Assessment Centers of Community Education Centers

Introduction

The concept of an Assessment Center was developed by the New Jersey Department of Corrections in 1997 as a method of providing a "step down" process for male State prisoners who have attained full-minimum status. The Centers were designed to be relatively brief (60 to 90 days) placements in a secure setting. As soon as the inmate arrives at the Assessment Center, he is no longer addressed as an inmate rather he is addressed as a resident. While the difference in the terms may be viewed as a question of semantics, the change serves as a constant reminder that the person at the Assessment Center is one step away from the prison. Throughout the resident's stay, he is allowed visits and telephone calls, but he is not permitted to leave the grounds and no furloughs are granted under any circumstances.

History of the Assessment Centers

The history of the New Jersey Assessment Centers begins in 1998 with the opening of Talbot Hall in Kearny as a 500-bed facility. By March 1999, the Bo Robinson House in Trenton was transformed from a halfway house into a 320-bed Assessment and Treatment Center. The Assessment Centers were designed so that residents could participate in a comprehensive assessment and orientation to treatment regimen prior to their transition to a halfway house. Currently, residents at Talbot Hall reside at he facility for an average of 90-days, while the residents at Bo Robinson Center are placed for 60 days. The discrepancy of 30 days between the two Centers recognizes the fact that the Talbot Hall staff works with men whose needs are generally more extensive than the

residents at Bo Robinson. For example, Talbot Hall houses more residents classified as violent offenders than does the Bo Robinson Center.

Purpose of the Assessment Centers

As stated, the Assessment Centers' purpose is primarily twofold- an orientation to the treatment process and a comprehensive assessment of each resident. These purposes work in a coordinated method and treatment is conceptualized as a component of assessment and assessment as an element of treatment. Both assessment and treatment contribute to each other in a synergistic fashion creating a system that is greater than the sum of its parts. The following article will be an artificial delineation of treatment and assessment; however, in reality, they are linked together.

The comprehensive assessment of a resident combines the ongoing, naturalistic observations of the clinical staff with the objective instruments that are administered and interpreted by the assessment staff. The assessment process culminates in a summary report that includes the resident's scores on the tests, evaluations from the clinical staff, a comprehensive review of the official file, and information from the structured interview. The assessment's purpose is to provide detailed information for the Department of Correction's Classification Committee so that the Department of Corrections' personnel can determine placement for the resident. The assessment data are also used to formulate the resident' master treatment plan prior to his departure from the facility.

The orientation to treatment is meant to expose the resident to the elements of relapse prevention, to change criminogenic thinking patterns, and to develop a set of realistic goals that the resident can take with him to his next stop on his journey which is usually a halfway house. The resident is introduced to the treatment information through

lectures and small group interactions. Individual sessions with the Senior Counselor are utilized to develop the initial treatment plan and the Continuum of Care plan. The treatment combines features of cognitive-behavior therapy, primarily Rational Emotive Behavior Therapy (REBT), the principles of AA/NA, Reality Therapy, and the Seven Habits of Highly Effective People as designed by Stephen Covey.

The Assessment Process

Although a series of assessment instruments will be reviewed, no one instrument stands alone to determine the final recommendation for placement and treatment. The final recommendations for treatment and placement are based on the convergence of the information from a number of different vantage points. The resident is enlisted as an active participant in the assessment and treatment process and feedback about the assessment results are provided to the resident. The resident's response to the assessment feedback is considered a valuable source of clinical information.

The following represents an artificial breakdown of the various domains that are assessed.

Substance Abuse Assessment

The resident is administered the computerized version of the Substance Abuse Subtle Screening Inventory- 3rd version (SASSI-3) within the first five to seven days of his arrival. The SASSI includes items that assess the resident's open recognition of alcohol and drug use for the past six months prior to incarceration. In addition, there are items that contain subtle attributes that the research team at the SASSI Institute found distinguishes substance dependent individuals from non-dependent individuals (Miller,1994) . The SASSI team designed the items in the instrument with a disease

model of substance abuse in mind (in other words, without treatment the disease process will be degenerative and life-long, even with treatment, it is still a lifelong process). The SASSI results are sent to the assessment office for incorporation into the assessment report and also to the Senior Counselor's office to assist with the development of the resident's initial treatment plan.

The resident's file serves is considered a valuable source of information about the resident's substance abuse history. For example, many residents were administered the Addiction Severity Index (ASI) while in prison. If so, then the ASI results are incorporated into the assessment. If the resident was in a prison-based Therapeutic Community, the file may have a summary of his progress. Another source of information about substance abuse comes from the structured interview. During this interview, the resident is asked direct questions about his substance abuse history. The Assessment Counselor also gathers information from the resident's Senior Counselor about the resident's substance abuse. The substance abuse assessment comes from a convergence of sources and the recommendation about further treatment is based on information from multiple sources.

Cognitive and Vocational Assessment

The Wonderlic Personnel Test (WPT) is self-administered test that is administered in a group format soon after the resident arrives at the Assessment Center. The WPT assesses the resident's cognitive functioning in a number of domains including following instructions and solving problems independently. The WPT is a well-known test that is designed as a brief measure of intelligence (Wonderlic, 1999). Research has found that the WPT score is highly correlated with other measures of intelligence

including the Wechsler Adult Intelligence Scale (Frisch & Jossop, 1989). The WPT results are utilized by the Assessment Center staff in a number of ways. The results are initially used to assist in the staff in determining if a resident needs extra assistance in understanding the policies and procedures of the facility. Residents who score low on the WPT are assigned another resident as a "buddy" to provide extra support. At a later time, the WPT results are used in the assessment summary to assist with vocational planning for the resident as the WPT scores can be tied into levels of cognitive functioning required for different occupations. The Wonderlic Basic Skills Test (WBST) is a brief measure of the resident's math and language skills (Long, Artese, & Clonts, 1999). The WBST is administered to assess the resident's work-related math and language skills and the scores can be tied in with the Dictionary of Occupational Titles.

The residents are administered the Self-Directed Search (SDS), a self-administered, self-scored career interest inventory that is based on Holland's six-factor RIASEC (Realistic, Investigative, Artistic, Social, Enterprising, and Conventional) personality theory (Holland, Powell, & Fritzsche, 1994). The theory behind the SDS is that people are more likely to pick and persevere in a career that fits their personality style. For example, a person who scores in the Social and Enterprising category would be interested in careers where a person interacts extensively with other people. A vocation such as a counseling would fit well with a person who scored as Social and Enterprising.

The information from the WBST and the WPT and the SDS can be used in the halfway house for vocational planning to help match the resident with a job that aligns as closely as possible with his ability as measured by the WBST and WPT, and career interest as measured by the SDS.

Risk Assessment

The Level of Service Inventory-Revised (LSI-R) is a risk/needs assessment instrument with strong psychometric properties that includes an overall risk score that suggests the probability of recidivism and a series of recommendations based on the score (Andrews & Bonta, 1995). The LSI-R comprises subscales that include dynamic factors such as the Attitudes and Orientation subscale- these subscales can assist with treatment planning. For example, a resident who scores in the very high need range for the Education/Employment subscale can be funneled into a vocational training program at a halfway house. Because the LSI-R has a number of dynamic factors, the test can be re-administered to track the resident's progress as he works his way through a program. The LSI-R total score has been shown to have good predictive properties for classifying residents into high, medium, and low risk categories (Andrews & Bonta, 1995).

Residents who committed violent offenses, residents with a psychiatric history, or residents who exhibit behavioral problems at the facility are administered the Personality Assessment Inventory (PAI) to further determine level of risk. The PAI is a 344-item broadband personality inventory with 22 nonoverlapping scales. The test results include a full Aggression Scale, three Aggression subscales (verbal, physical, and attitude) and a Violence Potential Index that is not linked to the Aggression Scale (Morey, 1991). Other special instruments include the SARA (Spousal Assault Risk Appraisal Guide) for cases where there is concern about domestic violence. The SARA is a 20-item checklist with the scoring information coming from an interview and collateral sources (Kropp, Hart, Webster,& Eaves, 1999). The checklist includes a history of violating restraining orders and attitudes that support domestic violence as part of the items. The Psychopathy

Checklist: Screening Version or PCL: SV is utilized to assess the possibility that a high-risk resident has psychopathy. The scores from the PCL: SV are derived from a structured interview and collateral sources. The PCL: SV has 12 items including grandiosity, deceit, and impulsivity (Hare, 1991). In addition, violent offenders are administered the Aggression Questionnaire (AQ). The AQ is a 34-item specialized self-report instrument that assesses a variety of aggression domains including physical and verbal aggression, hostility, and indirect aggression (Buss & Warren, 2000).

Besides the administration of instruments, a structured clinical interview along with a comprehensive review of the file is carried out. The interview and file review information assess a number of domains including substance abuse, the resident's family system and his current level of risk for recidivism. During the interview, the counselor constructs a genogram with the resident. The genogram is a schematic representation of the resident's family with information that includes family supports, family history of domestic violence, family history of substance abuse, and family criminal history. The genogram highlights the possible generational transmission of criminogenic role modeling and substance abuse. The interview also includes questions about the resident's substance abuse history and treatment, psychiatric history, medical history, employment history, military history, religion, and hobbies/interests. The interview not only focuses on the resident's areas of need, but also, on areas of strength that can be used to moderate the risk factors in his life. The assessment counselor also notes how the resident behaved in the interview. Was he defensive with his answers? How cooperative was he with the assessment process? Was his story diametrically opposed to the file version of the current offense?

The Assessment Counselor also receives an evaluation form from the Senior Counselor that assesses the resident's progress in the facility. The counselor rates the resident's behavior, job participation, and overall program participation. Merits and demerits are attached to explain the ratings. This form provides dynamic information about the resident's behavioral status and is considered valuable data for assessment. One of the key differences between the Assessment Center and an individual psychological assessment is the fact that the clinical and assessment staff work together to gather information about the resident's needs and level of risk throughout his stay at the Center. Observational data from the clinical staff is considered critical information for the comprehensive assessment of the resident.

Education at the Assessment Centers

Residents who have not completed High School or earned a General Equivalency Diploma (GED) are evaluated with the Test of Adult Basic Education or TABE. This test assesses the resident's current reading and math levels to assist with classroom placement for GED instruction. Residents without their GED are prepared for this test through the INVEST learning program. INVEST is a computerized tutorial program that evaluates a resident's math and language levels then it uses the information to develop an individually tailored curriculum to assist the resident as he prepares for the GED. For those residents who are not able to use the INVEST due to an extremely low reading or math levels, small group instruction is provided. If the resident does not attain his GED at the Assessment Center, then he can take his computer disk with his individualized program on it to the halfway house, as long as the halfway house has INVEST at its facility. Recently, The Assessment Centers became certified GED testing sites. On

September 18th, 2000, the Assessment Centers conducted their first GED testing with a group of residents. If the resident has not completed his GED at the Assessment Center, then the resident can take the data from his INVEST learning on a computer disk and continue his GED preparation at the halfway house.

Treatment Process

Simultaneous with the assessment process, the residents are also given an orientation to treatment. The treatment processes, like the assessment procedures, begins with the resident's arrival. Initially, a significant amount of time is spent by the operational and clinical staff in orienting the resident to the facility and its rules and regulations. During the resident's orientation period, he is given a pre-test to determine his baseline level of knowledge about the treatment and relapse prevention process. An initial treatment plan is developed with the resident through an individual interview and review of the SASSI results. Throughout the course of his stay, the residents are exposed to information about relapse prevention and changing criminogenic thinking in a didactic and small group format. Near the end of his stay the resident is given a post-test to gauge how much he has learned about the treatment process.

Other programs for residents include a Family Services program to help residents stay connected and/or build connections with their families, especially their children. Recognizing the need for aftercare, an Alumni program was instituted to assist the residents in finding employment, applying for college and financial aid, and other services after they are finished with their incarceration. All residents fill out a resume to take with them to assist with job search.

The Continuum of Care or Master Treatment Plan

Throughout the resident's stay at the Assessment Center, he and his Senior Counselor are working together to draw up a master treatment plan or continuum of care plan. The care plan includes the following categories: health/substance abuse, anticipated recovery plan, a support network, criminal relapse prevention, psychological recovery, family support, educational plans, employment history, transportation needs and vocational/educational plans. This plan represents a combination of the dynamic (changeable) and static (unchangeable) factors that will impact in a positive or negative manner towards reducing the resident's level of recidivism. The plan also includes moderating factors such as whether or not the resident has a supportive network in the community. At the end of the plan, the senior counselor writes up a discharge summary and treatment goals. After the continuum is completed with the resident and he signs the form, the information is passed onto the halfway house for further review.

Classification Committee

Near the end of the resident's stay, he meets with the Department of Corrections (DOC) staff to determine his placement. The Department chairperson and two other DOC personnel review the resident's file and the Assessment Counselor summarizes his/her results and provides a recommendation for placement. After a careful review of the information, the Department chairperson determines placement for the resident. Residents are classified to halfway houses that either have intensive substance abuse treatment as a component of the services or halfway houses that provides a less intense level of treatment. Approximately ten per cent of the residents who are presented to the Classification Committee are deemed inappropriate for placement because their

assessment does not support their community placement. These residents are returned to their sending institutions for placement in a minimum-security prison.

All halfway houses have a work release component and some educational opportunities. The halfway houses are sent a copy of the resident's assessment package to assist them with initial treatment planning. Prior to leaving the facility, the resident signs a release of information so that the material can be transferred to the halfway house.

Summary

The Assessment Centers in New Jersey operate as modified therapeutic communities to assist full-minimum status prisoners as they re-integrate back into their respective communities. The work is carried out in a secure environment and the residents follow a highly structured regimen throughout their internment. The Assessment Centers staff provides information in a didactic and small-group format about altering criminogenic thinking and relapse prevention from drug/alcohol abuse. In addition, the resident is a participant in a series of tests, interviews, and surveys that assist him in developing, with staff assistance, a comprehensive assessment package and continuum of care plan. A strong component of the Assessment Centers is the fact that the Center staff work together in a systematic fashion in carrying out the goals of the Center. Information that enhances the resident's assessment comes from the clinical staff and the assessment staff provides data to the clinical staff for therapeutic interventions during the resident's stay.

The Center staff is in the early phases of research in an effort to provide validation of this approach as a way of reducing recidivism and enhancing the quality of life for residents as they re-integrate back into society. Data from the comprehensive

assessments are being analyzed in order to discover possible ways to increase the effectiveness of the treatment programming for the residents.

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