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**Criminal Justice Drug Abuse
Treatment Studies (CJDATS):
Targeted Intervention Components
(TIC) for Correctional Re-Entry
Programs, 2002-2008 [United
States]**

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Data Manual

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Criminal Justice
Drug Abuse Treatment Studies

Targeted Intervention Components (TIC) for
Correctional Re-Entry Programs:
Study Data Manual

Study Summary

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Summary

The TCU Treatment Model (Simpson, 2004) provides conceptual and scientific foundations for the use of targeted interventions that address discrete client problems related to treatment readiness and motivation, anger and hostility, criminal thinking, risky behaviors for HIV/AIDS/Hepatitis C, communication, and other social skill deficits. Specific aims are to establish a set of targeted interventions that –

- address counseling needs in community re-entry treatment programs,
- meet "evidence-based" standards of effectiveness for correctional populations,
- represent brief, flexible, and focused treatment tools, and
- can be readily adopted as user-friendly and manual-guided applications.

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Brief Report{ TC "Brief Report" \f C \l "1" }:

Link to: [Targeted Interventions for Corrections Brief Report](#)

Study Protocol{ TC "Study Protocol" \f C \l "1" }:

Abstract: Community-based re-entry treatment programs for correctional populations typically are not integrated into an overall “continuing-care” plan and are not managed or monitored according to procedures designed to help guide or maximize their effectiveness. The TCU, UCLA, and UDEL partners in CJ-DATS have a need for and interest in assessment and counseling materials to meet these deficiencies. Thus, our objective for the present study is to establish guidelines and resources (to be made accessible via the CJ-DATS Web site) for an *evidence-based library of targeted treatment intervention components for outpatient (i.e., moderate severity) re-entry correctional programs*. They will be no-fee, user-friendly, and manual-guided techniques that can be integrated with programmatic assessments of client needs and progress. These materials will be drawn largely from existing drug treatment resources, such as those listed in the NIDA “blue book” ([Principles of Drug Addiction Treatment](#)) and others developed by CJ-DATS Research Centers. The TCU Treatment Model (Simpson, 2001, 2003; Simpson & Knight, in press) provides the conceptual and scientific foundations for this system of care. It implies that treatment planning should be *assessment-based and needs-guided*, related directly to efforts of the CJ-DATS Core Measurement Workgroup and TCU-lead study now in progress on Performance Indicators for Corrections (PIC). Measures in the PIC include psychosocial and cognitive functioning (including criminal thinking) as well as treatment engagement indicators that can identify client needs and monitor performance of clients and programs that use the intervention components prepared as part of the present study.

A. Specific Aims

This 3-year study is expected to deliver up to 10 targeted interventions for addressing problems involving readiness for recovery, treatment motivation, criminal thinking, session attendance/participation, counseling relationships, depression, anger/hostility, vocational or educational needs, HIV risk behaviors etc. A series of field trials will test and validate each of these specialized therapeutic modules for use with community-based correctional populations. The specific aims are as follows.

1. Select and adapt (with inputs from our Research Center partners) appropriate evidence-based behavioral and cognitive treatment resources (8-10) for use in applications by community/outpatient correctional programs (see Appendix for example of materials on “Dealing with Anger”).
2. Confirm the effectiveness of these targeted intervention components for improving short-term treatment engagement and performance indicators using randomized experimental designs with correctional re-entry treatment samples.
3. Identify client-level assessments of treatment needs and performance (building on results from the PIC study) to help select and assess use of appropriate intervention modules.

B. Background & Significance

The CJ-DATS project emphasizes a “systems perspective” for addressing substance abuse treatment issues in correctional populations. At the time this proposal was written, there were five research protocols under review. For an overview, CJ-DATS is planning a national *Survey of Treatment Practices in the CJ System* – focusing on systems integration, organizational structure, and functioning – to help document the institutional framework in which treatment services are delivered. Within that context, a series of projects is planned for addressing inmate performance and progress throughout corrections-based treatment (i.e., *Performance Indicators for Corrections*, PIC), pre-release assessment of needs for guiding transition into community re-entry (i.e., *Inmate Pre-Release Assessment*, IPASS), and two re-entry interventions (i.e., *Transitional Case Management*, TCM, and *Integrated Community Correctional Addiction Treatment*, ICCOAT). These plans are responsive in some respects to needs expressed by our major partners, which they view as involving (1) pre-treatment assessment of problem severity and needs, (2) inmate performance and progress during treatment, (3) assessment of needs for transitional care or community re-entry, and (4) treatment guidelines for community-based outpatient treatment. In regard to Item 1 (pretreatment needs assessment), several state and regional correctional systems as well as BOP have adopted the TCU Drug Screen for use (but not as part of any current CJ-DATS protocol). Items 2 and 3 are addressed as part of the CJ-DATS PIC and IPASS studies, respectively, in which TCU, UCLA, and UDEL (the collaborating centers for this TIC proposal) are participating.

However, our partners’ immediate needs for community-based outpatient program guidelines (i.e., Item 4) are not addressed by the planned CJ-DATS re-entry protocols (TCM and ICCOAT). These concerns revolve around treating the large volume of low-to-moderate problem severity cases, those most appropriate for targeted intervention (in contrast to high severity cases that should be going into more intense residential settings, such as modified TCs). Indeed, budget-crunch policy revisions are now causing several states to rethink treatment alternatives to jail or prison. For example, the *Houston Chronicle* (June 27, 2003) reports that beginning September 1 “first-time offenders in Texas get treatment, not jail.” Thus, TDCJ is moving to an even higher level of need for guidelines for treatment providers, and there are concerns about contracting for transitional services (such as with state-certified or nationally affiliated treatment providers) without the benefit of systematic guidelines on what constitutes “evidence-based” practice. Previous treatment evaluation research findings (e.g., Simpson, Wexler, & Inciardi, 1999a, 1999b, [The Prison Journal](#)) emphasize the crucial role of post-prison treatment transitional care – but not how to do it.

The draft outline for a CJ-DATS concept paper entitled “*Drug Abuse Criminal Justice Interventions: Findings and Principles*” (per Prendergast, Wexler, & Leukefeld) likewise stresses the importance of having a “continuum of care” and that “accumulated evidence from several decades of research refutes the nothing works argument.” The list of findings and best principles assert that techniques are available for internalizing motivation, a variety of intervention options should be offered in CJ settings depending on levels of risk and problem severity, assessment should aid in making appropriate treatment service placements, re-entry and other transitions are critical times for targeted interventions, and aftercare interventions have been found to improve outcomes. The proposed study intends to help operationalize these points.

A review of substance abuse treatment process and outcomes by Simpson (2003) offers a conceptual framework for planning this proposed project. Figure 1 graphically illustrates key treatment ingredients found to operate as sequential therapeutic elements – early engagement, early recovery, and stabilized recovery – for sustaining treatment retention and thereby improving drug-related outcomes after discharge. These are represented in the “treatment process box” at the center of the chart. Client attributes that impact treatment process (and treatment assignments) are represented in the left margin, along with program attributes that determine several key aspects of organizational functioning. The model also summarizes the major points of contact for interventions – represented across the top and bottom of the figure – that typically are the focus of “technology transfer” efforts to move evidence-based treatment into practice. These include the behavioral, cognitive, and social skill training strategies commonly used in drug treatment programs. They also include specialized readiness interventions for client motivation at intake and techniques for changing organizations (now emerging more explicitly as the focus of translational research). Finally, the role of “wrap-around” services for social support and personal health care of clients is acknowledged in the right margin of the chart.

Applications of this general treatment model for outpatient correctional programs

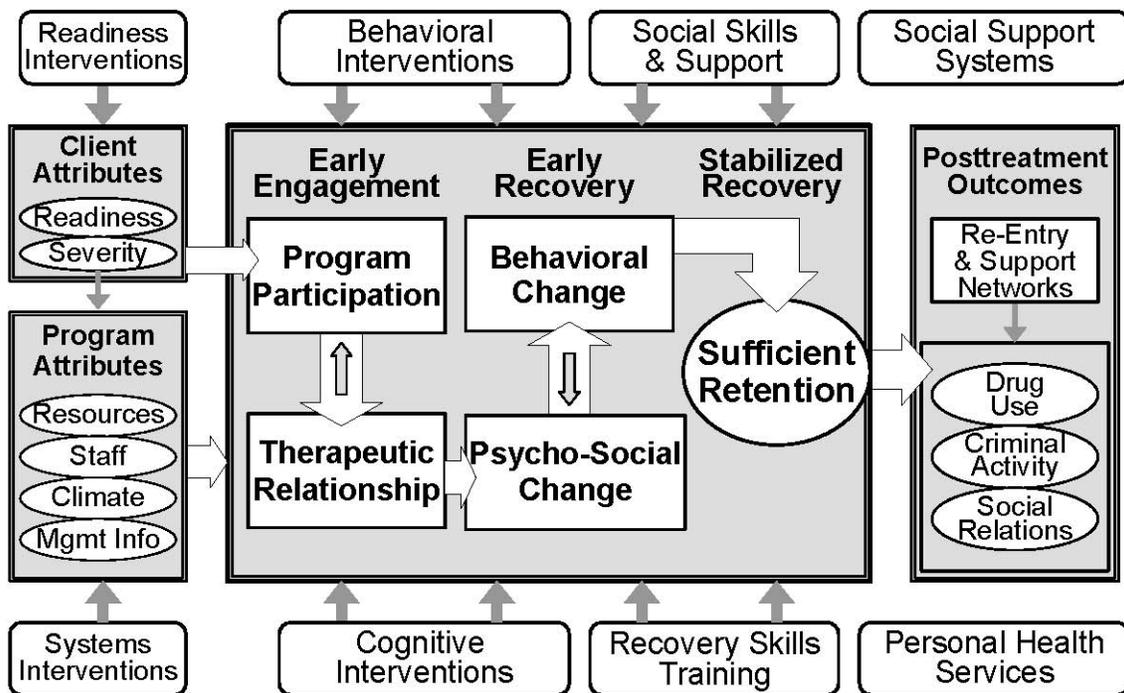


Figure 1. Overview of TCU Treatment Model, representing sequential influences of client and program attributes, stages of treatment, and evidence-based interventions on post-treatment outcomes.

require the development of guidelines adapted to the needs of criminal justice systems. These treatment interventions must be relatively brief, flexible, and group focused (as opposed to individualized counseling), especially in times of shrinking treatment budgets and resources. As

a context and background for the proposed study, several elements of the TCU treatment model are presented below, especially those concerning general treatment settings in the U.S. and a summary of evidence-based interventions indexed to particular treatment stages in the model.

B.1 Treatment Settings and Program Attributes

Almost 14,000 specialized drug treatment facilities in the U.S. currently provide services in a variety of settings (Substance Abuse and Mental Health Services Administration, 2003), mainly in residential, outpatient drug free, and methadone (agonist maintenance) programs such as those represented in DATOS (Etheridge, Hubbard, Anderson, Craddock, & Flynn, 1997). As indicated by findings in DATOS (see Simpson, Joe, Broome et al., 1997), about 60-70% of clients in these community residential or outpatient treatment programs are involved in the criminal justice system (e.g., parole, probation, awaiting trial). Diagnosing drug dependence and abuse is a critical but imperfect step to determining treatment needs and optimal setting (Gerstein & Harwood, 1990). Assessment strategies, treatment resources, and decision rules for program admissions across state and local systems are highly diverse, particularly for correctional populations (Farabee et al., 1999; Hiller, Knight, Rao, & Simpson, 2002). Even though drug use histories and related problems of clients are legitimate and appropriate considerations for selecting treatment approaches and settings, there is growing sentiment that virtually all programs share some common treatment process components (Connors, Donovan, & DiClemente, 2001; Norcross & Goldfried, 1992).

This does not mean that all programs are alike or equally effective. Indeed, those within a particular therapeutic orientation (or modality) vary tremendously in their ability to retain clients in treatment, and the traits of their clients differ widely (Simpson, Joe, Broome et al., 1997). Since higher levels of addiction severity (including drug injection frequency and alcohol use), criminal history, and psychosocial dysfunction at treatment intake are typically associated with poorer outcomes, programs that draw more high-severity caseloads face more difficult treatment challenges than others. Even after adjusting for client differences, however, programs within the same type of treatment modality show differential effectiveness, demonstrating that both client attributes and program features have distinctive but complex influences on outcomes (Broome, Simpson, & Joe, 1999). Moos, King, Burnett, and Andrassy (1997) found that in Veterans Administration programs, high expectations for clients, clear policies, structured programming, high proportion of staff in recovery, and more emphasis on psychosocial treatment were related to better client participation in treatment (and which independently predicted better outcomes at discharge). Comparable findings from TOPS were reported by Joe, Simpson, and Hubbard (1991).

A long-standing call for “matching clients to treatment” sometimes mistakenly assumes that centralized and comprehensive assessments are routinely conducted for large numbers of treatment seekers, who then can be appropriately matriculated into a rich diversity and clearly articulated array of specialized treatment programs. More practical, however, is the modest expectation that interventions and services within each program should be tailored to acute client needs and stage of therapeutic progress (McLellan et al., 1997). But even this limited application of client-to-treatment matching calls for a level of sophistication in assessments and availability of comprehensive (or “wrap-around”) services that are uncommon in the real world. Programs often lack proficiency in customizing services to progressively address distinct stages of client recovery, but evidence is

growing in support of the effectiveness and efficiency of reserving more intensive services for clients with more severe problems (Gottheil, Thornton, & Weinstein, 2002; Hser, Polinsky, Maglione, & Anglin, 1999; Thornton, Gottheil, Weinstein, & Kerachsky, 1998). Similar support for matching client problem severity to treatment intensity comes from a national study of cocaine users showing low-problem clients do about equally well in virtually any type of program, but outcomes plummet for high-problem cases treated in outpatient and short-term programs. These higher severity clients do much better in long-term, intensive residential services (Simpson, Joe, Fletcher, Hubbard, & Anglin, 1999). Regardless of client problems and severity, treatment setting, and post-treatment outcomes, however, there are similarities in the therapeutic processes involved.

The weakest evidence represented in the TCU treatment model involves these interactions between program effectiveness and institutional dynamics in the drug treatment field (Simpson, 2002). In particular, better assessments and conceptual models for resources, staff functioning, organizational climate, and how to use information for client and program management are crucial (Heinrich & Lynn, 2002; McCaughrin & Howard, 1996; Schneider, Salvaggio, & Subirats, 2002; Simpson, 2002). However, the need for this research is gaining attention in the growing national agenda for translational studies on getting evidence-based practices into broader field applications. Meta-analytic results suggest organizational training can be effective, depending on training method used, the skill or task being trained, and goals for the employee training (Arthur, Bennett, Edens, & Bell, 2003), but organizational readiness for change, the climate for acceptance, and systems infrastructure must also be considered in planning intervention strategies for altering institutional functioning.

B.2 Evidence-Based Interventions

The term “science or evidence-based” interventions as used in this proposal refers to treatment modules or materials that have been shown to be effective either as a stand-alone treatment component or as part of a larger, integrated set of materials. In several instances (such as with the TCU modules), evaluations have focused on interim criteria that have been established as part of the client change and recovery process, including participation, engagement, during-treatment cognitive or behavioral changes, and length of stay in treatment (e.g., the TCU treatment model). Thus, the wider meaning of “evidence-based” implies that scientific and theoretical foundations are used to associate treatment interventions with client needs, progress during treatment, and outcomes. Note, however, that there are limitations to the availability of interventions that meet rigorous “evidence-based” criteria and that the TIC study will include some interventions that might meet less stringent “evidence-based” criteria but are included because they have a research base sufficient to meet the particular definition proposed for this study.

Concerns aroused by the term “evidence-based” are ones we agree with. However, switching to “research-based” or other alternative terminology would not solve the problem facing our partners who already are stuck with this politically charged phrase. We suggest that “evidence-based” be defined pragmatically as meaning there are scientific research findings showing client pertinent during-treatment performance indicators are significantly improved by the manualized intervention, and that this conceptual process is embedded in a theoretical framework for how treatment works. The NIDA “blue book” on *Principles of Drug Addiction Treatment* provides general support for some of the interventions to be selected, but CJ-DATS studies will go another step forward by adapting and testing materials for special applications in correctional populations per se. Some of the major publications that provide these foundations are summarized below.

B.2.a Improving client readiness for treatment. Not everyone enters treatment with the same level of motivation or problem severity, so it is not surprising that some clients can benefit from special “induction” efforts (Katz, Brown, Schwartz, & Weintraub, in press; Simpson & Joe, 1993). The use of systematic efforts to improve treatment readiness and engagement of clients reflects a fairly recent change in drug treatment practice. Motivational induction is particularly beneficial in settings such as correctional programs where low motivation is a common problem (Farabee, Simpson, Dansereau, & Knight, 1995), among adolescents (Battjes, Gordon, O'Grady, Kinlock, & Carswell, 2003), and in outpatient treatment for the mentally ill (Carey, Carey, Maisto, & Purnine, 2002). Adaptations of cognitive-based enhancement tools by Dansereau and associates (Blankenship, Dansereau, & Simpson, 1999; Czuchry & Dansereau, 2000; Sia, Dansereau, & Czuchry, 2000) are effective as the basis for treatment readiness training in small group settings. These tools include a popular pedagogical board game called “Downward Spiral” as a vicarious approach to personalizing the multidimensional consequences of drug abuse (Czuchry, Sia, Dansereau, & Dees, 1997), along with cognitive exercises and associated homework applications for exploring personal needs and strengths (Sia, Czuchry, & Dansereau, 1999). Results from this series of experimental studies show readiness training raises motivation and program participation, as well as client ratings of sessions, peers, and counselors. Thus, motivation is viewed as a dynamic “state” that must be sustained throughout treatment.

B.2.b Improving program participation. Behavioral intervention protocols that offer voucher-based incentives for increasing treatment session attendance and drug abstinence have been effective in various types of drug treatment settings (Griffith, Rowan-Szal, Roark, & Simpson, 2000; Higgins, Alessi, & Dantona, 2002). These contingency management approaches originally were more likely to focus on relapse indicators such as urinalysis results, but over time have been expanded to other engagement criteria. They have been particularly useful in outpatient methadone treatment (Higgins et al., 1994; Petry & Simcic, 2002; Robles, Stitzer, Strain, Bigelow, & Silverman, 2002; Silverman, Higgins et al., 1996; Silverman, Wong et al., 1996), where they can raise the odds of client participation in sessions by 2.5 (Joe & Simpson, 2003). Low-cost adaptations that emphasize social recognition, small gifts, or treatment supportive items (e.g., bus tokens or car fare) also have been effective for community-based programs (Rowan-Szal, Joe, Chatham, & Simpson, 1994; Rowan-Szal, Joe, Hiller, & Simpson, 1997), as has a procedure by Petry and colleagues using a “fish bowl” for drawing prizes contingent on negative urinalysis results (Petry & Martin, 2002; Petry, Martin, Cooney, & Kranzler, 2000; Petry et al., 2001).

Improving the quality and structure of treatment counseling has likewise shown benefits in raising participation levels and retention rates (Gottheil et al., 2002; Hoffman et al., 1994; Rowan-Szal, Chatham et al., 2002). Merging contingency management with cognitive-behavioral therapy (usually a form or variant of relapse prevention training) has been another method for effectively improving treatment to achieve better attendance, engagement, and retention (Epstein, Hawkins, Covi, Umbricht, & Preston, 2003; Farabee, Rawson, & McCann, 2002; Rawson et al., 2002; Rowan-Szal, Bartholomew, Chatham, & Simpson, 2002).

B.2.c Improving therapeutic relationships. Shifting focus from session participation to therapeutic relationship calls for increasing emphasis on cognitive tools, counselor skills, intervention strategies, and context. Treatment effectiveness is not strictly aligned with any particular treatment philosophy, orientation, or setting, thereby prompting an interest in how much counselor skills or strategies may interact with client attributes to determine outcomes. In terms of specific skills, training, or experience, results sometimes have been obtuse and inconsistent. An early study by McLellan, Woody, Luborsky, and Goehl (1988) compared four counselors on the basis of outcomes for their clients. Their background and education were not related to client success, but counseling content and process provided a few clues by suggesting that being well organized, systematic, and

comprehensive were favorable traits. This implies having more ready access to clinical records that are user-friendly and relevant to treatment needs, as well as being properly trained in their use, would enhance treatment. Joe, Simpson, and Sells (1994) similarly found that methadone programs with better client retention and outcome rates reported higher professional quality in assessing client needs and planning treatment. Attempts to quantify effective counselor traits point to interpersonal skills and empathy as being important qualities (Miller, 2000; Valle, 1981). When broken down into more explicit dimensions, factors such as expertness, trustworthiness, and attractiveness emerge (Corrigan & Schmidt, 1983; Heppner, Rosenberg, & Hedgespeth, 1992).

Comprehensive “full-course” manualized treatment interventions like the Matrix Model (Obert, London, & Rawson, 2002; Rawson et al., 1995) include a prescribed sequence of behavioral and cognitive approaches, tailored initially for stimulant users in outpatient programs. More specialized cognitive strategies show evidence of having special benefits for improving therapeutic relationships (Ahmed & Boisvert, 2002; Dansereau, Dees, Greener, & Simpson, 1995; Magura, Rosenblum, Fong, Villano, & Richman, 2002), and similar combinations of cognitive-behavioral social skills and cognitive skills training programs are reportedly the most effective for prison settings and correctional populations (Pearson, Lipton, Cleland, & Yee, 2002). Ideally, use of these interventions should be “needs-driven,” based on appropriate assessments of client functioning and progress.

Studies of counseling based on a cognitive visual representation and communication technique illustrate how engagement, progress during treatment, and follow-up outcomes can be improved (Dansereau, Joe, & Simpson, 1993; Joe, Dansereau, Pitre, & Simpson, 1997). Joe and Simpson (2003) found it raised by two-fold the odds that methadone treatment clients would have higher engagement scores. This technique, derived from basic psychological research on problem-solving (e.g., Larkin & Simon, 1987) and in educational psychology (e.g., Dansereau & Newbern, 1997), uses cognitive (node-link) maps that allow counselors and clients to display issues and solution plans in a form similar to that of flow charts and organizational diagrams (see Czuchry & Dansereau, 2003, for an integrative overview of this research). For didactic or knowledge-based applications, information maps are used to present details on important topics such as relapse, communication, HIV/AIDS, depression, or the physiological impact of certain drugs.

Results indicate that this type of conceptual visualization technique reduces reliance on purely verbal communication (Dansereau et al., 1993), increases attentional focus (Czuchry, Dansereau, Dees, & Simpson, 1995), and improves memory for session content (K. Knight, Simpson, & Dansereau, 1994). Further, the use of mapping has been shown to be effective in a variety of settings and with a variety of treatment outcome measures (Collier, Czuchry, Dansereau, & Pitre, 2001; Czuchry & Dansereau, 1999; Dansereau et al., 1995; Dansereau, Joe, Dees, & Simpson, 1996; Newbern, Dansereau, & Dees, 1997; Pitre, Dansereau, & Joe, 1996; Pitre, Dansereau, Newbern, & Simpson, 1998). Workshop, manual, and Web-based methods for transferring mapping have been developed and disseminated (see Dansereau & Dees, 2002).

B.2.d Improving early and stabilized recovery. Relapse prevention (Marlatt & Gordon, 1985) is a classic technique used in substance abuse treatments to enhance behavioral self-control in preventing relapse to drug use and building cognitive vigilance for high-risk situations that represent “triggers.” The intent is to establish new habit patterns for thinking and acting that can be stabilized and maintained over time. Obviously, the extent to which a client has already become engaged in treatment in terms of participation and therapeutic relationship will influence the deployment of relapse prevention and related strategies for strengthening recovery.

More systematic use of social support systems and networks also has become a focal concern since families often have been omitted from client treatment plans. Miller (2003) argues that families can be part of the problem as well as the solution; they may themselves need psychosocial treatment to deal with drug use problems of a loved one, but they also can give effective support to recovery of the client. Family history, childhood background, parental support, and conflict influence psychosocial adjustment in adulthood as well as engagement and progress in drug treatment (Broome et al., 1997; De Civita, Dobkin, & Robertson, 2000; D. K. Knight, Cross, Giles-Sims, & Simpson, 1995; D. K. Knight & Simpson, 1996; Mallinckrodt, 1991). The focus of family-based interventions takes into account the existing social structure and resources because as client age increases, family contacts and investments can be diminished (Lemke & Moos, 2002).

After defining an appropriate network of “significant others,” there is a variety of strategies that can help strengthen social adjustment and coping skills. Twelve-step programs are examples (Apodaca & Miller, 2003), but other more structured and proactive interventions also are available. The Community Reinforcement and Family Training approach (CRAFT; Meyers, Miller, Smith, & Tonigan, 2002; Miller, Meyers, & Tonigan, 1999) and A Relational Intervention Sequence for Engagement intervention (ARISE; Landau et al., 2000) follow manualized guides for recruiting and engaging clients in treatment. Similarly, Brief Strategic Family Therapy (BSFT; Robbins, Bachrach, & Szapocznik, 2002; Szapocznik & Kurtines, 1993), Multidimensional Family Therapy (MDFT; Liddle et al., 2000; Liddle et al., 2002), and Multisystemic Therapy (MST; Henggeler, Schoenwald, Borduin, Rowland, & Cunningham, 1998) address special developmental needs of adolescents.

The core objective of these interventions, of course, is to build social skills that link to support systems. These needs are especially important in drug treatment programs for women who have lost custody of children and have poor economic prospects unless family connections and support can be re-established. D. K. Knight, Joe, and Simpson (2003) focused specifically on the intersection of social relationships and treatment process for women in residential treatment and found that level of social support was directly associated with engagement indicators and treatment completion. Specialized group education materials – often delivered in female-only or male-only group settings for sexual health and communication skills training, parenting skills training, or transition to aftercare training – can improve knowledge and psychosocial functioning (Bartholomew, Hiller, K. Knight, Nucatola, & Simpson, 2000; Bartholomew, Rowan-Szal, Chatham, & Simpson, 1994; Gainey, Catalano, Haggerty, & Hoppe, 1995; Hiller, Rowan-Szal, Bartholomew, & Simpson, 1996). The secondary effect of these 6-to-8 session training modules (for residential and outpatient settings, as well as in correctional populations) has been to increase treatment retention and completion.

Findings from a recent review of 38 studies on women’s treatment by Ashley, Marsden, and Brady (2003) add support to these conclusions. They found six treatment components to be significantly related to longer treatment retention and completion, reduced drug use and HIV risk behaviors, and physical/mental health; these included (1) child care services for mothers in treatment, (2) prenatal care and parenting skill training, (3) use of women-only treatment groups, (4) educational sessions on health care and social skills, (5) access to mental health care, and (6) use of more comprehensive or multi-service combinations of treatment.

There are few interventions designed uniquely for stabilized recovery – the third stage of recovery – but several of the ones discussed above for early recovery apply. Twelve-step programs also are popular for this stage (Fiorentine & Hillhouse, 2000; Hillhouse & Fiorentine, 2001; Weiss et al., 2000), along with expanded efforts to make favorable changes in the family and social support networks of clients (Broome, Simpson, & Joe, 2002; D. K. Knight & Simpson, 1996). A training manual entitled Straight Ahead: Transition Skills for Recovery (Bartholomew, Simpson, & Chatham, 1993) provides a counseling guide to meet some of these specific needs, and a companion series of Time Out manuals that address communication and sexuality in gender-specific groups also merit

consideration (Bartholomew, Chatham, & Simpson, 1994; Bartholomew & Simpson, 1996). Probably the most popular are relapse prevention strategies (Marlatt & Gordon, 1985) that focus on relapse triggers, dangerous situations, and cognitive restructuring.

B.3 Staging Treatment Engagement Processes to Guide Clinical Interventions

Recognizing and implementing evidence-based interventions appropriately staged to client needs at each conceptual phase of treatment can improve effectiveness. However, treatment counselors need a practical navigation system with streamlined client assessments and easy-to-use clinical interpretations of needs and progress that address diagnostic and treatment planning goals.

The TCU treatment model offers a graphic framework for communicating how these elements fit together for improving efficiency and effectiveness. It also demonstrates that treatment developers, evaluation scientists, and federal agencies have some important work to do. This includes formulating a structure for recognizing “evidence-based” interventions and assessments, as well as promotion of effective dissemination strategies. Intervention manuals and strategies must be well organized, user-friendly, prescriptive in procedures and purpose, easily accessible, and packaged for efficient training and adoption. They need to be categorized according to type of application and purpose, clinical skills required, appropriate treatment settings, and philosophical assumptions. Assessments to orchestrate this process must be brief, focused, practical in clinical value, readily interpretable, packaged in an efficient and user-friendly format, and available for easy access on demand. It is especially important that assessment guidelines and client information systems eliminate massive redundancies and irrelevancies that now characterize most states, and that assessment components be linked for logical applications and automated for common report generation. And counselors must be trained to use them efficiently and effectively.

Assessment systems and treatment intervention manuals (or selected sessions of interest) have become widely available free-of-charge via the Internet (e.g., see www.ibr.tcu.edu), and the popular response to these resources points to the need for their further development. However, a wider array and better guides for using Web-based assessment and information management tools need to be created, tested, demonstrated, and made available to connections-based programs and their staff.

C. Research Design and Methods

This 3-year project will be conducted incrementally, starting with core assessments for client needs and progress during transitional treatment as well as preparation of targeted intervention modules that address these needs. As described below, interventions will be selected with inputs from collaborators regarding particular issues treatment program staff determine as priority needs to build on, rehearse, or refine recovery skills presumably initiated in correctional residential treatments. **It is expected that approximately 8-10 targeted interventions will be adapted and tested for correctional settings (and hopefully there would be specialized modules from other CJ-DATS Research Centers added to this “library” as the project progresses).** Standardized evaluation protocols (e.g., 100-150 clients randomly assigned to experimental versus comparison groups, with pre-post evaluations of performance measures) will be used to replicate effectiveness evidence for correctional programs.

The Lead RC (TCU) will coordinate all aspects of this study as well as absorb the majority of data scoring and analytical burden. Collaborating RCs (CRCs) will work with their Collaborating Partners (CPs) to identify priorities for targeted intervention topics, contribute edited manuals/modules as appropriate, and coordinate evaluations in which their CPs participate. CPs will each be asked to designate a representative for a “TIC Clinical Panel,” which will have a major role in the study in terms of communication and decision-making responsibilities. To avoid increased travel costs, input from TIC Clinical panel will be primarily via e-mail or telephone.

C.1 Description of Interventions

Existing manuals and materials from “evidence-based” strategies (i.e., those supported by published outcome findings) will be selected for editing and reformatting into a generally consistent look, then tested for effectiveness in a series of short-term experimental studies coordinated across participating CJ-DATS RCs. A 3-stage process will be followed. First, recommendations will be obtained from the project collaborators, using a checklist of targeted intervention topics to determine priorities. Next, materials that match this list will be identified by CRCs (along with suggestions from CPs) then reviewed in terms of supporting evidence as well as its clinical applications appeal to collaborators (e.g., length, formatting, ease of use, etc.). Finally, materials selected will be “edited” as needed into a consistent and user-friendly format (to be approved by the “clinical panel” from CPs) before being entering its “CJ-DATS Evaluation” process. This will be an on-going process over the course of the planned 3-year duration of the study, during which time up to 10 targeted interventions will be adapted and evaluated.

Samples of the kinds of targeted intervention topics expected to emerge (and some existing resources for these materials) are listed below. A sample mock-up of a final counseling packet that might eventually be posted on the CJ-DATS Web site is included in the Appendix, taken from the set TCU counseling manuals and from which several interventions are being conceptualized.

Examples of Topics to be Considered:

- Strengthening support networks and social skills (e.g., Parenting)
- Vocational/employment support
- Health/nutrition/recreation
- HIV education/sexuality/sexual health
- Managing stress, anger, trauma, co-occurring disorders
- Maintaining motivation/monitoring recovery

Multiple interventions per topic. There may be multiple intervention packages on the same general topic, and indeed this is regarded as preferable. For example, anger management may be addressed with different strategies (psychological, cognitive, behavioral) and has several sources to draw from (e.g., TCU manuals, UCLA Matrix program, CSAT materials, etc.). Some programs may have a philosophical or value orientation more conducive to one or the other, or they may desire to use repetitive training with different approaches. Another consideration may involve length or number of sessions required by the intervention. Having multiple options allows programs more flexibility in selecting interventions that fit their needs and interests.

Training and fidelity. Although the targeted interventions envisioned for this project are expected to be straightforward and flexible, there may be special training required occasionally. Keeping in mind the limited resources available in CJ-DATS, preferences will be given to self-contained instructions and small-group training using conference calls (with follow-up tutoring as needed). However, there may be instances in which formal face-to-face workshop training is required. These will be negotiated and planned on a regional basis since most evaluations (especially if workshop training is required) will be conducted in a limited number of facilities and in the same geographic zone.

In regard to concerns about "implementation fidelity," information about intervention delivery primarily will be collected through observational methods (similar to ones developed by the UKY and UMD groups) and will include information such as session attendance, counselor skills and delivery competence, rapport building, and intervention-specific tasks. At minimum, we expect to be able to assess the degree to which each group received the intended intervention and to what extent this may have differed across groups. We also plan to assess services received prior to the intervention that may have affected the impact of the targeted interventions. The plans conform to the notion of "implementation checks" (Dennis, Perl, Huebner, & McLellan, 2000) and are not intended to represent comprehensive evaluations of technology transfer.

C.2 Assessment Instruments

The CJ-CEST will be implemented as the core "needs and engagement" assessment instrument. As described in more detail in the PIC study protocol, it includes scales on motivation, psychosocial functioning, and criminal thinking. Special needs assessments based on behavioral and social functioning domains currently being identified by the Core Measures Workgroup (e.g., HIV/AIDS risks, health/social skills needs, stress, etc.) are expected to be added, and possibly additional domains from the CAI. These will be intended for defining areas of need and tracking changes in general functioning/engagement over time.

Customized instruments also must be developed for *each specific intervention*, designed to evaluate information learned, session quality and satisfaction, and cognitive changes. These will be modeled in part after similar assessment included in the TCU manuals and used as the basis for related evaluations.

These motivational/informational/behavioral/cognitive assessment components will be the foundations for documenting client functioning needs and changes, as well as pre-post measures for each targeted intervention. However, decisions about the final set of assessments will be tailored to the time, needs, and interests of the CPs as well as the evaluation criteria selected for each intervention study.

C.3 Data Collection Coordination

As noted earlier, the Lead RC (TCU) will coordinate all aspects of this project as well as absorb the majority of data scoring and analytical burdens. CRCs will work with their respective CPs (via the TIC Clinical Panel) to identify priorities for targeted intervention topics, contribute edited manuals/modules as appropriate, and coordinate local evaluations in which their CPs participate. Each CP will select (via the TIC Clinical Panel) the interventions of primary interest and designate special programs to be involved in evaluations, following prescribed client assignment and assessment protocols.

In serving as the Lead RC, TCU will coordinate the final selection of targeted interventions by collaborators, give advice and assistance in the editing/reformatting implementation manuals, coordinate (and sometimes provide) clinical training for the interventions to be evaluated, prepare and score optical scanning instruments for evaluations, create master data files, and conduct pre-post outcome analyses for intervention evaluations. The series of intervention studies will be scheduled sequentially, determined in large part by the overall timing and level of demands by CJ-DATS on staff and resources.

Each study generally will be limited to one to three treatment facilities to gain optimal project efficiency, and TCU will coordinate with the CPs and CRCs involved in order to provide standard research design guidelines, evaluation implementation, intervention training (as needed), assessment forms (in preprinted optical-scan format), instructions for conducting self-administered pre-post assessments, and data analysis. These procedures will become a “standardized protocol” replicated across the CPs/CRCs throughout the 3-year period scheduled for intervention evaluations (with Ms. Janis Morey, Research Associate for the CJ-DATS project at TCU, designated as the field manager and point of contact for data collection).

C.4 Study Evaluation Design

For each of the interventions, the same general evaluation design will be followed. In brief, consenting clients within a participating program will be randomly assigned to either the Targeted Interventions (TIC) or Comparison Condition (CC). Recognizing that random assignment of clients to condition may not be feasible across all participating sites, an alternative strategy will be for existing cohorts or groups of clients within a program to be randomly assigned to one of the treatment conditions (or a similar quasi-experimental design). Regardless of how "random" assignment occurs, clients in the TIC and CC conditions will be asked to complete a pre-intervention assessment battery (described above). The selected targeted intervention will then be provided to the TIC clients. Upon completion, clients from both conditions will be asked to complete a post-intervention assessment battery (similar to the pre-intervention battery). Once the intervention and assessment phase is completed, those assigned to participate in the CC will be offered the opportunity to participate in the targeted intervention – thus, all participating clients will be offered the chance to participate in the targeted intervention.

This two-group design was selected in order to assess the incremental effectiveness of the targeted interventions when added to an existing outpatient treatment program's set of services activities. Assuming that the selected intervention condition is effective, relative to the comparison condition, an evidence base will be formed supporting the use of the specific targeted intervention.

C.5 Eligibility Criteria

C.5.a. Sites

- Correctional outpatient treatment programs (providing primary or secondary/aftercare treatment services).
- Ability to randomly assign clients or cohorts to the study conditions.

- Ability to recruit a minimum of 84 participants from one or more outpatient programs for each of the interventions to be tested. Participants can be from successive cohorts within a program or from different cohorts across programs (or a combination of both).
- Willingness of outpatient provider to disclose treatment participation information on study participants (e.g., admission and discharge dates), assuming the participant signs a release of information form.

C.5.b. Subjects

- Subjects recruited from correctional outpatient treatment programs.
- Have received a referral or mandate from a correctional authority (e.g., judge) to participate in a community-based outpatient program.
- Have enough time remaining in treatment to be able to complete the intervention.
- Consent to participate in the study.

C.6. Sample Size (Power Analysis)

To estimate power, we considered two potential dependent variables (TCU CEST Treatment Satisfaction and Treatment Rapport). Prior TCU research findings based on the administration of the CEST instrument to in-prison treatment samples indicated a mean response of 38 (on scale from 10 to 50), with a standard deviation of 6, for both scales. In the proposed study, a univariate two-group repeated measures analysis of variance (incorporating the Greenhouse-Geisser correction) will be used to test differences between intervention and comparison conditions on these as well as similar measures. Therefore, in the power analysis, 38 served as the expected mean response for the comparison group at both pre- and post-test (i.e., no change), and the mean response for the intervention group was estimated as increasing from 38 at pretest to 44 at post-test. Additional assumptions included a significance level of .05, a correlation of .30 between time points, and a constant standard deviation of 6. Based on these assumptions, 42 clients per condition (intervention and comparison) would provide 80% power to detect overall condition differences, and 96% power for both the overall difference across time and the condition-by-time interaction. The proposed study will therefore require a minimum of 42 clients per condition, although larger samples are preferable.

C.7. Analysis Plan

C.7.a. Study Hypotheses

For each of the targeted interventions, three hypotheses are proposed:

1. The *Targeted Intervention Condition* will produce significantly better pre- to post-intervention improvements on knowledge specific to the intervention than will the *Comparison Condition*;
2. The *Targeted Intervention Condition* will produce significantly better pre- to post-intervention improvements on related psychosocial and motivational measures than will the *Comparison Condition*;
3. The *Targeted Intervention Condition* will produce significantly better post-intervention improvements on measures of treatment process (e.g., Treatment Satisfaction) than will the *Comparison Condition*.

C.7.b. Variable Definitions and Properties

This study uses the TCU treatment process model as a conceptual foundation for the proposed variable selection and evaluation plan. It emphasizes treatment engagement and performance measures as evaluation criteria because they have been established as improvement indicators that are linked directly to treatment retention, completion, and post-discharge outcomes (e.g., relapse and recidivism). Treatment is not viewed as a singular event but involves a sequence of integrated efforts to improve cognitive, behavioral, psychological, and social functioning of clients. Client engagement and performance measures represent legitimate and feasible short-term treatment evaluation criteria that can be related to distinct interventions that make up “treatment,” and they are less likely to be contaminated by the types of confounding factors that enter into long-term follow-up studies. Indeed, specific components of treatment (i.e., interventions) are highly impervious to problems associated with traditional effectiveness evaluations using long-term outcome designs in natural settings (associated with uncontrolled confounding influences). The rationale for this study was therefore to combine the theoretical framework of the TCU process model with evidence of improvement on short-term engagement indicators to establish “evidence-based” interventions. For re-entry programs, these materials will in many cases serve as “boosters and review” of primary treatment during incarceration. Although it could be argued that long-term outcomes are needed to establish “effectiveness” of treatment, to rely exclusively on long-term outcomes would deny the value of what has been learned about treatment engagement and process, and *it would extend substantially the timeline for CJ-DATS contributions*. Thus, a distinction should be made between “interventions” (referred to as *targeted* in this study) and “treatment” (which is defined by the composite set of interventions used in a therapeutic episode). *Evaluating interventions* can be a series of short-term studies (as proposed here), but *evaluating treatment* is a task requiring a more complicated long-term study that includes cumulative *process* information about client needs and services received as well as post-discharge records on recidivism and relapse.

Independent variables. The independent variable is treatment condition, with two levels: *Targeted Intervention Condition* and *Comparison Condition*.

Dependent variables. The primary dependent measures will be those identified as part of the PIC study (e.g., motivation, psychosocial functioning, and criminal thinking), by the Core Measures Workgroup (e.g., HIV/AIDS risks, health/social skills needs, stress, etc.), and by the RC preparing the targeted interventions (e.g., knowledge tests). Intervention completion status (completed, transferred, AWOL, etc.) will be recorded.

C.7.c. Analyses

Basic descriptive statistics – including response rates, means, standard deviations, inter-item correlations, etc. – will be conducted initially. Non-normal items will be transformed as necessary and non-parametric statistics will be used when appropriate.

Pre-intervention differences (e.g., age, race, etc.) between the TIC and CC will be assessed. When differences are found, covariation with outcome variables will be examined to determine if these characteristics should be included in analyses as covariates. A similar analysis will be conducted to determine whether group equivalence has been compromised by attrition in the post-intervention sample using the baseline characteristics of the post-intervention sample only. Based on our prior experience conducting similar studies of targeted intervention, we expect less than 5% attrition. Because we expect very little missing data, we do not anticipate needing to employ strategies to deal with missing data (such as the use of mean substitution). However, if large amounts of missing data occur, SAS Proc MI and Proc MI Analyze will be used to impute values for the missing data.

Hypotheses will be tested primarily through the use of ANOVA for repeated measures. ANOVA will be used to compare conditions on the pre-post intervention continuous measures (e.g., treatment satisfaction) described above. To compare scale responses, we will use 1-way, between subjects ANOVA. If covariates are required, analyses will be extended to ANCOVA or logistic regression as appropriate to the dependent variable. When sample size allows, a 2-way ANOVA (Condition by Assessed Need) will be conducted to determine if the targeted intervention had a more profound effect on those clients identified during the pre-intervention assessment as having a need for the intervention.

C.7.d. Gender-Specific Issues

RCs will be encouraged to recruit female clients when possible. If sufficient samples of female clients are obtained, gender differences will be assessed as part of the analytic plan.

C.8. Human Subjects Issues (ADAPTED from Prendergast's long-term study)

Participants in each of the intervention study protocols will be male and female drug abusers recruited from participating correctional outpatient treatment programs. After providing consent, participants will be assigned to an intervention group or to a comparison group (where they are to continue receiving the standard set of treatment services). Participants will be at least 18 years old or older. Inclusion criteria for individuals who volunteer will include having enough time remaining in treatment to complete the specified targeted intervention. Each participant will be assessed and interviewed using a standardized assessment battery, which will cover basic background, motivational, informational, behavioral, and cognitive assessments (previously described). All materials will be used only for research purposes and will remain strictly confidential. Potential study participants will be screened for eligibility (i.e., time left in program) and, for those eligible to participate, the study protocol will be explained. Informed consent will be provided and an Informed Consent Form will be signed by each participant prior to enrolling in the study protocol. Potential risks include psychological distress, which may occur when answering questions related to drug use and criminal/delinquency activities. Confidentiality will be fully protected. A Federal Certificate of Confidentiality will be obtained. Questionnaires will only be identified by a participant's unique number. Only research staff will have access to this confidential information. The risk to individuals who participate in the study protocols is minimal. Participants may benefit from the intervention services and ways in which they can change their attitudes and behaviors related to drug abuse and criminal justice related behaviors.

Participating centers will work closely with the CJ-DATS Steering Committee to maintain compliance with policies established by the IRB and NIDA/DESPR Data Safety Monitoring Board and to make every effort to ensure the protection of human participants and issues relating to subject confidentiality. In addition, human participants' protocols will comply fully with the special protections pertaining to behavioral research involving prisoners as participants (Protection of Human Participants, Code of Federal Regulations, 45 CFR 46, Revised March 8, 1983). In this regard, all potential subjects meeting eligibility requirements to participate in the research project will have an equal possibility of being selected. Selection for the study and a specific targeted intervention will be voluntary, and all clients will be given the opportunity to participate in the intervention; they will not be coerced in any way to participate, nor will there be coercion of any type after a subject has been selected; subjects will be assured that an individual's participation or non-participation in the study is voluntary (Section 46.305) and participants can terminate at any time without repercussions.

Clients under criminal justice sanction, which includes court-mandated community outpatient treatment, will be told about the nature and purpose/aims of the study protocol, and the data collection. A staff member also will explain to each potential participant that: a) Neither participation nor refusal to participate in a study protocol will affect their legal status; b) No

individual or identifiable data collected as part of a study protocol will be made available to any criminal justice authority including prison, jail, probation, parole or community mandated treatment; and c) If potential participants do NOT wish to participate, their normal time in the criminal justice setting (if applicable) for termination will not be affected. Potential participants who choose NOT to participate in the study protocol will not be identified in their records, and non-participation will NOT become a matter of official record in any file.

D. Dissemination Plans

Progress and products from this project will be communicated through the CJ-DATS newsletter, based in particular on the results of targeted intervention process and outcome studies published from these findings. Our assessment protocols and “approved” intervention manuals also will be posted on the CJ-DATS Web site for use without cost to the field. Dissemination and training procedures will be provided to our CJ-DATS partners (as time and resources allow), and offered if requested at appropriate professional conferences and through regional (e.g., ATTC) training venues.

E. Estimated Costs

As noted earlier, the Lead RC (TCU) will coordinate all aspects of this project as well as absorb the majority of data scoring and analytical burdens—including the costs associated with these aspects of the project. CRCs will be asked to cover the costs associated with working with their respective CPs (via the TIC Clinical Panel) in their efforts to identify priorities for targeted intervention topics, contribute edited manuals/modules as appropriate, and coordinate local evaluations in which their CPs participate. When project meetings are held, CRCs also will be asked to cover travel costs for their designated TIC Clinical Panel.

In serving as the Lead RC, TCU will cover costs associated with coordinating the final selection of targeted interventions by collaborators, providing assistance in the editing/reformatting implementation manuals, and coordinating (and sometimes providing) clinical training for the interventions to be evaluated, preparing and scoring optical scanning instruments for evaluations, creating master data files, and conducting pre-post outcome analyses for intervention evaluations.

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Instruments

[TIC Anger pre-post instrument](#)

[TIC CJ CEST Survey](#)

[TIC Communication pre post instrument](#)

[TIC Criminal Thinking pre-post instrument](#)

[TIC HIV pre-post instrument](#)

[TIC Motivation pre-post instrument](#)

[TIC Social Skills pre-post instrument](#){ TC "Instruments" \f C \l "1" }

Form Codebooks{ TC "Form Codebooks" \f C \l "1" }

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List of Available Datasets{ TC "List of Available Datasets" \f C \l "1" }

[TIC Anger module data](#)

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Published Articles{ TC "Published Articles" \f C \l "1" }

Morey, J., Knight, K., Simpson, D., & Flynn, P. (2007). A Brief HIV Risk Reduction Intervention for Substance-Abusing Offenders. *The Prison Journal*, 87.

Appendix A{ TC "Appendix A" \f C \l "1" }:

Links to the TIC Module Documentation

[Building Social Networks](#)

[Common Sense Ideas for HIV Prevention and Sexual Health](#)

[Getting Motivated to Change](#)

[Ideas for Better Communication](#)

[Understanding and Reducing Angry Feelings](#)

[Unlock Your Thinking: Open Your Mind](#)