Adult Prison Therapeutic Communities In America

By

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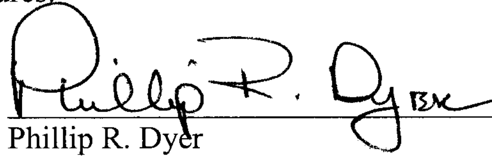

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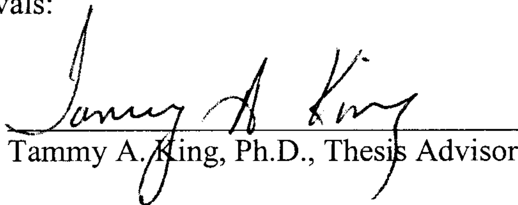

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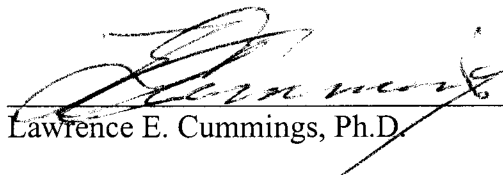

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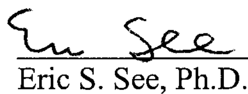

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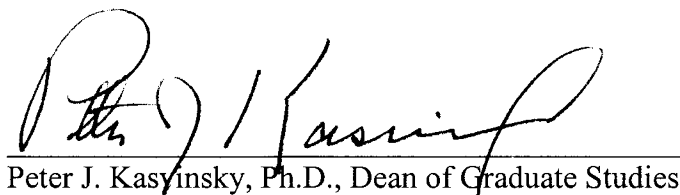

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ABSTRACT

This research is designed to describe information from all state department of corrections and/or rehabilitation addressing the relevance of Therapeutic Communities within their prison institutions. The over-riding philosophy of Society today appears to be lock the offender behind prison walls and forget about him or her until they are released in some manner. On the other hand, there appears to be an effort to find answers to the ageless question, "can offenders be rehabilitated while in prison?" If rates of incarceration continue to rise at their current pace, it has been estimated that one out of every 20 Americans born in 1997 will serve time in prison at some point in their lives. Unlike exaggerated Hollywood images of hopelessly criminal psychopaths, many of today's prisoners can be rehabilitated with the proper intervention and prevention programs. Continuing aftercare programs and combating the literacy issues and providing meaningful job training will assist in the war on crime, as well as, appropriate treatment for substance and addiction. Absent such treatment and training, most offenders will commit more crimes, get arrested and return to prison. The choice is ours as well as theirs.

A determination has been made to gather information concerning the effectiveness of Therapeutic Communities (TCs) that exist throughout the country in state prisons.

Questionnaires were sent to all 50 states. After all data were collected, descriptive and comparative statistics were conducted on the data. It was found that TC programs are being developed, implemented, and extended throughout the country. TCs are safer environments for both correctional officers and inmates, and are reducing crime and recidivism rates for those individuals who participate and graduate from TC prison programs.

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I delicate this thesis to my beloved son so I may honor his name and memory, David Ray Dyer. I thank my God for the times of life that He granted each of us together as father and son on this earth and I anticipate those times, which are to come. In addition, I also delicate this thesis to my father, Chief, the most courageous man I have ever known. To a little girl, Earla, who never had the privilege to walk just one step at a time, but taught me never to give up. To my grandmother, Mary, the apple of my eye and to my mother, Catherine, who has stood and remained by my side, as a friend, a guardian....as my mother. Finally to my Uncle Earl, for providing life-saving advice so many years ago, constant insight into the criminal justice system, and most importantly for his friendship throughout all these years.

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CHAPTER I

Introduction/Problem Statement

Never before in the history of penology have more individuals been incarcerated in the United States as today. Just before Christmas last year, the Justice Policy Institute released a report predicting that 2 million people in the United States would be behind bars by February 15, 2000. "It's shocking to me," says Justice Fellowship President Pat Nolan that "one out of 125 Americans are in prison. Tying that with the recidivism rate, up to two thirds in most states, that says we're horribly failing" (Peck, 1999, 3).

One way to rehabilitate offenders has been the use of Therapeutic Communities. The definition used in this research is therapeutic communities are a rehabilitation program which addresses addictive behaviors within adult prison environments. In 1943 Dr. Maxwell Jones developed the concept of the Therapeutic Community, often referred to as milieu therapy. The European Democratic model TC had its beginnings in 1947 in England. This was the result of Dr. Jones, a renowned British consultant psychiatrist, Post-Graduate Medical School of London and Mental Health Consultant to the World Health Organization, and others after World War II in their attempts to rehabilitate repatriated prisoners of war. As Senior Psychiatrist at Belmont Hospital, London, he founded the Industrial Neurosis Unit which was the first true Therapeutic Community based on the purposeful creation of community to serve as both structure and content for therapeutic change in the lives of individuals. His 1953 book, the Therapeutic Community, reported on the development and management of the TC.

Dr. Jones began his work with traumatized war-torn men trying to help them deal with feeling powerless. He then moved the Therapeutic Community into a horizontal format where the men would be fully empowered to make decisions concerning their lives, forming a community that would address their needs without any time barriers (Van Voorhis, Braswell, and Lester, 1997). Another reason for the Therapeutic Community's development was the demand for medications to control the disturbing behaviors of inmates, so they would become less intimidating to staff and more amenable to treatment. A third stimulus for the development of the Therapeutic Community was the increasing number of inmates and the relative shortage of trained counselors (Jones, 1968, 1973). His documentation of successful outcomes established the efficacy of the TC model in treating difficult cases. The patients treated and studied at the Unit were difficult cases. They were males, known to be chronic failures, "trouble-makers," unable to hold jobs, and were regarded as "desocialized patients with severe character disorders". They were unemployable, and many were regarded as beyond treatment. The theory tested by Dr. Jones and his associates was that a healthy group life would make healthy individuals from this extreme sample. The successful results of the program firmly established the Therapeutic Community as an effective model for individuals needing to be resocialized into the community.

A Therapeutic Community may be based upon any number of treatment philosophies. There are primarily two counseling modalities utilized in the criminal justice field today, nondirective and directive. Nondirective counseling's philosophy is that the offender is the only rightful person to determine his or her future and that no one can tell another what is right for him or her (Rogers, 1951). Directive counseling is the

opposite of nondirective counseling, the major philosophy being that the offender has failed to solve problems himself or herself and that is why he or she needs help. It is the counselor, not the offender, who is responsible for the counseling process (Masters, 1994). Some examples of directive counseling are Psychoanalytic/Dynamic. Both claim that only after the offender verbalizes and understands his or her problem can he or she gain insight and change. Insight cannot occur until the offender's unconscious desires are made conscious (Master, 1994). Relationship counseling's major premise is that the offender does not have a good relationship with other human beings (Masters, 1994). Rational-Emotive counseling, developed by Ellis in 1973, addresses the offender's cognitive processes. The major premise is that offenders will change only when they are ready to perceive things differently (Masters, 1994). Glasser, a Los Angeles psychiatrist, originated and developed Reality Therapy counseling (Masters, 1994). This modality emphasizes that offenders must learn to take responsibility for their behaviors and to face reality. To face reality, offenders have to fulfill two basic social needs that all humans must meet: (a) to love and be loved and (b) to feel important, unique, and worthwhile (Glasser, 1965).

It is important to note that TCs within prison settings predominantly use Behavior Modification counseling methods (Masters, 1994). There are several premises involved: first, people behave as a result of and are motivated by reinforcements; second, behavior is learned and, therefore, can be unlearned; third, the same laws apply to humans and other animals; fourth, to change behavior, the consequences of behavior (environment) must be changed; and, last, once behavior changes (external behavior) occurs, how one thinks (internal behavior) also changes (Masters, 1994).

The Therapeutic Community (TC) program encompasses many of the theories discussed. Individuals in these TCs need, not only to modify previous behavior, but new thought processes and their conduct needs to be reformed. Individuals in TCs focus typically on attributes such as honesty, courage, integrity, trust of and being accountable to others, a sense of direction, and self-confidence. Members of TCs are learning to address their anger, shame, guilt, fear, rejection, loneliness, resentment, and failures in their past, present, and future (Deitch, 1999). The Therapeutic Community is a model that is cross-cultural. It has been utilized all over the world working with individuals regardless of their culture, once it has been modified to the uniqueness of that particular culture.

In a prison setting, inmates in TC programs are housed separately from the rest of the prison population. The programs focus on criminal behavior, substance abuse, sexual abuse, and issues related to living in the unit. While most prison activities stress security and custody issues, the TC emphasizes the inmates' personal growth and provides a safe place for free expression (Wexler and Love, 1994, 181-182). Wexler and Love indicate that from a prison administrator's perspective, TCs can be useful to isolate inmates participating in the program. Residents tend to be self-regulating and motivated to avoid conflict and cooperate with correctional staff. At a minimum, inmates are occupied; at the maximum, TC programs provide effective rehabilitation (182).

Members of the Community are referred to as “family”. Instead of being addressed as inmates members are normally referred to as residents. Each member is concerned for the others’ survival and "doing the right thing" for the benefit and growth of the Community and the individual. Any member of the Community may correct,

confront, "patch-up" (positive comments about what a person is doing right) out of concern and tough love when wrong behaviors are being displayed. Members of the TC are accountable to each other and responsible to themselves for following all structural design of the program. Members constantly and publicly disclose their fears, hopes, guilt, and shame through group and individual sessions. In addition there are selected inmates (usually graduates) within each TC who serve in a variety of resident positions, such as: interns, staff assistants, and staff aids that serve as role models.

Within the therapeutic structure of the program all residents (undergraduates) are required to hold a position of work, such as: monitors, sergeant-of-arms, public relations, service crews, and other positional tasks. One of the most fascinating social developments in the U.S.A. today is the growth and proliferation of TCs, where former drug addicts are living and struggling together to gain a new, drug-free outlook on life. These Communities are tightly regulated and run, not by university-trained or board-certified professionals but mainly by former addicts who have been in similar programs and have shown an aptitude for this kind of work (Sugarman, 1974). If a resident is not willing to abide by the institutional and program rules of the prison TC, she/he is terminated and returned to general prison population, in essence banishment or expulsion (Deitch, 1999).

The Therapeutic Community approach in working with a variety of individuals is guided by a perspective on the disorder, the person, recovery, and Right Living. In other words, the addiction is viewed as a disorder of the whole person involving some or all of the areas of functioning. The person or individual is distinguished along dimensions of psychological and social dysfunction, for example, problems with authority, poor impulse

control, as well as educational and vocational deficits. The goal of treatment is a global change in lifestyle and identity. Some assumptions about recovery are that it is a self-help-process or step-by step learning that moves the person toward a stable change in behavior, and that remaining in treatment requires the individual's continued motivation to change. In the TC view of Right Living, certain beliefs and values are essential to recovery, personal growth and healthy living. Some examples are: focusing on the here and now, honesty, social responsibility, a good work ethic, and economic self-reliance.

The most important element of the TC process is community as the primary method of change to bring about needed social and psychological individual changes. Every activity in a TC is designed to produce therapeutic and educational change in the individual participants; however, it is the participants who are the mediators of these changes. Therefore, in the TC environment and structure, the community is both the teacher and the healer.

There are eight essential concepts of *Community as Method.*

1. **Use of Participant Roles** - Each individual participates in and contributes to all activities of daily life in the TC. This provides him or her with the opportunity to learn by taking on a variety of social roles such as peer, friend, coordinator, and tutor. Individuals are active participants in the process of changing themselves and others.

2. **Use of Membership Feedback** - Peer members are the primary source of instruction and support for individual change. Providing observations and authentic reactions to the individual is the shared responsibility of all participants.

3. **Use of Membership as Role Models** - Each participant strives to be a role model of the change process. Along with the responsibility each member has to provide feedback to others as to what they must change, each TC member must also be a living example of such change.

4. **Use of Collective Formats for Guiding Individual Change** - TC members engage in the process of change primarily with their peers.

Education, training, and therapeutic activities occur in groups, meetings, seminars, job functions, and recreation. The learning and healing experiences essential to recovery and personal growth unfold in a social context and through social exchanges in community.

5. **Use of Shared Norms and Values** - Rules, regulations and social norms protect the physical and psychological safety of the community. However, there are also beliefs and values that serve as explicit guidelines for self-help recovery and for teaching Right Living.

6. **Use of Structure and Systems** - Work in the community includes the many jobs and management roles needed to maintain the daily operations of the facility. The organization of this work is a primary vehicle for teaching self-development. Learning occurs not only through specific skill training, but also in adhering to procedures, in accepting and respecting supervision, and in behaving as a responsible member of the community - being someone on whom others can depend.

7. **Use of Open Communication** - The public nature of shared experiences in the community is used for therapeutic purposes. The private life of the individual, his feelings and thoughts are matters of importance to the recovery and change process, not only for the individual, but also for other members of the community. Therefore, all personal disclosure is eventually publicly shared.

8. **Use of Relationships** - Friendships with particular individuals, peers and staff are essential to encourage the individual to engage and remain in the change process. Relationships developed in treatment are the basis for the social network needed to sustain recovery beyond treatment.
(De Leon, 1998, 22-23).

Because of the widespread and sometimes indiscriminate use of the term "therapeutic community" there has been a clouded understanding of the model. Not all programs that call themselves therapeutic community use the social and psychological models of treatment associated with the therapeutic community approach. It is extremely important, therefore to define the TC approach and describe the basic components of the generic TC program model. The following are the basic elements of a TC program

regardless of whether it is adapted to a prison environment, adolescent population or day program. These are the fourteen generic therapeutic community components:

1. **Community Separateness** - TC oriented programs have their own names, often created by the clients, and are housed in a space or locale that is separate from other agency or institutional programs, units, or generally from the drug-related environment.

2. **Community Environment** - The inner environment contains communal space to promote a sense of commonality and collective activities such as group meetings. The walls display signs that state in simple terms the philosophy of the program and the message of Right Living and recovery. Structure Boards identify all participants by name, seniority level and job function in the program, and daily schedules are posted. These visuals display an organizational picture of the program that the individual can relate to and comprehend, which promotes affiliation.

3. **Community Activities** - To be effectively utilized treatment or educational services must be provided within a context of the peer community. So, with the exception of individual counseling, all activities are programmed in group formats. These include at least one daily meal prepared, served and shared by all members; a daily schedule of groups, meeting and seminars; team job functions; organized recreational and leisure time, and ceremonies and rituals such as birthdays and phase graduations.

4. **Peers as Community Members** - Members who demonstrate the expected behaviors and reflect the values and teachings of the community are viewed as role models. Indeed the strength of the community as a context for social learning relates to the number and quality of its peer role models. All members of the community are expected to be role models. TCs require these multiple role models to maintain the integrity of the community and assure the spread of social learning effects.

5. **Staff as Community Members** - The staff is a mix of recovered professionals and other traditional professionals such as correctional, mental health, medical and educational professionals. It is essential for them to be integrated through cross-training that is grounded in the basic concepts of TC perspective and community approach. While their professional skills will define their staff function as nurse, guard, or caseworker, it is essential that they understand that their generic role as staff is now that of community member. They are not providers or treatment specialists, but rather they are rational authorities, role models, facilitators and guides in the self-help community method.

6. **A Structured Day** - Regardless of its length, the day has a formal schedule of varied therapeutic and educational activities with prescribed formats, fixed times, and routine procedures. The structure of the program relates to the TC perspective, particularly the view of the client and recovery. Ordered, routine activities counter the characteristically disordered lives of these clients and distract from negative thinking and boredom, factors associated with their addictions.

7. **Phase Format** - The treatment protocol or plan of therapeutic and educational activities is organized into phases that reflect the developmental view of the change process. Emphasis is placed on incremental learning at each phase, which moves the individual to the next stage of recovery.

8. **Work as Therapy and Education** - Consistent with the TCs self-help approach, all clients are responsible for the daily management of the facility which includes cleaning, activities, meal preparation, maintenance, coordinating schedules, meetings, and so on. In the TC, the various work roles help bring about essential educational and therapeutic effects.

9. **TC Concepts** - There is an organized curriculum focused on teaching the TC perspective, particularly its self-help recovery concepts and view of Right Living. The concepts, messages and lessons of the curriculum are repeated in the various groups, meetings, seminars, and peer conversations as well as in readings, signs, and personal writings.

10. **Peer Encounter Groups** - The peer encounter group is the main therapeutic group, although other forms of therapeutic, educational and support groups are used as needed. The minimal objective of the peer encounter in any TC is to heighten individual awareness of specific attitudes or behavioral patterns that need to change. However, depending on the type of TC, the encounter group process may differ in degree of staff direction and intensity.

11. **Awareness Training** - All therapeutic and educational interventions involve raising the individual's consciousness of the impact of his conduct and attitudes on himself and on the social environment. And, conversely, it involves increasing his awareness of the impact of the behaviors and attitudes of others on himself and the social environment.

12. **Emotional Growth Training** - Achieving the goals of personal growth and socialization involves teaching individuals how to identify feelings, express feelings appropriately and manage feelings constructively through the interpersonal and social demands of life in the community.

13. **Planned Duration of Treatment** - How long individuals must be involved in the program depends on their stage of recovery, although a minimum period of intensive involvement is required to assure internalization of the TC teachings. The optimal lengths of time for a full program involvement must be consistent with TC goals of recovery and its developmental view of the change process.

14. **Continuance of Recovery** - Completion of primary treatment is a stage in the recovery process. Regardless of whether aftercare is implemented within the boundaries of the main program or separately, the perspective and approach guiding aftercare must be continuous with that of primary treatment in the TC.
(De Leon, 1998, 24-27).

The Therapeutic Community concept can be applied in almost any setting and with almost any population. In recent years, TC models have been increasingly adapted for incarcerated individuals in prison settings. Overcrowded prisons, increased influx of drug offenders, and the documented success of TC prison models in reducing recidivism and relapse have fostered this development. Modifications of the traditional TC model are shaped by the unique features of the individual correctional institution and the prison culture itself. However, to maintain integrity as a TC, the basic components of the generic TC program and the eight essential concepts of using community as method must be preserved.

The Therapeutic Community Model is a belief system. It demands that practitioners/staff believe that this model works; that the individual can change and that it is the group, the community facilitates this change. In addition, it is a scientific system. There are theories, researched methods, and measurable behaviors at work that yield predictable outcomes regardless of where the model is practiced (Deitch, 1999).

Within TCs there are five primary, distinct yet overlapping categories of activity. Each category is equally important and has distinct goals, theory, and methodology. Those activities that promote change are:

1. **Behavior Management/Behavior Shaping** - Interventions and methods that teach and reinforce new ways of behaving until these are ultimately integrated by the individual. The focus is on the "here and now."

2. **Emotional/Psychological** - The goal is for the individual to gain insight into his or her past and understand how it influences "here and now" behavior.
3. **Intellectual/Ethical and Spiritual** - Focuses on educational abilities relevant to social survival as well as the exploration and examination of values--of great ideas. Goal is to equip individuals with language that will allow them to discuss and handle their feelings vs. acting them out.

4. **Vocational/Survival Skills** - Focuses on developing pro-social behavior, teaching work skills and attitudes through contribution the individual makes in his or here everyday jobs for the community.

5. **Biomedical** - These are activities directed at the medical management of individuals in TCs that treat those suffering from thought disorders in addition to criminogenic and substance abuse disorders.
   (Deitch, 1999, 3).

Problem Statement

There remains a critical need to address and investigate whether the Therapeutic Community within the Criminal Justice System, particularly prison environments, is working. Are TCs being accepted by State and Federal prison officials as viable treatment approaches and alternatives to address offender addictive disorders and functioning? Is cross-training of TC staff being implemented more effectively today versus the past? Are ex-offenders being utilized by today's TCs as they were in the past? Is communication between staff more effective today in TCs than in the past? Is TC staff retaining sufficient control over the TC programs? Is the potential for alienation between security and treatment staff being addressed? Will TCs help to reduce crime and violence in

prison and provide a safer prison environment for employees and inmates? Will Therapeutic Communities help to lower recidivism rates throughout the country? By gathering descriptive data and information on Therapeutic Communities throughout the country, as implemented by State governments and private service contractors, research results help evaluate whether TCs' concepts/programs are being widely utilized by correctional management. If they are, what are the potentials for their success within prison environments? More importantly, what is the potential for participants (inmates) remaining in society, once released, as law-abiding citizens?

In the next chapter a detailed literature review on the development and utilization of TCs in adult correctional facilities will be presented.

CHAPTER II

Literature Review

This literature review focuses on the use of Therapeutic Communities beginnings and their use in prison environments. The Therapeutic Community (TC) is a structured method for changing human behavior in the context of community life and responsibility. The early TCs in America were part of a grassroots, non-professional movement in which substance abusers and offenders voluntarily joined together for self-help. They were seen as an alternative to the dominant culture and lifestyle, and were based on a common belief that their members would be unable to remain clean, sober, and crime-free outside a highly structured and ritualized community (Bush and La Barbera, 1997). As they are usually designed today, TCs are closed communities in which members are immersed in the life of the community, which predominantly revolve around common purpose, strict structure, commonly held and reinforced values, clear rules and norms, and enforced consequences. Generally the resocialization model that is enforced is Social Learning Theory. This theory suggests that criminal behavior is learned through a process of social interaction (NIDA Research Monograph 1994, 144). In contrast to traditional residential treatment programs where the counselor or therapist is the primary agent of change, in a TC the community itself is the agent of change. In the TC professional staff largely focus on maintaining the community (Bush and La Barbera, 1997). The staff can also be described as the primary culture carriers (Deitch, 1999).

The quintessential element of the TC is community. What distinguishes the TC from other treatment approaches is the purposive use of the community as the primary method to bring about needed social and psychological change in the individual. Every

activity in a TC is designed to produce therapeutic and educational change in the individual participants; however, it is the participants who are the mediators of these changes. Thus, in the TC, the community is both teacher and healer (DeLeon, 1994).

Therapeutic Communities in prison environments incorporate the following common features:

- isolation from the rest of the prison inmate population,
- use of ex-offenders and ex-addicts as staff members,
- development of a safe environment,
- use of confrontation and support groups,
- clearly specified cardinal rules,
- institutional, basic rules and sanctions,
- development of pro-social attitudes.

Normally, inmates are saturated in a highly structured and supportive environment. Within this highly structured setting inmates live and often work for an extended time (often a year or longer) away from negative prison influences (NIDA Research Monograph 1994, 144). Frequently, TCs in a prison setting, focus on the inmate's criminal behavior and cognitive patterns, substance abuse, sexual abuse, and issues related to living within the Therapeutic Community Unit (NIDA Research Monograph 1994, 144).

While prisons stress security and custody issues, the Therapeutic Community constructively emphasizes the inmates' personal growth and provides a safe place for the inmate to practice free expression. This freedom of expression can be a focus of conflict among the TC treatment staff and other correctional personnel. On the other hand, inmates (residents) tend to be self-regulating and motivated to avoid conflict and cooperate with correctional staff. From an administration perspective inmates are

occupied; from a Therapeutic Community program perspective inmates are afforded an opportunity for effective rehabilitation.

Historical Development of TCs

Philosophies similar to Therapeutic Communities have been found in the Dead Sea Scrolls of approximately 2000BC. A group of people living in the desert, called the Essenes, organized their lives relevant to the survival of each of its members. The rule of order, a way in which they lived, continuously expanded both the capacities to survive amidst terrible environmental challenges and the challenges of wanting to live a good life. Their "Manual of Discipline" is a combination of directions, prescriptions, rules and notations for personal conduct, for carrying on the affairs of the community, for discipline, for admission to and expulsion from the order, and for worship. Deitch describes these enduring principles as follows:

- Concern for the soul and physical survival
- Search for meaning
- Challenge and admonish with love
- Be invasive - accountable to the community
- Public disclosure of acts, fears, hopes, guilt
- Public explanation for wrongs done
- Banishment possible - done with concern
- Leadership by elders - by model (The Essenes and Christianity, 1957).

Although Essene principles highly impact today's TCs, other historical events played a role in their developing modern TCs. The Essene principles began to falter about the 4th century when Rome absorbed Christianity and priests were given power and authority. In the 5th century, under Pope Leo, confessions of one's secret wrongs were no longer public, thus resulting in the loss of public disclosure, absence of public expiation

or punishment, and no visible amends. Members of a church, or a group of Christians, no longer were accountable to the community or to each other, but only to the priest.

In 1517, Martin Luther, an Augustinian monk, was upset that indulgences in sin could be bought and paid for with money, status, and power. Luther questioned the need and validity of sins being confessed to a priest. As a result, Martin Luther became the cornerstone and began the Reformation Movement in Europe, by nailing his 95 theses to the church door at Wittenburg, Germany. The upshot of Luther's theses was that Christians are saved by faith, and faith alone, and that no amount of works (including the purchase of indulgences) made any difference at all (http://www.lepg.org/religion.htm).

In the 17th century, England was infested with a brand new "drug", called gin. England became known as the land of the drunkard, thus causing more death and destruction than has ever occurred in the usage of any other drug. As a result, many turned to theology and the church for help with these alcoholics! Religious leaders attempted to change or alter the lifestyles of those who were involved with the gin epidemic (Deitch, 1999). This alternating of life styles is a prominent principle of today's TCs. In response to this devastation many church groups rose up to address the situation. For example a strong religious group, the Methodists, led by John Wesley, an evangelist from Oxford, opened the door of hope for men and women. He referred to them as victims of society. These individuals had been excluded from the political process and from most of the protections of the common law. Wesley gathered them together into new social groups in which each person found acceptance and a new sense of dignity (Outler, 1984).

In 1908 while visiting England, Dr. Frank Buchman (born in Pennsylvania) underwent a spiritual experience which altered the course of his life. Describing it he said, "I began to see myself as God saw me, which was a different picture of the one I saw of myself. I realized how my sin, my pride, my selfishness had eclipsed me from God. I was the center of my own life. That big "I" had to be crossed out. It produced a vibrant feeling as though a strong current of life had suddenly been poured it to me."

The strength of this experience convinced Buchman that moral compromise was destructive of human character and relationships, and that moral strength was a prerequisite for building a just society. His experience led him to give the rest of his life to helping others, through personal encounters and the sharing of personal experience. In the 1920s, Buchman was a frequent visitor to Oxford University, which inspired the "Oxford Group". He felt that the remedy for bitterness and fear were honesty, purity, unselfishness, and love. Personal change would lead to social change (http://www/mra.oprg.uk/general/founder.html).

Among those whom Buchman befriended and influenced were the founders of Alcoholics Anonymous (AA). AA is perhaps the most famous outgrowth from his work. Bill Wilson, the known founder of AA, an alcoholic himself, helped develop the following 12 steps which are suggested as a Program of Recovery:

1. We admitted we were powerless over alcohol – that our lives have become unmanageable.
2. Came to believe that a Power greater than ourselves could restore us to sanity.
3. Made a decision to turn our will and our lives over to the care of God as we understood Him
4. Made a searching and fearless moral inventory of ourselves.
5. Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.
6. Were entirely ready to have God remove all these defects of character.

7. Humbly asked Him to remove our shortcomings.
8. Made a list of all persons we had harmed, and became willing to make amends to them all.
9. Made direct amends to such people wherever possible, except when told do so would injure them or others.
10. Continued to take personal inventory and when we were wrong promptly admitted it.
11. Sought through prayer and meditation to improve our conscious contact with God, as we understood Him, praying only for knowledge of His will for us and the power to carry that out.
12. Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics, and to practice these principles in all our affairs. (Alcoholics Anonymous, 1955, 58-59)

From New England, TCs expanded to California. The beginning of the TCs in the United States addressed drug dependence verses mental illness. In 1958, Charles Dederich created the organization, Synanon. Synanon, based in Santa Monica, California, was a truly innovative organization. Dederich was not only familiar with the group dynamics of Alcoholics Anonymous but was an active campaigner for that organization. He developed the harsh verbal reprimand or "haircut" because it suited his personality and he observed that it was effective; members of the group lived together at first because they were homeless but this principle of joint residence became a fundamental rule of Synanon. He also broke radically with all previous social work traditions by saying (sometimes explicitly, sometimes by implication), "Junkies need Synanon, we don't need them." In line with this, he established the policy of demanding, before accepting them into the house, that they agree to conform to all rules and make some "investment" as a token of sincerity. Some examples of these investments were telephoning at designated times, giving up prized personal possessions, or by doing something difficult but meaningful, such as yelling for help before a group of residents. All of these features of Synanon are reproduced in many other organizations (Sugarman,

1974). A dramatic move was made from working with outpatient Alcoholic Anonymous meetings to moving into a residential environment including fundamentals dealing with the heroin addict and the alcoholic. Synanon developed the concept of addicts treating other addicts without the intervention of therapeutic professionals in a 24 hour a day residential format (Weppner, 1983).

Dederich intuitively began to shape methods that would provoke recovery by providing and developing, and by provoking conflict and dissidence in individuals. The person would experience internal conflict over their self-image (how they perceived themselves). They were encouraged and challenged by residents in the group to do something different other than what their criminal thinking, drug use, and self-image demanded. He challenged residents to think about morality, human values, and apply those principles of right living to their everyday lifestyle. Dederich felt that when behaviors are managed, the addict soon returns to the same old behavior, but when you shape character and reward that new character, change occurs. Synanon received no public money and there was no public accountability.

Synanon encountered several problems and eventually failed (Sugarman, 1974). From the beginning Synanon had difficulties with the Santa Monica city council, which was responding to worried citizens who did not want "dope fiends" for neighbors (Weppner, 1983). Synanon took the position that modern American society is basically not a good place to live. Their policy was to create their own sub-culture or sub-society in which people could live by the values of Synanon residents, turning their backs on the rest of the American society.

Under Dederich's influence, Synanon staff came to take the view that Synanon stood for better values, and they felt they upheld these values with far more integrity than did the typical representatives of secular American society. In Synanon, people were learning to live by the values of honesty in personal relationships, concern for each other, responsibility in accepting the consequences of one's actions, and working for what one wants. Synanon leaders came to reject the idea that the values of mainstream American society were basically sound and that their main task was to prepare former addicts to return, drug-free, to that society (Sugarman, 1974).

Synanon ran into extreme problems with the law because the leaders made decisions without consulting members of the city council as well as their own membership. They resorted to violence and attempted murder in an effort to silence its critics. Dederich even made tape-recorded messages to members encouraging them to beat up "punks who messed with Synanon." In 1980, Dederich was found guilty of conspiracy to commit murder (Weppner, 1983). In other words, with no accountability (especially government institutions) to anyone except its own members, Synanon came to be defined by its leaders more as a social movement with radical or perhaps utopian goals and less as a rehabilitation program. However, it may be a misnomer to state that Synanon failed. In fact in 1975, at the National Drug Abuse Conference held in New Orleans, over three hundred separate Synanon-type programs throughout the United States were listed. Weppner had visited fifteen different therapeutic communities located from New York to California to Florida. Daytop and Phoenix House in New York City and Spectrum House in Miami are examples of programs initially started or staffed by people who left Synanon (Weppner, 1983).

The Daytop Lodge experiment, as it was first known, began in the fall of 1963. It started as a branch of the Probation Department of the New York Supreme Court, Second Judicial District (Brooklyn and Staten Island). Chief Probation Officer Shelly was one of the prime movers to establish an innovative program for male drug offenders with felony convictions on probation to his department (Sugarman, 1974). Mr. Shelly along with several other individuals from New York City toured Synanon and concluded that the Synanon "concept" of treating addicts should be implemented. Daytop came to play an important part in bringing the Synanon approach to the East Coast and in particular to New York City. In the early planning stages of what became the vast Phoenix House program of New York City, Daytop staff played an important role in advising city officials and visits to Daytop were important in convincing them to support a therapeutic community type of program. As plans for the Phoenix program developed, former Synanon personnel were hired, and today comprise the greater part of senior Phoenix House staff (Sugarman, 1974). It differed from Synanon by using a mixed staff. A mixed staff being a composition of both professionals and non-professionals. Leadership within the structure did not depend on one having experienced recovery. What counted was the mix of staff, who led a moral life and shared values of right conduct and right living within the Therapeutic Community.

The Therapeutic Community expanded to Philadelphia, Rhode Island, Florida and into Sweden, Germany, London and Italy. By the 1980s TCs were utilized throughout Asia in prisons, adolescent and residential programs (Deitch, 1999). Deitch reports that clients and staff members all have influenced and helped expand what is known today as TCs within prison settings. These strong influences throughout history have been, and

are now, a model focused on right conduct and right living. It does not focus on saying, "do not do drugs", but focuses on responsible conduct. Therapeutic Communities reinforce and encourage participants to engage in ethics and morality, being concerned with self-discipline and self-restraint, and showing compassion. When you do what is desirable - you disable doing the undesirable things that previously occurred.

As stated earlier, members of the Therapeutic Community within the prison system are learning to address their anger, shame, guilt, fear, rejection, loneliness, resentment, and failures in their past, present, and future. Inmates reinforce these skills daily for a designated period of time moving in different phases. The desired end result is that the inmate returns to society better equipped to manage his/her environment and his/her own negative behaviors and emotions.

Community-based therapeutic communities (TCs) have been found to have a positive effect on reducing the criminal activities and drug use of clients who complete their programs (De Leon et al. 1972; Simpson 1979, 1980). It is important to point this out as many of those individuals during these studies had criminal histories.

The Bureau of Prisons (BOP) officials was attracted to the TC approach because of the development of the unit management system. The unit management system organizes institutions into functional units; each unit is managed by a unit manager who supervises the unit team (Levinson, 1980). By utilizing the unit management system it makes it possible to manage a large prison as if it were several smaller institutions, each with its own case management team, disciplinary committee, and treatment staff. Therefore, under the unit management system, it was easy to make one of the units a TC within the Bureau of Prisons own program plan.

Early drug treatment programs were funded by provisions in Title II of the Narcotic Addiction Rehabilitation Act (NARA), which authorized Federal judges to commit convicted felons to prison drug treatment programs. One of the early NARA drug treatment sites was at the Terminal Island Federal facility in California. This treatment program included a residential program that was a precursor to the TC.

One of the first and best-known prison-based TCs was established in 1969 at the Federal Bureau of Prison's (BOP) maximum-security institution in Marion, IL. This program was called Aesklepieion, which was developed and implemented by Dr. Marty Groder, a BOP psychiatrist (Wexler and Love, 1994, 183). It is of interest that the Marion facility had at this time recently received inmates transferred from BOP's original maximum-security facility, Alcatraz. During the evolution of the Marion TC, several other offshoot programs were developed at other federal and state prisons (Wexler and Love, 1994, 184). What also distinguishes the Aesklepieion program from earlier prison programs is that most of these earlier programs were offered in low-to-minimum-security facilities. Therefore, resulting in an assured success.

Another key feature of the Aesklepieion program was that inmates could "call a game" on another inmate or a staff member, meaning that the individual was being confronted or challenged about a particular topic. This allowed inmates to be empowered to take action, in sharp contrast to the normal routine of the general prison population. In addition, another unique feature utilized by the Aesklepieion program was the use of transactional analysis (Berne 1961; Harris 1967) and its special language. Code words and phrases (e.g., little professor, replaying tapes) added to the special nature of the

program and gave the participating inmates a special form of exclusiveness in a prison environment that frequently prohibits individuality.

The above strategies developed by the Aesklepieion staff were to confront the "Convict code". The "Convict code" is a general term referring to inmate resistance to communicating with staff, supporting any staff or administration activity, and sabotaging as many aspects of the prison operation as possible. Often inmates in many institutions physically enforce this "Convict code".

What was found to be effective and attractive for inmates in the Aesklepieion program also became a source of conflict. The exclusive program language, special "perks" (privileges), and staffing of the program created mistrust among other staff members and inmates who were not involved in the program. Inmate participants were isolated from all other inmates because of their program activities and because most inmates had jobs in the same area of the institution. It was felt that inmates had too much control over the unit; the fact that they could confront staff as well as other inmates made working in the unit a threatening process for those staff members who were not involved in the program. Because of the mistrust, isolation, lack of communication, a perceived threat to security, and the low priority for programs, the TC program eventually closed within the Marion Federal facility.

Many of the state prison TCs were derived from the Aesklepieion TC at Marion and former inmates from Marion were employed to develop and manage these TCs (Wexler and Love, 1994, 187). For example, the Federal Correctional Institution (FCI) located at Oxford, Wisconsin, was implemented by former Marion staff and Marion inmates (Wexler and Love, 1994, 187). Other Federal facilities that included TCs were

listed by Camp and Camp (1989) as follows: Ft. Worth, Tallahassee, Terre Haute, Terminal Island, Danbury, FCI Miami, and FCI Seagoville, Texas (Wexler and Love, 1994, 187). All of these programs were eventually closed. In many of these programs, it was found that some inmates were involved in dealing and using drugs, staff had loss of control over the program, the selling of admissions into the TC unit, and little supervision, proved to federal prison officials that TCs were not beneficial and did not work anyway. The Federal initiative in the use of TCs in prison settings, along with all other programs, declined in the late 1970s. According to Camp and Camp (1989) the decline of support for TCs and general dissatisfaction with all types of treatment programs resulted in the closing of TCs in Federal prisons.

State prison systems experienced many of the same problems identified in Federal prison systems: programs out of control, staff mistrust, and poor communication. The first TC state prison program was initiated in 1962 in the Nevada State prison system. It was operated and implemented by former Synanon members. It is noteworthy; that the Arkansas Department of Corrections was one of the first prisons to establish a TC in a work release facility. Several other state prison systems used the TC as a treatment modality. The Connecticut and Virginia State prison systems opened TCs based on the Aesklepieion model. All of these were eventually closed because of similar reasons experienced within the Federal prison system.

While other State and Federal TC programs were closing in the late 1970s, it is interesting to note that the Stay'n Out program, implemented in 1977, was the first in-prison TC to be extensively evaluated. Stay'n Out is located in two New York State prisons: one for men at the Arthur Kill Correctional Facility on Staten Island, and the

other for women at the Bayview Correctional Facility in Manhattan. The rationale for the development of Stay'n Out program was based on the growing research on community-based TCs, according to Wexler and colleagues (Wexler et al.,1988b). Community-based TCs are widely accepted and have been demonstrated to be effective with clients who have criminal histories (Bale, 1979; De Leon, 1984; De Leon et al., 1972, 1979, 1982; Holland, 1978; Nash, 1973; Sells et al., 1976; System Sciences, Inc., 1973; Wilson and Mandelbrot, 1977).

Evaluation of the community-based Phoenix House program (De Leon 1984; De Leon et al. 1979) provided direct support, because the Stay'n Out model is based on the Phoenix House program. Not only were the results of the Phoenix House evaluation supportive of TC effectiveness in a 5-year follow-up study, but it was found that the successful outcomes (i.e., reduced crime, reduced substance abuse rates, and increased employment) were related to the time spent in treatment (De Leon et al., 1979, 1982; Simpson 1979, 1980). This Time In Program (TIP) is a critical component of the TC concept.

The evaluation of the Stay'n Out TC provided the opportunity to gather new information about the TIP effect as noted by De Leon (1984) in community-based TCs. It was expected that inmates would remain in the TC longer than the community-based TC program participants. For example, compared to the general prison population, the prison TC unit provided more desirable housing, more activities, more special incentives, and offered opportunities to impress the parole board. The research showed that the program was successful in implementing and maintaining a positive TC treatment environment, was capable of retaining inmates for optimal treatment duration (9 to 12

months), and facilitated positive personality changes as assessed by standard psychological measures (Wexler et al. 1985).

Another independent confirmation of the utility of TCs in prison has been provided by the evaluation of the Cornerstone Program (Field, 1984, 1989). Cornerstone is a prerelease treatment program for alcohol-and drug-dependent offenders, which opened in 1976 on the grounds of the Oregon State Hospital in Salem. Just as was the case in Stay'n Out, Cornerstone participants had severe histories of criminal behavior. For example, in 1984 Cornerstone clients had an average of about seven felony convictions and had served more than seven years in prison.

The effectiveness of prison TCs has been substantiated by evaluation research of these two prison TC programs. The Stay'n Out, Cornerstone, and other prison TC program evaluations have provided convincing evidence that prison-based TC treatment can produce significant reductions in recidivism rates (Wexler and Love, 1989)

In response to increasing public demands that something be done about the growing drug problem, state and federal legislatures have enacted determinate and mandated sentencing laws, resulting in a sharp increase in the number of inmates in U.S. prisons.

One response to the growing need for in-prison drug treatment programs was the Bureau of Justice Assistance (BJA) program called Project Reform. Project Reform was designed to help state prison systems develop corrections-based drug treatment programs (Wexler et al., 1991). The program was funded through the Anti-Drug Abuse Act of 1986, which called for substantial new resources for correctional drug treatment efforts. The project began in July, 1987.

Project Reform made it possible for 11 state prison systems to share resources in developing drug abuse treatment programs, complete with an evaluation component. It offered technical support and assistance, consultants, orientation and training, to state prison systems in developing new programs for their growing populations (Wexler et al. 1991).

Therapeutic Communities liberally use group dynamics, educational techniques, and group pressure to help the offender (Masters, 1994). It involves creating a total therapeutic milieu within the traditional prison that is meant to create a psychological change within the offender that will make the offender law abiding after release from prison. They are experiments in social living, in which offenders learn to manage themselves in a law-abiding fashion. The aim of TCs in criminal justice settings is to create a normal environment within a prison, so that the offender will not be released in a worse condition than he or she was in when incarcerated. TCs attempt to foster reintegration of the offender and are collaborative efforts to modify traditional prison structures and practices in a way that fosters rehabilitation (Masters, 1994).

In addition to the above treatment philosophies, group counseling is considered to be the primary clinical tool and/or a modality (Masters, 1994). Group counseling involves three or more people who meet to solve personal problems in a group, with the benefit of a group counselor or leader. During the 1940's and 1950's, group counseling began to be widely used in the criminal justice system as a way to handle offenders more efficiently (Kratcoski, 1981). Another important counseling modality for TCs is family counseling. Family counseling is based on a systems theory and the premise is that the

family is a system as such strives for balance or homeostasis whenever stress occurs (Masters, 1994).

The Therapeutic Community provides a rare and unique aspect; this is the utilization of offenders and ex-offenders as staff within institutional settings. In the 1970's, Briggs developed a change system environment in a California prison for violent youthful offenders (Whitely, Briggs, Turner, 1973). The results of the experiment are positive. During a four-year period these offenders, who were prone to violence had no acts of violence with weapons; and with total inmate supervision of other inmates within the program structure, there were no escapes. This was not the case when trained correctional staff was in charge of the supervision (Whitely, Briggs, Turner, 1973).

However, this internal commitment achieved by the residents of the program produced a challenge to the professional staff. Inmates were keen on and highly adept at putting concepts into action and testing them for effect. Unlike the professional, those who "guarded" them, they did not become caught-up in professional jargon and explanations. The inmates could easily abandon an ineffective course, and try something new, quickly grasping sophisticated concepts, translating them into action, observing "interactions", and developing new strategies with other residents of the program (Jones, 1976).

There are three promising approaches to counseling offenders in prison settings; therapeutic communities, group counseling, and family counseling. These approaches offer the criminal justice system ways of helping the large number of offenders who are expected to enter the criminal justice system in the future (Masters, 1994).

In a private statistical study conducted from December, 1993 to December, 1994 by Corrections Corporation of America (CCA), a private company based in Nashville, Tennessee, it was discovered in their Metro LifeLine Therapeutic Community, that only 34 percent of those inmates released from incarceration, who successfully completed the program, had been re-incarcerated during this time period (CCA's Metro Davidson County Detention Facility, LifeLine Program Handbook, 1993). At the same time it was noted with a control group of 119 non-treatment randomly selected inmates, the re-incarceration rate for that group was 67 percent.

In addition to this recidivism data a grievance and disciplinary study was conducted with 254 treatment inmates and 254 non-treatment inmates. In one calendar year, the non-treatment inmates had 61.2 percent more grievances filed compared to the treatment inmates. Non-treatment inmates received 81.7 percent more disciplinary actions than treatment inmates.

In the following chapters, methods will be presented on how this research project will obtain and evaluate descriptive data concerning TCs. The focus of this project will be to provide a review of all TCs currently being utilized in the U.S.A. in efforts to rehabilitate adult offenders sentenced to correctional facilities.

CHAPTER III

Methodology

Introduction

According to the mass media, the prison system is not very promising. Prisons do not appear to either deter crime or rehabilitate which is evident from the recidivism rate. The offender is taken from society for a period of time, thus a feeling of safety for the victim, however many of those offenders will return to society. Have those offenders been rehabilitated? Has the root problem that caused them to commit an offense in the first place been addressed? Or do we send the ex-offender back into society more "hardened" than before their crime and incarceration? How many of these offenders have learned to address their fears, rages, shame, and guilt? Have they had positive reinforcement for good behavior? While incarcerated, where did that positive reinforcement develop? Did the offender know how to live morally before they went to prison? Better yet, is anyone teaching or role modeling how to live a crime free and moral life upon release?

The recidivism rate continues to rise daily, as the media reports, statistics proving that many offenders, who avoid trouble within the institution, and do, will again return to crime upon their release from prison. Therefore, prison adjustment and avoiding trouble in the institution are not the same as rehabilitative programs that end criminal behavior. Rehabilitation should focus on an attempt to solve the problem(s), which brought the offender(s) to prison.

Therapeutic Communities have the premise that many inmates desire positive prison adjustment, desire to avoid trouble, and are motivated to change. This coupled

with the structure and designed activities of the Therapeutic Communities milieu provide opportunities to confront and solve the problems which brought the offender into the correctional system.

This research is designed to discuss information from all state department of corrections or rehabilitation addressing the relevance of Therapeutic Communities within their institutions. It will determine how many therapeutic communities exist throughout the country, gather impressions as to are TCs working, do they have the potential to reduce recidivism, and provide other descriptive information.

Method

In January, 2001, a cover letter (See Appendix A) and a questionnaire (See Appendix B) were forwarded to all fifty state department of corrections and/or rehabilitation with an enclosed prepaid return envelope addressed to the Criminal Justice Department at Youngstown State University. Prior to the questionnaire being sent, a telephone call was made to each state department of corrections and/or rehabilitation. This procedure was to alert the Department of Corrections or Rehabilitation that a questionnaire had been forwarded to them in an attempt to identify the correct individual, best suited to provide the most articulate information related to the questionnaire.

The survey instrument addressed the following issues: are therapeutic communities being utilized, where are those prison facilities located; are delivery of services provided by state or private agencies, their capacities and participation, and what type(s) of programs and length of those identified programs. Additional questions addressed if therapeutic communities were safer environments with less disciplinary, security, and inmate violence problems compared to the inmate general population, were

TC staff receiving some type of cross-training, and if policies and procedures were developed for TCs within each responding state. The survey solicited responses concerning recidivism rates being monitored and the potential for reduction of recidivism rates within the responding states.

A follow-up questionnaire was forwarded in February, 2001, to those Department of Corrections, which had not responded to the initial questionnaire. In March, 2001, information and data were viewed and recorded. All results and findings from the questionnaire are addressed in the next chapter.

Responses were assessed and tabulated for all returned questionnaires from each state. The collection and analysis of the responses to the questionnaire provided a clear composite of therapeutic communities within prisons throughout the United States. Additional data, related to the results of the questionnaire, contained important information and gave insight to whether or not therapeutic communities are good management tools used by prison administration. SPSS/PC+, a computer software packet for social scientists, was utilized to conduct descriptive statistics. Results are presented in the following chapter.

CHAPTER IV

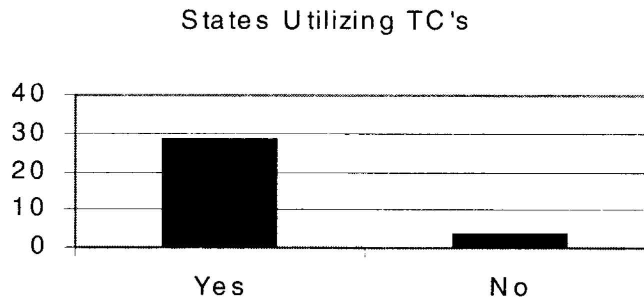
Analysis and Findings

In the previous chapter, the methods for data collection were presented. The survey instrument was sent to fifty state department of corrections and/or rehabilitation. The data were collected to determine if TCs are being utilized and if they are effective.

Survey Participants

Thirty-four of the states returned their survey instruments (68%). Five of the respondents reported they were not utilizing TCs. One reported via telephone that their state used TCs. Unfortunately that state declined to answer the questionnaire due to workload (see Figure 1). See Appendix C for a map depicting which states responded to the survey instrument.

Figure 1



One respondent completed questions one through five. However, for the remainder of the survey instrument, respondent stated "do not operate, so I don't know". Therefore, questions one through five will be based upon 29 respondents who have TCs. Questions six through twenty-one will be based upon 28 respondents. Another respondent answered questions one through 11, but did not respond to questions 12 - 21.

The same scenario will apply as previously stated. Questions 12 - 21 will based upon 27 respondents.

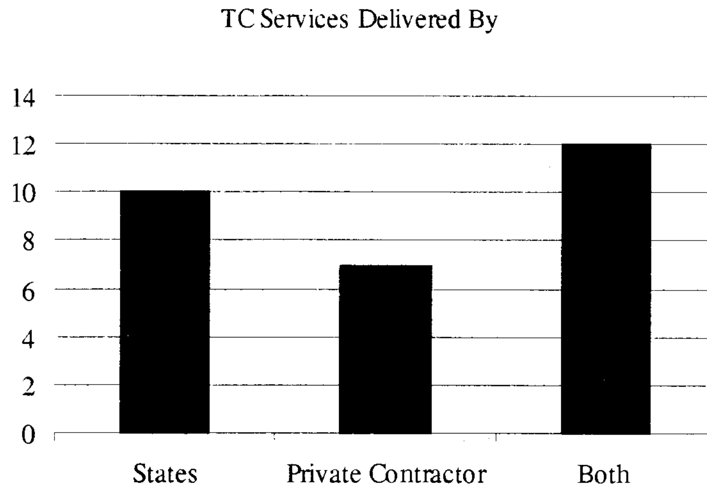
Facilities

The majority of state prison systems that operate TCs have more than one TC in various locations within the state. The type of facilities ranged from minimum to maximum security institutions to pre-release centers. Some of the state prison systems had large numbers of TC participants, such as Texas and California, and other respondents reported much fewer numbers of TC participants within their programs, such as Alaska. Many of the state respondents had TC programs for both male and female inmates, although the majority had only males in their programs and the male/female ratio was not requested of respondents.

Who Delivers TC Services:

Twenty-nine (n = 29) responded to the question "who provides service delivery". 12 states, 41.4% reported that their TCs utilize both private contractors and are state operated. Ten states, (34.5%) are state operated and seven (24.1%) states use private contractors to operate their TC programs (see Figure 2). Private contractors include: CCA, Wackenhut, Civigenics, Phoenix House, Gateway Foundation, Quest Recovery Services, Comp Care, and DCCCA, Inc. Numerous other private contractors, such as Akeela House in Alaska, provide services within that particular state.

Figure 2



Months Program Has Been in Existence

The lengths of operation reported varied depending upon the program and who delivered services. The ranges varied from seven months to 240 months. For example, Alaska, which is a new program, reported starting their TC program in the year 2000. Minnesota responded that they had TC programs in existence ranging from 48 months to 240 months. (See Table 1).

Table 1

State	Facilities within state using TCs	Months program has been in existence	Length of program in months	Inmate capacity	Inmate participation
Alaska	1	7	12	44	44
California	15	120	18	8,000	8,000
Colorado	5	96	12	350	346
Connecticut	4	120	6	304	304
Hawaii	2	132	15	255	255
Idaho	2	36	12	87	87
Illinois	15	120	24	2,797	2,600
Indiana	2	48	12	264	264
Iowa	2	7	9	108	108
Kansas	3	72	24	184	175
Kentucky	1	12	6	96	65
Michigan	3	30	9	556	403
Minnesota	5	240	6	400	400
Mississippi	1	12	12	396	396
Missouri	7	72	24	2,065	2,049
Montana	1	18	Did not answer	88	65
Nebraska	3	72	10	181	181
Nevada	1	24	12	105	90
New Hampshire	3	120	11	430	430
New Mexico	7	60	14	540	503
Ohio	5	108	12	574	460
Oklahoma	4	12	12	350	Did not answer
Pennsylvania	8	190	12	900	900
Rhode Island	3	96	12	120	120
Texas	27	125	12	8,200	8,000
Utah	2	24	12	208	203
Washington	3	36	12	300	200
West Virginia	3	36	12	160	160
Wyoming	3	66	9	44	31

Total Inmate Capacity

The inmate capacity, number of bed space, in the TC programs ranged from 44 in Alaska and Wyoming to 8,200 inmates in the State of Texas. Although Wyoming reported a capacity of 44, the state is in the process of expansion. California reported a

capacity of 8,000 inmates, with six institutions and a bed capacity of 2,115 being added in the future. Fourteen TCs are operating at full capacity with 14 just slightly under capacity. One State did not respond. (See Table 1)

Programs Addressed by TCs

Respondents (n = 29) were asked to report program components that are being provided within their TC programs, one, all, or a combination of services. (See Table 2)

Table 2

Programs Offered By TCs

Program	Frequency	Percent
Substance Abuse	29	100
Behavior Modification	22	75.9
Domestic Violence	11	37.9
Sexual Abuse	14	48.3
Cognitive Model	24	82.8

The Therapeutic Community concept can be applied in almost any setting and with almost any population. All of the respondents reported their TC programs address substance abuse issues and concerns, therefore, implying that most of their inmate TC population have, directly or indirectly, alcohol and/or other drug abuse issues. Some TC programs are specially designed and implemented to address the needs of certain types of offenders, for example, sexual offenders and domestic violence offenders. It is evident, from the above information, that many of the major components of 'change' are being addressed by prison TC personnel.

Other TC program components that were reported by respondents were 12-Step education, criminal thinking, life skills, mental health issues, job seeking, parenting, anger management, and relapse prevention. As one respondent stated, "TCs are holistic programs".

TCs Reduce Grievances and Disciplinary Reports

Twenty-five (86.2%) respondents reported that they believe that TCs have fewer frequencies of grievances/disciplinary reports in comparison to the general prison population. One respondent stated they were "not sure yet"; another respondent stated it was "too early to tell"; and one other respondent stated "there has not been a system study of these areas to do a comparison".

Less Violence on TC Units Compared to General Prison Population

Twenty-four respondents stated "yes", TCs have less violence in their unit than is found in general population. Over 85 percent stated their TC units are less violent than the general prison population. Four states did not respond to this question.

Safer Environment for Correctional Officers/Inmates

Twenty-four (85.7%) responded to the question "are TCs safer environments as compared to the general prison population for correctional officers and inmates". Three (3) respondents did not answer the question and one reported "no" with the following explanation: "All of system relatively safe, compared to most systems". The following are comments of respondents when requested to explain:

- Fewer assaults, fewer incidents/discipline, fewer violations, few infractions.
- All disciplinary violations lower, any signs of unrest or trouble brewing is immediately known, no secrets.
- In five and one half years of operation - no assaults.
- Increase community responsibility, sets higher standards for behavior.
- Never had 'Use of Force' necessary.

- Problems are de-escalated and dealt with at a lower level before violence occurs.
- TCs produce a better behaved, more responsible inmate.
- Safer environment reported by staff and inmates.
- No substance abuse, almost no verbal violence and no physical violence.
- Too early to tell.
- There has not been a system study of these areas to do a comparison.
- TCs are safer environments for both Corrections Officers and inmates compared to general population because the TCs address the offenders' problems, teach coping skills, promote family communication, the counselors are readily available, and the intensive treatment that is received by the offenders.
- Increase community responsibility, sets higher standards for behavior.
- Very few incidences of violence in the TCs or positive drug screens.
- Relatively safe, compared to most systems.
- Major misconduct frequency of RSAT participants appears to be less than that of General Population.

Recidivism Rate Monitored

According to the data, 13 states, (46.4%), are monitoring the recidivism rates within their particular TC programs. Recidivism rates ranged from a minimum of five percent to a maximum of 33 percent. Wyoming reported that of TC participants who had completed the program, 26 percent return to custody and eight percent of them new crimes. Several programs were in the process of conducting studies and data collections. Ten (35.7%) of the TC programs are not currently monitored. Several of the respondents, who currently are not monitoring their respective programs, stated that they are preparing to do so. Several respondents do have aftercare and/or follow-up linked to conditions of release. The minimum of aftercare reported was three months to a maximum of 12 months. For instance, California stated that upon parole, inmates have a six-month option of a residential placement, whereas, Colorado uses a six to 12 month follow-up for successful releasees from their TC programs. Therefore, from inmate entry while still

incarcerated, parole, and transitional placement could be as much as monitoring the recidivism rate for a period of two years or longer.

Good Inmate Role Models

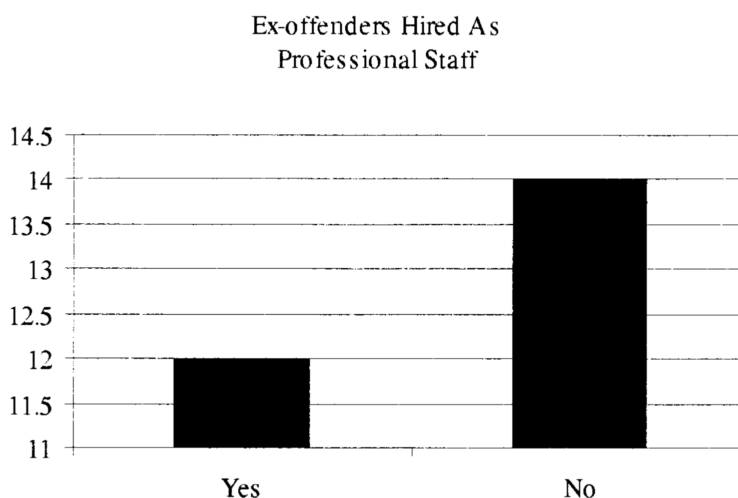
An extremely high percentage (89.7%) of the respondents (n = 25) reported that their TCs had good inmate role models. One respondent stated "selection of inmate peer mentors and definition of their role(s) is an area we need to work on". One other respondent stated that "the program is too new". One respondent did not fill-in this question. From those respondents who answered “yes”, the following comments were also included:

- Graduate offenders are used as "paid" staff; tutors live and work within unit as role models and help with homework/education.
- Peer assistants are used within the community.
- Graduates and peers are used.

Ex-offenders Hired as Professional Staff for TC Programs

Respondents were somewhat divided in this area. Twenty-six respondents (n = 26) responded to this question. Of the 26 respondents, twelve (42.9%) stated that they do hire ex-offenders to work within their TC programs. Fourteen respondents (50.0%) do not hire ex-offenders (see Figure 3). One respondent reported "not yet, but would consider it". Two respondents did not answer this question.

Figure 3



Length of Programs in Months

Many respondents reported both a minimum and maximum time for the length of the TC programs. For example, the State of New Mexico has a minimum of nine months and a maximum of 12 months in their minimum-security facilities, with all others having a minimum of twelve to a maximum of fourteen months. Only the maximum length of the program was recorded. Kansas, Illinois, and Missouri reported their program length to be 24 months with California reporting 18 months. The majority of the respondents stated that their program length was 12 months. Six months in length was reported by Connecticut, Kentucky, and Minnesota. (See Table 1) The average length for all the programs combined are approximately twelve to twelve and a half months.

Inmates Moving Through Levels/Phases

Therapeutic Communities contain phase movements. Frequently, these phase movements are for a certain length of time with determined criteria established to measure the eligibility for movement to the next phase. Two respondents did not address this question. The remaining 25 reported, that inmates do move through levels and

phases. The majority of respondents (92.6%) reported their programs encompassed Phase I, Orientation, Phase II, Education/Treatment and Phase III, Transition/Re-Entry and /or Aftercare (See literature review concerning the typical). The inmates who complete the program vary from state to state. From 15 percent to as much as 98 percent of inmates completed the TC programs with an average of 68.2 percent.

Once Inmates Complete TC Program

Once an inmate completes a TC program and graduates from that program there are a number of things that may occur. For example, an inmate may be allowed to remain in the TC program and continue to be an example to other inmates participating. He or she may assume certain roles (i.e. intern, instructor, mentor, etc.). An inmate is normally granted the opportunity to either remain in the program or he/she may return to the general prison population. Some TCs do not even allow inmates to enter the program until they are close to being released or paroled. Twelve respondents reported that TC graduates were allowed to remain in the TC environment and program, while 11 were not allowed to remain in the TC program. Ten respondents reported that graduates are returned to the general prison population, with 11 reporting that inmates were not returned to the general prison population.

Respondents were asked about follow-up and aftercare. Thirteen respondents reported that inmates who graduate from the TC program have a follow-up or aftercare component to their programs. The length of those services range from three months up to 12 months. Upon parole, or other types of release from the institution, 10 respondents indicated that inmates were placed in other TC settings, such as, community-based

residential facilities or counseling services. Seven respondents reported that inmates were not placed in a TC setting.

Respondents provided the following qualitative data concerning what happens once an inmate completes the TC program:

- Two programs release to a community TC.
- They are scheduled to be eligible for release.
- Referred to substance abuse counseling as a condition of parole.
- Released to parole to the streets or to a halfway house.
- Trying to target only those that can receive a work release or parole, otherwise, we are moving them to the minimum custody institution.
- Offenders are discharged or moved to community corrections upon completion of the program.
- The offenders are released from incarceration once they are have completed the TC program. The SAFPF (Substance Abuse Felony Punishment Facilitiy) offenders are released to a Transition Treatment Center for three months, and then they must complete a one-year out patient program as part of their probation. Offenders are sentenced to a SAFPF as a condition of their probation or a modification of their parole.
- Upon parole, have option of six (6) month's residential, etc.
- Placed in follow-up treatment based on evaluated need.
- Placed in outpatient, intensive outpatient, recover home beds.
- Upon parole inmates encouraged to participate in community alcohol and drug programs. Some are referred to community corrections centers.
- Released to parole/probation with follow-up recommendations.
- Referred to and participate in treatment upon release from prison.
- Up to forty (40) community corrections TC beds are available in community facilities.
- Project Bridge is an RSAT funded transition program. Utilize one for men, one for women.

Standard Written Policy and Procedure for all TCs

Fourteen (51.8%) of the respondents reported that they do not have statewide written standards for all TCs that are operational within their particular state. One explanation why approximately one half of the states do not have standard policies may be that private agencies develop and operate TCs under their own policies and procedures throughout the country. For example, Corrections Corporation of America (CCA) and

Wackenhut, operate TC programs for various states. Eleven respondents (40.7%) reported that they do have a written standard policy for all TCs within their respective states.

Inmates Volunteering for Program/Bed Capacity

Out of the 27 respondents, 20 (70.4%) reported that they accept inmates who are volunteering to enter their TC programs, while six (22.2%) stated they do not. One respondent did not answer the question. What is interesting to note is that many reported that they do not have enough bed capacity (40.7%) to accommodate all volunteers and those inmates who are ordered to TCs. Nine respondents (33.3%) reported they do have adequate bed capacity. One respondent did not answer the question.

One hundred percent (n = 27) of the respondents stated that their TC participants are separated in some manner from the rest of the general prison population.

Twenty-four (88.9%) of the respondents reported that they do have a waiting list for inmates either attempting or are eligible to enter their TC programs. Two (7.4%) do not have a waiting list. One respondent did not answer the question.

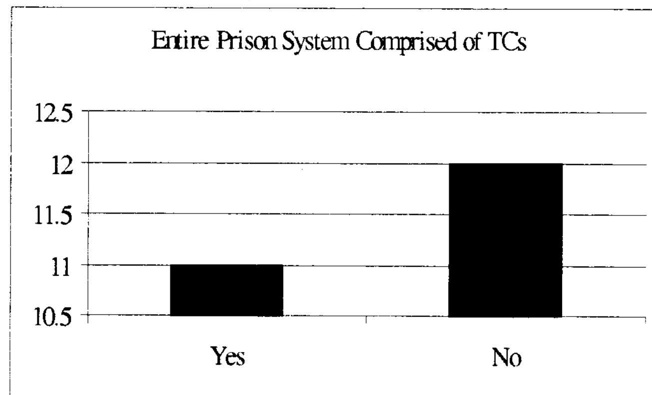
Entire Prison Comprised of TCs

Respondents were asked to comment on whether or not they felt an prison system could be a TC program. It is possible to have a prison system or prison unit completely housed by TC participants. For example, the Texas Department of Corrections' Kyle Prison, which is an institution of 500 inmates, is a total TC institution. In addition, the State of Oklahoma Department of Corrections Davis Correctional Facility, operated by CCA, at Holdenville has a bed capacity of 480 inmates and is a total TC institution. Eleven respondents (40.7%) claim that it is possible to have a prison system which is

comprised of the TC concept and structure. Twelve respondents (44.4%) stated that it was not possible to have an entire prison system composed of TC participants only (see Figure 4). Four respondents did not answer the question. The following comments were made concerning the possibility of an entire prison comprised of TCs:

- Notion of inmate hierarchy of responsibilities and consequence appropriate for all inmate management.
- If administrators and money are committed to it, no reason why not.
- Once the CO's and security staff understand the concepts, I believe the prison can be run much more safely and effectively.
- The BJCC has worked towards a facility-wide TC.
- Texas has already done it (reported by Utah).
- Only if the administration (director, warden) is 100% supportive. If corrections officers are properly trained. If funding and staffing are appropriate.
- We are proceeding to establish in every institution.
- Not at present
- One example might be Maryville, MO.
- If question is entire prison – "Yes"; if question is entire prison system – "No".
- Depends on demands for service.
- Best, most efficient use of staff and space. Highest potential program integrity

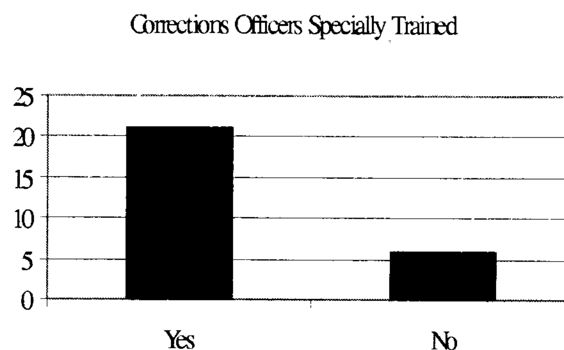
Figure 4



Corrections Officers Specially Trained

One area of concern, according to many studies from the literature review, is the misunderstanding of management and security staff of the TC concepts and perspectives. Effective and efficient training of prison staff is one method to address this concern. Twenty-one respondents (77.8%) stated that they do provide training to correctional officers who work in TC programs. Six respondents (22.2%) reported they do not provide training for their correctional officers who work in TC programs (see Figure 5).

Figure 5



TCs have the Potential to Reduce Recidivism

It is possible that TCs do have the potential to reduce recidivism according to the respondents. Out of a total of 27 respondents, 26 (96.3 %) reported, "yes", while one did not answer the question. Respondents gave the following explanations of the potential to reduce recidivism:

- Long term structural programming has been linked to successful outcomes.
- Inmates actively involved in their TX and management of unit, mirrors society better than passive TX programs.
- Provided that an effective aftercare program is in place.
- Only if we establish a community-based TC for inmates after release from prison. Don't have one currently.

- TCs provide the inmate with a program which allows him to change the ways he thinks, feels and acts to become more prosocial and responsible.
- This approach combines behavioral and thinking changes in a highly structured environment.
- TCs provide a more intensive approach most chronic addicts need.
- Holistic approach prepares participants for return to real world with skills that will allow them to succeed.
- I think (TCs) actually do reduce recidivism. We are working on a data collection system to be able to support this with statistics.
- Using the Key/Crest studies and the RJDonovan studies, this should be the end result.
- Doing it already.
- Inmate completing TCs have a better chance to reintegrate into society upon release.
- Relapse to drug use is strongly associated with criminal activity and/or parole violations. Treatment of drug dependence is fundamental to all initiative to reduce recidivism.
- Programming provided just prior to release and once offender is released immediate referral to treatment w/sustained un-announced drug testing. Treatment in community should be based and build on prior treatment received in prison.
- The prevalence of drug and alcohol abuse/dependency in inmates is similar to national averages. The literature has repeatedly documented the efficacy of TCs (i.e. recidivism) if properly implemented and administered.
- Two different vendors provide service - one to men and a second to women resulting in a variety of methods in use.

Summary

Although this survey is an inconclusive review of adult therapeutic communities in America, the survey does provide critical and important data related to the increased utilization of TCs in prison settings. The collected data states that the majority of states are implementing therapeutic communities and many of these TC programs have been in existence for some time. Several states are expanding their current TCs for larger capacities, while other states are developing and implementing new TC programs. The respondents overwhelmingly state that TCs are safer environments, that there is less violence, less frequencies of grievance and disciplinary reports compared to the general prison populations. It is noteworthy from those who reported that they are monitoring their TC programs and recidivism rates were lower compared to general prison recidivism rates throughout the country.

In the next chapter the major findings of the survey will be addressed in detail. Some remaining TC barriers and potential problems will be discussed, along with future research that need to be addressed, and recommendations to enhance TCs in prison environments.

CHAPTER V

Conclusion

From 1980 to 1996, the number of people in prison has tripled due to overwhelming criminal activity spawned by drug and alcohol abuse. If this rate of increase continues, then one in every 20 Americans born in 1997 will spend some time during their life in prison, including one in every 11 men and one in every four African-American men. While the 130,000 female inmates constitute only 7.7 percent of the prison population, their numbers are rising at twice the rate of increase for male inmates. Drugs and alcohol account for incarceration of 80 percent of these women as well (Casa Report, 1998).

Therapeutic Communities operated in prison settings are being widely utilized and effective compared to five to ten years ago. The majority of states are operating TC programs within prison settings, some being state operated and others operated by private contractors, such as CCA, Gateway, Wackenhut, and Civigenics. Several states have operational plans for the expansion of their current TC capacity and bed space. On a larger scale, California is planning to add over 2,000 beds that will be housed in six future institutions. At the other end of the spectrum, Kentucky will add 50 beds when their new program begins. Some states (Oklahoma, Texas, California, and Missouri) operate total TC prison units within their statewide prison systems. Although prisons are providing TC services to mostly medium and minimum security inmates, they are operating and providing TC services within some maximum security institutions. In addition, states are offering TC programs in pre-release facilities, pre-parole units, state-jail institutions, mental health facilities, and community-based residential facilities.

There are many positive effects resulting from the use of TC programs in prisons. TC grievances are less frequent as compared to the general prison population. The same is true for disciplinary reports that are written by prison personnel in relationship to inmate behavior(s). Overwhelmingly, according to our respondents TCs are safer environments for both inmate participants and correctional officers who work within those TC programs. Inmate graduates of prison TC programs serve in a variety of positions and they are considered to be a part of the staff. They serve as tutors, peer assistants, interns, staff aids or staff assistants, and instructors. The inmates are considered to be good role models for other inmates still in the program and to the general prison population. When there have been prison disturbances, TC participants frequently maintain a low profile and have even assisted in restoring order to the situation. From a prison management point of view this should be appealing to prison administrators.

Several states are operating prison units within their states, usually with an inmate population of about 500. The majority have their TC programs separated from the remainder of the prison population. A slight majority of the respondents stated they do not believe that a TC program can be implemented in an entire prison system. For large institutions, because of the number of inmates, this may be so, however, for smaller inmate populations, such as 500, it is a very valid prospect.

Acceptance into a TC program should not be dependent upon whether an inmate is eligible for parole only. Regardless of whether TC participants are going to be paroled or not, individuals who choose to remain in a TC prison program should be given the option to either remain in that specific program or not. Data gathered indicated that about

half of the graduates were allowed to remain in the program. The TC perspective is "right living", and "right living" can be achieved and accomplished even inside a prison environment, especially for inmates who have lengthy prison sentences.

A point of interest was that many states do not have written standards of policies and procedures related to the operation of TC programs regardless if they are state operated or private contractors. Even where private corporations are operating TC programs, state agencies should, at the very least, develop and monitor those TC programs. Some, but not all, private corporations have existing contracts with local and county governments, however, not with state agencies because they do not supervise inmates of that particular state where the facility is operational. To maintain the integrity of the TC basic components of a generic TC program model, state agencies could provide this service.

Normally composed of three to four phases all of the states are utilizing some type of phase movement in their TC programs. The majority listed their phases as Orientation, Education/Treatment and Transition.

The length of time in a program is very significant. Most states have TC programs that last 12 months. As stated in the literature review, this Time In Program (TIP) can be extremely important to offender recidivism rates. Several studies suggest that nine months to 12 months is sufficient whereas others have suggested 12 months to 14 months. Although successful completion of TC participants varies from state to state, most are graduating from these prison TC programs.

An exceptional margin of respondents reported that TCs do have or are now reducing recidivism rates. Many states are currently monitoring their recidivism rates,

however, others are not, but realize the importance of data collection and measurable outcomes.

Even though states are divided in their hiring policy of ex-offenders to work in prison TCs, a number of ex-offenders are employed by some state operated programs, certainly, private operated prison TC programs. One reason for not hiring ex-offenders may be state hiring guidelines and policies related to hiring procedures of individuals with felony convictions.

Several studies have reached conclusions that ex-offenders can have a positive effect with other inmates. In the past, numerous scandals have plagued TCs, such as, inmates having too much control over the operation of the TC program, selling of admissions to other inmates to enter the program, drugs on the unit, and relapse of program ex-offender employees. To balance those concerns and past problems, it is also noteworthy to state, that numerous ex-offenders are providing excellent service to incarcerated offenders in TC programs. If little else than being a positive example and providing motivation to TC participants, the effort could have positive effects upon TC programs.

It is important that ex-offenders be sufficiently trained whether they have completed a TC program or not. (There are many ex-offenders who have become highly successful in becoming a positive, productive citizen in society, but may not have participated in a TC program for a variety of reasons). It is recommended that a highly sophisticated training curriculum be developed by state agencies or the regulatory agency addressing the training of ex-offenders to become employed in TC prison programs. This curriculum could address counseling techniques and methods, historical perspectives, TC

concepts and on the job training. In addition, the training curriculum could be implemented through continuing education at universities and colleges. The training length should be no less than 24 months, thus, allowing the selected ex-offender to obtain an associate degree with the option of furthering their education. In other words, the only criteria for an ex-offender working in a TC program should not be that they have simply graduated from that program, it can be a part of the selection process, but not the only component. This would ensure more quality of services, enhance the abilities and creativity of ex-offenders employed in TC programs, and hopefully, prevent some of the scandals from the past.

Great importance should be given to, if possible, the perspective of TC staffs being a mixture composed of recovered professionals (ex-offenders) and other traditional professionals.

In relationship to the above training, it is also critical that cross-training for all correctional officers working in TC programs be required. This training would not only be available to those working in the program, but available to all correctional officers within the prison system.

In general, correctional officers are not familiar with being challenged by inmates. Correctional officers are normally trained that "all inmates are the same" and for a good reason. Security. All prison authority is to be respected by TC participants, the ideal is comply now and complain later. However, for correctional officers working in TC prison programs, training should stress not only the inmate similarities, but also the inmate differences within the TC program structure. The correctional officer is normally considered to be a part of the TC community. In addition, all management personnel

such as wardens, assistant wardens and unit managers would be educated and familiar with the TC concept. This allows for participation by all TC personnel, but also maintains proper control over the TC program. The data collected suggests that cross training is being provided by the majority of states, however it is not being provided by all states.

One area of concern expressed is the lack of community-based treatment programs, even though several prisons do provide some aftercare to their graduates for continuing treatment. However, as in the past the aftercare component still remains a problem, although many states are addressing this issue. To maintain the continuance of recovery for participants, state and private agencies should provide aftercare transitional programs no shorter than six to 12 months in duration, even longer if it is found to be necessary. In regard to private institutions, when inmates are transferred from one institution to another institution, problems are encountered when the availability and consistency of treatment within the TC program cannot be maintained. It is suggested that inmates who are receiving institutional treatment in a TC program at the very least be given consideration to transfer to an institution that has a similar TC program. More research is needed in this area, however, one of the main goals of TCs is for the participants to internalize "right living behavior and thinking".

The survey instrument could have been improved by more specific questions, such as questions five, fifteen and eighteen. This would have enhanced the integrity of the questionnaire. Question number five states, "Does your program address only one, combination of, or all of the following: substance abuse, domestic violence, cognitive model, behavior modification, sexual abuse, other". The intent of the survey instrument

was to identify the primary model type of program being implemented. The intent of question number fifteen was to identify if aftercare was being provided in prison and whether inmates have a choice to remain in TC programs after graduation. In addition, question number eighteen, "Do you feel it is possible to have an entire prison system comprised of TCs?", could have been more specific. For instance one respondent stated if an entire prison "yes", if an entire prison system, "no". The intent of the question was, is it possible to have an entire prison composed of TCs. These questions may have been confusing to respondents. The inability of some respondents (who operate TCs) to answer the questions on the survey limited the study as well.

Several major limitations do exist. One, the number of TC participants is not an exact number of all TC program participants in prison settings throughout the United States. For example, one respondent reported they did not have a TC program within their prison system. However it is known, by this researcher, that a TC program does exist within that particular state and is operated by a private contractor. Second, although the total reported number of TC participants (about 26,000) is small compared to the larger general prison population. It is significant to note that the survey instrument only asked for the "potential" of reducing recidivism rates.

The potential of TCs in prison environments for the reduction in crime is significant. It is time to open a front on the war on crime and that front should be in our jails and prisons. Recent declines in crime underscore the importance of aggressive enforcement, but if we are to reduce crime further, we must find additional cost effective ways to decrease drug and alcohol related crime. This means using punishment and rewards to cut drug and alcohol abuse by exploring less expensive alternatives to

incarceration for non-violent substance abusers and using the power of the criminal justice system to get substance abusing offenders into treatment so that the cycle of crime may be broken. Even substance abusers that are convicted of violent offenses should be incarcerated, but we should also provide these offenders with treatment in the hopes to reduce their criminal activity once they are released from prison and while some remain incarcerated for the remainder of their lives. A major investment in research to improve prevention and treatment of alcohol and drug abuse is essential, particularly of the incarcerated offender. Specific attention should be developed to designing cost-effective diversion, prison and post-prison treatment, and rehabilitation programs. Therapeutic Communities in prisons provide this potential. It is important to provide treatment to inmates while in prison for all that need it, this includes minimum-security inmates to maximum-security inmates.

Again it is important to train correctional officers and other personnel in substance abuse and addiction so that they can better prevent the use of alcohol and drugs in prison and better assist inmates in the TC recovery process. And once an inmate who has been released to community supervision, it becomes absolutely imperative that treatment and aftercare services be available for individuals who need them.

In addition, parole officers who would provide community supervision should be trained to effectively assist parolees in locating additional services and encouraging parolees to continue their treatment. No doubt, some of the above recommendations would involve a new way of viewing prisons throughout the country. To implement new Therapeutic Communities in prisons, the full cooperation and acceptance from administrators and management staff is imperative. The vast majority of substance

abusers return to society, therefore it is essential that effective treatment programs such as TCs be available while the offender is still incarcerated.

It is also important that written minimum standards be developed for regulation of all prisons whether they are state operated or private operated facilities. This allows for effective monitoring of TC programs and, again, maintains the dignity of the TC concepts.

Research could be enhanced and improved by accessibility to continuing data that would be provided by all 50 states. Further research should address not only credentials of professionals working in TCs, but the strengths and weaknesses of recovered professionals as well. Further research should be implemented to address the training curriculum available to correctional officers and other institutional personnel. As stated above, most security staff is trained with the concept that all offenders are the same. But within TCs this barrier could be broken down, offenders are not all the same, there are similarities, but there are extreme differences as well.

Therapeutic Communities should be given the opportunity as a viable treatment modality to become successful within the prison environment. The potential is promising to address issues such as recidivism rates, reduction in crime, safer environment for the inmate and correction officers and for effective prison management purposes.

BIBLIOGRAPHY

Alcoholic's Anonymous World Services, Inc.(1955). New York City, NY: Alcoholic's Anonymous World Services Inc.

Bandura (1979), Nietzel (1979) as stated in Therapeutic Community: Advances in Research & Aplication NIDA Research Monograph. U.S. Dept. of Health & Human Services-Public Health Services: National Institute of Health

Bush, Dudley, and La Barbera, Martin (1997). "Counseling in the Corrections-Based Therapeutic Community: Issues for New TC Counselors, " paper presented at the 25th Annual Conference of the Nation Association of Alcohol and Drug Counselors, San Francisco, July, 1997

Califano Jr, Joseph A. (1998) CASA Report Forward Statement to Behind Bars: Substance Abuse and America's Prison Population. The National Center on Addiction and Substance Abuse at Columbia University

CCA Metro Davidson County Detention Facility (1993), Lifeline Program Handbook

Deitch Ph.D., David (1999), taken from the video and as stated in Therapeutic Community Model:History and Overview. University of Missouri, Kansas City, MS: Center for Substance Abuse Treatment, Mid-America Addiction Technology Transfer Center

DeLeon (1984), DeLeon et al. (1979) as stated in Therapeutic Community: Advances in Research & Aplication NIDA Research Monograph. U.S. Dept. of Health & Human Services-Public Health Services: National Institute of Health

DeLeon (1979, 1982); Simpson (1979, 1980) as stated in Therapeutic Community: Advances in Research & Aplication NIDA Research Monograph. U.S. Dept. of Health & Human Services-Public Health Services: National Institute of Health

DeLeon (1974), Phoenex House: Studies In a Therapeutic Community (1968-1973), Library of Congress Cataloging in Publication Data, MSS Information Corporation, New York, NY

DeLeon (1998), taken from the video Therapeutic Community: Theory and Research. University of Missouri, Kansas City, MS: Center for Substance Abuse Treatment, Mid-America Addiction Technology Transfer Center

Field (1984, 1989) as stated in Therapeutic Community: Advances in Research & Aplication NIDA Research Monograph. U.S. Dept. of Health & Human Services-Public Health Services: National Institute of Health

http://www/mra.org.uk/general/founder.html (1995) Dr. Frank Buckman, Founder of MRA. Rex Dily: Freeway Publication, London England

http://www.lepg.org/religion.htm, The Reformation

Howelett, Duncan (1957), The Essenes and Christianity. New York, NY: Harper & Brothers

Johnson, Robert (1996), Hard Time. Belmont, CA: Wadsworth Publshing

Jones, Maxwell (1953), The Therapeutic Community, New York, NY, Basic Books

Jones, Maxwell (1968), Beyond the Therapeutic Community, New York, NY: The Carlton Purington Rollins Printing - Office of the Yale University

Jones, Maxwell (1976), Maturation of the Therapeutic Community, New York, NY: Human Sciences Press

Kratcoski, P. C. (1981), Correctional Counseling and Treatment. Monterey, CA: Duxbury.

Levinson, R. (1980),TC or not TC?, That is the question. In: Toch, H., ed. Therapeutic Communities in Corrections. New York: Praeger

Lipton et al. (1975); Wexler et al.(1988b) as stated in Therapeutic Community: Advances in Research & Aplication NIDA Research Monograph: U.S. Dept. of Health & Human Services-Public Health Services, National Institute of Health

Lipton (1989); Lipton et al (1992), Wesler et al. (1988a) as stated in Therapeutic Community: Advances in Research & Aplication NIDA Research Monograph: U.S. Dept. of Health & Human Services-Public Health Services, National Institute of Health

Martinson (1989), Public Interest Paper, Camp & Camp

Masters, Ruth (1994), Counseling Criminal Justice Offenders, Thousand Oaks, CA; Sage Publications

Outler, Albert C. (1984), The Works of John Wesley: Nashville, TN, Abingdon Press

Peck, Jeff (1999), Jubilee, Magazine of Prison Fellowship Ministries - Winter 1999

Pauck, Paul (1984), From Luther to Tillich, New York, NY: Harper & Row Publishers

Rogers, C. R. (1951). Client-centered Therapy. Boston: Houghton-Mifflin

Sharp, Victor (1975), Social Control in the Therapeutic Community, Westmead, Farnborough, Hants, England: Saxon House

Sugarman, Barry (1974), Daytop Village: A Therapeutic Community: New York, NY, Holt, Rinehart and Winson, Inc.

Tims Ph.D., Frank M.; DeLeon Ph.D., George; Janinchill, Ph.D., Nancy (1994), Therapeutic Community: Advances in Research & Aplication NIDA Research Monograph: U.S. Dept. of Health & Human Services-Public Health Services, National Institute of Health

Van Voorhis, Patricia; Braswelk, Micheal; Lester David (1997), Correctional Counseling and Rehabilitation: Cincinnati, OH, Anderson Publishing Co.

Weppner, Robert S. (1983), The Untherapeutic Community, University of Nebraska Press, Lincoln, Nebraska

Wexler et al. (1988) as stated in Therapeutic Community: Advances in Research & Aplication NIDA Research Monograph: U.S. Dept. of Health & Human Services-Public Health Services, National Institute of Health

Whiteley, Briggs, Turner (1973), Dealing with Deviants: New York, NY, Schocken Books

Appendix A

Cover Letter for Questionnaire

Phil R. Dyer
Youngstown State
University
Criminal Justice
Department

January 8, 2001

PERSON
State Dept.
Address
City, State Zip

Dear

My credentials are extensive and I have been in the Criminal Justice profession for close to thirty years. I have been a consultant to several national criminal justice agencies, and continue to provide seminars and workshops on offender behaviors, characteristics, and effective intervention strategies to human development service agencies throughout the country. Currently, I am a student at Youngstown State University working on a thesis toward my Masters Degree in Criminal Justice with an emphasis in Correctional Administration and Criminal Theory.

I am requesting the attached questionnaire be forwarded to the department that would employ the Director of Therapeutic Community, Director of Rehabilitation or the most qualified personnel within your particular state.

The term therapeutic community has come to represent a distinct approach that can be applied in almost any setting with almost any population. In recent years, TC models have been increasingly adapted for incarcerated substance abusers in prison settings. Overcrowded prisons, the influx of drug offenders, and the documented success of TC prison models in reducing recidivism and relapse have fostered this development. Modifications of the traditional TC model are shaped by the unique features of the individual correctional institution and the prison culture itself. It is imperative to maintain the integrity of the essential TC concepts of community.

Please note that the survey instrument does not include programming questions for mentally ill or mentally challenged. I am interested in gathering important information related to Adult Therapeutic Communities that are being implemented within prison environments throughout the country and are being operated by state agencies or private agencies.

If you do not utilize Therapeutic Communities within your state, it would be greatly appreciated if you would complete the questionnaire. Please check off Question #2 and return this to me for tabulation.

Please place the survey instrument in the self-addressed enclosed envelope and if possible return by January 26, 2001. I wish to express my sincere thanks and gratitude for completing the survey instrument and for your honest and informative answers.

Respectfully requested,
Phil R. Dyer

Appendix B

Adult Therapeutic Community Questionnaire

ADULT THERAPEUTIC COMMUNITY QUESTIONNAIRE

1. State where this department is located: ______________________________

2. Do you currently use Therapeutic Communities in your State Prison Facilities?
   Yes_____No_____
   a. If yes please list those facilities:______________________________________

      ____

      ____

   b. Are Therapeutic Community services delivered by: State____Private Contractor____Both_____
      If private contractor please name of contractor: ______________________

3. How many years has your program been in existence? ______

4. What is the total inmate capacity for TC's within your State? ______

   a. How many inmates are actually participating? ______

5. Do your programs address only one, combination of, or all of the following: (please check only those that apply)
   a. Substance Abuse ______ b. Behavior Modification ______
   c. Domestic Violence ______ d. Sexual Abuse ______
   e. Cognitive Model ______ f. Other ______________________

6. TC's reduce grievances and disciplinary reports from the inmates who participate?
   Yes_____No_____

7. TC's are a safer environment for both Correctional Officers and inmates compared to general population? Yes_____No_____

   a. If yes, please explain:

   ____

   ____

8. Has the recidivism rate been monitored? Yes_____No_____

   a. If it has, what is the recidivism percentage for those individuals participating?
      ______(%)

9. Do you have good inmate role models within your TC population? Yes_____No_____

    a. If no, please explain:

    ____

    ____

    b. Do you hire ex-offenders as professional staff for TC programs?
    Yes_____No_____

10. Is there less violence on your TC units in comparison to general prison population?
    Yes_____No_____

11. What is the length of your total program? ________________

12. Do inmates move through levels/phases? Yes_____No_____

    a. If yes, please list those phases/levels:

    ____

    ____

13. What percentage of inmates complete the TC Program? ________________________

14. Once inmates complete the TC program are they:

    a. Permitted to stay within the program? Yes_____No_____
    b. Released to general population? Yes_____No_____
    c. If released to General Population, is there a follow-up or after-care program?
    Yes_____No_____
        1. If yes what is the length of your aftercare (months)?

        ____
    d. Placed in TC settings upon parole or other type of releases?
    Yes_____No_____

    e. Other, please explain______________________________________

    ____

15. Do you have a standard written policy and procedure for all TC's within your state?
    Yes_____No_____

    a. Could you please attach a copy of those procedures? Yes_____No_____

16. Do inmates volunteer for T.C.? Yes_____No_____
    a. If volunteering, do you have enough TC bed capacity to accommodate inmates?
    Yes_____No____
    b. Other:

____

17. Do you feel it is possible to have an entire prison system comprised of TC's?
Yes_____No_____

a. If yes, why?

____

____

18. Is your TC population separated (housed) from the remaining prison population?
Yes_____No_____

19. Do you have a waiting list for inmate placement? Yes_____No_____

20. Are Corrections Officers working in the TC Unit specially trained to work in TCs?
Yes_____No_____

21. Is it your opinion Therapeutic Communities have the **potential** to reduce recidivism rates within your State? Yes_____No_____

a. Please explain: ____

____

Thank you for your assistance! Please don't forget to attach a copy of Policy and Procedures if available. If you desire a copy of published results please mark here →

Yes ____ No _____

Appendix C

United States Map Depicting State Response

Shaded area designates states who responded

White area signifies states who did not respond

Appendix D

Human Subjects Review Letter of Exemption

Youngstown State University / One University Plaza / Youngstown, Ohio 44555-0001

January 23, 2001

Dr. Tammy King, Assistant Professor
Mr. Phillip Dyer, Graduate Student
Department of Criminal Justice
UNIVERSITY

RE: HSRC Protocol #27-01

Dear Dr. King and Mr. Dyer:

The Human Subjects Research Committee has reviewed your Protocol, "Adult Therapeutic Communities in America," (HSRC#27-01), and determined that it is exempt from full committee review based on a DHHS Category 5 exemption.

Any changes in your research activity should be promptly reported to the Human Subjects Research Committee and may not be initiated without HSRC approval except where necessary to eliminate hazard to human subjects. Any unanticipated problems involving risks to subjects should also be promptly reported to the Human Subjects Research Committee.

The HSRC would like to extend its best wishes to you in the conduct of this study.

Sincerely,

Eric Lewandowski (cc)

Eric Lewandowski
Administrative Co-chair
Human Subjects Research Committee

ECL/cc