

Joint Legislative Audit and Review Commission

The Virginia General Assembly

**Substance Abuse
and Sex Offender
Treatment Services for
Parole Eligible Inmates**

**REPORT OF THE
JOINT LEGISLATIVE
AUDIT AND REVIEW COMMISSION ON**

**Substance Abuse and
Sex Offender Treatment Services
for Parole Eligible Inmates**

**TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA**



SENATE DOCUMENT NO. 8

**COMMONWEALTH OF VIRGINIA
RICHMOND
1992**

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Preface

In response to a recently completed Joint Legislative Audit and Review Commission (JLARC) study, *Review of Virginia's Parole Process*, JLARC staff were directed to assess the delivery of treatment programs for sex offenders and substance abusers incarcerated in Virginia's prisons. Because these types of rehabilitation efforts can impact the rate at which inmates establish eligibility for and receive discretionary parole, JLARC staff were asked to examine the adequacy of treatment services for these inmates. This report presents staff findings and recommendations regarding these issues.

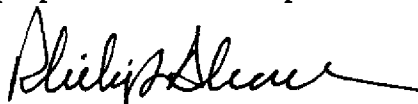
In 1990 a high percentage of the 14,841 inmates housed in State correctional institutions had substance abuse problems or were convicted of some type of sexual offense. Over the years, the Department of Corrections (DOC) has developed a loose network of institutionally-focused services for educating and treating substance abusers and sex offenders. However, the level of treatment need in the prisons and field units is substantially beyond the department's ability to provide these services.

Due in part to a lack of DOC central policymaking, a number of factors undermine the effective delivery of substance abuse and sex offender treatment services. For example, the lack of a standardized assessment tool for identifying inmates with substance abuse problems, as well as inadequate screening techniques for inmates with sexual deviancies, may cause counselors to overlook inmates in need of these types of treatment. Also, the department has not developed guidelines, policies, or standards to support the delivery of treatment services. Finally, many counselors have little time to spend providing treatment services and are not adequately trained to deliver such services.

Before considering any major expansion of substance abuse and sex offender treatment programs, the DOC central office needs to put in place a comprehensive policy and plan which can be used as a blueprint for guiding the effective and consistent implementation of treatment services in the institutions. One approach that the department can take to organize its treatment system for substance abusers is the strategy it used to develop its mental health delivery system.

If improvements are made to DOC's treatment system, stronger links to the parole decisionmaking process are possible. One potential benefit of this could be a long-term reduction in problems of prison overcrowding.

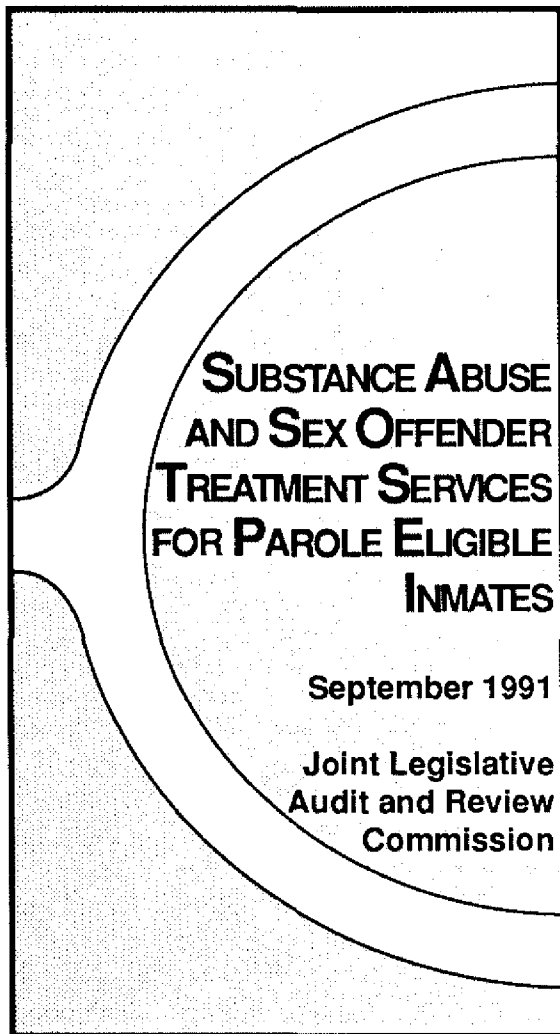
On behalf of the Commission staff, I wish to acknowledge the cooperation and assistance provided by DOC staff in the preparation of this report.



Philip A. Leone
Director

September 26, 1991

JLARC Report Summary



In 1991, the Joint Legislative Audit and Review Commission (JLARC) completed a year-long study of Virginia's parole system. During the course of this study, institutional counselors within the Department of Corrections (DOC) expressed concern about the level and quality of the rehabilitation programs offered throughout the correctional system. Because of the impact that prisoner rehabilitation ef-

forts can have on the rate at which inmates establish eligibility for and receive discretionary parole, JLARC staff were asked to extend the parole study to include an assessment of DOC's system for delivering counseling and treatment services to substance abusers and sex offenders.

This report examines the planning process and service delivery system used by the Department of Corrections to organize and provide treatment for inmates with substance abuse problems and those who are sex offenders.

Need for Substance Abuse and Sex Offender Treatment is Substantial

Data on the number of inmates with substance abuse problems and those who are sex offenders illustrate the need for a treatment system to address these problems. In 1990, there were 14,841 inmates in the prison system. Statewide, 81 percent of this population had a substance abuse problem when they were initially incarcerated.

A closer look at the data on this group, indicated that 70 percent of the population regularly used some form of illegal drug. The data also indicate that approximately 41 percent of this group may be cross-addicted — regular users of both alcohol and drugs.

About ten percent of the 14,841 inmates who were incarcerated in a State prison or field unit in 1990 had been convicted of some type of sexual offense. By design, most of these inmates are housed in

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the State's major prison facilities. In most of the major prisons, the size of the sex offender population closely approximates the statewide rate of 10 percent. In eight facilities, sex offenders constitute at

least 15 percent of the total inmate population.

Organization of Treatment Services Within Corrections

The department currently organizes policy and program development activities for treatment services in the Division of Adult Institutions. The responsibility for supervising this non-security aspect of corrections has been placed with the Chief of Operations for Programs. The primary responsibility of the chief is to work with other DOC staff to establish policy governing the various aspects of treatment service delivery within the prisons and field units.

In addition to general policy direction, the Chief of Operations for Programs and his staff provide technical assistance and advice to four regional administrators. These administrators are responsible for ensuring that all of the major prisons and field units in their respective regions operate according to department policy. Each of the four regional administrators has a program manager in his office to oversee the development and implementation of treatment programs in the prisons and field units.

It is the responsibility of the institutional counselors to implement treatment programs within each correctional facility. Currently the department employs more than 250 staff in various counselor positions to carry out this function.

Policy Needed for Substance Abuse and Sex Offender Programs

Data collected during this study indicate that DOC has not adequately planned and implemented a system of inmate treatment services for sex offenders and substance abusers due to other programming priorities.

During the five-year period from 1985 to 1989, the General Assembly appropriated more than \$30 million dollars for treatment services. The department used most of the appropriated resources to hire rehabilitation counselors to provide case management and some counseling services to all inmates. DOC officials did not, however, formulate specific policies to govern the development of substance abuse and sex offender programs. As a result, counselors throughout the correctional system had to organize treatment programs for inmates with these problems without the benefit of any proactive and consistent guidance from DOC's central office.

In 1989, as a precursor to developing agency policies to remedy this problem, DOC officials organized a committee of staff

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members to establish a set of goals and objectives for the development of inmate programming. Later, four regional program managers (RPM) were hired by the department to help organize the input of field staff in meeting the goals

and objectives. This "bottom-up" approach to planning was viewed by DOC as the foundation for the actual formulation of agency policy regarding inmate programs.

However, at the time of the JLARC review, more than 70 percent of the committee's objectives that could impact policy development for substance abuse or sex offender programs had not been met and DOC's senior administration officials were unaware of any problems.

Poor organization of the goal setting process, insufficient coordination with regional office staff, and lack of guidance and direction from central office staff are the three primary reasons that this approach to policy development by the department has not been successful. One central office staff person who has been involved in DOC plan-

ning activities, characterized the entire process as "disorganized and haphazard."

As a result of these problems, five years after the department created a unit to develop policies for all treatment programs, and almost two years following the development of specific program goals and objectives, the department has formulated only one, vaguely worded policy to provide a framework for substance abuse and sex offender treatment. This policy does not address issues of inmate assessment, program standards, performance measures, staff training, or program evaluation.

Future DOC expansion of treatment programs for substance abusers and sex offenders should be contingent on the development of a comprehensive policy and plan which can be used as a blueprint for guiding the effective and consistent implementation of treatment services in the institutions.

Recommendation (1): *To ensure that the department takes a more active role in the development of a delivery system for inmates in need of substance abuse or sex offender treatment, the Board of Corrections should direct the department to develop a policy for programs that establishes a framework for a comprehensive service delivery system. (The department should consider using a strategy similar to the approach used to successfully develop its mental health delivery system.)*

Recommendation (2): *To ensure that the department develops policies to address issues of assessment, program standards, and staff training for a substance abuse and sex offender treatment system, the Board of Corrections should require the Department of Corrections to include in its plans for a treatment system a description of these policies.*

Program Services for Substance Abusers and Sex Offenders Are Not Adequate

Data analyzed from a sample of inmate treatment plans and progress reports indicate that 25 percent of all inmates with a substance abuse problem do not receive any type of treatment prior to their first parole interview. Another 55 percent do receive treatment but the services are limited to the support group interventions of Alcoholics and Narcotics Anonymous.

Participation in AA and NA is generally considered to be most beneficial when it is offered in conjunction with, or follows a more intensive substance abuse therapy program.

Nonetheless, data from the file reviews indicate that very few inmates with substance abuse problems (three percent) benefit from any type of therapeutic counseling. Moreover, the department makes no attempt to tailor

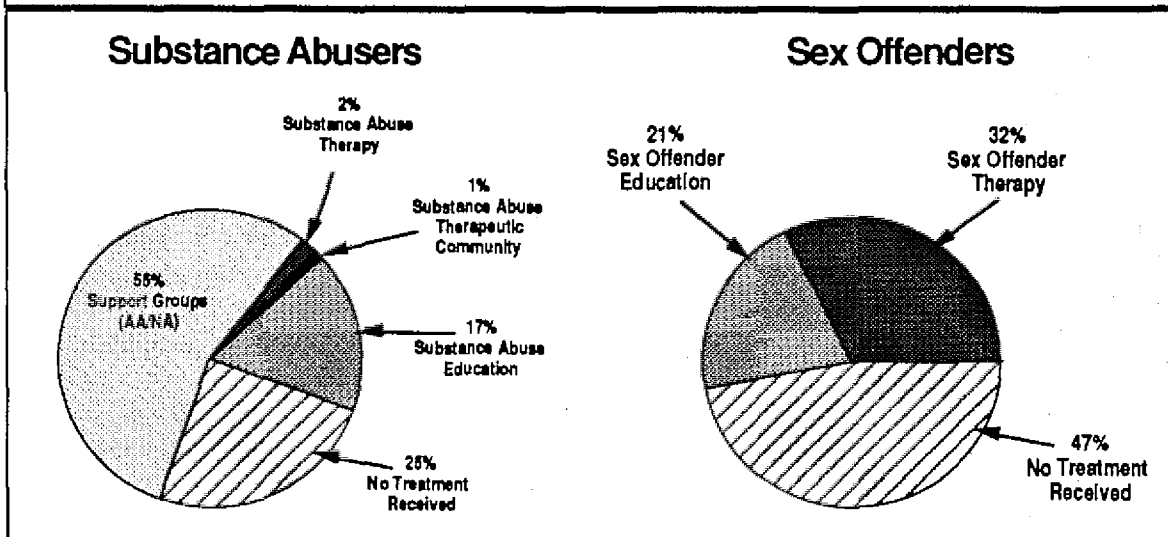
the substance abuse treatment that inmates receive to the nature of their dysfunction.

Apart from the issue of program access is the question of consistency of service within the various prisons and field units. At the time this study was conducted, DOC had not promulgated any standards to govern the development of treatment programs in the prisons and field units. Without such standards, there is a great deal of variation in the content of the substance abuse programs which serve inmates with similar problems.

Statewide, 24 prisons and field units offer educational services as a method for treating substance abusers. In 15 of these facilities, these services represent the only strategies (aside from AA or NA support groups in some cases) being used to treat substance abusers. In the 11 other facilities, some attempt is made to supplement the

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Types of Treatment Received by Inmates Before Their First Parole Interviews



educational activities with therapeutic counseling services.

The major problem with the therapy programs is that there are no guidelines, standards, or training to support these activities. A consistent comment made by counselors interviewed during site visits was that they learned by doing because there was no training or departmental guidelines to assist them.

In terms of sex offender treatment, only ten of the major prisons and one field unit offer these type programs. Based on the review of the treatment plans, JLARC staff determined that almost half of all sex offenders establish eligibility for discretionary parole without having received any treatment services. This problem occurs because the department has only 336 program slots statewide for more than 1,400 sex offenders.

As with substance abuse treatment, one major problem which plagues sex offender programming in DOC is that there are no agency specific requirements for the service providers, or guidelines outlining the basic elements of therapeutic counseling. A program advisory committee has developed a training manual for staff responsible for

Implementing sex offender treatment programs. However, the focus of this training is on the delivery of sex education services. Members of this committee, complain that the department's silence on this issue has created problems with decisions that are being made concerning who gets designated to implement sex offender programs. One member stated:

Some counselors are being forced to run sex offender groups who are not qualified, interested, or comfortable with the subject. Some counselors have non-related backgrounds like music, have no experience in sex offender therapy, are not equipped to provide treatment, but are running groups and we have no authority to do anything about it.

Recommendation (3). To enhance the level and quality of treatment services available for substance abusers, the Board of Corrections should require the Department of Corrections to develop a multi-tiered system of treatment that includes service options for inmates with different levels of

drug and alcohol abuse problems. In addition, the Board of Corrections should require the department to specify minimum requirements for program content and establish guidelines for the development of therapy programs.

Recommendation (4). To enhance the level and quality of treatment services available for sex offenders, the Board of Corrections should require the Department of Corrections to implement a comprehensive program that includes education and intensive group therapy as the major treatment interventions. In addition, the Board of Corrections should require the department to specify minimum requirements for counselors conducting the group therapy, and establish guidelines for the development of therapy programs.

DOC Assessment Process Needs Improvement

One key to planning the development of any treatment system is a uniform assessment process. The actual program needs of an inmate population will vary based on differences in the severity of the identified problems. Accordingly, counselors must be able to distinguish among inmates based on observed differences in the nature of their problem and outline treatment plans tailored to the inmates' identified needs.

The department's assessment of inmates for both substance abuse problems and deviant sexual behavior appears to be closely tied to their arrest records. Because a standardized assessment tool is not utilized to determine the need for substance abuse, the severity of the inmate's treatment needs may be misdiagnosed.

Using the inmates' criminal records to determine whether sex offender programming is needed overlooks those inmates whose crimes simply do not give evidence of any sexually deviant behavior that may have been a part of their past.

Recommendation (5). To facilitate an appropriate determination of treatment needs, the Board of Corrections should require the Department of Corrections to adopt a uniform assessment instrument to be used at the time of an inmate's initial classification.

Recommendation (6). The Department of Corrections should require that counselors look for any evidence of sexual deviances and not rely exclusively on offense history in making recommendations for treatment of sexual problems.

Counselors are Overwhelmed with Case Management Duties

Based on an analysis of counselor time allocation data, JLARC staff found that in a typical work week, counselors are able to spend only four hours on implementing treatment programs. The caseload demands placed on the counselors in DOC's prisons and field units have resulted in the vast majority of counselors performing primarily case management functions. These include conducting evaluations for good time, preparing various inmate reports, and meeting with each inmate on their caseload once per month.

The amount of time counselors spend preparing paperwork for the day-to-day case management of inmates is partly a function of the size of their caseload. JLARC analysis of data from the Department of Corrections shows that current inmate-to-counselor ratios remain consistently above the recommended level of 50-to-1. The statewide average caseload per counselor is 67 inmates. Fifty-two percent of the facilities had counselor-to-inmate ratios of greater than 55-to-1.

To address this problem, the department needs to develop a multi-tiered counseling system. With this type system, DOC could establish case manager positions to handle administrative functions, and a separate set of counselor positions to provide treatment services.

Recommendation (7). *The Department of Corrections should, based on its average daily inmate population, determine the number of case managers that would be needed to meet a ratio of 50 inmates per one case manager in each correctional facility. The department should also identify the number of counselors that would be required to implement a multi-tiered treatment system for substance abusers and sex offenders. The results of this analysis should be presented to the Board of Corrections as part of the Department's plans for developing a treatment system.*

Training for Counselors Can Be Improved

While a reduction in caseload would allow counselors more time to develop and implement treatment programs, there is some question as to whether they possess the qualifications necessary to do so. Because rehabilitation counselors are expected to primarily perform case management duties, it is possible for persons who do not have counseling experience to be considered for rehabilitation counselor positions.

While the majority of DOC counselors possess degrees in human services related fields, data from the JLARC survey reveals that 16 percent of the counselors have backgrounds that are completely unrelated to this area. For example, four counselors have only high school diplomas, two have degrees in music, another two have business degrees, and five have associate degrees. In one facility, nine of the 10 counselors have degrees in fields that are not related to counseling.

The lack of stringent requirements for counselor qualifications points to the need for department-provided training in the development and implementation of treatment programs. However, there is little indication that training to develop counselor skills has been a priority of DOC. Prior to recent department funding reductions, there was

no departmental policy requiring training in the development and implementation of treatment programs.

Upon being hired, counselors are required to complete 80 hours of training to orient them to the policies and procedures of the department. This training provides an introduction to such areas as inmate classification, the parole process, security procedures, and grievances. However, it provides very little in the way of training for the provision of treatment programs.

Recommendation (8). *In establishing two tiers of counseling, the Department of Corrections should develop position qualifications which make the appropriate distinctions between the responsibilities of case managers and those of counselors. Additionally, the department should conduct a thorough assessment of its training and develop policies specifying the education and training requirements for counselors who will develop and implement treatment programs.*

Recommendation (9). *To provide additional training and consulting services to treatment staff in prisons and field units, the Department of Corrections' should explore the following two options: (1) development of service agreements with State universities and (2) contract with persons who specialize in therapeutic counseling to provide workshops for treatment staff in the four regions.*

Implementation of Good-time Policies Not Monitored by DOC

The current good-time system was created to establish a more direct link between inmate participation in treatment programs and the amount of good time earnings they receive. Other factors being equal, inmates who address their treatment needs through participation in programs should receive larger prison term reductions for purposes of parole eligibility.

The establishment of a link between the accrual of good time and evidence of rehabilitation was intended to serve as an incentive for inmates to participate in programs. In practice, however, present DOC policies allow inmates who refuse treatment to continue receiving the highest levels of good time (30 days of good time for every 30 days served). A review of inmate files revealed that this was a particular problem for sex offenders. Specifically, 95 percent of the inmates who were recommended for sex offender treatment programs but refused to participate still maintained the highest level of good time.

DOC officials conceded that policy overrides should be used to lower the good time earnings when inmates refuse treatment. However, this is a discretionary decision of prison staff. DOC does not have any internal controls procedure outside of the institutions to determine whether the appropriate amount of good time is being awarded.

Recommendation (10). *The Department of Corrections should develop a policy that specifically prohibits inmates who refuse treatment from being placed in the highest levels of good time. In addition, the department should develop compliance review procedures to routinely monitor the performance of institutional staff in implementing this and other policies for its good-time system.*

Stronger Links Between Treatment and Parole are Possible

One reason for expediting inmates' parole eligibility dates on the basis of their prison rehabilitation efforts is to increase their chances of first receiving, then succeeding on parole.

Data from this study indicate that there is a relationship between an inmate's participation in treatment programs and his likelihood of being released on parole at the first date of eligibility. However, according to one Parole Board member, stronger links to the parole decisionmaking process could be established if DOC improved its methods for assessing inmate problems, provided more consistent and quality treatment, and informed Board members of the results of inmate participation in these programs.

Recommendation (11). *The Department of Corrections should work with the Parole Board to develop an interagency agreement that includes guidelines for conditioning the release of some inmates to successful participation in specific treatment programs. These guidelines should specify how the inmates' needs assessment will be conducted, describe the services they will be provided, and identify inmate program performance measures that can be used by the Board to assess the quality of the inmate's participation.*

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Introduction

In 1991, the Joint Legislative Audit and Review Commission (JLARC) completed a year-long study of Virginia's parole system. During the course of this study, institutional counselors within the Department of Corrections (DOC) expressed concern about the level and quality of the rehabilitation programs offered throughout the correctional system. Because of the impact that prisoner rehabilitation efforts can have on the rate at which inmates establish eligibility for and receive discretionary parole, JLARC staff was asked to extend the parole study with an assessment of DOC's system for delivering counseling and treatment services to substance abusers and sex offenders. This report presents the results of JLARC's review.

In December of 1989, DOC reported that 15,133 persons were confined in Virginia's prisons and correctional field units. More than 4,200 of these inmates (28 percent), were categorized as recidivists — persons who had been paroled or discharged from prison and were now serving at least a second prison term in a State facility for crimes committed in the Commonwealth of Virginia.

Efforts to address the problem of recidivism both nationally and in Virginia have often focused on increasing inmate employability through various job or vocational training programs. These efforts were based on the premise that lack of employment is a major cause of recidivism. Supporters of this perspective held that if parolees were not provided with the job skills necessary to compete in the primary labor market, the probability of their returning to prison is increased.

Recently, it has become apparent that many persons who repeatedly engage in criminal behavior are characterized by a number of personal problems that may either directly cause or contribute to anti-social or criminal behavior. For example, data from the Department of Corrections indicate that almost half of the inmates who were incarcerated for all 12 months in 1990 should be characterized as moderate to heavy abusers of alcohol. Even more alarming is the fact that seven out of every ten inmates in Virginia's prisons and field units regularly used illegal drugs prior to their incarceration.

These figures are consistent with national data which show that the level of alcohol use is far greater among persons convicted of crimes than among the general population. Moreover, similar research has also established empirical links between increased drug use and crime. While these findings have not diminished the role of job training in inmate rehabilitation, they have succeeded in focusing attention on the increased need for corrections officials to incorporate drug and alcohol treatment services in rehabilitation programs for inmates.

In addition to these services, Virginia prison officials must also develop programs to contend with a growing number of sex offenders among the inmate population. In a recent report to the Senate Finance Committee, DOC reported that as

many as 16 percent of all inmates housed in State prisons and field units have committed sex offenses. While prison officials point out that there is no consensus on the best method for treating these inmates, they feel that the likelihood of a sex offender recidivating can be substantially reduced through education and therapy programs.

TREATMENT SERVICES, GOOD TIME, AND PAROLE IN VIRGINIA

One of the major barriers to operating effective treatment programs in a prison setting is the inherent difficulty associated with convincing inmates to participate. Often inmates who have committed sexual offenses or are substance abusers will not participate in programs because they are unwilling to acknowledge that they have these types of problems. One method that has historically been used by corrections officials to influence the behavior of inmate populations is "good time." In Virginia, good time is a correctional policy that reduces the amount of prison time that an inmate has to serve before establishing eligibility for discretionary and mandatory parole.

Traditionally, good time has been provided to inmates in the State prison system solely for remaining free from infractions. However, in 1981, the General Assembly passed a bill adopting Section 53.1-200 of the *Code of Virginia*, which fundamentally altered the State's approach to inmate rehabilitation. This law required DOC to base the awarding of good time on the inmates' "compliance with written prison rules or regulations; a demonstration of responsibility in the performance of assignments; and a demonstrated desire for self improvement." Based on this more comprehensive assessment of inmate rehabilitation, the General Assembly required that DOC vary the actual amount of good time provided each inmate according to the following good conduct allowance (GCA) classification scheme:

- Inmates in GCA Class I receive 30 days of good time for every 30 days served.
- Inmates in GCA Class II receive 20 days of good time for every 30 days served.
- Inmates in GCA Class III receive 10 days of good time for every 30 days served.
- Inmates in GCA Class IV receive no good time.

Underpinning these changes to the good-time system were two assumptions regarding its implementation. First, because a proportion of inmates' good-time earnings serve to advance their discretionary parole eligibility dates, the programming on which the credits are based should address inmate problems in ways that may help them earn parole release and lead crime-free lives. The second assumption was that the Department of Corrections would devise a system to objectively evaluate and quantify the inmate's progress in a number of areas, including participation in rehabilitation and treatment programs.

Organization of Treatment Services Within Corrections

The department currently organizes policy and program development activities for treatment services in the Division of Adult Institutions (Figure 1). The responsibility for supervising this non-security aspect of corrections has been placed with the Chief of Operations for Programs. This position reports directly to the Deputy Director of the Division. The primary responsibility of the Chief is to work with other staff members to establish policy governing the various aspects of treatment service delivery within the prisons and field units.

As shown in Figure 1, managers or coordinators from five program areas report to the Chief of Operations for Programs. These are: (1) inmate health services; (2) mental health services; (3) substance abuse services; (4) inmate program services; and (5) inmate classification and records. The coordinators for program and substance abuse services work with the Chief of Operations for Programs to develop policy governing the operation of all treatment services except those in the area of mental health.

In addition to general policy direction, the Chief of Operations for Programs and his staff provide technical assistance and advice to four regional administrators. These administrators are responsible for ensuring that all of the major prisons and field units in their respective regions operate according to department policy. To oversee the development and implementation of treatment programs, each administrator has a regional program manager. Staff in these positions provide technical assistance to the counselors responsible for implementing treatment programs, as well as work with central office staff to develop policies governing these types of services.

The Treatment Delivery System

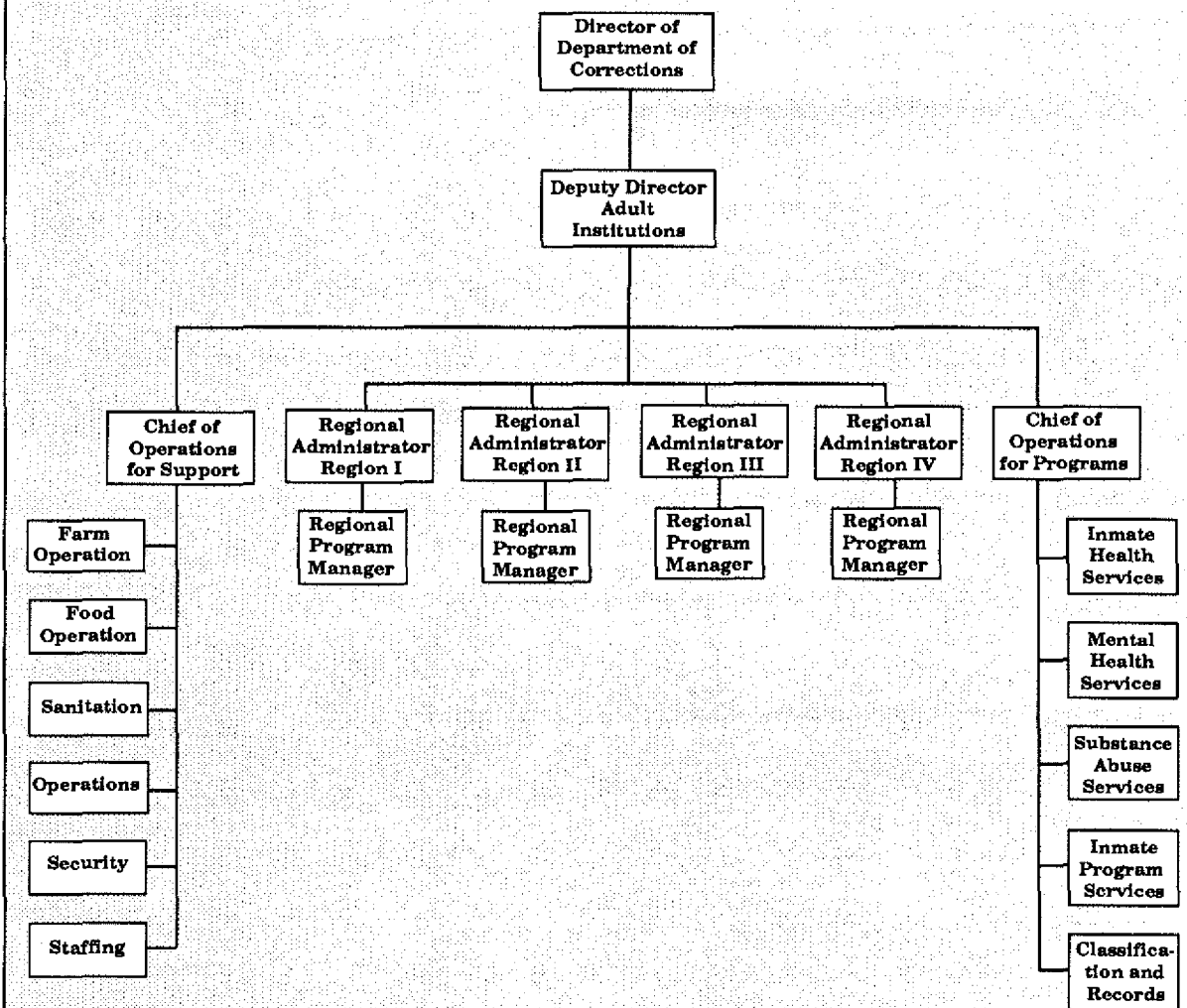
It is the responsibility of the institutional counselors to implement treatment programs within each correctional facility. Currently the department employs more than 250 staff in various counselor positions to carry out this function. With the assistance of community volunteers, these counselors have developed more than 300 activities or programs across the State prison system. While the focus of these activities and services varies considerably, the basic goal is the same — to help inmates address the nexus of personal and social problems that may have contributed to their criminal behavior.

Most of these treatment programs fall into one of the following categories: substance abuse programs; sex offender treatment services; stress management and anger control programs; life skills training; and inmate support, recreation, or activity groups. This report focuses on those activities designed by DOC staff to help substance abusers and sex offenders.

Substance Abuse Programs. DOC developed its first major program for substance abusers in 1974. Using federal funds, the department established a program called the House of Thought (HOT) at the James River Correctional Center. HOT was established as a therapeutic community which reserved beds for 24 inmates with long-

Figure 1

Organization of Treatment Services in the Department of Corrections' Division of Adult Institutions



Source: JLARC graphic based on Department of Corrections organizational chart.

standing substance abuse problems. Through this concept, staff created a treatment environment designed to strip the inmates of negative self-images by completely separating program participants from the general population. Within this separate community, inmates had to adhere to clearly defined rules, submit to a reward and punishment system, and engage in group therapy sessions that encouraged self-examination, peer confrontations, and support.

In 1982, the department closed HOT because of budget problems. Since that time, various DOC counselors have organized a number of drug and alcohol services throughout the department to treat the large number of inmates who are substance abusers. The strategies offered through these efforts include self-help support groups such as Alcoholics and Narcotics Anonymous, drug education services, structured group counseling, and the more intensive therapeutic communities.

The self-help support groups are based on the 12-step program of Alcoholics Anonymous (AA) which emphasizes group discussion of substance abuse problems and ways to remain alcohol or drug free. These types of activities are provided by the department at a minimal cost because they rely mostly on volunteers to serve as group leaders.

The drug education activities are based on the premise that increasing the inmates' knowledge about the adverse social and biological effects of alcohol and drug abuse will deter them from continued abuse of these substances. Many of these programs are designed to encourage the inmates to conduct critical self-evaluations, promote rational thinking, and develop alternative and better problem-solving techniques. These programs are typically short term, lasting one to two hours per week for four to 16 weeks.

Therapeutic Treatment. Drug and alcohol treatment programs that offer some form of therapy are distinguished from self-help support groups and education programs in the objective and method of treatment. The objective of therapy is to encourage the inmates to explore their feelings, attitudes, and substance abuse problems as a means of creating an internal desire for a drug or alcohol free lifestyle. These sessions require that skilled professionals be present to identify inmates who are in denial, exhibiting manipulative behavior, or withdrawing from the therapy. Peer interaction and confrontations must be encouraged but controlled by treatment staff.

The Therapeutic Community Concept. Perhaps the best-developed therapy programs in the department are the three substance abuse therapeutic communities (TC) in the Staunton prison, Botetourt field unit, and the Virginia Correctional Center for Women (VCCW). Similar to the concept developed through HOT, these are the most intensive substance abuse activities currently offered in the department. These "communities" are self-contained units that operate 24 hours a day and are separate from the general prison population. There are 30 beds in the TC at Botetourt Correctional Unit, 41 beds in the TC at Staunton Correctional Center, and 58 beds at VCCW.

The goal of the TC is to cause a complete change in the lifestyles of the participants, including abstinence from drugs and the elimination of criminal or antisocial behavior. These communities are modeled after "in-patient" substance abuse

programs operated outside of the Department of Corrections for severe substance abusers.

As noted earlier, the concept on which the program model is based requires that all participants be separated from the rest of the inmate population to live as a "community" for periods ranging from six months to one year. The purpose of this is to create a closed system which shields the participants from the counterproductive influences and activities of the general population. This allows the counselors to implement activities which are designed to strip inmates of their negative attitudes and self-images and provide positive support and direction.

According to the program description for the Staunton TC, some of the objectives of the program are to:

- Provide an atmosphere to examine and eliminate maladaptive behaviors and learn more effective and socially acceptable behavior;
- Provide an atmosphere in which substance abusers can interact, providing reinforcement for the commitment to remain drug-free through positive and negative feedback, confronting negative behavior, and attempting to understand those attitudes and behaviors that impact personal growth and development;
- Provide an atmosphere in which substance abusers can examine the impact of attitudes, values and behaviors on interpersonal relationships, such as family, friends, co-workers, etc.

Participants in the program must conform to the rules of the "community," accept gradually higher levels of responsibility, and be subject to sanctions as a means of reinforcing "community" goals. Peer pressure, inmate confrontations, and eventually peer support are alternatively used as mechanisms within the program to deal with inmate game playing and manipulative behavior.

Participation in the therapeutic community is strictly voluntary. In order to maximize the post-incarceration impact the program has on the inmate, an attempt is made to coordinate the timing of the program as close to the inmate's release as is possible. In Staunton, inmates must be no more than 18 months away from their parole eligibility dates or less than 12 months from their mandatory parole release dates. In Botetourt, program participants generally have approximately six months remaining until their mandatory parole release date.

Federal Grant Substance Abuse Programs. DOC has also used federal grant funds to provide substance abuse services. Among other things, these funds have been used to hire eight substance abuse therapists for six DOC facilities. These therapists are responsible for developing new programs or expanding those which have already been created, and for providing the necessary supervision to assist some staff in their efforts to receive State certification.

Sex Offender Treatment Programs

The development of a formal treatment program for sex offenders within the Department of Corrections also had its genesis with the HOT program. In the late 1970s, the Virginia State Crime Commission recommended that DOC develop a program to treat sex offenders. At that time, the department was operating "weekly treatment groups" for sex offenders at three different facilities. In response to the request of the Crime Commission, officials at DOC first provided resources to allow several staff members to attend conferences that provided information on developing treatment strategies for sex offenders within the correctional setting. In addition, these staff met with therapists from the few states that were actually implementing these types of programs in various prisons.

After completing their review of sex offender programs, these staff members were allowed by the department to expand the HOT program to include treatment of sex offenders. When HOT was closed in 1982, the department used a grant from the National Institute of Corrections to fund a training program for counselors in other DOC facilities who were interested in establishing sex-offender programs. As a result, several variations of the HOT program were developed in a few major prisons.

In 1984, DOC created the position of "Coordinator of Sex Offender Treatment Programs." Before this position was redefined in 1987, the coordinator brought together various individuals from within DOC and the community to discuss sex offender issues. This group, which was later sanctioned by the department as the Sex Offender Program Action Committee (SOPAC), now provides advice to the department on sex offender programming and promotes the development of treatment programs in the institutions.

Currently most of the treatment programs for sex offenders in the prisons focus on providing education and therapy services. These programs are based on a model that was developed by a psychologist at the Bland Correctional Center. The basic premise of this model is that sexual deviancy is a learned behavior which can be modified through intensive treatment. The education component is typically designed to expose the participants to basic information on human sexuality, discuss the different types of sexual offenders, and clarify appropriate male and female sex roles.

As with the programs for substance abuse, the psychotherapy component is regarded as the most effective intervention in the treatment process. During these sessions, participants are required to openly discuss their offenses and are forced to confront the impact that their crimes had on the victims.

Measuring Inmate Performance in Treatment Programs

In order to incorporate the inmates' performance in these treatment programs in the overall assessment of their behavior for good time, DOC had to develop a method for evaluating and quantifying rehabilitation efforts. To accomplish this, the department developed a structured evaluation instrument that uses a scoring system with a 100-

point scale. With this scale, the inmate's performance is rated in five areas: personal conduct (10 points), infractions (20 points), educational programs (30 points), treatment programs (20 points), and work or vocational programs (20 points).

As shown in Figure 2, evaluation forms for each inmate in treatment are completed by the staff conducting the program. Assessments in the other areas are completed by the housing supervisor, work supervisor, or educational instructor. The counselor is responsible for coordinating these evaluations and reporting the results to an Institutional Classification Committee. This committee determines if the inmate has been found guilty of any institutional infractions by an Adjustment Committee before the inmate's total GCA score is determined. Currently an inmate must score 65 to 84 points to establish the second highest good time earnings level. Inmates must receive a score of at least 85 points to be eligible for the highest GCA level.

DOC officials feel this system is an effective administrative tool because it encourages those inmates who need treatment to seek it, and then rewards those who demonstrate progress towards rehabilitation.

STUDY MANDATE

Near the conclusion of its study of Virginia's parole system, JLARC staff were asked to extend the review to address concerns expressed by counselors in the prisons and field units regarding inmate treatment programs. At that time, a number of DOC counselors indicated that the rehabilitation objectives of the revised good-time system were being undermined by insufficient treatment programs. Moreover, because of the small relative weight given to treatment in the GCA scoring system (20 percent), some counselors indicated that inmates were earning the highest levels of good time without having legitimate treatment needs addressed.

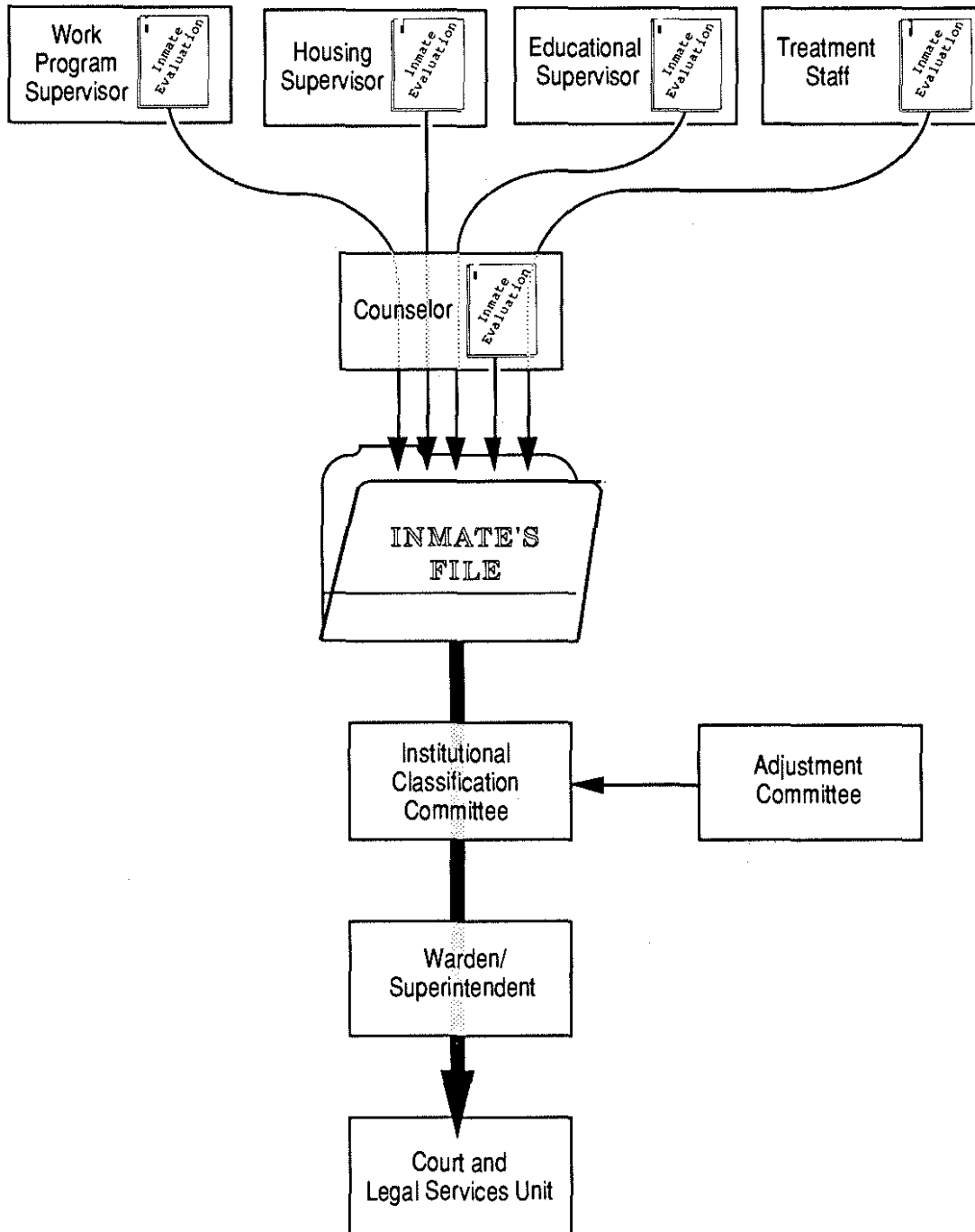
According to these staff, the number of quality programs being developed to provide counseling and therapy to sex offenders and inmates with substance abuse problems was constrained by the following factors:

- the failure of the Department of Corrections to develop a consistent delivery system for treatment programs;
- excessive counselor caseloads and the attendant case management responsibilities which preclude the development of treatment programs; and
- the inability of DOC to provide the training that many counselors need to implement quality therapeutic treatment programs.

Because of the potential link between successful inmate rehabilitation efforts, discretionary parole, and a reduction in recidivism rates, JLARC was asked to review the methods used by the department to organize and implement treatment programs in the

Figure 2

The Good-Time Credit Allowance System for State Felons



Source: Graphic from JLARC study *Review of Virginia's Parole Process*.

prisons and field units. Based on the results of this review, JLARC was directed to suggest any changes to agency policy or practice that might improve the quality of treatment programs within the department.

STUDY APPROACH

Although the department offers a variety of programs under the general category of inmate treatment and rehabilitation, this study focused on the programs being developed for the two most recognized inmate problems — substance abuse and sexual deviancy. According to DOC reports and data, these are two of the most pressing problems among the inmates which demand therapeutic intervention.

The JLARC review of treatment programs within DOC was primarily designed to address the concerns expressed by counselors during the parole study. The three major issues shaped by these concerns relate to: (1) the organizational and planning activities used by the department to develop substance abuse and sex offender treatment programs; (2) the actual program implementation strategies in the prisons and field units; and (3) the impact of inmate participation in treatment programs on their good-time earnings level and parole experiences. The major research questions raised by these issues and examined in this study are as follows:

- Has the development of treatment programs for substance abusers and sex offenders been a priority within the Department of Corrections?
- Does the Department of Corrections' current program planning and development framework for treatment ensure the statewide development of quality substance abuse and sex offender treatment programs?
- Does the level of need for substance abuse and sex offender treatment programs in the State correctional system exceed the department's capacity for providing these services?
- What type variation currently exists in the substance abuse and sex offender treatment programs in State prisons and field units?
- What, if any, factors exist in the State's prisons and field units which adversely affect the development of quality treatment programs?
- How are the good time earnings for inmates who do not receive the treatment recommended by DOC staff adjusted to reflect a lack of program participation?

In order to complete this study of treatment programs within DOC, JLARC staff had to organize data collection efforts at the State level and the prisons and field units. A key aspect of the analysis focused on the evolution and nature of DOC's organization and planning strategies for treatment programs. This required the collection of

information from senior DOC officials, other central office staff, regional program managers, and two department advisory committees.

Next, JLARC staff collected information to facilitate a descriptive analysis of the department's substance abuse and sex offender programs. Finally, the institutional files for a representative sample of inmates with documented problems of substance abuse or deviant sexual behavior were examined to analyze the relationship between receiving treatment, earning different levels of good time, and receiving discretionary parole.

Examining DOC Organization and Planning for Treatment Programs

To evaluate the department's planning process, several structured interviews were conducted with the agency's senior management officials and policy development staff. Some of the questions asked during these interviews focused on: the evolution of the planning process for treatment programs; current department strategies for identifying programming needs and developing program policy; and the department's oversight and monitoring roles for treatment programs.

Interviews with Regional Program Managers. The department recently created four regional program manager positions to guide the implementation of State policy for treatment in the field. These positions were also established to develop policy suggestions based on information obtained from the counselors who implement the programs. Structured interviews were conducted with each of these managers regarding their roles and responsibilities. In addition, these individuals were also asked to discuss the status of many of the major activities that the department included in its recently developed plan for treatment programs.

Interviews with Advisory Committee Members. The department has established two committees to provide advice and make policy suggestions for both substance abuse and sex offender programs. JLARC staff conducted interviews with members of both these committees regarding the nature of the work being conducted for the department. Members were questioned about the direction they received from DOC staff and asked to comment on the program models they were considering proposing for statewide implementation.

Nature of Treatment Programs in Prisons and Field Units

A second focus of this review was on the nature of the various substance abuse and sex offender treatment programs which are being implemented in the prisons and field units. To collect these data, JLARC staff conducted mail surveys of each institution, interviewed staff who work in the correctional facilities, and visited several facilities to observe various aspects of program implementation.

Mail Surveys. Anecdotal comments offered by various counselors in DOC prisons and field units during the parole study provided the basis for many of the questions that were asked in the JLARC mail survey of the treatment program supervisors. The overall objective of the survey was to collect the information needed for a systematic assessment of any problems that counselors face in trying to develop programs, as well as to develop a description of the existing services for sex offenders and substance abusers.

Some of the areas for which JLARC requested information were: the educational qualifications of counseling staff; perceptions about the quality of training provided by the department; assessment techniques used to identify persons in need of substance abuse and sex offender treatment services; information on any factors that serve as impediments to the development of effective treatment programs; and descriptions of the programs being provided.

To supplement and verify the information provided in the surveys regarding programs, JLARC staff used the annual program descriptions that each facility is required to submit to the Chief of Operations for Programs.

In addition to the survey of treatment supervisors, JLARC staff mailed a one-page worksheet to each counselor working in a prison or field unit to collect time allocation data. On this worksheet, counselors were asked to indicate how their time was allocated across different job functions in a typical week.

Review of Inmate Files

The final issue addressed in the study was the relationship between participating in treatment, good time earnings, and parole. To complete this portion of the study, JLARC staff examined a representative sample of files for inmates who were sex offenders or had documented problems of substance abuse. These file reviews allowed JLARC staff to address the following questions:

- What proportion of the inmates who need substance abuse and sex offender treatment actually receive it prior to their first interview for discretionary parole?
- What proportion of those inmates who do not receive the recommended treatment still earn good time at the highest level allowed by State statute?
- What proportion of those inmates with severe substance abuse problems receive only support group or education services by the time of their first parole eligibility date?

To supplement the work conducted on the relationship between inmate treatment and discretionary parole, JLARC staff interviewed the Chairman of the Virginia Parole Board. The purpose of this interview was to determine how the Board viewed the

treatment provided inmates during their incarceration and whether future plans were being made to condition parole for some inmates on successful completion of institutional programs.

REPORT ORGANIZATION

The two remaining chapters of this report provide a discussion of the department's planning and program development activities for substance abuse and sex offender programs, and describe the nature of the programs that exist in the prisons and field units. The third chapter also discusses the problems counselors face in trying to provide these services. A number of recommendations to improve the State planning and implementation of treatment programs are provided in each of the chapters.

II. The Department of Corrections' Treatment System

Developing a treatment system which will rehabilitate inmates during their incarceration is a complex and difficult undertaking. In order to operate safe and secure institutions, prison officials must exercise considerable control over inmate activity and movement. Without exception, these decisions are made based on the assessed risk of each inmate to both the institution in which he is housed, other prisoners in the facility, and the general public.

The inherent difficulties associated with inmate management and control are exacerbated when prison officials must accomplish these objectives in facilities burdened with problems of inmate crowding. Before a system of treatment services can be incorporated in this environment, considerable planning must take place to balance the demands associated with developing effective programs with the requirements of operating a safe and secure prison system.

Data collected during this study indicate that the Department of Corrections (DOC) has not adequately planned and implemented a system of inmate treatment services for sex offenders and substance abusers due to other programming priorities. During the five-year period from 1985 to 1989, the General Assembly appropriated more than \$30 million dollars for treatment services. The department used most of the appropriated resources to hire rehabilitation counselors to provide case management and some counseling services to all inmates. DOC officials did not, however, formulate specific policies to govern the development of substance abuse and sex offender programs. As a result, counselors throughout the correctional system had to organize treatment programs for inmates with these problems without the benefit of any proactive and consistent guidance from DOC central office.

In 1989, as a precursor to developing agency policies to remedy this problem, DOC officials organized a committee of central office and institutional staff members to establish a set of goals and objectives for the development of inmate programming. Later, four regional program managers (RPM) were hired by the department to help organize the input of field staff in meeting the goals and objectives. This "bottom-up" approach to planning was viewed by DOC as the foundation for the actual formulation of agency policy regarding inmate programs.

However, at the time of the JLARC review, more than 70 percent of the committee's objectives that could impact policy development for substance abuse or sex offender programs had not been met, and DOC's senior administration officials were unaware of these problems. Consequently, five years after the department created a unit to develop policies for all treatment programs, and almost two years following the development of specific program goals and objectives, the department has formulated

only one vaguely worded policy to provide a framework for substance abuse and sex offender treatment.

ESTABLISHING A PROGRAM PLANNING FUNCTION WITHIN CORRECTIONS

In 1985, DOC officials created a formal planning and policy development structure for inmate programming within the correctional system. The program areas that were targeted to benefit from increased planning included basic inmate health services, rehabilitation or treatment programs (e.g., substance abuse services), and mental health services.

One general objective of this JLARC review was to determine how the planning and policy development process for two categories of inmate programs — treatment services for substance abusers and sex offenders — has been implemented. The analysis revealed that planning for the purposes of developing a treatment system for these inmates has lagged due to competing demands on the time of staff responsible for policy development, and a lack of direction from DOC's top management.

The Initial Planning Activities of the Department of Corrections

In order for a correctional treatment system to be effective, inmate programming needs must be clearly identified. Further, the treatment strategies designed to address inmate problems must have well-defined objectives and be delivered with the appropriate intensity. Finally, the treatment system must be implemented by qualified and trained counselors with the cooperation and support of non-program staff at every level of the correctional system. These requirements call for unambiguous State policy in key areas such as assessment techniques, program operational standards, and staff training.

JLARC staff interviews revealed that in 1985, when DOC created a unit to develop policy for all treatment programs, these issues had not been addressed through agency policy. However, due to inadequacies in the department's case management and good-time systems, the initial planning activities were not focused on the development of policies to govern the delivery of substance abuse and sex offender treatment services (Exhibit 1).

In 1988, the agency hired a substance abuse specialist to implement the services necessary to meet the requirements of the grant the agency received from the Department of Criminal Justice Services (DCJS). This, however, was not a part of a planning strategy to organize a system of treatment services. Moreover, the attention required by other functions assigned to the Chief of Operations for Programs — mental health and classification issues — impinged on the time that staff could devote to developing a treat-

Exhibit 1

**Program Planning Priorities for the
Chief of Operations for Programs**

<u>Program Area</u>	<u>Nature of Planning Activity</u>	<u>Year Started</u>	<u>Year Completed</u>
Case Management	Established policies to improve the process for documenting inmate treatment needs and developing progress reports.	1985	1990
GCA System	Developed administrative procedures to govern legal revisions to good time system.	1985	1990
Mental Health	Worked for changes to <i>Code of Virginia</i> to allow department to forcibly treat mentally ill inmates, developed Marion as a licensed mental health facility, and organized a three tiered system of services.	1987	1989
Substance Abuse Grant	Developed proposal for a substance abuse grant to provide an array of services in selected prisons and field units.	1988	1991
Program Advisory Committee	Formed an advisory committee to develop a framework for inmate treatment services.	1989	1990
Implementation of goals and objectives for inmate programs	Hired four regional program managers to implement the objectives of the Program Advisory Committee.	1990	1990

Source: JLARC staff interviews with DOC central office staff.

ment system for substance abusers and sex offenders. As a result, policy development activities to govern the delivery of these services did not begin in earnest until 1989.

Focus on Case Management. A major responsibility of the institutional counselor is to provide the necessary case management services to ensure that inmate treatment needs are properly identified and addressed through available programming. To document treatment needs, the department requires counselors to develop an institutional treatment plan and progress report for each inmate. The treatment plan is used to identify the inmates' primary and secondary needs. The progress report is used by the counselors to describe the effort an inmate makes to address those needs identified in the treatment plan.

DOC's central office staff stated that before any attention could be given to planning for treatment services, the entire case management process had to be improved. Prior to 1985, the department's policies regarding the development of treatment plans and progress reports created inconsistencies and inefficiencies in counselor case management practices. Counselors were required to evaluate each of the inmates on their caseload every six months, but there was no recognition of the relationship between establishing a treatment plan, evaluating progress towards meeting treatment objectives, and documenting the results. One staff member stated, "I conducted a check on 100 inmate files and discovered that none were in compliance. In some cases treatment plans were never done and progress reports did not exist."

In response, DOC staff reported that the initial thrust of program planning in the department was on creating a set of policies to establish consistency in report development and case management practices across the institutions. After five years of work, a revised set of policies which streamlined the case management process was established in 1990.

Improving Implementation of the Good-Time System. As noted earlier, the General Assembly changed the laws governing the awarding of inmate good time in 1981. These changes required DOC to vary inmates' good time earnings on the basis of their institutional behavior and "a demonstrated desire for self improvement."

The policies that were initially established by the department to guide this more comprehensive assessment of inmate behavior were too general in nature and imposed only minimal staff requirements for documentation of inmate performance. As noted in the JLARC report, *Review of Virginia's Parole Process*, this led to inconsistencies in the assessment process which were often based on poorly documented inmate evaluations.

According to DOC's central office staff, making revisions to improve the implementation of the new system was a staff intensive activity which limited the amount of time that could be dedicated to policy development for treatment. As shown in Exhibit 1, DOC staff report that work on developing these policies was conducted over the same five-year time period as the revisions to counselor case management guidelines. When questioned about the protracted nature of this process, DOC staff commented that to avoid past problems, time consuming pilot tests had to precede promulgation of the current guidelines for good time.

Higher Priority for Other Services. Before the department could begin to deal with service delivery for sex offenders and substance abusers, DOC officials stated that they also had to address those basic inmate needs which the agency is mandated to meet. These officials indicated that limits to available funding for these services automatically directs the agency's priorities away from treatment. One DOC official commented,

The priorities of the DOC's Executive Committee are mental health, basic health services, and dental care for inmates. In corrections, case law supports required health care for inmates. These requirements must be met before additional money can be spent on treatment.

Accordingly, the department has been working to improve its mental health services since 1987. The major activities that were implemented to put this system in place were establishing Marion Prison as a licensed mental health facility, working for changes to the *Code of Virginia* to allow DOC to forcibly treat inmates, and organizing three levels of mental health services within the correctional system.

Lack of Direction from DOC's Top Management. Perhaps the key reason explaining the dearth of DOC policies for treatment programs for sex offenders and substance abusers is a lack of guidance or direction from the agency's top officials. Although the Chief of Operations for Programs and staff have been involved in developing a plan for a treatment system, senior DOC officials have not articulated general plans to steer this process. For example, the department has not established any timeframes for development of a system of treatment services. Moreover, the administration has been equally silent on its position regarding centralized assessment of inmates to determine program needs, statewide mandates of program standards, or the feasibility of creating a State program certification and evaluation process.

This has fostered confusion among staff charged with developing program policy. During JLARC staff interviews with the Chief of Operations for Programs and his staff, differences were expressed about the basic focus of the policy development process. For example, one staff member felt strongly that particular program models would not be mandated. Another disagreed, stating that if a prison offered a program which did not meet the requirements of the State model, a plan for compliance would have to be submitted. In a later interview, both officials concluded that standards would be mandated.

Differences of opinion also characterized staff members' understanding of the department's position on standardized assessment. While one DOC official thought an assessment tool would be mandated, another disagreed. "We must allow staff [in the prisons] to do what works in their institutions."

At the time of this study, DOC's top officials were unaware of any problems with the policy development activities of the Chief of Operations for Programs and staff. Although the process was initiated in November of 1989, and is now considerably behind schedule, one senior official stated, "I have not received a report on the status of the [policy] work." When asked about centralized assessment, program standards, and performance measures, senior administration officials admitted that they "do not have

the answers" to these questions. They point out that the department has historically deferred to the prisons and field units on these types of issues:

Programs have always worked in a decentralized management philosophy. Wardens have the responsibility and complete freedom to create innovative programs If programs have lagged it is because the General Assembly has not provided the necessary resources to fund them.

One manager within the Division of Adult Institutions stated that the objective of the department is to be "more persuasive than directive. Strong direction does not work. By giving the counselors the freedom to develop programs you tap the power source where it is." However, this same official pointed out that it could take "five to 10 years" for a treatment system to develop with this approach.

This unusual amount of deference to the decisions of field staff in the correctional system is illustrated in the one policy on treatment programs that the department established in 1990. The stated purpose of the policy is to "provide a uniform and comprehensive system for the development, operation, and evaluation of programs in adult institutions." As shown in Figure 3, this policy is extremely vague, allowing correctional facilities to adopt virtually any type of strategy as a treatment program. The policy only requires that the institutions develop some type of program. No mandates are presented concerning issues of program assessment, program standards, and performance standards.

Staff within the department's program unit agree that the policy is vague, but they point out that all facilities will be required to operate "core programs by June of 1992," including substance abuse and sex offender activities (only in the major prisons). They concede, however, that the department has not developed any specific mandates to direct staff in the development and operation of these "core programs."

According to an experienced treatment specialist working in one State institution, this approach to policy development is a symptom of a larger problem within DOC:

Treatment in the department has always been do it as best you can. There is no legal mandate for treatment or other external pressures [to force] the department to create a treatment system. The department is crisis oriented. Whatever the crisis is, the department will work on it and let other issues drop.

Another counselor commented:

DOC needs to be proactive and systematic in their assessment of what the inmate population needs. Once this is done a systematic treatment program could be integrated with security. Currently facilities must rely on counselors to come up with innovative ideas for programs which are not supported at the institutional level and central office.

Figure 3

Department of Corrections' Program Requirements Established Through Agency Policy 832

Purpose: To establish a uniform comprehensive system for the development, operation, and evaluation of programs in the adult institutions

	<u>Addressed in the Policy</u>	
	YES	NO
Mandates program development	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Mandates specific types of programs	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Requires assessments of need	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Mandates program standards	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Establishes performance standards	<input type="checkbox"/>	<input checked="" type="checkbox"/>

Source: Department of Corrections, Department Operating Procedure 832.

Uniform Policy for Substance Abuse and Sex Offender Treatment Needed

Incorporating the input of field staff before policy is formulated is both a common and sound approach to management. The problem in this case is the department's application of the philosophy. The bottom-up approach to policy development requires that the input of field staff be gathered and considered before policy is finalized. It does not require the State agency to relinquish its responsibility for basic guidance.

When this is done, the actual treatment process becomes fragmented and unfocused. In order for a treatment system to be developed, the department will have to play a considerably more active role in establishing the basic features of the system.

Recommendation (1): To ensure that the department takes a more active role in the development of a delivery system for inmates in need of

substance abuse or sex offender treatment, the Board of Corrections should direct the department to develop a policy for programs that establishes a framework for a comprehensive service delivery system.

IMPLEMENTING PLANNED GOALS AND OBJECTIVES

In 1989, DOC officials formed a Program Action Committee (PAC) consisting of various staff members throughout the department. The basic purpose of the PAC was to establish goals and objectives for treatment services which, if developed, could provide the basis for the agency's framework for inmate programming.

During the course of this study, JLARC staff interviewed various DOC staff members about the progress that has been made towards meeting the goals and objectives established by the PAC. The results from this study indicate that this process has been unproductive. More than 20 months after this committee was formed, most of the deadlines for meeting many of the key program goals have passed and the work has not been completed. This has slowed the development of policy for substance abuse and sex offender treatment services.

Failure to Meet the Goals of the Program Action Committee

In the department's approach to policy development, input of the field staff is a vital component. According to staff members, one of the most common routes to policy development requires field staff to generate ideas through counselors, various staff committees, or the regional offices. These ideas are reviewed and analyzed by the Chief of Operations for Programs and his staff.

If these staff believe that a basis for policy exists in the information presented by field staff, a draft is developed and sent to the Deputy Director of Adult Institutions for review. If the Deputy approves the draft, the information is forwarded to the Director for final review and approval.

Proponents of this approach to policy development contend that it works for two reasons. First, because field staff provide the framework for the policy, the chances of acceptance are increased. Second, the likelihood for successful implementation is also enhanced because local staff have an understanding of the spirit in which the policy was written.

The PAC was organized to establish a number of program goals that could potentially fuel the development of the department's program policy. Some of the areas for which goals were established included inmate program needs assessment, program standards, program evaluation, staff training, and model substance abuse and sex offender programs.

In most cases, the established goals had multiple objectives with different timeframes for completing each one. For example, the goal of program standardization was supported by the following objectives and timeframes:

1. To submit program component requirements at each facility by March 1, 1990.
2. To review documentation in accordance with [DOC policy] to determine if individual facility programs meet the required standards by July 1, 1991.
3. To develop a framework for a certification process for programs by January 1, 1991.
4. To submit per facility, based on current programs, the compilation of identified data necessary for a certification process quarterly from July 1, 1990, to July 1, 1991.
5. To identify per region those staff members to act as an audit team by December 1, 1990.

Figure 4 shows the difficulty experienced by DOC field staff in meeting those objectives established by the PAC that could potentially impact policy for substance abuse and sex offender programs. Three-quarters of the objectives have not been met, and the deadlines established by the department have passed. More importantly, for many of these objectives, staff report that virtually no progress has been made towards completing the work.

Factors Contributing to DOC Problems in Meeting Program Objectives

A number of factors have contributed to the problems that DOC experienced with meeting the goals and objectives established by PAC. Key among these are the following: (1) poor organization of the goal setting process; (2) insufficient coordination with the regional offices; and (3) delegation of work to regional program managers (RPMs) without the needed direction.

Poor Organization of Goal Setting Process. A number of DOC staff interviewed for this study indicated that the role of PAC was never clearly articulated by central office staff. According to these individuals, the initial plan was for PAC members to establish the objectives and be directly involved in the implementation of particular activities. However, when the regional program managers (RPMs) were hired, members of the PAC removed themselves from the process and left the managers with the responsibility for carrying out the objectives. The fact that most of the RPMs were not hired until several months after the goals and objectives were established aggravated problems with the delays in the process.

Figure 4

Progress Made by the Department of Corrections Towards Implementing Objectives for Inmate Programs

<u>Program Goal</u>	<u>Number of Performance Objectives Established</u>	<u>Number of Performance Objectives Achieved</u>	<u>Has Deadline Now Passed?</u>
Program Needs Assessment	4	2	YES
Program Standards	5	0	YES
Program Evaluation	3	0	YES
Staff Training	1	0	YES
Substance Abuse Advisory Committee	1	1	YES
Sex Offender Advisory Committee	2	1	YES
TOTAL	16	4	

Source: JLARC staff interviews with DOC staff.

At least three of the four RPMs stated that they were being asked to implement objectives that they had no part in developing. According to one RPM, "The goals were too ambitious, did not reflect the input of the field, and could not have been feasibly implemented within the prescribed timeframes."

The following comments from one DOC central office staff person who characterized the process as "disorganized and haphazard" seem to underscore the concerns expressed by some of the RPMs. Moreover, they suggest that the department did not have a clear vision about the role of the PAC and its relationship with the RPMs.

PAC was formed to establish the goals and objectives and provide oversight of the implementation activities. The committee was unofficially disbanded in 1990 with the creation of the RPMs. This created some problems because the managers essentially inherited the objec-

tives established by PAC but did not have any input into the process. However, once the managers were hired the Chief of Operations for Programs did not see the need for a continuation of PAC.

Insufficient Coordination with Regional Offices. The regional offices provide a critical link between central DOC staff and the field units. The general responsibility of the administrators in these four offices is to ensure that all of the prisons and field units in their region operate according to DOC policy.

The RPMs were placed in these offices to handle all program-related issues and implement the objectives established by the PAC. Although the staff in these positions sometimes work directly with the Chief of Operations for Programs, they report to, and are supervised by the regional administrators (Figure 5).

This organizational arrangement has, in effect, established reporting relationships for the RPMs outside of the regular chain of command. Because they are still accountable to the administrators, there is a heightened need for open lines of communication between the regional offices and the Chief of Operations for Programs regarding the expectations and performance of the RPMs.

The results from this study indicate that the Chief of Operations for Programs and his staff have not provided the necessary direction, communication, and follow-up with the regional offices to facilitate implementation of the program objectives. One administrator complained:

We need more direction from Richmond We get dates and deadlines but they do not reflect the realities of the day to day work in the region They [central office] need to get input from the field but they must be realistic about what is being asked. The expertise [to develop these objectives] is not consistently there in the field.

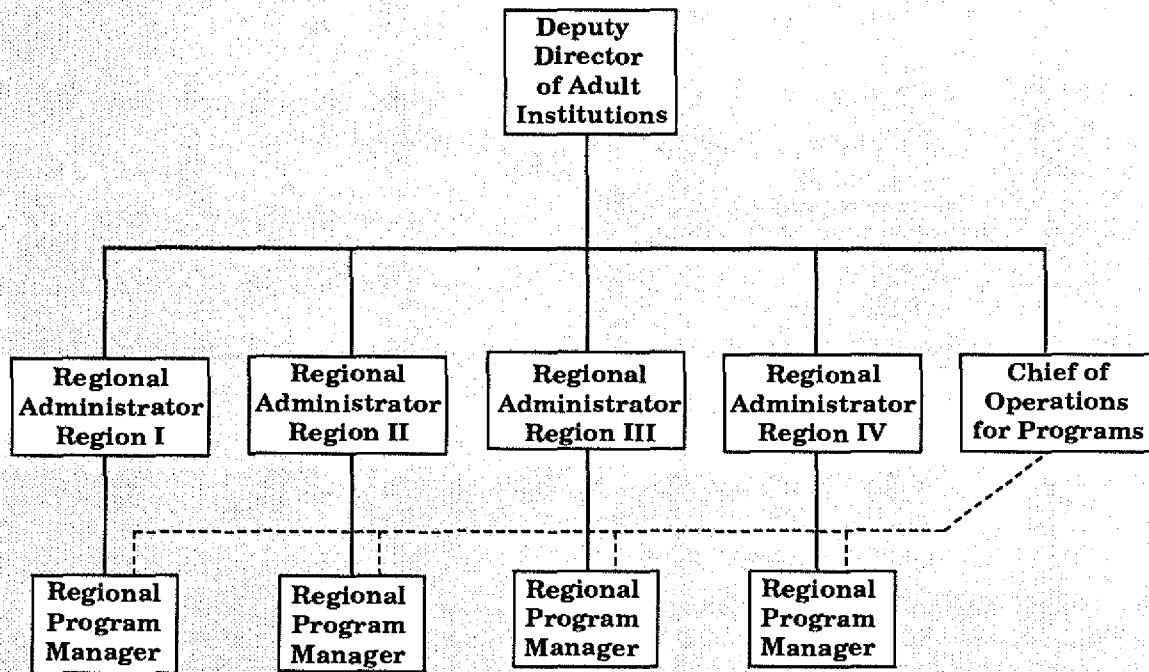
Critically lacking, according to several administrators, is follow-up from the Chief of Operations for Programs on the nature and status of the work being conducted between his staff and the RPMs. When informed that 70 percent of the objectives had not been met, one regional administrator complained, "Nobody [from central office] has called or written to give any indication of problems [with the objectives]."

Interviews with the Chief of Operations for Programs and staff seem to support the administrators' complaints of limited guidance and communication. When the issue of responsibility for the lack of success in meeting the objectives was raised, JLARC staff were told, "Our responsibility for the goals and objectives ended when the RPMs were hired." In later interviews, DOC staff conceded that they were jointly responsible for getting the work done but indicated that there was simply no time to do it.

At least two administrators feel the work to complete the objectives is the responsibility of central office. One administrator pointedly stated, "These [objectives] are the responsibility of the Chief of Operations for Programs."

Figure 5

Organizational Relationship Between Chief of Programs and the Regional Program Managers



Source: JLARC staff interviews with DOC staff.

Delegation Without Direction. The objectives in the mission statement developed by the PAC create a number of major responsibilities related to the building of a treatment system. Some of these are as follows:

- *Program Needs Assessment:* To determine if the programs currently available at the facility meet the needs indicated by the inmate profile.
- *Program Standards:* To develop and submit program component requirements at each facility.
- *Program Certification:* To develop a framework for certification for all programs.

- *Program Evaluation*: To develop a single evaluation instrument for inmate programs.
- *Staff Training*: To evaluate the present training related to programming provided to all staff.

These are ambitious objectives which will require considerable staff time and expertise to implement. For example, to meet all of the objectives under the goal of program standardization, the RPMs must develop the standards, determine how current programs compare to the standards, develop a certification process, and formulate an audit team to conduct regional reviews.

The current process being used by the department to develop these objectives is delegation to the RPMs. In response, the RPMs formed regional advisory committees in their respective areas to organize the input from the field. To avoid duplication, sub-committees have been formed in each advisory group to deal with topic-specific issues. During the course of work on the objectives, the RPMs meet once a month with the Chief of Operations for Programs and his staff. Once the committees complete work on the topics, the RPMs meet with the Chief of Operations for Programs and his staff to discuss the products (Figure 6).

By virtually all accounts, this process has been slow and the direction and assistance provided by central DOC staff minimal. One RPM offered the following summary of the problem:

The RPMs agreed to establish these groups to incorporate the input of the wardens, assistant wardens, and counselors in the policy development process. However, the meetings [in my region] are not attended as well as I would like. Wardens do not allow staff to attend in some cases. Counselors and administrators are busy in other areas.

Other RPMs were critical of the direction that the Chief of Operations for Programs and his staff have provided. One of these program managers stated:

I was not told by central office that the RPMs would be expected to develop and implement the objectives. Our role was to provide field input. It is important to emphasize that central office did not play a strong role in indicating what we were expected to do and when it needed to be done.

The sentiments of another RPM were similar:

We decided as a group to meet monthly with the Chief of Operations for Programs and his staff to discuss the field work as it related to the objectives. [Central office staff] did not discuss any mandate for meeting the goals and objectives according to established deadlines.

The Department of Corrections' Bottom-Up Approach for Planning and Policy Development



DOC Planning Process is Ineffective

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number of local obstacles to develop a particular issue. More importantly, it does not appear that the RPMs have the time to spend on implementation of the objectives. Their present job duties require that they work with the wardens in their region to plan and develop programs, provide quality assurance audits for programs throughout their region, provide technical support to the program staff, and serve on numerous committees across the State. One RPM works with five different committees that meet monthly to deal with a myriad of issues, some of which are not related to the implementation of the performance objectives.

This is evident from the comments of one RPM, who stated that her duties pose an added burden because treatment programs within the department have not been advocated. She stated that as a result, there is a substantial amount that needs to be accomplished:

Counselors' positions have evolved without thought. Some do not have degrees. Some have no experience running treatment programs. The assistant wardens for treatment have evolved as security positions instead of facilitating growth of treatment. The treatment program supervisors in some cases perform security duties. Counselors are used as a dumping ground for non-counseling duties and they are not always informed of department policy. So part of my job is advocacy, technical assistance, and networking.

Impact of Problems with Planning

Without the systematic input of field staff, DOC has refrained from formulating any policies to develop a treatment system for sex offenders or those with substance abuse problems. As a result, the department does not have control over the methods used by local staff to determine inmate programming needs, to implement particular treatment services, or to evaluate the success or failure of the programs. In addition, DOC has failed to establish minimum training requirements for those staff who are responsible for implementing the programs.

According to specialists in the fields of substance abuse and sex offender treatment, uniform assessment techniques, program standards, an evaluation system, and staff training programs are the basic requisites of any system that is designed to provide quality treatment. Without uniform assessment techniques, services cannot be targeted to the inmate population based on their level of dysfunction. Without program standards, there are no controls to minimize inconsistencies in services across prisons. Without an evaluation system, the department has no way of assessing the efficacy of the treatment it provides. Finally, without minimum training requirements for staff, the integrity of the treatment system is placed at risk.

Recommendation (2): To ensure that the department develops policies to address issues of assessment, program standards, and staff training for a substance abuse and sex offender treatment system, the Board of Corrections

should require the Department of Corrections to include in its plans for a treatment system a description of these policies.

CONCLUSIONS

Until recently, there was little evidence supporting the efficacy of rehabilitation programs offered through the prison system. Recent studies are now suggesting that these types of programs can work if the system for service delivery is well planned. At a minimum, this requires that sound policies be established to govern program assessment strategies, standards for program service, staff training, and the program certification process.

This analysis revealed that the department has not adequately planned and organized the treatment services presently being offered in the prisons and field units. Recent attempts to establish a planning function for treatment have been undercut by shifting priorities, a lack of organization, and insufficient direction.

As a result of these problems, counselors who are responsible for developing treatment programs must conduct these activities without the necessary guidance and direction. As will be discussed in the following chapter, this has produced an uneven level of treatment across the system. In order to address these problems, DOC officials must play a considerably stronger and more active role in planning the development of inmate treatment services.

III. Treatment Programs Within Corrections

Data from the Department of Corrections (DOC) indicate that a substantial number of the inmates in State prisons and field units have problems with some form of drug or alcohol abuse. Further, a smaller but substantial number have been charged and convicted of various sex offenses.

More than 80 different substance abuse and sex offender programs are presently operating throughout the prisons and field units to help inmates with these problems. However, there is no systematic approach within DOC to organize and deliver these services. As a result, services are provided throughout the correctional system in an inconsistent and fragmented manner. As an example, approximately half of the sex offenders in the system are unable to gain access to any type of treatment prior to their first date of parole eligibility even though some may request it. Most substance abusers do receive treatment, but for many of these inmates the intensity of the services is not sufficient given the nature of their problems.

In general, the overall quality of treatment programs within the institutions suffers due to a number of problems. Included among these are a lack of funding, excessive case management responsibilities for counselors, a lack of program standards, and insufficient staff training opportunities.

Despite these problems, data from this study do reveal that the parole rate for inmates who receive treatment is somewhat higher than the rate for those who do not. Moreover, if improvements are made to the treatment system within DOC, the possibility for establishing more formal linkages to the decisionmaking process of the Parole Board does exist.

THE NEED FOR AND AVAILABILITY OF TREATMENT WITHIN CORRECTIONS

In recent years the importance of identifying and providing treatment services to inmates with substance abuse problems and those convicted of sexual crimes has been given increased attention. One reason for this renewed interest is the number of studies that have established links between inmate participation in treatment and lower rates of recidivism. Accompanying this heightened interest in treatment for inmates are questions about the ability of correctional systems to identify and effectively serve those segments of the prison population who are characterized by these problems.

In Virginia, concerns have been expressed about the actual size of the inmate population that needs treatment and whether DOC is able to deliver the appropriate interventions. Data analyzed in this study indicate that there is a substantial need for

both substance abuse and sex offender treatment services in the State prison system. Although some of the inmates with these problems receive treatment, in many cases the services provided appear limited given the magnitude of the dysfunctions.

Level of Need for Substance Abuse and Sex Offender Services

To measure the need for treatment within DOC, JLARC staff analyzed data from several of the department's automated files. The first step in this analysis was to create a file of all inmates who were incarcerated in a State prison or field unit for all 12 months of 1990. Next, using information contained on the inmate's criminal and substance abuse histories, all offenders with convictions for sexual crimes or those with documented drug or alcohol abuse problems were categorized as needing treatment.

The results from this analysis indicate the magnitude of the problem faced by State correctional officials. In 1990, there were 14,841 inmates in the prison system. Statewide, almost 83 percent of this population had a problem with either substance abuse or criminal convictions for sex offenses (Table 1). In one facility, Fairfax Correctional Unit, nine out of 10 of the inmates housed there during 1990 were identified as having one of these types of problems. Even in the facility where the need for services is the lowest, the Virginia Correctional Center for Women (VCCW), more than 70 percent of the inmate population could possibly benefit from some type of treatment.

Substance Abuse Among Inmates. To be considered a substance abuser for this study, DOC records had to indicate that the inmates had a moderate or severe alcohol problem or were regular users of illegal drugs at the time they were received into corrections. Using this definition, the data show that the most pervasive problem among inmates appears to be substance abuse. As shown in Table 1, 81 percent of all inmates housed in a DOC prison or field unit in 1990 were substance abusers.

A closer look at the data on this group indicated that 70 percent of the population regularly used some form of illegal drug. The types of drugs that were reportedly used include marijuana, cocaine, heroin, and various mood altering prescription drugs. The percent of inmates who used alcohol was lower (45 percent). However, in analyzing the information on these inmates, JLARC staff found that over half were considered heavy or chronic users. The data also indicate that approximately 41 percent of this group might be dual-addicted — regular users of both alcohol and drugs.

Sex Offenders. As shown in Table 1, ten percent of the 14,841 inmates who were incarcerated in a State prison or field unit in 1990 had been convicted of some type of sexual offense. By design, most of these inmates are housed in the State's major prison facilities. According to DOC officials this is done for security purposes and to give these inmates an opportunity to participate in sex offender programs which are not typically offered in the field units.

In most of the major prisons, the size of the sex offender population closely approximates the statewide rate of 10 percent. In eight facilities, sex offenders constitute

Table 1

Sex Offenders and Inmates with Substance Abuse Problems

<u>Facility</u>	<u>Percent of Population in Need of Treatment</u>	<u>Percent of Population in Need of Sex Offender Treatment</u>	<u>Percent of Population in Need of Substance Abuse Treatment</u>
Statewide	84	10	81
Appalachian	81	0	81
Augusta	86	17	83
Baskerville	79	1	79
Bland	84	12	79
Botetourt	87	2	87
Brunswick	86	15	83
Buckingham	88	18	83
Capron*	83	1	83
Caroline	85	1	84
Chatham	77	4	75
Cold Springs	89	0	89
Culpeper*	78	0	78
Deep Meadow	85	1	85
Deerfield*	84	12	82
Dinwiddie	82	1	81
Fairfax	91	0	91
Fluvanna	86	1	86
Greensville	85	20	80
Greensville S Bldg.	82	12	77
Greensville H Bldg.	69	13	56
Halifax	81	2	80
Harrisonburg	72	0	72
Haymarket*	88	1	88
Haynesville	86	2	85
James River	85	7	83
Keen Mountain	87	20	84
Marion	86	12	81
Mecklenburg	86	10	83
Mecklenburg S Bldg.	85	11	84
Nansemond*	81	4	81
New Kent*	83	1	83
Nottoway	86	13	82
Patrick Henry	82	1	82
Pocahontas	83	1	83
Powhatan	86	17	81
Powhatan Infirmary	83	8	83
Powhatan M Bldg.	85	9	83
Powhatan North	86	7	83
Powhatan Receiving	82	9	80
Pulaski	84	0	84
Rustburg	85	1	84
Smith Mountain	81	1	80
St. Brides	80	6	78
Southampton	86	18	83
Southampton Receiving	84	13	74
Stafford	84	1	84
Staunton	83	15	77
Tazewell	77	1	77
Tidewater	82	1	82
VCCW	72	2	71
VCCW Receiving	83	4	83
White Post	86	2	86
Wise	86	3	86
Youthful Offender Ctr.*	68	3	65

*These facilities are no longer in operation.

Source: Automated inmate files from the Department of Corrections

at least 15 percent of the total inmate population. The Keen Mountain and Greenville prisons have the highest proportion of sex offenders (20 percent) in the State.

INMATE ACCESS TO TREATMENT PROGRAMS

Given the number of substance abusers and sex offenders in the State prison system, one basic question concerning inmate access to treatment is whether the department is able to accommodate those inmates who need and want services. Closely related to concerns about access to treatment is the issue of the appropriateness of the interventions. The treatment specialists who were interviewed as a part of this study emphasized the importance of making decisions about the type of treatment provided based on the severity of the inmate dysfunctions.

In order to address both of these issues it was necessary to review the treatment plans for a representative sample of sex offenders and those inmates with substance abuse problems. The following steps were taken to select the sample:

- First, DOC's automated files were used to identify all sex offenders who were received in corrections prior to 1990 and had their first parole interview in 1990. This step was repeated for all inmates with substance abuse problems.
- Second, separate representative samples of the inmates' hard copy institutional files were randomly selected for both sex offenders and substance abusers.
- Third, the treatment plans, progress reports and other related information in these files were reviewed to determine whether treatment was recommended and received prior to the inmates' first parole interview. These reports were also examined to determine if the program services varied according to the severity of the inmates' problems.

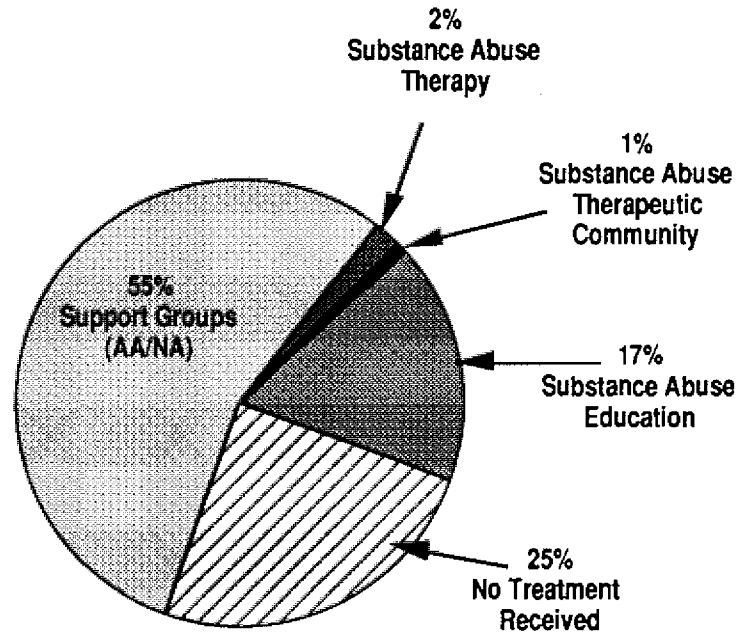
Treatment Available for Substance Abusers

Data analyzed from this sample indicate that 25 percent of all inmates with a substance abuse problems do not receive any type of treatment before they establish eligibility for discretionary parole (Figure 7). Another 55 percent do receive treatment but the services are limited to the support group interventions of Alcoholics Anonymous (AA) and Narcotics Anonymous (NA).

Participation in AA and NA is generally considered to be most beneficial when it is offered in conjunction with or follows a more intensive substance abuse therapy program. In this sense, support groups play an important role in keeping people who have participated in treatment in touch with their substance abuse problems. AA and NA are not, however, therapeutic. In fact, treatment specialists both in and outside of

Figure 7

Substance Abuse Treatment Received at the Time of First Parole Interview



Notes: These figures were calculated from a sample of 335 inmate files. The sampling error was five percent. Figures do not include cases in which data on the type of treatment received was not available.

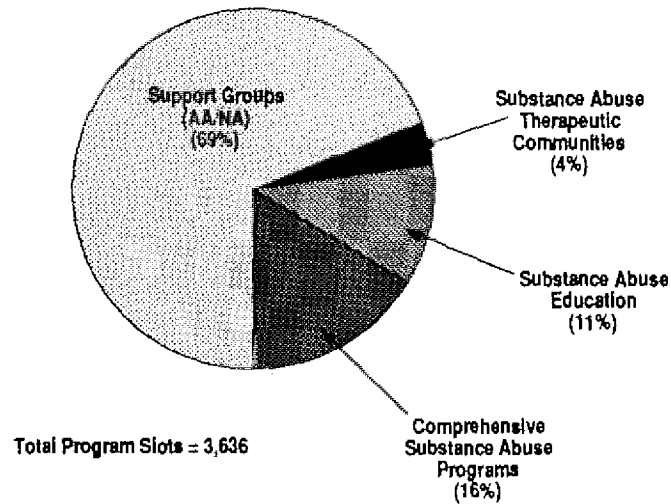
Source: JLARC staff analysis of inmate files.

the department contend that these programs are more appropriate as aftercare interventions and should not be used as the primary service for inmates with severe and long-standing substance abuse problems. However, data from the file reviews indicate that very few inmates (only three percent) with substance abuse problems benefit from any type of therapeutic counseling. Additionally, only 17 percent receive substance abuse education. Indeed, when a picture of all the substance abuse services that are available across the entire state prison system is developed, the data show that almost 70 percent of the program slots for substance abuse are limited to AA or NA services (Figure 8).

As shown in Table 2, this often results in a mismatch between the nature of the inmates' dysfunctions and the type of treatment received. Inmates determined by counselors to be frequent abusers of alcohol were more likely to receive AA or NA support than educational or therapeutic counseling. The following case study is further evidence of the problems that can occur when AA or NA services represent the basic thrust of programming in the department.

Figure 8

Substance Abuse Program Slots in DOC Facilities



Note: Data on AA/NA program slots for Cold Springs Correctional Unit and Staunton Correctional Center were unavailable.

Source: JLARC analysis of DOC data and survey of prisons and field units, FY 90-91.

Table 2

Percent of Inmates Who Are Moderate and Severe Alcohol Abusers in the Different Types of Substance Abuse Programs

<u>Treatment Received</u>	<u>Documented Alcohol Abuse Level</u>	
	<u>Moderate Abuse</u>	<u>Severe Abuse</u>
AA/NA Support Groups	73%	77%
Alcohol Education Program	20	19
Comprehensive Therapy Programs	5	2
Therapeutic Communities	2	2
Totals	100%	100%

Source: JLARC analysis of data from DOC treatment plans, progress reports and automated inmate files.

An inmate was serving a 13-year prison sentence for separate property crimes including three grand larceny convictions, one breaking and entering, and one drug distribution charge. In addition, the inmate's record revealed 12 prior petty larceny convictions and one grand larceny charge. At the time of his arrest for the property and drug crimes, the inmate's treatment plan indicated that he was using one and a half grams of cocaine daily. The inmate's pre-sentence investigative report states that he was injecting three or four grams of cocaine daily. The treatment plan developed by staff at the Powhatan Reception Center characterized his drug problem as "severe." Prison records also indicate that the inmate was extremely interested in participating in a drug treatment program to help him overcome his dependency. Prior to his first parole interview, DOC was only able to provide the inmate with access to the Narcotics Anonymous program at St. Brides Correctional Center.

In some facilities attempts are being made to offer a more comprehensive service. However, as the following case example illustrates, problems of access persist.

Among the more than 800 inmates that were incarcerated in Staunton Correctional Center for all 12 months in 1990, 627 were considered substance abusers. Currently, there are 15 counselors working at this facility. With the assistance of a substance abuse grant, two counselors have developed a therapeutic community to treat 41 inmates (six percent of all substance abusers in the facility). Because of the intensive-ness of the treatment, the counselors that operate this program can only carry 21 inmates on their individual caseloads. This program is also scheduled to receive a case manager to handle the paperwork generated on these inmates.

In addition to the therapeutic community, there are two other special programs in the facility that require the full-time work of two additional counselors. This leaves 12 counselors to work with the remainder of the inmates in the general population. Because the caseloads of the counselors that work with the special service programs are small, these staff must handle actual inmate to counselor ratios of more than 70 to one. With these caseloads, they only have time left to organize one AA support program. This is clearly inadequate for the substantial number of substance abusers that are in the general population.

Variation in Substance Abuse Programs

Apart from the issue of program access is the question of consistency of service within the various prisons and field units. As reported earlier, DOC has not promulgated any standards to govern the development of treatment programs in the prisons and field units. Without such standards, there is a great deal of variation in the content of the

substance abuse programs which are used to serve different inmates with similar problems.

Statewide 24 prisons and field units offer educational services as a method for treating substance abusers. In 15 of these facilities, these services represent the only strategies (aside from AA or NA support groups in some cases) being used to treat substance abusers. In the 11 other facilities, some attempt is made to supplement the educational activities with therapeutic counseling services.

Lack of Consistency in Education Curriculum. Presently there is no standard curriculum for substance abuse education in the department. The program descriptions submitted to DOC's central office by treatment staff in each correctional facility reveal considerable diversity in the objectives and content of the substance abuse education programs. For almost half of the programs, the basic purpose appears to be to inform inmates about the nature and effects of substance abuse.

During each of the JLARC staff site visits, counselors indicated that the sole objective of a number of these programs is to provide inmates with information on the different terminologies for drugs (e.g., street names like angel dust for PCP) and the physiological effects of the substances. These counselors pointed out that the courses provide nothing for the inmates that will lead to insight into substance abuse problems and prepare them for more intensive therapy. Moreover, one counselor pointed out that, because of their extensive drug use, many inmates are probably better equipped to teach the courses than some counselors.

Other substance abuse education programs are more comprehensive in nature. One education program, for example, exposes inmates to techniques that will help improve their self-image, personal problem-solving skills, and communication skills. In addition, it provides information on family dynamics, cultural dynamics, addiction, and the recovery process. A key feature of some of these courses is to educate inmates about factors that can cause a relapse.

Therapeutic Counseling

Phase II of the comprehensive substance abuse program is group therapy. During this phase, inmates are forced to confront the unique factors that led to their own substance abuse problems. The DOC program descriptions indicate that a variety of therapeutic techniques are used to help the inmates understand the nature of their problems and learn alternative ways to deal with the personal situations that led to substance abuse. Most of these sessions are led by one or two counselors and are interactive in nature. Inmates are encouraged to confront each other about their problems.

The duration of the substance abuse therapy programs varies. In some institutions, the programs are offered for a fixed period of time, such as 16 weeks. In

others, however, the program is on-going and could potentially last the duration of the inmate's prison term.

The major problem with the therapy programs is that there are no guidelines, standards, or training to support these activities. A consistent comment made by counselors interviewed during the site visits was that they learned by doing because there was no training or department guidelines to assist them. During one of the site visits a counselor stated:

When I came to this facility, there were no standards for treatment programs. You were told to run a program. Any training had to be secured through your own initiative and sometimes your own resources. Occasionally, turnover among staff would result in major changes to the program because someone else felt the program should be conducted differently.

The general lack of consistency in programs due to a lack of State guidance is illustrated by the following counselor comments:

There is not now nor has there been a system of treatment [in DOC]. There is no uniform curriculum so there is no continuity in treatment across the department. This creates a real problem for inmate transfers who move from one type treatment program in one facility to another in [their new assignment]. To minimize the problem [my facility] developed an in-house training program and a set curriculum. We do not accept program participation for inmate transfers because we do not know what they have received.

A System of Treatment is Needed

Currently, substance abuse programs in the prisons and field units, including the therapeutic programs and other grant funded activities, are not planned or implemented as a part of a service delivery system. This merely perpetuates the inconsistencies in treatment and fails to properly address the issue of service gaps.

An example of one approach that the department can take to organize its treatment system for substance abusers is the strategy it used to develop its mental health delivery system. As noted earlier, this system was established to provide three tiers of services based on the assessed dysfunction of the inmate. Those inmates with severe problems receive intensive services at the Marion facility. Inmates in need of intermediate care are incarcerated in one of five DOC prisons that provide these services. Other prisoners with mental health problems are considered to be in "outpatient" status by the department. These inmates remain in the general population but must regularly meet with their psychologist.

There are two benefits to this approach to treatment. First, it provides a better match between the severity of the problem being treated and the type of intervention used as treatment. This can enhance program success by avoiding problems of placing chronic abusers in the less intense support group activities.

Second, this approach is more cost-efficient. When inmates with less severe problems (i.e. recreational or casual drug users) are placed in intensive therapy programs, additional program slots will have to be created to accommodate those with chronic abuse problems. This may result in a substantially larger expenditure of resources than would be necessary if the scope of any given service is planned according to the number in the inmate population who actually need specific types of programs.

Recommendation (3). To enhance the level and quality of treatment services available for substance abusers, the Board of Corrections should require the Department of Corrections to develop a multi-tiered system of treatment that includes service options for inmates with different levels of drug and alcohol abuse problems. In addition, the Board of Corrections should require the department to specify minimum requirements for program content and establish guidelines for the development of therapy programs.

Treatment Available for Sex Offenders

Currently, ten major prisons and one field unit offer sex offender programs. However, the amount of treatment available for sex offenders is inadequate. Based on the review of the treatment plans, JLARC staff determined that almost half of all sex offenders establish eligibility for discretionary parole without having received any services (Figure 9). This problem occurs because the department has only 336 program slots statewide for more than 1400 sex offenders (Figure 10).

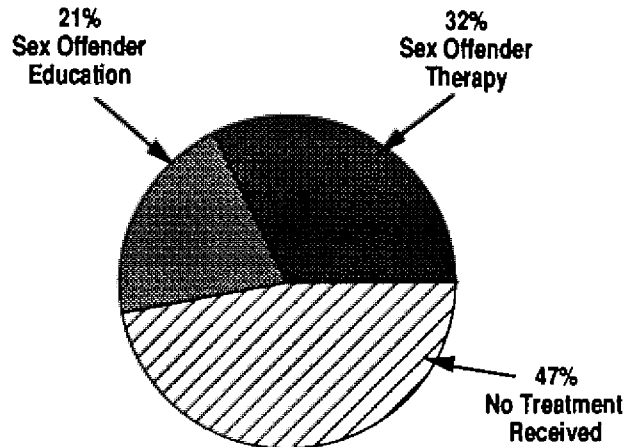
The limited number of treatment programs for sex offenders in the system is partially a reflection of the non-directive role of DOC officials regarding this issue. In this environment, the impetus for program development must come from the individual counselors. The Sex Offender Program Advisory Committee (SOPAC) that was established by a DOC counselor in the early 1980s has worked to improve program access for sex offenders.

Two members of this committee, however, feel that the work of SOPAC has slowed because many of the members are volunteers, the turnover is high, the committee can only meet once per month, and the support of the department is inadequate. One member stated that SOPAC was being looked upon to expand treatment for sex offenders, but "they [DOC] will not even provide typing support."

Sex Offender Services More Comprehensive. When services are provided for sex offenders, the mix of treatment they receive is considerably more comprehensive than was the case for substance abusers (Figure 10). Almost one third of the sex offenders in DOC prisons receive therapy (usually after receiving education services) prior to their first date of parole eligibility.

Figure 9

Sex Offender Treatment Received at the Time of First Parole Interview

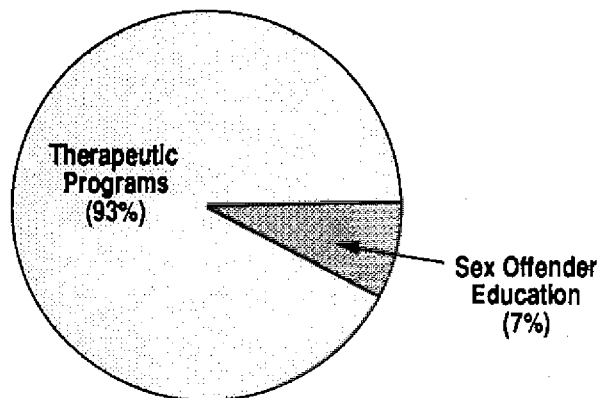


Notes: These figures were calculated from a sample of 50 inmate files. This was more than twice the number required to achieve a sampling error of five percent. Figures do not include cases in which data on the type of treatment received was not available.

Source: JLARC staff analysis of DOC data and surveys of prisons and field units, FY 90-91.

Figure 10

Sex Offender Program Slots in DOC Facilities



Total Program Slots = 336

Source: JLARC staff analysis of DOC data and surveys of prisons and field units, FY 90-91.

Before being allowed to participate in therapy, inmates must admit their guilt in the offense as a part of the education treatment phase. During the therapy phase, sex offenders are forced to examine their crimes and the factors leading up to their crimes in a group setting. As with the substance abuse therapy, the groups are both interactive and confrontational. Offenders are held responsible and accountable for their actions.

Impact of SOPAC. The comprehensiveness of the sex offender programs is largely attributable to the impact of the SOPAC. The objectives of SOPAC according to a current member are to: (1) establish consistency in treatment for sex offenders; (2) increase the level of sex offender treatment; and (3) improve training for staff who run the program.

To accomplish this, SOPAC initially worked with programs that were already established to provide basic training to staff. Since that time, the committee has developed a training manual and has been working with different counselors throughout the prison system to improve the quality of programs. In addition, SOPAC has developed a program model that members hope will be mandated statewide.

This model has four different phases of treatment for the sex offender: (1) educational, (2) pre-treatment, (3) group therapy, and (4) relapse prevention. Phases two and four of these programs were added to the basic model of education and therapy in an attempt to provide a continuum of sex offender treatment services. The pre-treatment phase of the program serves two purposes. First, it is intended to prepare the inmate for intensive therapy by helping him understand why he is in treatment. Secondly, the pre-treatment phase provides staff with the opportunity to determine whether the sex offender is really motivated to address his sexual deviancies through intensive treatment.

The relapse prevention portion of the program is for inmates who have successfully completed the other three phases. It is designed to help the sex offender identify "red flags" in his life that may lead to the commission of a sexual offense, and it presents techniques for preventing the offense from taking place.

Guidelines Needed for Therapeutic Counseling

The major problem with the sex offender programming is that there are no agency specific requirements for the service providers, or guidelines outlining the basic elements of therapeutic counseling. SOPAC has developed a training manual for staff responsible for implementing sex offender treatment programs. However, the focus of this training is on the delivery of sex education services. The Committee has yet to develop training in the therapeutic aspects of sex offender treatment.

While the department recognizes the difficulty associated with treating this population, no policy or guidelines for providing therapeutic sex offender counseling have been developed. One of the treatment program supervisors interviewed by JLARC staff for this study summarized the problem by stating:

The reality is that staff skill levels vary tremendously across facilities. Some counselors simply do not have the background The department has no standards for the providers [of treatment programs], thus it is up to the facility to create competent sex offender counselors.

Members of SOPAC complain that the department's silence on this issue has created problems with decisions that are being made concerning who gets designated to implement sex offender programs:

Some counselors are being forced to run sex offender groups who are not qualified, interested, or comfortable with the subject. Some counselors have non-related backgrounds like music, have no experience in sex offender therapy, are not equipped to provide treatment, but are running groups and we have no authority to do anything about it.

According to a licensed therapist interviewed by JLARC staff regarding his past work with DOC, this is a common problem in the department. "One of the biggest problems [with sex offender treatment] is the department's expectation that counselors with no experience or interest in the area can run successful groups." In response, DOC officials stated that this is not an expectation of the department but point out that there are no resources to expand training for counselors in this area.

Finally, the comments of one of the counselors who has been conducting therapy sessions for sex offenders in the department for almost two years highlight the nature of the problem:

When I was assigned to the sex offender program almost two years ago, I had no experience in therapeutic counseling. No department guidelines were available so I read books and learned by doing [SOPAC] developed Phase I and Phase II training which is fairly good but not sufficient because it has no therapeutic focus. [As a result of this] the treatment we provide is not intensive enough to facilitate recommendations for parole release.

Given the complex nature of sex offender therapy, the absence of State guidelines that outline requirements for the service provider and define appropriate practices for therapeutic counseling is a critical shortcoming.

Recommendation (4). To enhance the level and quality of treatment services available for sex offenders, the Board of Corrections should require the Department of Corrections to implement a comprehensive program that includes education and intensive group therapy as the major treatment interventions. In addition, the Board of Corrections should require the department to specify minimum requirements for counselors conducting the group therapy, and establish guidelines for the development of therapy programs.

DOC ASSESSMENTS OF INMATE PROGRAM NEEDS

One key to planning the development of any treatment system is a uniform assessment process. The actual program needs of an inmate population will vary based on differences in the severity of the identified problems. Accordingly, counselors must be able to distinguish among inmates based on observed differences in the nature of their problem and outline treatment plans tailored to the inmates' identified needs.

The department's assessment of inmates for both substance abuse problems and deviant sexual behavior appears to be closely tied to their arrest records. Because a standardized assessment tool is not utilized to determine the need for substance abuse and sex offender treatment, the severity of the inmate's treatment needs may be misdiagnosed.

Substance Abuse Assessments

Efforts to diagnose substance abuse problems are made by the Department of Corrections at different points during an inmate's incarceration. The first attempt is conducted in one of three reception centers. These are DOC facilities established primarily for the purpose of processing the inmate into prison.

The counseling staff in the reception centers use the inmate's arrest history and information obtained off the pre-sentence investigative report (PSI) to determine whether the inmate has a substance abuse problem. To categorize the inmate's problem, counselors rely on the number of alcohol or drug related arrests and the number of incidents of job disruption or lack of employment due to substance abuse within three years of incarceration. According to DOC policy, counselors should also look for any other evidence of alcohol abuse. Based on this information, an inmate's abuse is identified as frequent, occasional, or no problem.

One frequent problem with this process is the lack of availability of the PSI. During the JLARC study of parole, staff determined that at any given time, PSIs were either not completed or not automated for 40 percent of the inmates scheduled for a parole interview. One classification staff member stated that there is often "a dearth of information" on the inmate at classification because the PSIs are missing.

When this occurs, counselors are often forced to rely almost exclusively on arrest information to determine whether the inmate has a substance abuse problem. Because many inmates' substance abuse problems are not apparent from their arrest records, relying on this information can result in misdiagnosis.

After the inmate leaves the reception center, the counselors in the institution where the inmate is assigned conduct another assessment of the inmate's treatment needs. Some counselors rely exclusively on the treatment plan established in the reception center to determine what programs the inmate should be encouraged to

participate in. In these cases, if the assessment made at the reception center was faulty, there is no opportunity for it to be corrected.

Other counselors conduct their own review of the same information that is available to the counselors in the reception centers. If the inmate's PSI is available, the counselors will review this and any other information in the file that will help them make an assessment of treatment needs. The process relies heavily on the counselors' own judgment, and there is a great deal of room for subjectivity.

The problems that occur by not having a formalized assessment tool to determine inmates' substance abuse treatment needs are illustrated in the following case study. This case was identified during file reviews to determine what proportion of inmates received treatment. JLARC staff found that some inmates that had been identified as having substance abuse problems were not recommended for treatment by their counselors.

A 31-year-old inmate was serving a four-year sentence for felony shoplifting and possession of stolen property. The inmate's initial treatment plan indicated that he had an occasional problem with alcohol. When the PSI was completed, it indicated a long history of drug use. On the PSI, the parole officer noted that the individual reported that he began his illicit drug use in the form of marijuana at the age of 13. He then began the intravenous injection of Phenemetrizine when he was 17. According to the parole officer, "The inmate utilized this substance on a continuous basis since his late teen years and he has extensive needle track trauma marks on both his forearms." The subject also admitted to the parole officer that he abuses cocaine by inhalation or "snorting." The parole officer noted on the PSI that while the subject "has some degree of insight into his drug-related problem, it appears that he has done little to deal with this problem."

The counselor who prepared the treatment plan recommended only that the inmate participate in Alcoholics Anonymous because "alcohol does appear to be a problem with this subject."

The inmate's institutional progress report, which was prepared in 1990, the year the inmate became eligible for parole, also does not recommend substance abuse therapy. The counselor who prepared the report noted, "The inmate does not have a drug or alcohol problem; therefore, he doesn't participate in [Alcoholics Anonymous] or [Narcotics Anonymous]."

If the department used an assessment tool to determine whether inmates have substance abuse problems at the time they are received into corrections, this type problem would be avoided. This instrument does not have to be based on the PSI, which may not be available at the initial assessment, and counselors in the prisons and field units would not be forced to duplicate the assessments conducted at the reception centers.

Staff at one of the major prisons have developed their own assessment and screening tool because of a lack of faith in the State's system. One of these staff members stated that she wished the department would develop something similar for statewide use. "The only reason we have the screening is because one of the staff members here happened to have the initiative and expertise to develop this component of the program."

Assessment Tool Associated with Federal Grant. The Department of Corrections included the use of a standardized assessment tool as part of its proposal to the Department of Criminal Justice Services for substance abuse federal grant funds. On the grant application, DOC indicated that one of the project objectives was to "provide a formal assessment of inmate drug and alcohol use, misuse, and abuse behaviors along with treatment planning during and after incarceration." In order to meet this objective, DOC officials decided to use an assessment tool referred to as COMPASS for the seven substance abuse programs funded by the grant.

According to DOC staff, the department does not plan to use this or any other assessment instrument on a statewide basis. Attempts to mandate the use of COMPASS were met with resistance from counseling treatment staff in DOC's receptions centers. The counselors complained that the instrument was too time consuming to implement. Due to these complaints, DOC's central office decided against using the instrument outside of the grant funded programs.

One staff member familiar with the assessment tool indicated that he would like to see COMPASS mandated for continued use in all reception centers. He pointed out that although the questionnaire takes 40 minutes to complete, it can be administered to a large group of inmates at once. Most inmates can complete the instrument with only brief instructions provided by the counselors. For those inmates who have trouble understanding the instrument or who cannot read, the questionnaire could be read to them by clerical staff or by a corrections officer. This staff member pointed out that a corrections officer must be present anyway if the questionnaire is administered to a large group of inmates.

Recommendation (5). To facilitate an appropriate determination of treatment needs, the Board of Corrections should require the Department of Corrections to adopt a uniform assessment instrument to be used at the time of an inmate's initial classification.

Identifying Sex Offenders

The process used by the department to ascertain whether an inmate has exhibited sexually deviant behavior requiring treatment also has problems. Currently the identification is based strictly on the inmate's past and current offenses. If the inmate has committed a sex-related crime, a recommendation will be made for participation in a sex offender treatment program.

This method of determining the need for sex offender treatment, however, overlooks those inmates whose commitment offense simply does not give evidence of any

sexually deviant behavior that may have been a part of their past. One sex offender therapist stated similar reasons against using the inmate's offense as the trigger to identify sex offenders. He suggested that the PSI reports provide a better picture of those inmates who are sexual deviants. For all cases, it was recommended that the counselors look carefully at the PSI and any other documents in the inmate's file that discuss the circumstances of the crime and his social background.

Recommendation (6). The Department of Corrections should require that counselors look for any evidence of sexual deviancies and not rely exclusively on offense history in making recommendations for treatment of sexual problems.

FACTORS AFFECTING THE IMPLEMENTATION OF TREATMENT PROGRAMS

Another objective of this study was to systematically assess what, if any, factors are present in the prisons and field units which work against the development of quality treatment programs. To determine this, JLARC staff surveyed counselors at each facility regarding issues of workload and the training provided by DOC's central office staff.

The study results indicate that a number of factors impede the development and implementation of effective treatment programs. Among these are the lack of resources for additional counselor positions, insufficient staff qualifications and training, and excessive counselor case management duties.

Counselor Caseload and Duties

Two consistent complaints voiced by counselors during the JLARC parole study were that they had too many inmates on their caseloads and they were overwhelmed with case management duties. This, they stated, made it difficult to both develop and implement treatment programs. The results from this analysis support these positions.

The caseload demands placed on the counselors in DOC's prisons and field units have resulted in the vast majority of counselors performing primarily case management functions. These include conducting evaluations for good time, preparing various inmate reports, and meeting with each inmate on their caseload once per month.

The amount of time spent preparing paperwork for the day-to-day case management of inmates increases as the number of inmates on the counselor's workload increases. Accordingly, because many counselors' caseloads are well above recommended counselor-to-inmate ratios, they can devote little time to developing and implementing treatment programs. While DOC has, in the past, hired two levels of treatment staff — lay counselors for case management and counselors to provide treatment — the elimination of the lay counselor positions has required counselors to take on case management functions.

Counselor-to-Inmate Ratios. In a 1986 report on non-security staffing in the Department of Corrections, JLARC recommended that DOC establish caseloads in the range of 45 to 55 inmates per counselor. Based on this recommendation, the department's goal has been to have one counselor for every 50 inmates. However, the specialization of some counselor positions and recent problems filling vacant job slots has resulted in higher than desirable inmate-to-counselor ratios.

JLARC analysis of data from the Department of Corrections shows that current inmate-to-counselor ratios remain consistently above 50-to-one (Table 3). The state-wide average caseload per counselor is 67 inmates. Only four of the DOC facilities had inmate-to-counselor ratios at or below the stated goal of 50-to-one (15 percent). Fifty-two percent of the facilities had counselor-to-inmate ratios of greater than 55 to one.

These figures do not completely reflect the actual workloads of many counselors. As noted earlier, in some prisons special inmate programs are implemented, and the staff assigned to those activities do not handle cases in the general population. This increases the caseloads for counselors who must work with the general population. For example, in Buckingham the ratio of inmates to counselors is 59 to one. However, treatment staff reported on the JLARC survey that counselors typically work with caseloads of at least 80 inmates.

Counselor Vacancy Rates. Persistent vacancy rates for counselor positions have been a problem for DOC. When prison officials are unable to rapidly fill vacant slots, the workload problems for counselors in the facility are exacerbated. In a time when the prison population is increasing, an inability to rapidly fill position vacancies poses even greater problems.

Data obtained from DOC indicates that since 1990, the vacancy rate for counselor positions at the end of each fiscal year was at least 15 percent (Figure 11). According to one DOC official, this problem has persisted even though the institutions have been allowed to actively recruit counselors for vacant positions during the recent funding reductions. The Statewide impact of this has been substantial. In 1990 for example, the General Assembly authorized the funding of 295 positions. Based on the average number of inmates in State prisons that year, the statewide ratio of inmates to counselors would have been 49. However, due to a vacancy rate at the end of the fiscal year of 20 percent, the average caseload was actually 61 inmates.

Vacancy rates pose particular problems for the small field units. In the Stafford field unit, for example, two counselor positions have been authorized for approximately 110 inmates. Presently, the administration has been unable to fill one of these positions. This means that one counselor is forced to work with the unit's entire inmate population.

Counselor Duties. To determine how their time is currently allocated, JLARC staff sent workload surveys to counselors in all institutions. The categories of job functions used on the worksheet were created based on research conducted during the

Table 3

Ratio of Inmates To Counselors In DOC Institutions

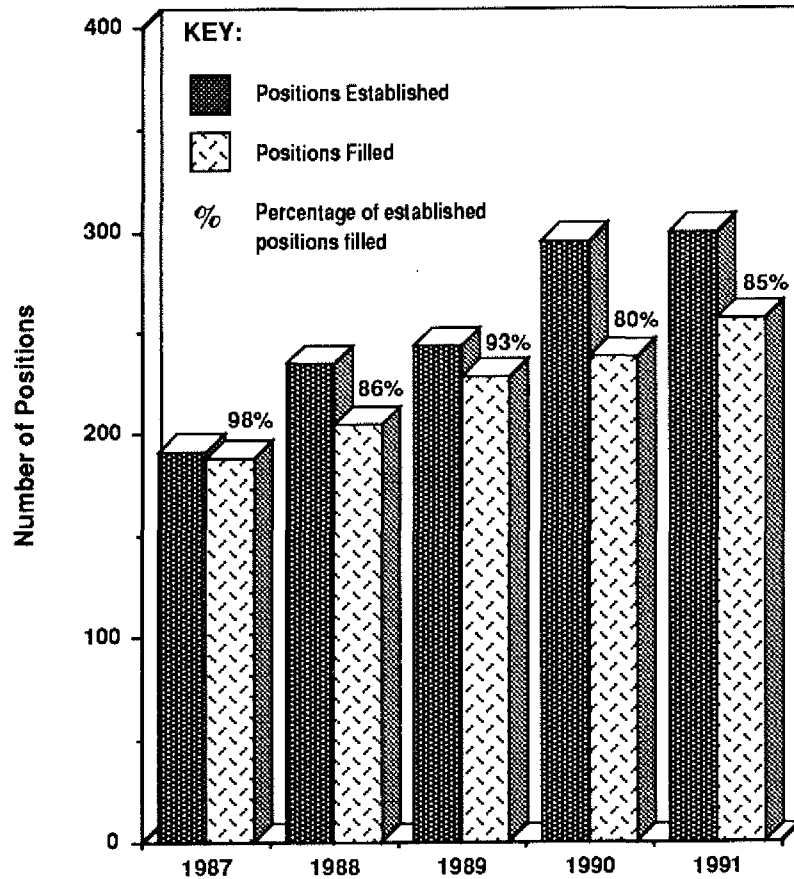
<u>Facility</u>	<u>Number of Inmates Per Counselor</u>
Appalachian	55
Augusta	75
Baskerville	71
Bland	66
Botetourt	54
Brunswick	63
Buckingham	59
Caroline	68
Chatham	54
Cold Springs	55
Dinwiddie	54
Halifax	5
Haynesville	55
Harrisonburg	60
James River	54
Keen Mountain	74
Mecklenburg	46
Nottoway	87
Patrick Henry	68
Pocahontas	63
Powhatan	57
Pulaski	65
Rustburg	67
Smith Mountain	50
St. Brides	58
Southampton	68
Stafford	107
Staunton	48
Tazewell	44
Tidewater	54
VCCW	51
White Post	53
Wise	54
Statewide Ratio	67

Notes: Data for the Greenville prison were not available.

Source: Inmate data provided by the Department of Corrections represents total number of inmates in each facility as of June, 1991. Data on the number of counselors is reported from the JLARC staff surveys.

Figure 11

Number and Percent of Counselor* Positions Filled Compared to Number of Positions Established



*Information is on rehabilitation counselors, supervisors, and treatment program supervisor positions.

Source: Department of Corrections Fiscal Statement.

parole study and interviews with counselors. On these surveys, counselors were asked to estimate the amount of time spent on each of the following activities in a given week:

- preparing reports such as the treatment plans, progress reports, and good time evaluations;
- conducting individual counseling sessions;
- participating on institutional committees; and
- developing and implementing treatment programs.

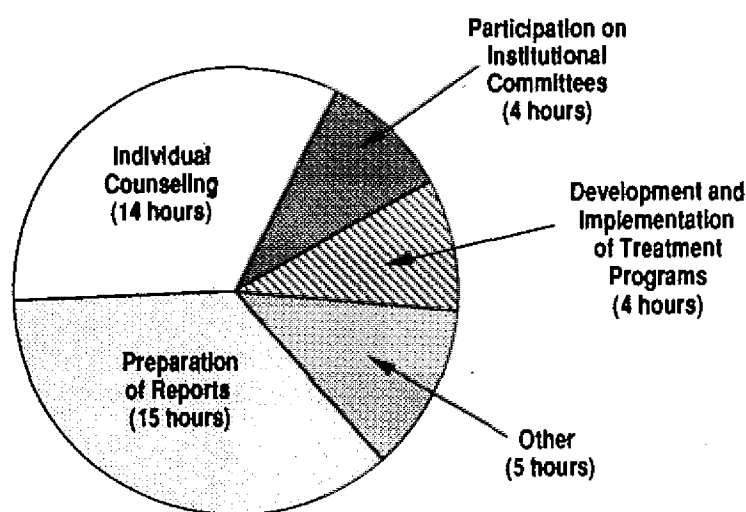
The response rate for the survey was 91 percent. Based on an analysis of these data, it appears that the magnitude of their caseloads and subsequent case management responsibilities leave counselors little time to develop and implement treatment programs. In a typical work week, counselors are able to spend only four hours on this activity (Figure 12).

The majority of the counselors' time is spent preparing reports (14 hours) mandated by department policy. In addition to these requirements, counselors also must meet with each inmate on their caseloads at least once a month. On average, counselors spend 13 hours per week on this activity. The remainder of the counselors' time is split almost evenly between developing programs and various other miscellaneous activities (5 hours).

Counselors told JLARC staff that while they recognize that more time needs to be devoted to the development of treatment programs, they must give first priority to mandated activities. Some counselors indicated that in order to adequately prepare for the programs that are offered, they must spend time at home developing program plans.

Figure 12

Average Number of Hours Spent on Counseling* Duties



Average hours worked in typical week = 42

*These figures do not include counselor or treatment program supervisors.

Source: JLARC staff analysis of DOC data from surveys of DOC Counselors.

Two-tiered Treatment System. The American Correctional Association (ACA) identifies staffing guidelines for correctional institutions. The ACA recommends that correctional facilities have two tiers of treatment staff — case managers and counselors. Under this system, the case managers are primarily responsible for administrative functions associated with the management of the inmates on their caseloads. The counselors, on the other hand, are responsible for providing rehabilitative services.

In 1975, the Department of Corrections instituted a system similar to that recommended by the ACA. Under this system, DOC hired both rehabilitation counselors and lay counselors. The lay counselors functioned in the capacity of case managers, while the rehabilitation counselors were responsible for the development and implementation of treatment plans and programs. The intent of this two-tiered system was to ensure that the treatment needs of inmates were not sacrificed to the administrative requirements of case management.

As the department moved away from the two-tiered system of staffing for treatment positions, it has experienced difficulty providing treatment services to those inmates who need them. Instead, counselors in the prisons and field units have been overwhelmed by case management functions. As one treatment program supervisor stated, “Caseloads and case management responsibilities need to be reduced substantially to allow adequate time for quality counseling and therapy sessions. Without these changes the quality and quantity of counseling will not change.”

Recommendation (7). The Department of Corrections should, based on its average daily inmate population, determine the number of case managers that would be needed to meet a ratio of 50 inmates per one case manager in each correctional facility. The department should also identify the number of counselors that would be required to implement a multi-tiered treatment system for substance abusers and sex offenders. The results of this analysis should be presented to the Board of Corrections as part of the Department’s plans for developing a treatment system.

Training for Counselors

While a reduction in caseload would allow the counselors more time to develop and implement treatment programs, there is some question as to whether they possess the qualifications necessary to do so. There is no consensus on what levels of experience and education should be exhibited to lead substance abuse and sex offender programs. However, JLARC staff interviewed six different treatment experts regarding the issue of counselor qualifications. Five of these treatment experts felt that in order to lead therapy groups, counselors should have at a minimum, a bachelor’s degree in a human services related field and supplemental experience or training in the development and implementation of treatment programs.

The department’s current hiring policy for counselors recommends that the applicant have a degree from an accredited college or university with course work in a human services field. It also suggests that applicants should have experience in

counseling, rehabilitation, or case management. However, because of the personnel policies of the Department of Personnel and Training, DOC is prohibited from establishing these qualifications as absolute requirements for employment. Instead, the department must, at times, accept an applicant's equivalent combination of experience and training as a substitute for a college degree. Even with this policy, DOC officials emphasize that before anyone without a college degree is hired as a counselor, it must be approved by the director.

Because case management duties are a major responsibility of the counselors, it is possible for persons who do not have a human service related degree or experience running treatment programs to be qualified as a rehabilitation counselor. While the majority of DOC counselors possess degrees in human services related fields, data from the JLARC survey reveals that 16 percent of the counselors have backgrounds that are completely unrelated to this area. For example, four counselors have only high school diplomas, two have degrees in music, another two have business degrees, and five have associate degrees. In one facility, nine of the 10 counselors have degrees in fields that are not related to counseling.

According to one treatment program supervisor, the lack of qualified treatment staff has contributed to a general lack of professionalism on the part of many of his counselors. He stated that the majority of counselors on his staff were pulled from their positions as correctional officers and do not have any experience in counseling. In addition, he stated that it is only because of the efforts of a few dedicated treatment staff that his facility has quality treatment programs.

No Training Policy for Counselors. The lack of stringent requirements for counselor qualifications points to the need for department-provided training in the development and implementation of treatment programs. According to one staff member, budget cuts "have gutted" most of the non-case management training that has traditionally been provided through DOC's training academy. However, there is little indication that training to develop counselor skills has been a priority of DOC. Prior to funding reductions, there was no departmental policy requiring training in the development and implementation of treatment programs.

Upon being hired, counselors are required to complete 80 hours of training to orient them to the policies and procedures of the department. This training provides an introduction to such areas as inmate classification, the parole process, security procedures, and grievances. However, it provides very little in the way of training for the provision of treatment programs.

Beyond this basic training, counselors must apply for supplemental training on their own initiative — either through the department or through external sources. There are questions, however, about the quality of the training in the area of treatment that is provided by the department.

When asked how they would rate the quality of the department's training for substance abuse and sex offender services, 57 percent of all of the treatment staff surveyed stated that the training was of average quality. Another 11 percent thought the

training was either below average or poor. The most frequent complaint of the counselors was that the training provided by the department was too general and that it should be more intensive. Other comments by four different treatment staff regarding training were:

Counselors need much more in-depth training for the treatment programs we facilitate Training for such programs is very sketchy and condensed. We need in-depth, intensive and on-going training to render treatment and therapy in group settings.

* * *

Most training has been somewhat superficial because the trainers lack depth themselves in the areas that could be most helpful to those being counseled.

* * *

Training is insufficient to provide [the] means to address the many problems of the inmate population.

* * *

Training is general in context. However, for [counselors] to project the level of expertise needed . . . more intensive training with an expert in the specific area needs to be offered.

Implications of Inadequate Training

Without training to supplement the education and experience of counselors, the quality of treatment programs in the Department of Corrections will suffer. It is unreasonable to expect counselors who have not had any exposure to the development and implementation of treatment programs to provide programs that will meet the treatment needs of inmates with severe substance abuse or sexual problems.

Although the current budget situation is obviously an impediment to the provision of training in the short-run, DOC has done little in terms of planning for training over the long term. One DOC official noted that despite budget cuts, standards are being written for security training in adult institutions. He stated that this is being done in anticipation of when training can be provided again. Similar standards, however, have not been developed in the area of treatment.

Recommendation (8). In establishing two tiers of counseling, the Department of Corrections should develop position qualifications which make the appropriate distinctions between the responsibilities of case managers and those of counselors. Additionally, the department should conduct a thorough

assessment of its training and develop policies which specify the education and training requirements for counselors who will develop and implement treatment programs.

Recommendation (9). To provide additional training and consulting services to treatment staff in prisons and field units, the Department of Corrections' should explore the following two options: (1) developing service agreements with State universities and (2) contracting with persons who specialize in therapeutic counseling to provide workshops for treatment staff in the four regions.

THE LINK BETWEEN TREATMENT PROGRAMS, GOOD TIME, AND PAROLE

The current good-time system was created to establish a more direct link between inmate participation in treatment programs and the amount of good time earnings they receive. Other factors being equal, inmates who address their treatment needs through participation in programs should receive larger prison term reductions for purposes of parole eligibility. Similarly, because participation in treatment should lead to a reduced risk of recidivism, inmates who have completed these programs in DOC should be more likely to be released on parole.

Relationship Between Good Time and Treatment Programs

In 1981, the General Assembly redefined the role of good time in Virginia by passing Section 53.1-201 of the *Code of Virginia*. This law established a good conduct allowance (GCA) system and required DOC to determine inmates' good time earnings based on an objective and comprehensive assessment of the inmates' behavior and progress towards rehabilitation.

The establishment of a link between the accrual of good time and evidence of rehabilitation was intended to serve as an incentive for inmates to participate in programs. Under this new system, inmates who show strong evidence of rehabilitation could reduce the amount of time to be served until parole eligibility by significantly larger amounts than inmates who refuse to take part in programs.

In practice, however, present DOC policies allow inmates who refuse treatment to continue receiving the highest levels of good time (30 days of good time for every 30 days served). A review of inmate files revealed that this was a particular problem for sex offenders. Specifically, 95 percent of the inmates who were recommended for sex offender treatment programs but refused to participate still maintained the highest level of good time. The following describes two such cases:

*An inmate was serving a 10-year sentence for sexual assault and rape.
The inmate's treatment plan recommended that he participate in a sex*

offender program. The inmate, however, refused. The progress report indicated that the inmate "remains infraction free, receives highly satisfactory housing evaluations, and has maintained a work assignment for nine months." In addition, the inmate received exemplary evaluations in the Literacy Incentive Program. According to the counselor, "About the only thing [the inmate] has not done is sign up for the sex offender program. This program has been mentioned to him in almost every counseling session. He chooses not to participate because he feels he is not a sex offender, despite the fact that he is currently incarcerated for a rape conviction." At the time this progress report was developed the inmate was still in GCA class I.

* * *

Another inmate is serving a 20-year sentence for rape, forcible sodomy and grand larceny. He has been in the highest GCA class since 1987. The progress report indicates that the inmate is "very obedient of rules and regulations, is not a trouble maker and shows no sign of aggressiveness. However, it appears his real problems concerning sexual deviancy have not been addressed. [The inmate] denies guilt in the sex charges, and is not receptive to sex offender therapy."

Policy Revisions and Compliance Monitoring Needed. One source of this problem is DOC's good time policy. Given the minimum number of points that are awarded for participation in treatment (20 points), inmates can earn the maximum scores in all other areas and have enough points to place them in GCA level I without participating in treatment. The policy does allow counselors to override an inmate's GCA score on the basis of any of six factors. One of these factors includes situations where an inmate's "point score in one area of evaluation is inordinately high or low affecting the GCA class level."

DOC officials conceded that overrides should be used to lower the GCA scores when inmates refuse treatment. However, this is a discretionary decision of prison staff. One DOC official stated that it is up to the institutional staff to ensure that the override system is utilized in these situations. He noted that DOC does not have any internal controls procedure outside of the institutions to determine whether inmates are being placed in appropriate GCA classes.

Under such conditions, the department is unable, in a timely and effective way, to monitor how institutional staff are using their discretionary authority to make adjustments to inmate good time. This partially undermines the five-year effort of the department to establish administrative procedures to govern the awarding of inmate good time.

Recommendation (10). The Department of Corrections should develop a policy that specifically prohibits inmates who refuse treatment from being placed in the highest levels of good time. In addition, the department should

develop compliance review procedures to routinely monitor the performance of institutional staff in implementing this and other policies for the good-time system.

Relationship Between Treatment Programs and Parole Release

One reason for expediting inmates' parole eligibility dates on the basis of their prison rehabilitation efforts is to increase their chances of first receiving, then succeeding on, parole. To determine if a relationship existed between participating in treatment and receiving parole, JLARC staff reviewed the parole status of a representative sample of inmates who needed treatment when they were initially incarcerated. Controls for the influence of prison misconduct on an inmate's parole chances were applied by selecting only those persons with at least the second highest good time earnings level.

Data from this study indicate that for inmates with substance abuse problems there is a relationship between inmates' participation in treatment programs and their likelihood of being released on parole at their first date of eligibility (Table 4). Substance abusers who received treatment had a 70 percent chance of being paroled. This compares to 51 percent for similar inmates who did not receive any treatment.

Table 4

Discretionary Parole Rates for Inmates According to Whether Treatment was Received at Time of First Parole Interview

<u>Treatment Received</u>	<u>Discretionary Parole Status</u>	
	<u>Granted</u>	<u>Not Granted</u>
Substance Abusers		
Treatment Received	70%	30%
No Treatment	51%	49%
Sex Offenders		
Treatment Received	17%	83%
No Treatment	5%	95%

Notes: The figures reported for substance abusers are based on a sample of 335 cases. The chi-square value for this relationship was 9.069, which was significant at a level of five percent. The figures reported for sex offenders are based on a sample of 50 cases. The chi-square value for this relationship (1.616) was not significant at a level of 10 percent. Figures do not include cases in which data on parole status or type of treatment received were unavailable.

Source: JLARC analysis of data from DOC treatment plans, progress reports and automated inmate files.

Although a similar pattern is observed for sex offenders, the rate of parole for this group across different categories of the treatment variable is substantially lower and is not statistically significant. For example, only 17 percent of the sex offenders who received treatment were granted a discretionary release by the Parole Board.

Comparatively, four percent of the sex offenders who failed to receive treatment were released by the Parole Board. As was discovered in the JLARC study of the parole process, the serious nature of sex offense crimes often results in Board members denying parole to this group of inmates regardless of the treatment received.

Stronger Links Are Possible. According to one Parole Board member, an attempt is made to consider treatment received by inmates as a part of the review process. However, this member noted that this is made difficult because of inadequacies in the treatment system. It was noted that the Board often “must determine if DOC has properly identified the inmate’s treatment needs and assess whether those needs have been met.”

While admitting that the serious nature of the crimes will prevent some inmates from ever being discretionarily paroled, this member stated that stronger links should exist between the two agencies. Before this can happen, it was stated, certain changes must take place in the system.

A major concern expressed was the inconsistency across prisons and field units in the level and quality of DOC services. The Board member stated that, because of this and perceived problems with treatment in the department, the Board is not entirely convinced of the efficacy of many of the programs.

Another problem cited was the department’s failure to notify and work with the Parole Board when special treatment programs like therapeutic communities are being established. This member stated, “It does not make sense to place inmates in these type programs [where the success of program is partially based on timing the completion of the treatment with the inmate’s release from prison] if the Board does have sufficient information to adequately consider the treatment in the decisionmaking. This happens when programs are planned and operated in a vacuum.”

Recommendation (11). The Department of Corrections should work with the Parole Board to develop an interagency agreement that includes guidelines for conditioning the release of some inmates on successful participation in specific treatment programs. These guidelines should specify how the inmates’ needs assessments will be conducted, describe the services they will be provided, and identify inmate program performance measures that can be used by the Board to assess the quality of the inmates’ participation.

CONCLUSIONS

The number of inmates who need treatment for either substance abuse or sexually deviant behavior is substantial. While Department of Corrections' officials recognize and understand the nature of the problem, no system has been established to effectively treat these inmates.

The current array of programs are patchwork strategies that result in an inconsistent and fragmented service delivery. Many inmates are not able to gain access to treatment, and for a substantial number who do receive treatment, the services are limited.

Any policy efforts that are established to improve the system must give attention to funding problems, excessive case management responsibilities for counselors, an uneven quality of treatment due to a lack of program standards, and the substantial training needs of counseling staff.

However, if improvements are made to the treatment system, there is a strong possibility that better linkages can be established between the Department of Corrections and the Parole Board. One possible benefit of this could be a long-term reduction in problems of prison overcrowding.

Appendix:

Agency Responses

As part of an extensive data validation process, the major State agencies involved in a JLARC assessment effort are given an opportunity to comment on an exposure draft of the report. Appropriate technical corrections resulting from the written comments have been made in this version of the report. Page references in the agency responses relate to an earlier exposure draft and may not correspond to page numbers in this version of the report.

This appendix contains the following responses:

- Virginia Parole Board
- Secretary of Public Safety
- Department of Corrections



COMMONWEALTH of VIRGINIA

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September 3, 1991

Mr. Philip A. Leone, Director
Joint Legislative Audit and Review Commission
Suite 1100, General Assembly Building, Capitol Square
Richmond, VA 23219

Dear Mr. Leone:

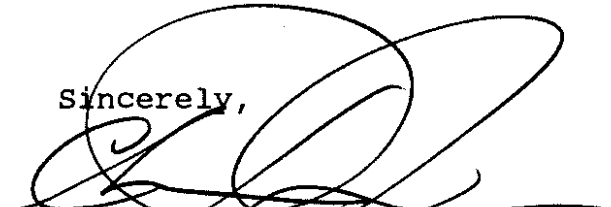
I wish to express appreciation for having the opportunity to offer my comments on your staff's exposure draft, Treatment Services for Parole Eligible Inmates.

For the record, the Virginia Parole Board supports any effort that serves to enhance treatment and programs to inmates in Virginia's prisons and that results in our having the best data available on cases up for review by the Board. Therefore, after having reviewed the report, I found that many of the recommendations would provide increased treatment coverage to inmates and would also compliment several initiatives of this agency.

I would like to commend the JLARC staff for the manner in which they conducted the study. I view some of the recommendations as another means to improve Virginia's parole process.

With kind regards, I remain

Sincerely,



Clarence L. Jackson, Jr.
Chairman

CLJJr:gb



COMMONWEALTH of VIRGINIA

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September 9, 1991

Mr. Philip A. Leone, Director
Joint Legislative Audit and
Review Commission
Suite 1000
General Assembly Building
Richmond, Virginia 23219

Dear Mr. Leone:

Thank you for your letter of August 28, 1991 and the accompanying draft of your report on Treatment Services for Parole Eligible Inmates. I am pleased that you have provided an opportunity for my staff to review this document and to comment on the findings and recommendations which have been made.

Their review indicates that they are in agreement with many of the findings in the report and, in fact have promoted similar programs in past years.

For example, the two-tiered counseling system, which the report recommends, is similar to the system employed by the Department of Corrections in the 1970's, when lay counselors were used. This system, which could not be sustained due to lack of funding, was subsequently discontinued.

JLARC also recommends that the Department implement a comprehensive program that includes education and intensive group therapy as the major treatment interventions. The Department also supports this recommendation; however, we are sure that JLARC recognizes that there are many competing priorities which could result in lawsuits, if not properly addressed. These priorities include mental health, basic health services, dental care, and classification for all inmates.


The Department does have some concern with factual data and there are some points of disagreement regarding some of the findings in the report. An example of this would be the aspect of the report which states that planning does not take place at a centralized level. Further examples are discussed at length in a companion document.

Mr. Philip A. Leone
September 9, 1991
Page Two

The Department is generally pleased to note that JLARC has reached some of the same positions that it (the Department) has been espousing for years and hopes that JLARC will lend support to the Department's efforts in seeking funding for the various recommendations which are made - especially Recommendations 7 and 8, which call for a system of two-tiered counseling.

Again, thank you for providing the opportunity to comment on the report. We hope that we may now have an opportunity to implement some of the programs which have long been pursued and to provide better treatment as well as basic health services for inmates. We are all in agreement that this is certainly desirable, providing that the aforementioned priorities are not compromised.

Sincerely,


Robert L. Suthard

RLS/dla



COMMONWEALTH of VIRGINIA

Department of Corrections

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September 5, 1991

Mr. Philip A. Leone, Director
Joint Legislative Audit and Review Commission
Suite 1000, General Assembly Building
Richmond, Virginia 23219

Dear Mr. Leone:

I appreciate receipt of the exposure draft prepared by JLARC, which addresses Treatment Services for Parole Eligible Inmates. I and my staff have had an opportunity to review this document and are pleased to note that many of the recommendations made are those which the Department of Corrections has been pursuing for a number of years.

For example, the two-tiered counseling system which is recommended was recognized and tried by us, but could not be sustained because of a lack of funding. JLARC also recommends that the Department implement a comprehensive program that includes education and intensive group therapy as the major treatment interventions. The Department also supports this recommendation.

The report does not seem to recognize the intense competition between programmatic alternatives facing the Department from 1985 to 1991. Given the very real issue of litigation, inmate rights, and an expanding population, the Department was forced to choose, and consequently has focused on, the programmatic issues of mental health, basic health services, dental care, and a strong classification system.

We do have strong concerns regarding the issue of factual data and there are some points of disagreement regarding some of the findings in the report. We have discussed these at length in a companion document.

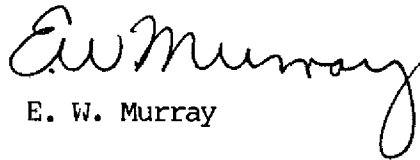
As an example, we differ on the aspect of the report which states that planning does not take place at a centralized level. We also are not given credit for some of the ideas that are proffered. However, we are pleased to note that JLARC has reached some of the same positions that the Department has been espousing for years. Consequently, we hope that JLARC will support us in the restoration of those dollars lost during the budget reduction process and those additional funds needed to implement the recommendations which are made - especially Recommendations 7 and 8, which call for a system of two-tiered counseling.

Mr. Philip A. Leone
September 5, 1991
Page Two

Again, we are pleased to have an opportunity to comment on the report and look forward to the prospect of JLARC's support in approaching the General Assembly for those dollars needed to implement the recommendations. We may now have an opportunity to implement some of the programs which we have long pursued, for the Department has repeatedly requested additional funding for programs as well as for capital construction to provide additional space for needed services.

We will be happy to sit down and work with members of JLARC in coming up with budget amendments to meet the recommendations which are now being offered.

Sincerely,

A handwritten signature in cursive script, reading "E. W. Murray". The signature is written in dark ink and is positioned above the printed name.

E. W. Murray

EWM/bh

DOC Response to JLARC Report "Treatment Services for Parole
Eligible Inmates" August 28, 1991 Exposure Draft

OVERVIEW

A review of the August 28, 1991 exposure draft "Treatment Services for Parole Eligible Inmates" reveals that the report portrays the Department of Corrections (DOC) as having provided an inadequately planned and directed treatment program system for Substance Abuse and Sex Offenders when, in spite of significant budgets cuts, severe overcrowding and growth, there were key initiatives and accomplishments:

The JLARC report places little significance on the major redirection of policy and practice in the inmate case-management and treatment-planning process. This includes the creation of a new correctional mental health treatment program that was recently recognized and licensed by the Department of Mental Health, Mental Retardation and Substance Abuse Services; the major accomplishments mandated by the General Assembly; such, as the creation of a Prison Bootcamp Program, a revamped Work Release program, revisions to the Youthful Offender Treatment Program, the regional and local jails inmate classification program; and DOC initiatives; such as, creating divisional and regional program managers, and many other recent new developments.

The report states that DOC needs to develop a three-tiered treatment system for substance abuse. However, in actuality the design of the current substance abuse delivery system is a multi-tiered model. Over the past two and a half years, state and nationally recognized consultants have worked extensively on contract for the DOC to develop a multi-tiered substance abuse program. Model programs are operating in several DOC facilities. It is difficult to understand how this could be construed as a lack of guidance and direction. Currently there are intensive 24-hour drug treatment programs, intensive substance counseling programs, educational programs and peer support groups based on the 12 step AA/NA model. In addition, there are mandated counselor training programs in substance abuse treatment. Additionally, extensive educational and treatment resources have been purchased and distributed to the programs in the field by the central office substance program coordinator. Similar efforts, but to a lesser degree, have occurred with the sex offender treatment programs.

In another area, the JLARC report places little recognition on the value or importance of the many other types of inmate programs. In order to maintain a stable operating environment and to meet the numerous needs and problems of inmates, there are about 300 programs covering a wide range of topics such as anger management, prerelease preparation, leisure time skills development,

lifeskills, work, and vocational and education activities. The report fails to note that these programs are also important to develop and refine. These programs should not be discounted. Inmates gain important skills and develop critical attitudes important to their preparation for the future. We believe the results from these programs are also important and of interest to the Parole Board.

The JLARC report critiques the DOC central office for a "dearth of DOC policies for treatment programs". However, most of the 800 series DOPs deal with policies related to inmate programming, as do the Director's Initiatives and the Deputy Director's annual objectives which outline various policy directions. The JLARC report critiques the 1990-91 Goals and Objectives (page 37) which are a clear statement of policy, thereby contradicting the allegations that there is a lack of policy direction. In another area, the Divisional Programs Manager and the Regional Program Managers were recently created positions that have a clear mandate to assist in the development of treatment policy. These positions have been instrumental in developing the 1991-92 goals and objectives which again articulate the general policy directions for treatment programs.

The program policy advisory committees (noted in the Report as PAC, SOPAC, DOPAC) were created by the administration as important management tools to insure that field input is included in management decisions and treatment policy development. The first two of these committees have created recommended goals and objectives, a program model, program standards, and training activities. These activities have been encouraged and supported by management as an effective tool in program development.

Another statement by JLARC (page 44) critiques the planning process as "ineffective" and describes it as "bottom-up", "unwieldy", "with limited direction from central DOC staff", yet the Report clearly documents that there are regular monthly meetings between the Program Managers and the central office staff. Also, as noted above, there is a clear interaction between upper management and the field by the utilization of various state and regional program advisory committees.

The report barely acknowledges the issue of funding initiatives. Over the past several bienniums the DOC has submitted a number of treatment related funding requests. There have been proposals developed for substance abuse in excess of two million dollars which were unfunded with general funds and supported by only very limited grant funding. Also, initiatives have been submitted for sex offender treatment (unfunded), inmate work programs (seriously underfunded), mental health treatment, and health services. Due to the \$36 million budget reduction in this biennium alone, the impact upon treatment programs has been significant. JLARC should recognize that reductions in staff training are directly attributable to budget cuts over the last biennium. Many of the report's recommendations to create policies for program standards,

to develop assessment techniques, program models, and additional training cannot be implemented without additional staff and dollars.

In spite of our concerns with accuracy of the report's findings, JLARC's recommendations are appropriate. The recommendations are similar to objectives developed by the DOC and are key steps towards refining treatment programs and effectively communicating with the Virginia Parole Board. It should be stressed that for DOC to implement these recommendations, significant additional resources must be provided by the General Assembly.

The remainder of this response includes an in-depth page by page reaction to the exposure draft and recommendations.

Specific Comments:

Page 1 The report claims to be a "study of DOC's system for delivering counseling and treatment". In fact, JLARC's study addresses only substance abuse and sex offender services. The Department's counseling and treatment services are much broader and include key programs of work, mental health, prerelease, health services, classification, and a myriad of special programs such as anger control and life skills.

Page 6 It is an oversimplification to state "it is the responsibility of institutional counselors to develop and implement treatment programs within each correctional facility". Institutional staffing includes Assistant Wardens for Programs, Treatment Program Supervisors, Psychologists, and at some sites, Counselor Supervisors, who support program development and implementation. Additionally, technical assistance is provided by the Regional Program Managers, the Divisional Program Manager, the Chief of Operations/Programs, and other consultants.

Page 7 The first paragraph neglects to mention the key DOC programs of work, mental health, classification, and health services.

The last paragraph states that the House of Thought was closed in 1982 because of budget problems and the need for bedspace. This is incorrect. Bedspace was not an issue in the closing. The House of Thought was closed due to statewide agency budget reductions.

Page 9 In addition to the federally grant funded Substance Abuse Therapeutic Communities at Staunton and Botetourt facilities, the DOC operates a 48 bed therapeutic community at the Virginia Correctional Center for Women.

Page 12 It is misleading to report that the Coordinator of Sex

Offender Treatment Program position was eliminated in 1987. The position was redefined and expanded to encompass other major program areas of substance abuse, work, recreation, and counseling services.

It is important to note that the psychologist who developed the model sex offender program is the Chairman of the Sex Offender Program Action Committee (SOPAC). The model is based on national models, and includes input from the model programs operating at Buckingham and Staunton Correctional Centers.

- Page 13 There are 70 good time performance points for programs when the programs of work and education are included.
- Page 14 The chart shows the Adjustment Committee only having input to the Institutional Classification Committee. Counselors consider Adjustment Committee reports when computing good time awards and it should be shown as a fifth area of consideration by the counselor.
- Page 15 It is misleading to state that small relative weight is given to "treatment" on the good time points. When the program categories of education and work are included, program participation monopolizes 70 points of the good time point scale.
- Page 23 The statement that "DOC has not adequately planned and implemented a system of inmate treatment services due to other programming priorities" underscores the DOC's limited resources. It is because resources are lacking that the Department has to determine difficult priorities among competing needs.

It is misleading to imply that the money appropriated for treatment services has been inadequately used. These funds are for counselor positions, who function primarily as case managers. The report reflects the assumption that counselors were hired primarily for programs. However, approximately seventy percent of the Counselor's job description includes case management duties. Case management is an important program which entails the identification of treatment needs, monitoring progress towards objectives, awarding good time, reducing or increasing custody, providing the Parole Board with Progress Reports, and transferring inmates to suitable institutions. In 1982, the General Assembly approved funding for 28 additional counseling positions to improve counselor caseloads in field units and some major facilities. However, there will be a need to fund additional counselor positions to improve services as recommended by JLARC.

Also, the statement that policies are lacking is

inaccurate. Over thirty division procedures are in place to direct case management. Additionally, written procedures also address inmate treatment programming and program development and operation.

Page 24 This section acknowledges the planning and policy development structure for inmate programming, which appears to contradict earlier statements in the report that DOC did not have such a plan.

The first paragraph is incorrect and fails to accurately describe the DOC's planning process. Planning occurs "at the top" with input from field staff. The committee formed by the Chief of Operations/Programs did include field staff, but also included the following central office staff: Divisional Program Manager, two Corrections Analysts (planners), the Executive Assistant to the Director, the Administrative Assistant to the Deputy Director, and the Mental Health Program Director.

The second paragraph reflects a misunderstanding of the DOC's planning process. The report does not recognize DOC's treatment system, which is larger than substance abuse or sex offender services. Additionally, the report fails to consider the job scope of the Chief of Operations, which includes, in addition to noted services, the key program areas of mental health, medical services, classification, volunteer services, religious services, recreation programs, and counseling programs such as anger control and life skills.

Over the past five years, the Chief of Operations/Programs has made major progress in program development. The following lists some of the accomplishments: revision of the 800 series Division Operating Procedures, including key changes in the inmate review cycle, the good time points system to require program participation, identification of primary and secondary treatment needs, and a progress report that recognized program participation; development of the mental health program including establishing a licensed mental health facility within DOC; planning and administering a federal substance abuse grant; establishing a Division Program Manager and Regional Program Managers; revamping the work release program with heavy program emphasis; creating the Program Advisory Committee to establish annual goals; creating the Boot Camp Program; creating a directory of programs throughout DOC; creating Division Operating Procedure 832 requiring annual reporting of programs; liaison with the Department of Correctional Education to ensure educational services are provided; and providing annual training to sex offender providers, family program sponsors, and recreators.

The second paragraph states that under 70 percent of the goals and objectives were met. Actually, substantial progress has been made in 10 of the 16 objectives noted. The Division's goal was to meet 60 percent of all goals and objectives.

The last paragraph omits Classification, which is a key program area targeted to benefit from increased planning. This Unit, which is under the direction of the Chief of Operations/Programs, is responsible for inmate transfers, custody assignments, good time awards, and file maintenance.

Page 25 The section headed "The Initial Planning Activities of the Department of Corrections" is inaccurate. The Department's initial planning activities were focused on the development of treatment services by ensuring classification systems were supportive. These classification systems included good time awards, counselor review of inmate needs, program assignments, custody assignments, and transfers. For the treatment system to be effective, and for institutions to operate smoothly, classification processes must first be in place and supportive of programming. When resources are limited, constitutionally mandated services, such as mental health and medical services, must be the first priority.

Page 26 Again the report reflects a misunderstanding of correctional policy by stating that Exhibit 1 illustrates that DOC's focus was directed towards improving case management rather than treatment services. Case management is a part of programming and cannot be separated from treatment services. Additionally, the Exhibit contradicts the report's conclusions since the last four program areas noted in Exhibit 1 are related to treatment services. The Exhibit fails to report SOPAC's concurrent training and program development activities, as well as the creation of the Program Manager Position.

Page 27 The first paragraph contradicts Exhibit 1 by stating that the substance abuse grant was not part of the planning process. The substance abuse grant was a program planning priority of the Chief of Operation/Programs.

The second paragraph shows a misunderstanding of correctional issues. The Department's initial planning activities were focused on the development of treatment services. For the treatment system to be effective, classification processes must first be in place and supportive of programming. Constitutionally mandated mental health and health services must be provided

before a correctional system can develop substance abuse and sex offender services.

The third paragraph also shows a misunderstanding of the role of correctional case management. Case management is extremely important to support programming, to track and document inmate needs and progress, and for inmate management, institutional security, and public safety.

It is erroneous to state that neither program planning nor the delivery of sex offender and substance abuse treatment began until 1989. The Sex Offender Program Action Committee (SOPAC) was meeting and the model programs were operating at Bland, Staunton, and Buckingham Correctional Centers. Additionally, the substance abuse grant was planned and developed during 1987 - 1988.

Page 30 The criticism of the DOC for not establishing timelines is unfounded. The Program Mission Goals and Objectives for 1990-1991 establish timelines for developing a system of treatment services. The Goals and Objectives document goals and objective timelines for centralized assessment of program needs, program standards, evaluation, and staff credentials and training. It should be noted there is a later contradiction in JLARC's report when the DOC is criticized for not achieving all the deadlines of the goals and objectives.

Additionally, "DOC management" reviewed and accepted the document and they were made a part of the Deputy Director's Division Objectives for 1990-1991. The claim that DOC management has been silent does not appear to be founded in fact.

Page 31 The final paragraph is incorrect. The core programs plan does not include sex offender programs at field units. It is correct to state that by July, 1992, major institutions will be required to have five core programs (substance abuse, sex offender, mental health, work and life skills) and that field units will have three core programs (substance abuse, work, and life skills).

Page 32 Division Operating Procedure (DOP) 832 was purposefully planned to be a general guidance procedure and outlines developmental standards for staff. DOC's annual goals and objectives develop more detailed guidance in specific program areas through the model program concept. As documented in the Index of the program area (800 series) Division Operating Procedures, separate DOPs are planned in specific program areas, including substance abuse and sex offender services.

Page 33 The report suggests DOC relinquished its responsibility for basic guidance. This statement contradicts DOC's system for giving guidance and support shown on page 43 of the report.

Pages 36 The key factor contributing to DOC problems in meeting
37, 38 program objectives is a lack of resources. Budget cuts during the FY 1990 and 1991 eliminated almost all of DOC's training and slowed hiring. Staff resources were beyond limits as a result of ongoing loss of revenue and rapid expansion of inmate populations without additional positions. In spite of these external forces, a majority of the Mission Goals and Objectives were achieved.

The Program Advisory Committee (PAC) was initially formed by the Chief of Operations/Programs to identify needs and to make policy development recommendations. Concurrently, the Director of Corrections determined the need to provide more direction in program development and established the new Regional Program Manager positions. PAC was developing its Goals and Objectives immediately before and during the hiring of the Regional Program Managers. Once the Regional Program Managers were hired, and considering the budget cuts and use of staff time, the Managers took over the role of providing field input and policy recommendation to the Chief of Operations/Programs. The use of regional committees was actually suggested and advocated by the Regional Program Managers, not by the administration.

The comment that the Goals and Objectives did not reflect field input is untrue. PAC field representation included Counselors, Treatment Program Supervisors, Assistant Wardens for Programs, and Institutional Operations Officers. PAC was a field/central management team.

Page 39 The Chief of Operations/Programs and staff provide on-going support and leadership to the Regional Program Managers. This is done through the development of annual program objectives and monthly meetings. The Chief of Operations/Programs, Divisional Program Manager, and the Regional Program Managers function as a team with some different but supportive job scopes.

Again, substantial progress was made towards 10 of the 16 objectives noted in the report.

Page 40 The Regional Program Managers report directly to the Regional Administrators. This reporting relationship is appropriate because the the Regional Administrators are the line supervisors to the Wardens and Superintendents. The Chief of Operations/Programs provides technical and

policy support but has no line authority with Wardens and Superintendents. The Chief of Operations/Programs works with the Regional Program Managers for policy development and field input. Once policy is finalized, it is formally communicated to the Regional Administrators and all Division staff through the Deputy Director. The Chief of Operations/Programs and the Regional Administrators participate in monthly management meetings held by the Deputy Director.

Page 42 The second paragraph is incorrect. Currently, objectives are developed jointly with the Chief of Operations/Programs, the Divisional Program Manager, and the Regional Program Managers. Central office staff are involved throughout the entire process, including developing objectives and implementation.

Page 45 The Department formed the Sex Offender Program Action Committee, the Drug Offender Program Advisory Committee, and the substance abuse grant.

Additionally, DOP 832 requires annual reports of programs including program descriptions and program evaluations against stated objectives. Additionally, reports must be submitted on any newly developed program. Guidance is provided to specific programs, often through the Regional Program Manager, as needed.

Page 56 Narcotics Anonymous and Alcoholics Anonymous twelve step programs are often the foundation of a state's prison substance abuse program.

Page 60 The issue of consistency of programs statewide has been acknowledged. The administration created PAC, the Regional Program Managers, SOPAC and the drug program efforts to bring more consistency of programs statewide.

Page 62 The statement alleging lack of administrative support for SOPAC is misleading. SOPAC was established by administrative staff and sanctioned by the Director. SOPAC elects from its membership a secretary, and the desire for central office to do the typing has not been raised at meetings. In fact, central office staff have served as secretary Pro Tempore during secretary absences.

Page 66 The statement "the Department's expectation that counselors with no experience or interest.. can run successful groups.." is a misperception. The Department's position is that programs should be run by qualified and trained staff. This is stated in DOP 832 and is being further addressed by SOPAC and DOPAC.

Page 81 DOC's hiring policy for counselors is erroneously

stated. In advertising vacant counselor positions, a college degree in a related field is listed as a preferred qualification. Applicants are screened for interviews according to the preferred qualifications. If, in exceptional cases, a person not having a related degree is recommended for hire, it must first have the approval of the Director of Corrections. It is the policy of the State Department of Personnel and Training that "equivalent combination of training and experience may be substituted [for a degree]", however, that it is the desire of DOC to hire degreed counselors.

Page 82 The quotations on this page are misleading because they appear to address all training offered by the Department. If they were made in the context of sex offender and substance abuse services training, this should be noted. This finding is not consistent with training evaluations submitted by participants and indicates a need for further study of training programs.

Page 86 In the case examples noted, the counselor and the Institutional Classification Committee are not complying with existing policies. Policies prohibit inmates from receiving related points if they are not complying with their treatment plan.

JLARC's concern with this issue supports the DOC's point that case management and classification program services must be effective and supportive of programming for programs themselves to be effective.

Page 90 To state that "no system" has been established to effectively treat sex offenders and substance abusers is inaccurate and misleading. The Department has been methodically progressing towards uniform department-wide programs for the past five years. This is evidenced by the efforts of SOPAC, the substance abuse grant, the creation of the positions of the Chief of Operations/Programs, Divisional and Regional Program Manager positions, the revision of the 800 series Division Operating Procedures, and clearly documented in the 1990-1991 Program Mission Goals and Objectives. Many excellent programs are operational, and SOPAC, the substance abuse grant and DOPAC provide some general framework and guidance for these efforts.

Other Comments

JLARC did not address two critical areas that impact programming, space and the role of Assistant Wardens for Programs and Treatment Program Supervisors at each institution. These should be examined carefully.

Recommendations

The DOC generally supports JLARC's recommendations. In fact, the recommendations are closely tied to DOC's goals documented in the 1990-1991 Program Mission Goals and Objectives. However, some concerns need to be noted.

Recommendation #1: Delivering a system of services for inmates in need of substance abuse or sex offender treatment will require additional resources. Resource needs are not addressed by JLARC.

Recommendation #2: Policies in the areas of assessment, program standards and staff training require significant resources to implement. It is impossible for DOC to implement such policies without additional resources. Resource needs are not addressed by JLARC.

Recommendation #3: The DOC already operates a multi-tiered substance abuse program which includes support groups, education, group counseling, and therapeutic communities. These programs are dependent upon federal grant funds. General funds for the program have been requested in previous years, and are again being requested. The programs are dependent upon adequate funding and it will be impossible for DOC to implement this objective without additional resources. Additionally, the state must pick up funding on the current grant-funded programs in the very near future. Resource needs are not addressed by JLARC.

Recommendation #4: The DOC will require additional resources to implement system-wide sex offender programs and to ensure (through training and monitoring) that staff meet minimum requirements for conducting therapy. Resource needs are not addressed by JLARC.

Recommendation #5: Assessment instruments will have a large impact on staff's time at the inmate receiving units. More staff resources and resources to purchase the assessment instrument will need to be provided for DOC to comply with this recommendation. Resources to train staff in assessment techniques are also needed.

Recommendation #6: Resources will be required to train staff in assessing sexual deviancies.

Recommendation #7: The DOC supports the development of a two tiered case manager/counselor system if additional resources are provided. It is important for any staffing pattern to include all programs currently conducted by counselors, not just sex offender and substance abuse services.

Recommendation 8/9: DOC agrees that under the two-tiered system, clear distinctions must be made between case manager and counselor duties. Additional resources are required to conduct the needs assessment, develop needed training, and training delivery. Also, funds would need to be provided for consulting services.

Recommendation 9 (actually 10): Resources need to be provided to

develop and implement a monitoring system.

Recommendation 10 (actually 11): DOC concurs with this recommendation.

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