

ASSESSING OFFENDER NEEDS AND PERFORMANCE FOR PLANNING AND MONITORING CRIMINAL JUSTICE DRUG TREATMENT

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With the rise of coerced treatment in both correctional and community settings, increased awareness and focus is being placed on motivation for change and treatment readiness as dynamic factors relevant to individual treatment planning. In addition, within correctional-treatment populations, the need for targeting criminal thinking and attitudes as primary treatment issues also has been well-established. The importance of these two issues to the effectiveness of treatment programming highlights the need for instruments that can reliably assess offender risk and needs, guide the treatment planning process, and monitor progress over time. This article provides an overview of how selected scales from the Texas Christian University Criminal Justice Client Evaluation of Self and Treatment and Criminal Thinking Scales instruments are being used to inform treatment planning and service delivery in a large, intensive therapeutic community program for substance-abusing offenders in Virginia.

Keywords: treatment planning; instrumentation; treatment performance; clinical application; intake assessment; therapeutic communities

Although great strides have been made in the past 15 years concerning the identification of criminogenic risk and need factors and evidence-based strategies for their remediation, more recent research in the correctional-treatment field suggests a continuing need for systematic, thoughtful approaches to screening, assessment, and treatment planning for enhancing correctional-program effectiveness (Lowenkamp, Latessa, & Smith, 2006; Welsh, 2006). In particular, Taxman and Bouffard (2000) identified the use of valid and reliable actuarial tools, sound screening and assessment processes, and clinical programming targeted more clearly at addressing criminogenic risk factors as key areas in need

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of more disciplined adherence by those implementing and delivering such programs. In addition, the National Institute on Drug Abuse (NIDA, 2006) publication *Principles of Drug Abuse Treatment for Criminal Justice Populations* states,

Over time, various combinations of treatment services may be required. Evidence-based interventions include cognitive-behavioral therapy to help participants learn positive social and coping skills, contingency management approaches to reinforce positive behavioral change, and motivational enhancement to increase treatment engagement and retention. (p. 19)

DEVELOPING A MODEL PROGRAM

In light of these conclusions, almost every correctional system in the United States strives to provide an optimal array of dedicated treatment services to drug-involved offenders. As part of the Commonwealth of Virginia Department of Corrections (VA DOC) comprehensive plan to provide effective treatment services to inmates, the Indian Creek Correctional Center (ICCC) was opened in 1995 as one of the largest prison-based substance-abuse therapeutic community (TC) programs in the United States. Located in Chesapeake, Virginia, the facility has served more than 7,000 inmates since it opened its doors and currently provides comprehensive drug treatment to approximately 800 male inmates daily.

Commitment to the continual evolvement of the ICCC into an evermore effective and efficient treatment program for drug-involved offenders has been, and continues to be, a primary goal for the VA DOC. Efforts toward this goal begin on the “front end” of the treatment continuum by selecting participants according to eligibility criteria that maximize the admission of appropriate offenders for the defined treatment regimen. These criteria include admitting only those inmates who have (a) a documented history of substance abuse, (b) committed a substance-abuse-related crime, (c) a sentence of 2 or more years, (d) a Level 1 or 2 (i.e., lower level) risk classification, (e) approximately 18 months left before release, and (f) not been classified as a sex offender. Initial efforts also include focusing on the back end of the treatment continuum by requiring successful graduates of the mandatory ICCC program to be released to a 6-month transitional TC reentry program in the community.

Since 2004, when the VA DOC awarded Civigenics, Inc. (the current private treatment provider) a contract to administer the TC program at the ICCC, the two organizations have been working together to enhance the primary treatment component of the continuum. The result of this collaborative effort has been the development of a research-based treatment strategy designed to equip inmates with a set of cognitive-behavioral core skills for returning to society as responsible, productive citizens free of addictive and criminal behavior. As a foundation to its TC philosophy, the 9- to 24-month program focuses on “right living” as an integral concept that is presented through role modeling, the provision of rewards and sanctions according to behavioral expectations, and confrontation of destructive thinking, attitudes, and lifestyles by ICCC program peers.

The five-phase ICCC program begins with an orientation when inmates are initiated and inducted into the TC culture, philosophy, and rules of the community. Next, the resocialization phase uses curriculum-based classes and role-plays to develop new life skills for the inmates. The third phase, maturation, focuses on a higher level of expectation and accountability, with the goal that participants will align with the TC community’s philosophy, values,

and standards. Fourth is the reentry phase that takes place within 90 days of release and requires continuation of the principles of “right living,” while beginning to plan for life on the outside. These four core phases are designed to provide a smooth transition into the final, postrelease phase, which consists of transferring into a transitional TC program (a halfway-house setting). The emphasis in this last step is on continuing to develop needed skills while maintaining attitudinal and behavioral changes resulting from the previous in-prison phases.

IMPROVING DELIVERY OF TAILORED SERVICES

The VA DOC and Civigenics administrators also recognized the importance of tailoring the program to address specific offender needs and to do so in a manner that enhances the offender’s level of responsivity to the treatment regimen. “Contrary to the ‘one size fits all’ approach, deliberate diagnosis, planning, and delivery of tailored interventions are fundamental to treatment effectiveness” (Simpson, 2006, p. 22). This conclusion is further supported by research findings pointing to the need to develop client problem profiles and allocate treatment services accordingly (Buhringer, 2006). The enormous challenge, however, is that matching services to offenders based on a complex set of factors (such as those associated with risks, needs, and responsivity) assumes the availability of services and staff sufficient to address the variety of profiles that are identified. These options seldom exist within correctional settings; when “gender and ethnicity are added to the equation, treatment matching approaches the impossible” (Shearer, 2003, p. 12).

Indeed, adapting the ICCC program to meet individual inmate needs also requires that existing financial and staffing resources be taken into consideration. Based on recent research findings (Knight, Simpson, & Hiller, 1999; Simpson, Joe, & Broome, 2002), a decision was made therefore to focus on assessing inmate problem severity at intake and to then provide treatment services that are more deliberately aligned to what evidence shows about the process of change and how it takes place (DiClemente, 1999; Simpson, 2004).

Strategically, two issues that emerged as priorities were (a) to improve the development of treatment plans so that they are based on a more accurate appraisal of inmate needs and (b) to focus on how existing services might be reconfigured to address these problems in the ICCC facility for engaging inmates to the fullest extent possible into the treatment process.

Selecting Tools for Identifying Needs

Effective treatment programs must have the ability to objectively and reliably obtain relevant information about offender needs. As indicated in *Principles of Drug Abuse Treatment for Criminal Justice Population* (NIDA, 2006), this type of information is critical in determining the nature and extent of an individual’s drug-related problems, establishing whether problems exist in other areas that may affect recovery, and enabling the formulation of an appropriate treatment plan. In accord with these guidelines—and in alignment with the VA DOC’s goal of continual evolution toward increased effectiveness—a collaborative decision was made to go beyond traditional measures of substance-abuse problems, current offense, and past history. The intent also was to identify issues involving criminal thinking and attitudes as well as personal levels of motivation.

The critical step in operationalizing this enhancement was finding an instrument capable of objectively and efficiently measuring these factors. The Texas Christian University (TCU) Criminal Justice Client Evaluation of Self and Treatment (CJ CEST) and Criminal Thinking Scales (CTS) instruments were chosen for the following reasons.

1. Of a variety of instruments considered, the CJ CEST and CTS were designed specifically for use with a correctional population.
2. The CJ CEST and CTS demonstrate theoretical and psychometric soundness (Carey, Purnine, Maisto, & Carey, 1999; Garner, Knight, Flynn, Morey, & Simpson, 2007 [this issue]; Knight, Garner, Simpson, Morey, & Flynn, 2006). Another instrument initially considered and likewise designed for use in correctional settings did not meet these psychometric standards. In addition, the three CJ CEST motivational scales (Problem Recognition, Desire for Help, and Treatment Readiness) reflect sequential phases or stages in the change and recovery process (e.g., Simpson & Joe, 2004).
3. Low scores on Problem Recognition and Desire for Help on the CJ CEST (Intake Version) are predictive of early dropout (Hiller, Knight, Leukefeld, & Simpson, 2002). Therefore, this instrument helps identify those most in need of enhanced motivational programming.
4. The fact that these instruments are simply worded, written in a self-report format, and can be administered easily in group settings makes them suitable for use in low-resource program settings.
5. Last, the dimensions focused on in these instruments (motivation, psychosocial, and criminal thinking) represent a best fit to the actual behavioral dynamics involved in the therapeutic objectives of treatment.

Once the TCU instruments had been selected, Civigenics requested and received assistance from research staff at the TCU Institute of Behavioral Research in selecting specific assessment scales best suited to the ICCC objectives. As previously indicated, the main target at intake was to measure motivation, criminal thinking, and hostility of inmates, then to develop customized treatment plans—especially when specialized services are needed to raise motivation and treatment responsiveness.

In the interest of going beyond mere identification of client problems at intake, the CJ CEST Hostility scale (from the psychological domain) as well as the Drug Use Problems, Desire for Help, and Treatment Readiness scales (from the motivation domain) were selected as key indicators for monitoring over time. (For more details on these scales, see Garner et al., 2007, in this issue). Research has shown that offenders with lower levels of hostility and higher levels of desire for help and treatment readiness are more likely to engage in the therapeutic process and remain in treatment (Hiller et al., 2002). Furthermore, the odds that an unmotivated, hostile client will engage in and benefit from treatment are significantly improved when targeted motivational enhancement strategies are provided (Farabee, Simpson, Dansereau, & Knight, 1995; Joe, Broome, Rowan-Szal, & Simpson, 2002; Simpson & Joe, 2004).

In addition, the Personal Irresponsibility and Street Values¹ scales from the CTS were selected because these measures are associated with low levels of readiness for treatment (for details, see Knight et al., 2006). Offenders who score higher on scales measuring criminal thinking also are less motivated for treatment and recovery (Knight et al., 2006). In general, these scales appear to identify more antisocial inmates who can be the most destructive to the group process in a TC program.

These selected TCU scales were incorporated into the existing baseline ICCC assessment and currently are being administered to all newly admitted inmates within 10 days of admission.

DEVELOPING THE TREATMENT PLAN AND PROVIDING TAILORED SERVICES

As part of the process of developing an offender's treatment plan, inmate responses to the TCU scales are compared with responses from other inmates within the program to determine relative levels of severity. This comparative information then becomes incorporated into the treatment planning process. Within 10 days after admission to the ICCC, every inmate completes the TCU Assessment, which contains the selected measures noted above (i.e., Problem Recognition, Desire for Help, Treatment Readiness, Hostility, Personal Irresponsibility, and Street Values). Comparisons with accumulated responses from other inmates in the program then serves as the basis for classifying each inmate as low, medium, or high depending on whether the inmate falls within the lower, middle, or upper third of the aggregated scores for each scale. For example, a score of 46 on Hostility (with scores ranging from 10 to 50) is classified as *high* because it falls in the top one third of the ICCC inmate scores. Likewise, a score of 28 on Desire for Help is classified as *low* because it falls in the bottom one third of the ICCC inmate scores on this dimension. In both cases, these scores represent problem areas that need to be addressed. Based on the collective set of scale scores, a profile is then created for each inmate and included as part of a treatment plan that places priority on providing services that address the greatest problem areas (see Garner et al., 2007; Knight et al., 2006).

USING SCORES FOR THERAPEUTIC DECISIONS

Deemed to be in greatest need of specialized services are those inmates who self-report having relatively low motivation for treatment (i.e., motivation scale scores that fall within the lower third of the scores for inmates in the ICCC facility) and high levels of hostility and criminal thinking (i.e., Hostility and Criminal Thinking scale scores that fall within the upper third). For those with this high-risk profile, a "Big Brother" is assigned who either is someone that also was highly resistant when coming into the program, yet who managed to see the benefit in what is offered and who has become a role model for others, or who is a high-level structure member who is much admired by peers in the program. This more conscious, deliberate approach to the assigning of Big Brothers enhances the effectiveness of this TC concept. It serves the traditional purpose of indoctrinating newcomers into the rules and expectations of the community, but strategically matching Big Brothers to new offenders in the program based on their needs profiles offers an important therapeutic advancement. Namely, it affects the level of treatment engagement and thereby assists in the amelioration of higher levels of hostility and defiance in program newcomers.

Other similar enhancements to early programming include a more targeted focus on raising participant awareness of errors in thinking. This involves discussion of how these have influenced the inmate's life, how they cause problems in adjustment to the TC, and the likely future consequences of not being able or willing to change these cognitive patterns. Other TC members reveal how their problems with errors in thinking have affected their own lives and their adjustment to the community as well as what they are now learning about them and how they are working to change them.

Counselors at the ICCC report that offering these more focused processes to low-motivated and high-hostile offenders, who typically exhibit behaviors detrimental to program

participation, appears to increase their openness to treatment. Ultimately, the intent is to move these individuals from active resistance (or passive compliance) to active engagement in the therapeutic process. For all inmates, regardless of severity levels, their treatment plans include specific targets identified by the TCU instruments that should be addressed as part of meeting the inmate's needs during the course of treatment. An example of such a target is the need to accept responsibility for one's actions. By now having objective measures of these dynamics, evaluations of the clinical impressions from staff are in progress.

CASE EXAMPLE

Bob entered the ICCC program in January 2006. Based on his intake responses to the TCU assessments, he was categorized as having a high level of hostility (a score of 32) and low level of motivation when compared with other inmates at the program (he also reported a medium-range score of 30 on Problem Recognition, a low score of 25 on Desire for Help, and a low score of 25 on Treatment Readiness). His scores on the CTS instrument were in the high range for Irresponsibility (29) and in the medium range on Street Values (22). Because Bob fell into the high category for hostility and the low categories for desire for help and treatment readiness, as well as demonstrating a high degree of personal irresponsibility in his thinking, his treatment plan included a requirement that he be assigned a high-structure member as a Big Brother. It is important to note that this Big Brother also had experienced a past tendency to cast blame on others and on circumstances rather than take responsibility for his own actions. For Bob, this meant that the TC "community as method" approach became focused, in part, on helping him replace his attitude of blaming others for his behavior with more personally empowering and prosocial alternatives. It also focused on the need to develop a work ethic through traditional TC tools (e.g., work as therapy, structured activities, role advancement, and rewards predicated on individual responsibility to the community as well as through the use of peer awareness/accountability and process groups).

Both his Big Brother and his peers in the community pointed out problematic patterns that arose during treatment because of Bob's dysfunctional worldview. Furthermore, alternative views that could be adopted and alternative ways of coping with situations that others had found effective were suggested for Bob to consider. As he decided which options he was willing to try and the community held him accountable for sticking with his commitment, Bob's initial TCU assessment scores were used to better maintain the proper focus on specific areas of needed improvement in his interactions with the community. This approach allowed treatment services to be more tailored to his needs by providing Bob with services and a TCU-guided strategy to help address his specific problems.

MEASURING CHANGES OVER TIME

The procedural improvements in managing clinical decisions using the selected TCU assessment scales at treatment intake have led VA DOC and Civigenics administrators to explore plans for an expanded administration of these instruments throughout the course of treatment. The purpose is to monitor inmate changes and reevaluate treatment plans for modification as needed. To this end, the ICCC program also has begun using the TCU assessments to monitor inmate functioning during the course of treatment. In recent months,

complete versions of the CJ CEST and CTS have been administered to 306 inmates who successfully completed the institutional portion of the TC program at ICCC from February 2005 to April 2006. Of these, 20 inmates were identified who had intake scores in the highest range of the Hostility scale and who were part of a group that completed the assessment again within 45 to 60 days before release. Scores for 11 of these inmates had dropped into the middle or lower hostility levels (relative to other inmates at the facility). In addition, 5 more showed a reduction in their average hostility scores, although not a large enough reduction to reclassify them into a lower level. Three individuals showed slight *increases* in their hostility score, and 1 showed no change, indicating that the program did not appear to be effective in addressing hostility problems for these inmates. These preliminary data represent significant improvement in 55% of those who began programming in the highly hostile range, however, and at least some improvement in 80% of this sample.

These early sample sizes are small, but the findings illustrate how the TCU measures can be used to assess inmate progress (or lack of progress) during the course of treatment. It does not establish which components of treatment may actually contribute most to positive changes, so this is an area for further investigation. The practical value envisioned by this strategy has led to management endorsement of its continuation and further study.

Only after the ICCC has implemented a strategy whereby the assessments are administered in the course of treatment (e.g., at intake and at the end of transitional treatment phases) will the program begin to be able to answer these practical questions. Once a longitudinal assessment protocol is in place, the ICCC expects to be able to identify and document inmate improvements. In addition, it will have a means for better identifying common profiles of inmate problems and the most effective remedial actions.

CONCLUSION

The VA DOC and Civigenics are making positive strides toward establishing the ICCC program as an efficient and effective model of TC treatment for drug-involved offenders. Through the incorporation of selected TCU scales into the intake-assessment process, the ICCC is increasingly able to specify action-oriented treatment plans that include a more sensitized focus on the individual's level of readiness for treatment programming. Furthermore, by using this information to better tailor services and better target personally relevant issues, the program is becoming able to deliver those services more effectively and efficiently.

According to McLellan and colleagues (McLellan, McKay, Forman, Cacciola, & Kemp, 2005), decisions regarding the allocation of specific treatment components also should be based on how well the clients progress toward their treatment goals. Indeed, a potential additional step for the ICCC program is to use the CJ CEST and CTS instruments as a part of a broader process of monitoring inmate progress and determining (on an ongoing basis) whether specific goals are being achieved in a measurable fashion. This can help determine when participants should graduate to the next phase of treatment. Motivational enhancement strategies may need to be introduced, or reintroduced, to inmates who continue to be resistant or whose scores show some signs of slippage in the course of treatment.

Additional considerations for future improvements include the use of early-phase intervention modules targeted at anger reduction for those scoring high in hostility as well as other modules specifically focused on enhancing motivation for those scoring low on the

motivational scales. Tailoring services in this fashion is realistic and will improve program sensitivity for increasing inmate responsiveness as well.

Benefits of adopting the TCU assessments have already become evident at both the *individual* and the *program* level. At the *individual* level,

1. treatment plans are now based on more focused, objective criteria specifically related to the particular person;
2. programming itself is becoming tailored with regard to issues of individual responsiveness;
3. inmates being served are more likely to receive the *targeted* services they need;
4. an infrastructure is being established that can be used to monitor offender performance and revise treatment plans dynamically;
5. treatment plans can be updated to be more sensitively matched with individual treatment experiences; and
6. prior to inmate release, a better assessment process can identify special needs and potentially help predict involvement in continued services in the community after release.

At the *program* level, greater accountability is being achieved through

1. gaining a clearer understanding of the impact of various treatment components on overall inmate performance during treatment;
2. measuring how much inmates improve (or do not) in targeted areas, particularly the ones critical for making decisions about the need for revising, adapting, or providing additional services; and
3. identifying areas requiring higher counselor competence and needs for special training.

Use of the TCU assessments has helped the ICCC program become more efficient with its resources and potentially more effective in its outcomes. In this regard, plans involve further outcome evaluations that include recidivism (i.e., return to custody) criteria. Not only are specific treatment needs of offenders being better identified and addressed, but the program design is being refined and given a sharper focus. The ability of these assessments to assist in guiding the treatment process ultimately provides greater program accountability and empirical data as to the short-term efficacy of the treatment process being implemented.

NOTE

1. The TCU CTS Street Values scale has been incorporated into the Power Orientation scale in the newer version of the form.

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