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When Worlds Collide: Establishing CREST Outreach Center

James A. Inciardi and Dorothy Lockwood

During the past few decades, therapeutic communities (or TCs) have demonstrated considerable effectiveness in the treatment of substance abuse (De Leon, 1985; Yablonsky, 1989). Also, correctional administrators and clinicians have found TCs instrumental in combating both relapse and recidivism among drug-involved offender populations (Holland, 1978; Wexler et al., 1988; Field, 1989; Inciardi and Scarpitti, 1992). Therapeutic communities were first established in community-based settings for a variety of populations, including nonoffenders, probationers and parolees, and later for incarcerated populations. However, the practicality of a *community-based correctional TC* was untested until the beginning of the 1990s with the establishment of the University of Delaware's CREST Outreach Center, a work release therapeutic community program located in Wilmington, Delaware (Lockwood and Inciardi, 1993).

CREST Outreach Center represents the clinical component of one of the National Institute on Drug Abuse's (NIDA) treatment-research demonstration projects. CREST was established under an award to the University of Delaware in late 1990. The primary goal of the research is to examine the feasibility and clinical efficacy of a therapeutic community "work release" center for drug-involved felony offenders who have spent a number of years in the penitentiary. The issues of feasibility and efficacy are especially important since CREST represents the first attempt in the United States at developing a correctional work release program around a therapeutic community model.

THE UNIQUENESS OF CREST OUTREACH CENTER

Before proceeding, to better understand the issues and problems associated with establishing CREST, we will discuss the major ways that the program differs from conventional therapeutic communities. As such, the following discussion briefly examines the premises of therapeutic community treatment, the nature of work release, and a few considerations on a combination of the two.

To begin with, and for those unfamiliar with the concept, a "therapeutic community" is basically a total treatment environment in a residential setting. The primary clinical staff of the TC are typically former substance abusers—"recovering addicts"—who themselves were rehabilitated in therapeutic communities. The treatment perspective of the TC is that drug abuse is a disorder of the whole person—that the problem is the person and not the drug, and that addiction is a symptom and not the essence of the disorder. In the TC's view of recovery, the primary goal is to change the negative patterns of behavior, thinking, and feeling that predispose drug use. As such, the overall goal is a responsible, drug-free lifestyle (see De Leon and Ziegenfuss, 1986; Yablonsky, 1989).

The TC process builds on the self-help concept in which all residents are held accountable to themselves as well as the community. This accountability and the resulting responsibility are accomplished through both positive and negative pressures. Residents progress in their treatment through earned privileges. In other words, by strictly employing an explicit reward system, clients are recognized and compensated for their positive achievements and held accountable for their negative behaviors. This reward system is implemented through specific rules and regulations that serve both to guide the residents and to manage the facility. Although the rules vary from TC to TC and are numerous, several are integral to the operation of any TC, including prohibition of violence, theft, threatening behavior, and drug use. Violation of these fundamental rules results in immediate expulsion.

Based on our experiences with correctional systems and corrections-based drug treatment, and with the evaluation of a whole variety of correctional programs, it appears that the most appropriate strategy for effective TC intervention with inmates would involve a three-stage process. Each stage in this regimen of treatment would correspond to the inmate's changing correctional status—in-carceration, work release, and parole, or whatever other form of community-based correction operates in a given jurisdiction (Inciardi, Lockwood, and Martin, 1991).

The *primary* stage of treatment should consist of a prison-based therapeutic community designed to facilitate personal growth through the modification of deviant lifestyles and behavior patterns. The community is segregated from the rest of the penitentiary, and thus recovery from drug abuse and the development of prosocial values in the prison TC would involve essentially the same mechanisms seen in community-based TCs. As in other TCs, therapy in this primary

stage should be an ongoing and evolving process. Ideally, it should endure for nine to twelve months, with the potential for the resident to remain a few weeks or months longer, if necessary. As such, recruits for the TC should be within fifteen to eighteen months of their work release date at the time of treatment entry.

It is important that TC treatment for inmates begin while they are still in the institution, for a number of reasons. In a prison situation, time is one of the few resources that most inmates have an abundance of. The competing demands of family, work, and the neighborhood peer group are absent. Thus, there is the time and opportunity for comprehensive treatment—perhaps for the first time in a drug offender's career. In addition, there are other new opportunities presented—to interact with "recovering addict" role models; to acquire prosocial values and a positive work ethic; and to initiate a process of education, training, and understanding of the addiction cycle.

Since the 1970s, work release has become a widespread correctional practice for felony offenders. It is a form of partial incarceration whereby inmates are permitted to work for pay in the free community but must spend their non-working hours either in the institution or, more commonly, in a community-based work release facility or halfway house (Inciardi, 1993: 661–662). Inmates qualified for work release are those approaching their parole eligibility or conditional release dates. Although graduated release of this sort carries the potential for easing an inmate's process of community reintegration, there is a negative side, especially for those whose drug involvement served as the key to the penitentiary gate in the first place.

This initial freedom exposes many inmates to groups and behaviors that can easily lead them back to substance abuse, criminal activities, and reincarceration. Even those receiving intensive therapeutic community treatment while in the institution face the prospect of their recovery breaking down. Work release environments in most jurisdictions do little to stem the process of relapse. Since work releasees mirror the institutional populations from which they came, there are still the negative values of the prison culture. In addition, street drugs and street norms tend to abound.

Graduates of prison-based TCs are at a special disadvantage in a traditional work release center since they must live and interact in what is typically an antisocial, nonproductive setting. Without clinical management and proper supervision, their recovery can be severely threatened. Thus, *secondary* TC treatment is warranted. This secondary stage is a "transitional TC"—the therapeutic community work release center.

The program composition of the work release TC should be similar to that of the traditional TC. There should be a "family setting," removed from as many of the external negative influences of the street and inmate cultures as possible, and there should be the hierarchical system of ranks and job functions, the rules and regulations of the environment, and the complex of therapeutic techniques designed to continue the process of resocialization. However, the

clinical regimen in the work release TC must be modified to address the correctional mandate of work release.

In the *tertiary stage*, clients have completed work release and are living in the free community under the supervision of parole or some other surveillance program. Treatment intervention in this stage should involve outpatient counseling and group therapy. Clients should be encouraged to return to the work release TC for refresher/reinforcement sessions, to attend weekly groups, to call on their counselors on a regular basis, and to participate in monthly one-to-one and/or family sessions. They should also be required to spend one day each month at the program and participate in a weekend retreat every three months.

Within the context of work release, the treatment regimen at CREST Outreach Center follows a five-phase model over a six-month period (Inciardi, Lockwood, and Martin, 1991):

Phase One is composed of entry, assessment and evaluation, and orientation, and lasts approximately two weeks.

Phase Two emphasizes involvement in the TC community, including such activities as morning meetings, work, group therapy, one-on-one interaction, confrontation of other clients who are not motivated toward recovery, and the nurturing of the newer people in the environment. This phase lasts approximately eight weeks.

Phase Three continues the elements of Phase Two and stresses role modeling and overseeing the working of the community on a daily basis (with the support and supervision of the clinical staff). It lasts for approximately five weeks.

Phase Four initiates preparation for gainful employment, including mock interviews, seminars on job seeking, making the best appearance when seeing a potential employer, developing relationships with community agencies, and looking for ways to further educational or vocational abilities. This phase lasts approximately two weeks.

Phase Five focuses on reentry, that is, becoming gainfully employed in the outside community while continuing to live in the facility and serving as a role model for those at earlier stages of treatment. At the end of approximately seven weeks, which represents a total of twenty-four to twenty-six weeks at CREST, residents have completed their work release commitment and are free to live and work in the community as program graduates.

In all phases of treatment at CREST Outreach Center, urine is monitored on a regular, however unscheduled, basis. Since urine monitoring is an aspect of standard Department of Correction (DOC) work release procedures, sanctions for dirty urines are imposed by DOC staff, following DOC guidelines. Typically, dirty urines confirmed on more than two occasions can result in cancellation of work release and return to the institution. Finally, since less than half of CREST's residents have received their primary treatment in the institution, the work release TC environment represents secondary treatment for some and primary treatment for most. For each group there are alternative sets of orientations, goals, and expectations.

The project design to evaluate CREST is of a quasi-experimental nature with both treatment and control groups. The treatment group includes all CREST clients, while the control group is comprised of a sample of residents from Plummer Center, an adjacent state-operated work release center. Plummer Center represents conventional work release in Delaware. Inmates have relative freedom during working hours and are held in secure dormitories after 10 P.M. Both the control and treatment group respondents are selected in a quasi-random design from the general populations of the state's five correctional facilities. However, approximately one-fifth of the treatment group are graduates of The KEY, a prison-based TC located in Delaware's Multi-Purpose Criminal Justice Facility. These individuals, all of whom are men, have completed their primary treatment while incarcerated, followed by secondary treatment at CREST. As such, there are three research comparison groups:

1. those who receive their primary treatment at The KEY and their secondary treatment at CREST;
2. those who receive their primary treatment at CREST; and
3. those who are placed in the conventional work release setting and receive neither prison-based nor community-based TC treatment.

At any given time, the treatment population at CREST includes twelve women and forty-eight men. The research protocol includes a baseline and two follow-up interviews with all treatment and control subjects, as well as HIV and urine testing at each contact. The baseline interview is administered in prison, approximately ten days prior to an inmate's transfer to CREST or Plummer Center. The first follow-up occurs six months hence, corresponding with completion of work release (for the control group) or graduation from CREST (for the treatment group). The final interview is conducted eighteen months after baseline. Treatment dropouts are also followed. All three interviews elicit data on basic demographics, living situations, criminality, drug use, treatment, sexual behaviors and attitudes, HIV risks, and mental health indicators. Participation in the project is voluntary. All respondents are paid small stipends for participating in the interviews, and they may choose to be interviewed but not participate in the lab work.

The question of "feasibility" has marked the establishment of CREST and implementation of this research project since the outset. A primary concern involves how to mesh research, treatment, and corrections or how to introduce progressive treatment interventions into a traditional correctional system. A second concern involves how to implement and operate a therapeutic community for drug-involved offenders within the context and procedures of a traditional, highly conservative, university bureaucracy. A third concern involves establishing a treatment facility in a community where relations with both the University of Delaware and the Department of Correction have been strained.

ORGANIZATIONAL SETTINGS: WHEN DIFFERENT WORLDS COLLIDE

Establishing CREST Outreach Center was an undertaking that served to test the mettle, spirit, ardor, courage, stamina, and other earthly things from which the principal investigator (PI), the project director, their department chair, and numerous other persons were made. The problems were many, including:

1. coping with state and local politics;
2. working within sets of procedures and guidelines that were established for traditional university pursuits—higher education and scholarship—but at odds with the delivery of drug treatment services;
3. adjusting to the mistrusts that exist between corrections and treatment, and between treatment and research; and
4. surviving the failures and shortcomings of a “recovering addict” treatment director who, in retrospect, appeared to be functioning on the edge of relapse.

Choosing a Site

The initial choice for location of CREST Outreach Center was an old military hospital complex situated on the grounds of a former state mental health campus. *During World War II, the compound had been a U.S. Army facility and included several buildings with both dormitory and kitchen facilities. Several of these structures currently house drug rehabilitation and mental health programs.*

One building, about the size of a small, suburban high school, was vacant—quite ideal for a therapeutic community. During a tour of the facility, however, it became clear as to why it was vacant—miles of asbestos-covered ceilings, posts, pickets, pipes, ducts, and shafts. The NIDA project budget included funds for renovation and equipment, but the costs for asbestos removal exceeded grant allocations by a factor of five. The state, furthermore, was unwilling to undertake the cost, even though at the end of the project it would take possession of a fully renovated and equipped treatment facility. Months later, it was learned that the state’s Secretary of Health and Social Services was contemplating selling the campus land and buildings and, therefore, was resistant to considering establishing additional programs on the grounds.

Since Delaware is a small state (population of about 700,000 and a land area of less than 2,000 square miles), there were few alternative sites. In fact, the only other real option was two small vacant buildings that the Department of Correction was considering for administrative offices. One had been an American Legion post; the other, a small courtyard away, had been a funeral home. Both buildings, in considerable disrepair, were adjacent to Plummer Center, the Department of Correction’s conventional work release facility.

The property posed several limitations. First, located in Wilmington, it was

in the northern part of the state, making service to downstate clients more difficult. Second, and most important, establishing CREST at the American Legion/funeral home site meant that the clients' sleeping area would be in the existing work release facility. This was a major issue, posing problems of autonomy as well as separation from work release residents who were not only not in treatment, but also had a fundamentally different and less structured daily regimen. It is essential to the operation of any TC that the program maintain a level of sovereignty, particularly from the custodial character of "corrections" (Jones, 1980; Inciardi et al., 1992). It is equally essential that TC clients not interact with non-TC clients, particularly inmates or work release residents. CREST was intended to remove its clients from the negative aspects of the prison environment and culture, where manipulation and street attitudes and values are commonplace (Levinson, 1980; Field, 1989). As such, establishing CREST adjacent to Plummer Center posed threats to the ideal TC environment.

With no other immediate options and already six months into the project timeline, the site was accepted in a spirit of acquiescence. After another three-month delay, the Department of Correction purchased the buildings and agreed to a set of procedures and structural changes that would ensure that CREST clients need not interact with other work release clients.

Local Politics

When the grant was awarded, the university, the state, and the Department of Correction were congratulatory and supportive. Individuals from these institutions had been identified in, and collaborated with, the development of the initial application. However, when the site for the facility was selected, two additional groups emerged. The first was the community, and the second was a small collection of local politicians, with the majority of the latter being either political "has-beens" or "wannabees" who claimed to be representing the former.

Several community members had the traditional "not in my backyard" response to CREST. Not only were they resistant to a drug abuse treatment facility in their neighborhood, but also they were opposed to what they perceived to be an expansion of the existing work release center. Their complaints were not unjustified. In years past, projects had been foisted upon them without their knowledge or input. Locating CREST next to Plummer Center represented yet another entry to a long ledger of grievances. In actuality, the number of residents at the work release center would not (and ultimately did not) increase with the establishment of CREST. Instead, seventy of the existing work release beds would be dedicated to CREST. With the renovations needed to separate the men from the women, combined with CREST's intended capacity of only forty-eight men and twelve women, work release beds were to be reduced by ten. As such, the overall work release population would decline. When the community became fully aware of these facts, opposition began to evaporate.

On the other hand, there were a few community leaders that were not as

easily dealt with. For example, one former local politician wrote to NIDA arguing that the grant should have been awarded to him because the University of Delaware was a racist institution, both unworthy and incapable of implementing the project. After NIDA informed him that he was ineligible to receive the funds, that funding was for a specific research-driven effort, that the award was an outgrowth of a peer-reviewed and competitive process, and that the University of Delaware was indeed a legitimate recipient, he then decided that the project investigators should disburse a portion of the funds to him. Having no success, he then argued that he be put in charge of fiscal monitoring.

Unable to directly control the project, this same individual attempted to instigate public resistance to CREST. Through a public access television show, he often spoke of Delaware's "Seven Satans" (the names changed from time to time), and at one point the principal investigator appeared on the list. Yet this local community leader never made any explicit allegations of wrong-doing; he just wondered aloud about what was going on at CREST and continued to claim that the university was a racist institution.

Not everyone was quite so amiable. A few asked for full-time positions, consultantships, or at least paid transportation to out-of-town (and even international) conferences, accusing the project's investigators of bias, insensitivity, and mismanagement when they were turned down. Others spoke against the university and the project in the media and at public forums, and one even wrote to the director of NIDA and the U.S. House of Representatives with unspecified allegations of scientific fraud. Public relations and participation in community activities became essential, and in time, tensions declined and the project moved forward.

Building the Midnight Wall

The story of renovating the American Legion/funeral home property and the building of CREST Outreach Center represents an example of the old saying that "if you don't start a project yourself it will never get done, and if you start it yourself you're stuck with it until the end."

There was much to be done. The floors, walls, and roofs in both buildings needed major repair; heating, air conditioning, plumbing, and electricity needed upgrading; a kitchen and eating area had to be fabricated; partitions had to be built; and the entire facility, inside and out, needed painting and other cosmetic relief. In addition, the Department of Correction had agreed to construct a third building in the vacant space between the two existing structures.

From the outset, the investigators were under the impression that the Department of Correction, using inmate labor, would oversee the renovations. When the DOC failed to start the process, the project director agreed to initiate the paperwork—obtaining building permits, securing blueprints, and getting them approved through the city and the state. The first stumbling block was encountered when the city of Wilmington refused to issue a building permit because

the DOC's zoning variance was in question. The second occurred when the city noticed that the DOC's business license had expired. The third involved the Handicap Accessibility Board's finding that the renovation designs were unacceptable.

Having resolved all these problems, the inmate construction chief that was to oversee the work was transferred to manage a Maryland prison project. The substitute construction boss was far less talented, and from time to time the PI and project director had to discharge construction crews and start anew. The construction meandered along in a state of muddled chaos and confusion for about three months, until the first construction chief returned from Maryland and provided needed oversight.

In all, renovations occupied a year's time, and throughout that period both the project staff and the inmate workers met with resistance from several members of the correctional staff. One individual in particular tried to intervene in every aspect of the process, occupying himself with such issues as who was doing the work, who was being paid and who was paying them, who was ordering and inventorying supplies, and who was in charge. He even remained on the site until midnight one night, supervising the construction of a small partition that came to be known by the inmates and staff as the "Midnight Wall."

University Policies and Procedures

The grant that ultimately funded CREST Outreach Center was greeted with considerable jubilation at the University of Delaware when it first arrived. It was a rather large award, almost \$5 million—a grant of staggering proportions for a social science department. There was a press conference, with such notable attendees as the president of the university, the commissioner of corrections, the attorney general, the lieutenant governor, and even a member of the U.S. House of Representatives. Who knew the extent to which the award was to challenge university traditions and unmask its petty tyrants?

The first problem revolved around staffing. University positions and job descriptions pertain to faculty and professional and clerical staff, not treatment program directors, therapists, and "recovering addict" counselors and counselor trainees. New position descriptions had to be written and salary guidelines established. And whereas the salary structure of university faculty and professional staff positions are based on such logical and tangible qualifications as academic degrees, publications, and other evidence of scholarship, there are different standards in the TC business. Experience always outweighs earned degrees, and as such, salaries are based on a different set of credentials. Attempting to hire a treatment director with only a high school education at a salary higher than that of some full professors met with considerable resistance. Eventually, the concept of supply and demand prevailed, and a TC director was hired.

Curiously, however, while the university personnel department balked at the

director's salary, it established a salary structure that tended to overpay other positions. For example, "recovering" counselor trainees were paid at a rate 25 percent higher than the market. This resulted from the university's designation of these positions as "professional." Thus, the entry-level salary was inflated for the scope of work. This was a nonnegotiable matter as far as the university was concerned.

There was a related procedural problem. The actual recruitment and hiring process in universities is designed primarily for faculty and administrators. The process of establishing a position, writing a description, conducting a search, interviewing candidates, having the process and dossiers reviewed by the personnel department, affirmative action, and perhaps others is time consuming—typically taking months. It is a cumbersome process that people in TC counseling networks are unfamiliar with. As a result, there was considerable frustration, with many good counselor candidates unwilling to wait out the process.

Compensatory time (time off for overtime) was also a problem. Since university professionals are given substantial autonomy and responsibility regarding time and attendance, there is neither "overtime" or "comp time." But in order to ensure the safety, mental health, and personal and social growth of clients in a treatment environment, the need for compensatory time is not only unavoidable, but it is a standard practice in treatment facilities. Staff members should not leave in the middle of group or individual counseling sessions when their shifts end. In addition, special events, particularly those in which clients' families participate, require extra staffing. Because the treatment facility remains open seven days a week, concessions must be made for staff who work hours other than nine to five, Monday through Friday. Moreover, like hospitals and prisons, residential treatment programs do not close on holidays. But the university never did recognize compensatory time, much to the displeasure and irritation of staff.

Another major area of difficulty was associated with purchasing supplies for CREST Outreach Center. Although most items can be ordered in advance, many needs are unpredictable and must be obtained on the spur of the moment. The university had no mechanism for such situations, except reimbursing staff for using their own funds.

Social activities are also integral to TC treatment, serving to educate clients in acceptable entertainment and social outlets and associated behaviors and practices. Funds must be available to go fishing or to the movies, for ice cream, or to attend social functions. Although clients who are working are expected to pay for their own activities, those still in primary treatment have no income. Although the grant application had budgeted for these activities and the funding agency had approved them, the university accounting system deemed such expenditures as not reimbursable and, thus, "not allowable" costs. Again, this was a nonnegotiable matter. The only alternative was for the principal investigator to personally provide the program with a steady flow of petty cash reserves.

There were numerous other issues, but in short, the project introduced a dif-

ferent operating structure into a university system. Not surprisingly, the university resisted, and in doing so, it frustrated both staff and clients and often stalled the progress of the project and the implementation and process of treatment.

Treatment versus Corrections

Establishing CREST Outreach Center introduced treatment into a correctional environment (work release) where none had existed before. The fundamental philosophies of treatment and corrections are inherently contradictory. On the one hand, treatment is intended to provide clients with increasing responsibility and, therefore, greater freedom. The correctional perspective, on the other hand, is punitive and custodial, aimed at limiting freedom. As such, correctional authorities are hesitant to embrace treatment programs, and TCs in particular since residents direct much of the program operations themselves. Some prison-based TCs have hired correctional officers and trained them to work in the programs, satisfying both correctional and TC needs (Jones, 1980).

Although such an arrangement was accomplished in Delaware's prison-based TC (Hooper and Wald, 1990; Inciardi et al., 1992), due to budget constraints the Department of Correction was unable to provide correctional officers at CREST Outreach Center. As a result, many of the day-to-day monitoring activities were left to the responsibility of CREST counseling staff and university research personnel. Although CREST and correctional staff worked closely to ensure the safety of the clients and the community, many officers remained anxious about the arrangement, a consequence of which was numerous antitherapeutic incidents—interrupting group sessions for head-counts, conducting surveillance from the roof of the facility, entering the building through fire escapes for the sake of its "surprise effect," interrupting group meetings for extended periods and writing up clients for petty incidents, opening closets and sorting through materials, submitting reports that the building was left unsecured, and interrogating or second-guessing treatment staff on clinical issues.

Continuous communication and cross-training between treatment and correctional staff eliminated most of the misunderstandings and tension. Monthly meetings to discuss procedural issues and concerns about specific clients served to build consensus and problem resolution. Coordination between the treatment and correctional staff occurred to a great extent because of the support received from the warden at the work release center. Frequently, the bridge between treatment and corrections is built by a warden who supports and encourages treatment, and this was clearly the case at CREST.

Treatment versus Research

There were several issues that created tension between treatment and research staff. The first was associated with client selection, while the second related to process evaluation.

Client selection mechanisms in therapeutic communities are of several types. There are “walk-ins” seeking help who are screened and evaluated by staff to determine suitability for TC treatment. Prison-based TCs typically “recruit” candidates from the general prison population, followed by screening and evaluation by staff. Finally, many community-based TCs accept court referrals. In none of these scenarios are clients recruited through random assignment. The majority of CREST clients, however, are randomly assigned from a pool of work release eligibles who have a history of drug abuse. As such, there are a number of clients who are not particularly excited about the prospect of entering CREST but voluntarily accept the assignment because they feel that turning it down might delay their work release entry. Most of these adapt, but others do not, and a few try to poison the environment.

Within this context, the statement most indicative of the treatment staff’s mistrust/confusion of the research aspects of the project emerged when a counselor remarked: “Oh, so you don’t intentionally send us the most difficult people!” This comment came after the random assignment process was explained by the project director during a seminar to CREST staff. When it was acknowledged that neither NIDA nor the project researchers expected all clients to graduate from the program, and that CREST staff were not being graded on the number of client successes, there were expressions of relief. Research workshops have continued and have proven essential for good research/treatment relations. Although treatment staff remain ambivalent about random assignment, they are now willing to cope with the overall process.

The other aspect of the research design that caused misgivings was the process evaluation component of the study. The intention of the process evaluation has been to document treatment procedures and staff/client as well as client/client interactions. Observation of CREST operations and activities combined with interviews with CREST clients and staff represent the “data” for the process evaluation. In the early phases of the project, however, counselors felt as if they were being watched and evaluated. As was the case with random assignment, after the purposes of the process evaluation were fully explained, staff no longer objected to the presence of researchers in the treatment environment.

Harassment and Relapse

If the difficulties associated with coping with state and local politics, working within sets of procedures and guidelines that were established for traditional university pursuits, and adjusting to corrections/treatment and treatment/research mistrusts were burdensome, they were trifling when compared to what was yet to come.

The history of therapeutic communities is marked with instances of productive, creative, charismatic leaders abusing their power or relapsing to drug

use (Weppner, 1983; Bratter, Bratter, and Heimberg, 1986). CREST experienced the failure of its clinical director in both of these areas.

When the Center for Drug and Alcohol Studies at the University of Delaware hired a clinical director for CREST Outreach Center, many TC observers across the country considered the program to be quite fortunate. The new director had *excellent credentials*: He was a graduate of Daytop Village, and his experience included work in such notable therapeutic communities as Phoenix House in New York City, Spectrum Programs in Miami, and the prestigious Palm Beach Institute. He had distinguished himself as a consultant with state and federal treatment and justice agencies, and as a participant and speaker at national workshops and conferences. Established therapeutic community researchers and clinicians viewed him as a "gifted" TC clinician.

Shortly after CREST accepted its first contingent of women clients, numerous allegations of sexual harassment by the clinical director began to surface. Within hours of his suspension from program duties pending an investigation, he relapsed to cocaine use and was arrested on multiple charges of possession of drug paraphernalia (including crack vials, spoons with cocaine residue, and hypodermic needles and syringes). Weeks later he was rearrested for patronizing a prostitute. *Subsequent investigations by the University of Delaware, the State Attorney General's Office, and the Department of Corrections yielded numerous allegations of sexual harassment and sexual abuse of both program clients and staff (Wilmington News-Journal, May 8, 1992, pp. A1, A6; May 12, 1992, p. A1; June 2, 1992, p. B1; June 6, 1992, p. C5; June 16, 1992, p. B1; April 8, 1993, p. B3).*

Although numerous university, state, and federal officials expressed support for the program, the university's provost decided that the Center for Drug and Alcohol Studies (and, hence, the University of Delaware) should no longer be involved in the direct provision of drug treatment services. As such, he mandated that if the project were to continue, the treatment had to be contracted to an outside provider. Two program modifications resulted.

First, the treatment component of the project was subcontracted to Correctional Medical Systems, Inc. (CMS), the same provider that operates The KEY, Delaware's prison-based therapeutic community. Although this surrendering was viewed with disappointment by both the governor and numerous federal officials, the new arrangement compromised neither the treatment nor the research aspects of the project. Moreover, CMS provided an administrative structure far more supportive of the treatment environment than that rendered by the university.

Second, even before the contracting of the treatment component of the project, the management of the program transitioned from a total hierarchical structure to a team approach. Not only did this provide a check-and-balance system with a reduced potential for the misuse of power, but it also engendered a structure more adept at addressing the multitude of programmatic

needs, such as staff training, primary treatment, secondary treatment, work release, coordination with the Department of Correction, aftercare, family counseling, and social activities. Counselors were assigned a caseload of clients for whom they would be the primary individual counselors for the entire program period, further ensuring that the needs of the residents would be met in a timely manner.

POSTSCRIPT

Although developing the administrative and treatment structure at CREST Outreach Center was taxing, most of the treatment implementation problems *and program modifications* resulted from a client selection process implemented for the sake of scientifically assessing program efficacy. As noted earlier in this chapter, client selection is based on a random draw from the pool of work-release-eligible inmates. Clinical assessments of readiness and suitability for TC treatment are not considered. In many instances, CREST admits clients who under more typical circumstances would not be considered appropriate for a TC.

Program modification also occurred as the result of clients' legal status. Because CREST residents are under the custody of the Department of Correction, understanding and complying with sentences are a priority. Sentence requirements often conflict with treatment completion. TC "graduation" occurs when the client has worked through his or her issues and has demonstrated major behavioral and attitudinal changes. On the other hand, prison sentences are set to end on a specific date, regardless of treatment progress. Legally, clients cannot be retained in the program beyond the maximum expiration date of their sentence, regardless of treatment progress. Similarly, clients who progress through treatment and are ready for graduation cannot be released until their sentence is completed. As such, CREST orientation now focuses on teaching clients the differences between "doing time" and "doing treatment."

In addition, staff has also had to adapt treatment plans in accordance with clients' prison sentences. Because the client's residential treatment period is only six months, three of which are spent working at a regular job in the community, emphasis has been placed on reentry and continuing recovery outside the program. The goal of most TCs is to effect an entire lifestyle change (De Leon, 1986; Sugarman, 1986). CREST, due to the short length of stay, has adopted a more realistic goal of assisting and preparing clients to choose recovery as a lifestyle by exposing them to a variety of experiences and options, enabling them to begin their recovery process while at CREST.

All things considered, CREST is doing extremely well. It is about a year behind schedule, primarily due to delays in site selection and renovation. CREST survived the turmoil caused by its former clinical director. In fact, although many programs have collapsed from such incidents, CREST endured, losing no clients in the process. Six months later, it had a waiting list. CREST also sur-

vived the university's abdication and is beginning to attract both national and international visitors.

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