a series of interviews, observations, records reviews, and informal group sessions. This qualitative approach can help develop a detailed narrative about what occurred during program implementation. Weiss (1998) states:

Qualitative investigation can reveal how ...a new entity takes shape, what problems are faced, who takes leadership, ...how goals are set and how the hundreds of decisions about its future are made (p. 85).

Data collection for the COSIG Pilot Project centered around four areas: staffings, meetings, participant interviews and clinical file evaluation.

- Community staffings provided information pertaining to released participants. The clinical team, in addition to the parole officer, met with participants to assess individual progress after release. Five community staffings were observed.
- Exit staffings occurred 30 days prior to release and allowed the in-prison treatment team and community treatment team to review each participant's release plan. Twenty-one exit staffings were observed.
- The weekly clinical staffings provided information about participants still in treatment and highlighted the participant goals. Twenty-six clinical staffings were observed.

This report is based on a series of interviews, observations, records reviews, and informal group sessions.

CABHP conducted two interviews with each participant: the exit interview 30 days prior to release and the follow-up interview 6-months after release. A total of 29 exit interviews and three follow-up interviews were conducted.

- Community meetings provided a forum for the participants and staff to share information about events in the past, present and future pertaining to the community. Forty-two community meetings were observed.
- Weekly staff meetings brought the team together to discuss program logistics and issues regarding in-treatment and released participants. Staff meetings were discontinued in May 2007 due to staff shortages. Sixteen staff meetings were observed.
- CABHP conducted two interviews with each participant: the exit interview 30 days prior to release and the follow-up interview 6-months after release. A total of 29 exit interviews and three follow-up interviews were conducted.
- CABHP also participated in monthly Services Pilot Project Implementation Team Meetings throughout the project.

For the meetings, field notes were recorded and later transcribed for thematic analysis. Interview notes were transcribed and compiled for analysis. Clinical assessment scores were collected for each client, and will be statistically analyzed later.

Clinical file evaluation, based on constantly updated staff case notes, provided quantitative data. Progress notes were reviewed and quantified based on the parameters of the COSIG evaluation tools.

Staffings, meetings, participant interviews and the clinical file evaluation provided the bulk of the data to evaluate the COSIG Pilot Project.

Participant Characteristics

In total, 77 participants were selected or volunteered into treatment. Four participants refused treatment and 12 others were later discharged from the program after entry. A total of 28 participants received COSIG re-entry services, and 26 of the 28 participants completed the in-prison treatment protocol. Two participants did not complete the in-prison treatment program because they were placed in protective custody, but were provided re-entry services following release from prison. Four participants returned to ADC custody: three due to parole violations and one was detained due to a safety issue. Table 1 (right) provides demographic data on the participants who entered the program.

**Table 1:
Participant Demographics**

N=73

Mean Age	35.1
Ethnicity	
Caucasian	57.1%
African American	19.6%
Mexican American	19.6%
Native American	1.8%
Other	1.8%
Marital Status	
Married	8.9%
Divorced	14.3%
Single	73.2%
Widowed	3.6%
Education	
Less than 12th Grade	53.8%
High School or GED	25.6%
Some College	15.6%
BA or Higher	5.1%
Criminal History (mean)	
Prior Felonies	3.7
Prior Paroles	4.3
Sentencing Offense	
Aggravated Assault	16.7%
Aggravated DUI	13.3%

Findings

The following findings are based on interviews, observations, and informal discussions over the first year of the Services Pilot Project. Information focuses on in-prison and aftercare components, as well as program funding. Quotations from participants and staff illustrate the observations.

Participant Selection

The Services Pilot Project was originally designed to be a randomized clinical trial. Initially, ADC identified eligible inmates based on the criteria discussed earlier. Once ADC identified participants, CABHP randomized them into either the treatment group or the control group. Those participants selected then underwent a final screening to ensure eligibility. Due to a number of factors, such as inmate behavior history, gang affiliation, etc., this process limited the number of inmates eligible to enter the program. Further complicating and limiting selection, ADC was reviewing its security classification system during this period. Changes to the classification disqualified some participants, who were no longer eligible for housing at ASPC-Tucson. These factors prevented initiating a complete cohort of 40 participants at program start. Rather, inmates joined the program in a staggered fashion. Consequently, the cohort did not reach the prescribed 40-participant level until the 13th month of the program in March 2007. Table 2 details in-prison participation by quarter.

Table 2: Participants by Quarter

Ending Quarter	March 2006	June 2006	Sept 2006	Dec 2006	March 2007	June 2007	Aug 2007
Maximum Number of In-Prison Participants in Program	14	34	35	34	41	38	34

Due to a number of factors, the initial selection process took a year to complete and participants had difficulty establishing trust as new members joined the cohort throughout the year. Yet, this staggered approach to filling program beds may have ameliorated some problems associated with understaffing during implementation.

Curriculum

Although the curriculum was delivered in a group setting, the material spoke to each participant individually. In addition to addressing co-occurring disorders, the modules covered a wide range of material, from coping skills to thinking distortion to parenting, aimed at identifying and breaking criminal thinking patterns and providing the basic life skills needed for long term success in the community. Participants worked through all 192 modules, although the course of study could be individualized to address specific areas of weakness. This flexible, individualized approach bolstered participant success. Participant response to the curriculum has been likewise individual and varied. Some appreciated the repetition of the modules, while others did not. During participant and staff interviews, both expressed a desire to review and possibly revise the curriculum.

Some modules are repetitive but they need to be repeated because you are dealing with people with mental health and substance abuse problems. It needs to be kept fresh in our minds.

Modules, it helped to change my thinking pattern and reduce my impulsive behavior.

Over half of all participants had never received any type of mental health or substance abuse treatment before this program, either during incarceration or outside of prison. For many, the diagnosis they received from the COSIG program was the first time they had completed a psychosocial evaluation. The curriculum provided a knowledge base on co-occurring disorders, which helped participants embrace treatment.

Once participants came to understand their diagnoses, the modules provided them the skills to manage their co-occurring disorders. Some of the more popular modules addressed changing thinking patterns, recognizing triggers, alleviating impulsive behaviors, and preventing relapse.

The modules provided participants with basic life skills necessary to lead a crime-free life. The modules taught participants to live a positive, day-to-day life as productive members of society by providing tools to balance finances and build a resume, as well as positive social and communication skills. These basic life skills, along with skills for managing their co-occurring disorders, provided the participants the tools to succeed in the community.

It gave me more insights into the stuff I used to deny. Most families deny a history of mental health so I had to deal with that too. I am more accepting of it now. I want to live a normal crime-free life. I am looking forward to it. No drugs. I never thought I would say it.

The program gave me insight to my disorders and how to manage them.

The modules clarified the need to address mental health and substance use dis-

Over half of all participants had never been involved in any type of mental health or substance abuse treatment prior to the COSIG program, either during incarceration or outside of prison.

orders at the same time. The COSIG curriculum provided a comprehensive understanding of co-occurring disorders and how each participant may manage their individual disorder.

It was pretty in depth about mental health and substance abuse. Mental health is one part of the problem and substance abuse is another. Substance abuse isn't usually the result of it; it just feeds the mental health. I got high not because of mental health or for a reason, they were two different categories. I better understand now the difference.

The educational aspects, the modules, learning to recognize the process to action of drug use and the behaviors. The sequence of events and the cycle of drug addiction.

Therapeutic Community Model

The Therapeutic Community Model was not originally envisioned as a core process of this project. In fact, circumstances, including co-housing the COSIG participants with the general population, prevent full adoption of the model. Despite this, elements of the model were introduced, embraced by both program participants and staff, and created an enhanced sense of community.

Participants held community meetings every Wednesday organized by the committee members, consisting of: a house manager, a mentor, a tutor and a motivator. During the meeting, participants exchanged “pull ups” or “push ups” with other members of the community. A push up is a positive affirmation for another member’s behavior and a pull up is a personal recognition of a negative behavior. This exchange allowed members to express their feelings in an open environment. The meeting also allowed staff and members to share any important business.

The relationships participants established helped them learn to share successes and failures and hold each other accountable. Through this sharing process, participants established trust and respect for each other. Accountability, community, trust and respect helped create a more comfortable, effective and open treatment environment.

Other inmates in the programs helped. If I had an issue or was feeling depressed other inmates would encourage or help me get through it and stay in the program.

The bond established by the therapeutic community worked to counter the prevailing “prison code” and worked against negative expectations, such as racism, as participants learned to relate to each other in positive, constructive ways.

Even trying to implement limited elements of the model had drawbacks. COSIG participants shared housing with inmates who were not part of the program. Accountability was critical to success in the community, but pressure from the larger prison community worked against this. Unless all participants were isolated, the prison code of conduct conflicted with attempts to create a cohesive culture within the COSIG program.

Housing, people in that house aren't in the program. People who are trying to change their prison thinking and get straight start veering off course because of the non-COSIG older guys. We don't need that. That's one of the biggest worries I have about leaving is that there are so many guys that aren't in COSIG in the house.

The Treatment Community model is not working in here because of the difference between what happens at the community meeting and at the pod. People are just trying to impress people.

Staff Relationships and Turnover

Positive relationships between participants and program staff benefited recovery. Many participants may not have experienced healthy relationships, and establishing positive relationships, especially with authority figures, helped the community succeed. The staff was dedicated to the success of participants. The compassion the staff showed allowed participants to trust and be open to treatment. The bonds of trust and communication established between staff and participants were the key to program success.

“The staff cares about you. I had regular contact and they give you a hand up not a hand out. They helped us empower ourselves.”

The concern from the staff. When I got here, I didn't know what was going on and was like DOC cares?

The staff was helpful. They encouraged me.

At the same time, staff turnover posed a challenge to success. As prescribed by the original program design, a complete staff consisted of: 1 full-time program coordinator, 2 full-time case managers, 2 full-time LISACs, 1.5 mental health professionals, and 1 half-time administrative assistant. Beginning in October 2006, the mental health professional requirement was changed to 2 half-time positions, one a psychologist and the other a nurse with mental health background. The program was completely staffed only through August 2006. Only one of two LISACs was on staff from September 2006 through July 2007. Only one of two case managers was available from March 2007 to July 2007. At the same time, ADC did continue to provide 1.5 FTE mental health professionals through May of 2007, even though the requirement had changed to one FTE beginning in October 2006.

Table 3: Staffing Levels

Complete Staff	As of 9/1/06	As of 3/1/07	As of 6/1/07	As of 7/27/07
1 Program Coordinator	1	1	1	1
2 Case Managers	2	2	1	1
2 LISACs	1	1	1	2
1.5 Mental Health Professionals (Thru Sep 06)	1.5	NA	NA	NA
1 Mental Health Professional (Oct 06 to present)	NA	1.5	1	1

Table 4 tracks the staff-to-client ratio over the course of the program, which has increased steadily for all staff positions.

Table 4: Staffing Ratios Timeline

	CY06												CY07							
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
Participants Entered		14		4		18	1					2		4	13		2			18
Participants Terminated from Program				2				2	1			1		1			3	2		2
Participants Released into the Community													2	3	3	3	4	1	6	6
Participant Totals		14	14	16	16	34	35	33	32	32	34	33	33	36	49	49	48	46	46	62
Participants in Prison		14	14	16	16	34	35	33	32	32	34	33	31	31	41	38	33	30	24	34
MH/SA Professional		4.5:1	5:1	5:1	5:1	10:1	10:1	9:1	9:1	9:1	10:1	22:1	21:1	12:1	16:1	15:1	13:1	12:1	12:1	17:1
Case Manager Ratio		7:1	7:1	8:1	8:1	17:1	17.5:1	16.5:1	16:1	16:1	17:1	16.5:1	16.5:1	18:1	49:1	49:1	48:1	46:1	46:1	62:1

Staffing shortfalls hurt the program, affecting in-prison treatment, aftercare services, communication and morale.

Staff turnover; it's a domino effect.

Due to staff shortages since August 2006, regular one-on-one counseling sessions, as prescribed by the program, were not consistently delivered. Failure to deliver the comprehensive treatment approach promised to participants on program entry impacted both the quality of care and participants' perception of the program.

The part that went away, the one-on-one. They focused on individual issues, very helpful. They got lost in the shuffle of losing staff and haven't come back yet.

Staff turnover, especially in regard to trust

As new staff filled open positions, they had to work to gain the trust of participants. Many participants voiced concerns that the staff was not invested in their recovery. High turnover encouraged participants to question staff commitment and, in turn, their own commitment to the program. Establishing trust was a slow process and starting over with new staff constituted a step backward.

Staff shortages also led to inconsistency in administering the required entrance and exit assessment testing, including the Addiction Severity Index (ASI), the SO-

CRATES (an assessment of readiness to change) and the Brief Psychiatric Rating Scale (BPRS), which should be conducted with each participant within 30 days of program entrance and 30 days prior to release. Staff conducted exit testing post-release for six participants and four never received the exit testing. Assessment testing was not only an important aspect of the evaluation component, it was necessary for the participant's individual treatment plan.

Staff turnover hindered the aftercare component when the Case Manager assigned to Maricopa County resigned on March 16, 2007. The Case Manager for Pima County worked to cover the responsibilities of the second case manager, but this dual role diminished the time committed to each participant.

[Most helpful was] the Pima County case manager's support and advocacy. The case manager thing was a huge support.

Although the COSIG program experienced a high rate of turnover, the core staff members continued to provide quality care and services despite staff shortages.

Community Treatment Team

The Community Treatment Team (CTT) included: COSIG case manager, COSIG program coordinator, parole officer, representative(s) from housing, community-based providers and mental health treatment providers. Members of the treatment team came to the prison to meet the participants or spoke to them on the phone prior to their release. The personalization of services helped reduce anxiety regarding release and increased confidence in the treatment team. The multi-disciplinary team met as needed to help ease each participant's transition.

The most important part of the CTT was communication. Communication within the treatment team was open and this increased accountability for the participants' actions and reduced the occurrence of overlapping services. Further, if something positive or negative occurred regarding a participant's transition, all members were contacted and a plan of action was devised cooperatively.

The CTT also provided growth opportunities for the participants. The partnering agencies not only provided treatment, but also educational work opportunities. Five released participants completed the Recovery Support Specialist training and are now employed by a community provider. Community partners provided drop-in services, recovery meetings and meals during the day. HOPE, Inc. provided space for the informal weekly Pima County alumni meeting. HOPE, Inc. and CHEERS hosted the monthly alumni meetings for Pima and Maricopa counties respectively.

All of the partnering agencies giving us a chance and a chance for employment.

[Most helpful was] having a network of community providers. When I got out it was comfortable because I knew them and had met them.

Peer Support

Peer support was a key component of the program. Attending alumni meetings was one of the core processes originally envisioned for the program. This peer support lessened the impact of staff shortages, primarily in Pima County, where participants created a weekly, informal support group meeting in addition to the regular monthly alumni meeting. Many shared the same halfway houses and supported each other by helping new arrivals adjust. Importantly, this represented a change in the way Community Corrections approached parolee interaction with other parolees in allowing them to mix as a support group outside of existing institutions. Although Maricopa County did not have as effective a support system in place, program staff are working to put such a system in place.

The peer support and having our own deal with the meetings. We were a cohesive unit and helped each other.

Importantly, the opportunity to provide this peer support is a departure from ADC's usual practice of prohibiting parolees from congregating together for mutual support. This is another example of the influence the COSIG program has had on the larger corrections system.

Services

Despite the staffing issues, participants still received comprehensive aftercare services, including referral and enrollment assistance. The referral service included RBHAs, AHCCCS, DES, treatment referrals (substance abuse, medical and mental health), and employment services. Participants also received subsidized housing, assistance with food, transportation, identification documents and other services on a case-by-case basis.

There were some service acquisition issues. Incompatibilities between the grant requirements and the ADC procurement system created inflexibilities and inefficiencies resulting in shortfalls in some areas. These problems frustrated re-entry program staff when they could not meet certain participant needs.

I didn't like how the money was allocated. It's frustrating how the system looks at money spent now versus the money spent later on a prison sentence.

Payment to various vendors did not occur in a timely manner. Six participants were moved from one halfway house to another because the state did not pay the rent on time. Housing instability hurt both the program participants and the ability of the program to find housing for other participants after release. The agency credit card frustrated program staff. The program coordinator was the only person who could use the agency credit card. This resulted in inefficient demands on the program coordinator's time.

The way the money gets paid out for rent. I have an outstanding balance. DOC has problems paying out.

Despite these issues, all participants, except for one, who declined aftercare, received aftercare services. None were overlooked or denied services. The ability of program staff to coordinate services with AHCCCS, the RBHAs and other service providers helped ensure the participants' service needs were met.

Summary

The central question of this report is whether the program is being implemented in sufficient fidelity that the expected results will materialize. To that end, each of the questions posed at the beginning of this report are addressed.

Is the pilot being implemented as designed?

A review of the status of core program elements provides answers to the first question. Of the eight core processes identified earlier, five appear to be fully implemented.

- Individualized Transitional Release Planning: all inmates departing prison have an ITRP.
- Pre-Release Residential Co-Occurring Treatment Services: all program inmates are participating in the treatment program. In addition, the program modules are presented as designed.
- Co-Occurring Subsidized Housing: all program participants who need subsidized housing are receiving it.
- Re-Entry Services: all program participants who want re-entry services are receiving them.
- Alumni/Relapse Prevention Group: alumni/relapse prevention group was formed in Pima County.

If not, what is the observed variance of the implementation from the original design?

The following core program elements are not being implemented as planned.

- Co-Occurring Integrated Clinical Team: there have been staff shortages since August 2006.
- Co-Occurring Informed Assessment: program testing has not been implemented as planned.
- Co-Occurring Case Management: the case management caseload has exceeded the planned caseload since March 2007, which has resulted in diminished time with both in-prison and post-release program participants.

As implemented, does the pilot promise to achieve the re-entry outcomes for which it was developed?

This is the most difficult question to answer at this time. Although there are some shortfalls in implementation, it is uncertain if the shortfall is serious enough to impact the re-entry outcomes. Many of the participants in the community are reported to be doing well. However, three of eight released participants who had reached the six-month point have been returned to prison. One other was returned last month just after release. The ability of ADC to fill the vacant positions, and continued support from ADC management make it possible for the program to achieve the planned goals for the participants. Subsequent reports will focus on the outcomes, both short term individual goals and longer term recidivism goals.

References

- Butzin, C., Martin, S., & Inciardi, J. (2002). Evaluating component effects of a prison-based treatment continuum. *Journal of Substance Abuse Treatment* 22, 63– 69.
- Edens, J., Peters, R., & Hills, H. (1997). Treating prison inmates with co-occurring disorders: An integrative review of existing programs. *Behavioral Sciences and the Law*, 15, 439-457.
- James, D. & Glaze, L. (2006). Mental health problems of prison and jail inmates. Retrieved August 16, 2007 from <http://www.ojp.usdoj.gov/bjs>.
- Messina, N., Burdon, W., Hagopian, G., & Prendergast, M. (2004). One year return to custody rates among co-disordered offenders. *Behavioral Sciences and the Law*, 22, 503-518.
- Knight, K., Sampson, D. & Hiller, M. (1999). Three year reincarceration outcomes for in-prison therapeutic community treatment in Texas. *The Prison Journal*, 79, 337-359.
- Moore, K., Wagner, C., Peters, R., & Hills, H. (2004). *Co-Occurring Disorders Treatment Manual*. Department of Mental Health Law & Policy, Louis de la Parte Florida Mental Health Institute, University of South Florida, Suncoast Practice Research Collaborative (SPARC).
- Peters, R. (2004). Introduction to this issue: Co-occurring disorders and the criminal justice system. *Behavioral Sciences and the Law*, 22, 427-429.
- Peters, R., LaVasseru, M., & Chandler, R. (2004). Correctional treatment for co-occurring disorders: Results of a national survey. *Behavioral Sciences and the Law*, 22, 563-584.
- Travis, J., Solomon, A., & Waul, M. (2001). From prison to home: The dimensions and consequences of prisoner reentry. Retrieved August 16, 2007 from <http://www.urban.org>.
- Weiss, C. (1998). *Evaluation* (2nd ed.). Upper Saddle River, New Jersey: Prentice Hall.

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