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Treatment Needs and Strategies for Individuals in Particular Criminal Justice Settings

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This distance learning course was developed for CEUMatrix by Ed Roberts, M.A, LCDC, CCJP. It is based on information found in the Treatment Improvement Protocol (TIP) Series 44 – *Substance Abuse Treatment for Adults in the Criminal Justice System. (*Center for Substance Abuse Treatment. *Substance Abuse Treatment for Adults in the Criminal Justice System.* Treatment Improvement Protocol (TIP) Series 44. DHHS Publication No. (SMA) 05-4056. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2005.)

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Treatment Needs and Strategies for Individuals in Particular Criminal Justice Settings

Introduction

> When the prison gates slam behind an inmate, he does not lose his human quality; his mind does not become closed to ideas; his intellect does not cease to feed on a free and open interchange of opinions; his yearning for self-respect does not end; nor is his quest for self-realization concluded. If anything, the needs for identity and self-respect are more compelling in the dehumanizing prison environment.
>
> —Thurgood Marshall (*Procunier v. Martinez.* 416 U.S. 396 [1974])

Research consistently demonstrates a strong connection between criminal activity and substance abuse (Chaiken 1986; Inciardi 1979; Johnson et al. 1985). Eighty-four percent of State prison inmates who expected to be released in 1999 were involved with alcohol or illicit drugs at the time of their offense; 45 percent reported that they were under the influence when they committed their crime; and 21 percent indicated that they committed their offense for money to buy drugs (Office of National Drug Control Policy [ONDCP] 2003). Data from the Arrestee Drug Abuse Monitoring program indicate that in 2000, 64 percent of male arrestees tested positive for at least one of five illicit drugs (cocaine, opioids, marijuana, methamphetamines, and PCP). Additionally, 57 percent reported binge drinking in the 30 days prior to arrest, and 36 percent reported heavy drinking (Taylor et al. 2001).

The consequences of crime related to substance abuse are substantial. The Bureau of Justice Statistics reports that in 1999 alone, 12,658 homicides—4.5 percent of all homicides for that year—were drug related (Dorsey et al. 1999). The emotional costs to people with substance use disorders, their families, and the victims of their crimes are immeasurable. The ONDCP estimates that the total crime-related costs of drug abuse were more than $100 billion in 2000 (ONDCP 2001).

The devastating emotional and financial costs of drug-related crimes have led to a number of strategies to break the link between drugs and crime, including stricter drug laws, "three strikes and you're out" legislation, increased surveillance, mandatory sentencing laws, and severe penalties for drunk drivers, to name just a few. These approaches have had mixed results, and opinions vary on their usefulness.

One consistent research finding is that involvement in substance abuse treatment reduces recidivism (a tendency to return to criminal habits) for offenders who use drugs (Anglin and Hser 1990; Harwood et al. 1988; Hubbard et al. 1984, 1989; Knight et al. 1999*a* ; Martin et al. 1999; McLellan et al. 1983; Wexler et al. 1988, 1999*a* ; Wisdom 1999). For example, when researchers conducted follow-up studies of clients treated through comprehensive treatment demonstration programs funded by the Center for Substance Abuse Treatment (CSAT), they found substantial reductions in criminal activity, including a 64-percent decrease in arrests (Wisdom 1999). In part because of the reduced criminal activity associated with substance abuse treatment for offenders, treatment has also been found to be cost-effective. According to the California Drug and Alcohol Treatment Assessment study (Gerstein et al. 1994), for example, every dollar invested in treatment saved approximately $7 in future costs.

This course will look at the treatment needs and strategies for individuals in particular criminal justice settings. Each of the four Chapters of this course will look at one of the following specific settings:

Treatment Issues Specific to Pretrial and Diversion Settings

Treatment varies not only because of the specific population to which an offender belongs but also because of a client's stage in the criminal justice system. After arrest and before trial, a large number of individuals move relatively quickly through the system, and many different agencies are involved with each case and its supervision. If offered, the offender may opt for treatment instead of formal charges, trial, sentencing, incarceration, or to reduce the length of incarceration.

Variations in local prosecution and diversion practices may affect a jurisdiction's ability to develop criminal justice and treatment linkages. Not all jurisdictions have established procedures or programs for individuals who abuse substances; those jurisdictions that do have programs to treat offenders often maintain such programs with limited resources. However, the pressure of overcrowded jails and prisons is serving to expand and institutionalize programs for drug treatment in pretrial and diversion settings nationwide. Still, outside of formal drug court and diversion programs, treatment access is limited. Types of treatment used in the pretrial setting are necessarily brief and include brief motivational interventions, behavior contracts, and referrals to detoxification and other services. A variety of sanctions also are available.

In the pretrial setting, the question of an individual's guilt or innocence has not been legally determined. It is vitally important, therefore, to note that

treatment should not compromise the due process rights of defendants. Treatment professionals need to bear in mind the presumption of innocence that exists during the pretrial period. Defendants' due process rights affect what they are willing to agree to and the type of information that they are willing to disclose. Defendants should not `be coerced into waiving due process rights, although a court may order substance abuse treatment as a condition of pretrial release.

Treatment Issues Specific to Jails

Those incarcerated in jails are undergoing significant stress related to arrest, the uncertainties of their legal situation, and the potential loss of their job or custody of their children. Appropriate treatment services for these individuals are based on the expected duration of incarceration and the information obtained from screening for a variety of possible problems. Brief treatment (less than 30 days) usually focuses on supplying information and making referrals but can include motivational interviewing. Short-term programs (1–3 months) have the time to work on communication, problem solving, and relapse prevention skills; introduce anger management techniques; and encourage participation in self-help groups. Longer term programs (3 months–1 year) can provide additional skills training, vocational and educational activities, and examine criminal thinking errors. The consensus panel recommends that jail staff implement discharge planning that includes gathering information regarding the need for a range of community services, including housing and health care.

Treatment Issues Specific to Prisons

The unique characteristics of prisons have important implications for developing and implementing treatment programs. In-prison drug abuse treatment, particularly when followed by community-based continuing care treatment, has been credited with reducing short-term recidivism and relapse rates among offenders who are involved with drugs. More recently, the sustained effects on longer term outcomes have been documented by studies indicating that 9–12 months of prison treatment followed by at least 3 months of community treatment are needed to produce significant improvement and reductions in recidivism and relapse. Because of the comparative stability of the prison population, several treatment options of differing intensities can be made available. The full range of services can be offered, including comprehensive assessment; treatment planning; placement; group, individual, family, and specialty group counseling; self-help groups; educational and vocational training; and planning for transition to the community. Therapeutic communities (TCs) are among the most successful in-prison treatment programs. They are highly structured, hierarchical, and intense interventions lasting a minimum of 6 months. TC participants live together, often separate from the general prison population, and take responsibility for their recovery

process. Participants work at increasingly more responsible positions as they learn self-sufficiency and become competent.

Treatment for Offenders Under Community Supervision

Parolees and probationers are both under community supervision; nonetheless, they generally represent different ends of the criminal justice continuum. Whereas parolees are serving a term of conditional supervised release following a prison term, probationers are under community supervision instead of a jail or prison term. Both parolees and probationers generally can be controlled and managed effectively by a combination of treatment and surveillance while under community supervision at a far lower cost than incarceration in jail or prison. The level of supervision varies according to individual circumstances, including the terms under which probation or parole was granted. Offenders under community supervision in urban areas who have substance use disorders have available several levels treatment and supervision, including residential, outpatient, halfway, and day reporting centers. Parolees may have difficulty meeting their basic needs when they are released and benefit from case management services to help with housing and employment. Reunification with family members and social support may also prove problematic.

Relapse prevention is extremely important for those under community supervision. Relapse, which is not unusual, can be met by increased supervision and an intensification of the level of treatment. Likewise, the intensity of supervision and treatment should decrease as the individual meets treatment goals. For both parolees and probationers, reassessment should be periodically conducted throughout the phase of community supervision. Following their contact with the criminal justice system, both parolees and probationers benefit from continuing contact with the substance abuse treatment system as a means of reducing relapse and recidivism.

Chapter 1:

Treatment Issues in Pretrial and Diversion Settings

The pretrial period of criminal justice processing is unique in that for most people it is brief and the outcome is uncertain. Yet, it represents an opportunity to identify those who could benefit from substance abuse treatment and begin to engage them in the process. Providing effective services at this early stage of involvement with the criminal justice system can result in heightened motivation to seek treatment and decreased recidivism.

After characterizing the population of arrestees, this chapter describes the processes of arrest, arraignment, plea bargaining, trial, presentencing, and sentencing. Diversion to treatment can occur at several points during the pretrial phase. Several types of diversion, including drug treatment courts, are discussed. The chapter continues with a discussion of some of the strategies that are effective during the pretrial stage, as well as some of the issues that are specific to it. Some of the qualities of effective pretrial and diversion programs are the next topic: the staff resources, training, coordination, program components and procedures. Finally, the chapter describes several existing diversion programs and lists resources, research findings, and conclusions.

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- **Conclusions and Recommendations**

Introduction

There are several challenges in developing treatment interventions during pretrial criminal justice processing and the presentencing phase. A large number of offenders move relatively quickly through the system, and many different agencies are involved with each case and supervision. At the pretrial stage, offenders have been charged with a crime, not convicted, and involvement with treatment may or may not be in the offender's legal interests. The trauma and uncertainty of the arrest can either help or undermine motivation for treatment. Diversion to treatment can occur at several points before incarceration. The offender may opt for treatment in lieu of incarceration or to reduce the length of incarceration by participating in treatment.

Variations in local prosecution and diversion practices may affect a jurisdiction's ability to develop the criminal justice treatment linkages presented in this chapter. Not all jurisdictions have established procedures or programs for clients who abuse substances; those jurisdictions that do have programs to treat offenders often maintain such programs with limited resources. Recognizing the disparities between available treatment programs for offenders, the following observations should be viewed as a starting point for discussions of treatment in pretrial and diversion settings.

- Expanding and institutionalizing pretrial treatment services are important goals. The pressure of overcrowded jails and prisons is expanding and institutionalizing programs for drug treatment in pretrial and diversion settings nationwide. In the past, the criminal justice system and the treatment community have often operated independently, but the advent of drug courts and other diversion programs has created a better climate for collaboration.

- Treatment remains a low priority in the criminal justice system at the pretrial stage, although it has been credited with helping to reduce criminal behavior. Each jurisdiction decides what priority to give substance abuse treatment and whether it merits significant financial resources. Outside of formal drug court and diversion programs, treatment access is limited.

- Pretrial defendants are often uncertain as to the status of their case and experience significant disruption related to their arrest. The uncertainty of their case disposition influences a counselor's ability to engage an individual in treatment. For example, defendants may be unsure whether treatment will be required by the court as part of their sentencing arrangements, or whether voluntary pretrial involvement in treatment would be more rigorously monitored than standard probation that they would receive as an alternative to involvement in diversion programs. For some, the arrest provides strong motivational leverage to engage individuals, while for others, the stress related to arrest and lack of clarity regarding their case disposition makes offenders less receptive to treatment.

This chapter highlights some of the innovative programs to treat offenders and the issues that substance abuse treatment and criminal justice personnel are likely to encounter when treating clients in a pretrial or diversion setting.

Characteristics of the Population

In 2000, the Arrestee Drug Abuse Monitoring Program (ADAM) collected data on male arrestees from 35 urban sites (National Institute of Justice 2003). Of the male arrestees tested and interviewed, more than 50 percent from every site tested positive for at least one drug. Marijuana was the drug detected most frequently, followed by cocaine.

In the 29 sites where data were collected on women, more than half tested positive for at least one drug. Unlike the male arrestee population, cocaine was most frequently detected among female arrestees, followed by marijuana and methamphetamine (National Institute of Justice 2003).

Nationally, 65 percent of all arrestees test positive for an illicit drug. Seventy-nine percent of arrestees are "drug-involved," meaning they tested positive for a drug, reported that they had recently used drugs, had a history of drug dependence or treatment, or were in need of drug treatment at the time of their arrest (Belenko 2000).

Approximately 13.6 million arrests were made in 2003, including 1.7 million for drug violations, the largest category of arrests. Seventy-seven percent of all the individuals arrested in the United States during 2003 were male. This represents a 0.4 percent drop in the arrests of males and a 1.9 percent increase in the number of arrests of females compared to 2002 figures. Drug- and alcohol-related arrests occurred at a rate of 1,470 per 100,000—the most numerous of crime types (Federal Bureau of Investigation [FBI] 2003).

In 2003, of arrests nationwide, 71 percent were Caucasian, 27 percent were African American, and the remainder were of other races. Race distribution figures also showed that Caucasians accounted for 68 percent of the property crime arrests and 61 percent of the violent crime arrests (FBI 2003).

Despite the common assumption that most offenders are incarcerated shortly after arrest, studies show that the majority of drug-involved offenders are supervised in the community following arrest. For example, in 1996 in large urban areas, 62 percent of drug traffickers and 71 percent of other drug offenders were released before trial (Dorsey and Zawitz 1999).

National Arrest Highlights in 2003

- Estimated total U.S. arrests: 13,639,479.
- Number of arrests for drug law violations: 1,678,192.
- Number of arrests for driving under the influence: 1,1448,148.
- 83.7 percent of arrestees were aged 18 or older.
- 46.3 percent of arrestees were under age 25.
- 76.8 percent of arrestees were male.
- Drug arrests rose 22.4 percent between 1994 and 2003 while total arrests declined 2.8 percent.
- Between 1994 and 2003 the number of females arrested increased by 12 percent while the number of males decreased by 7 percent (FBI 2004).

The Need for Treatment Services

Very few arrestees were in treatment at the time they entered the criminal justice system, yet 24 percent of those interviewed for the ADAM study in 1997 indicated that they needed treatment. Thirty-six percent of arrestees reported use of cocaine, but only 6 percent had ever received drug treatment (National Institute of Justice 2000).

Advice to the Counselor: General Considerations for Working with Clients in the Criminal Justice System

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- Treatment should not compromise the due process rights of defendants.
- Treatment professionals should bear in mind the presumption of innocence that exists during the pretrial period.
- Defendants' due process rights are of vital interest and affect what they are willing to agree to and the type of information that they are willing to disclose.
- Defendants should not be coerced into waiving due process rights.

Treatment Services in the Pretrial Justice System

The process through which an accused individual moves from arrest to full discharge of a sentence has many decision points, each with many variations from jurisdiction to jurisdiction, and each with many decision makers and possible decision outcomes.

Advice to the Counselor: Diversion to Treatment Decision Points

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Diversion to treatment can take place at several points in the criminal justice process:

- After arrest and prior to initial arraignment or bail hearing
- After initial arraignment appearance or bail hearing
- After preliminary hearing/probable cause hearing
- After guilty plea but before sentencing
- After conviction and sentencing, with sentencing suspended pending treatment completion

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Arrest

Arrest is the taking of a suspect into legal custody by police, probation or parole officers, or other authorized officials. Arrest may be authorized pursuant to a judicial warrant, which is issued when there is probable cause to believe that a crime has been committed and that the suspect committed the crime. Arrest without a warrant may be made by a police officer when there is probable cause to believe a felony was committed by the suspect. Arrests for misdemeanor violations generally require a warrant, except when the arresting officer sees the suspect committing the misdemeanor (e.g., in some cases of drug possession). Police have some discretion in whether to make arrests, although some jurisdictions have mandated arrest in certain situations, such as domestic violence or drunk driving.

For many individuals, further involvement in the criminal justice system might be prevented if police were informed about substance abuse and empowered to make referrals to a responsive treatment system. When possible, police officers should use their community contacts to explore substance abuse treatment services options for individuals involved with substances who come to their notice but who are not arrested.

From a treatment perspective, arrest and the related crisis may have a positive outcome. Arrest can be a significant event in a person's life, and for offenders whose arrest was related to their substance abuse, the event might make it difficult for the person to deny substance abuse problems. Arrest offers the opportunity for the individual to voluntarily choose to enter substance abuse treatment. Thus it is important for connections to be made between the treatment and criminal justice systems at this point. Representatives from both the criminal justice and substance abuse treatment systems can view arrest as an important point from which to establish linkages, engage the defendant in interventions, and promote collaboration between the systems.

It must be noted, however, that involvement of substance abuse treatment providers at the point of arrest may raise constitutional issues. If the arresting officer transfers the individual to substance abuse treatment rather than to the criminal justice system (which has laws protecting defendants' rights), questions may be raised about due process, civil liberties, and extension of the criminal justice system beyond permissible bounds. Once an individual has been arrested, the defendant is subject to the authority of the criminal justice system even if he or she has been transferred to treatment. The level of responsibility granted to the treatment program should be defined clearly, understood by both systems, and incorporated into the information flow between systems.

Arraignment

Arraignment is a technical term signifying presentation of the charges to the defendant. In many jurisdictions the term is reserved in felony cases for the presentation of charges in superior court. A first appearance is held in the lower court after arrest for bail setting and probable cause review. This hearing is not referred to as an arraignment.

The period of time between arrest and arraignment is a window of opportunity to intervene and articulate the value of substance abuse treatment. Drug testing, screening, and assessment for substance abuse and dependence, needs assessment in other areas, and relapse prevention are important components of intervention at this time as well as at other points along the continuum. A multidisciplinary approach, with treatment providers available to work with police and court personnel to guide offenders who abuse drugs into treatment.

During arraignment, charges are brought against the defendant, and the defendant is informed of his rights. The defendant then enters a plea in response. Additional personnel, including staff from pretrial service agencies, judges, prosecutors or defense attorneys, court referral officers, and representatives of referral systems, handle this process and become involved as the defendant moves through the arraignment process. Each of these individuals can refer the defendant to substance abuse treatment services.

As a result of the arraignment, a defendant can be released on his or her own recognizance (i.e., a sworn promise to return); detained pending the posting of a certain amount of bail; detained with no bail (very unusual); or released under certain conditions, such as keeping a curfew, reporting periodically to a supervising officer, or wearing an electronic tracking device.

Pretrial Diversion: Supervision in Lieu of Detention

An increasingly common condition of release is participation in some form of treatment in which a pretrial supervision agency or probation department monitors compliance. Should the individual fail to comply with the conditions of release, he or she can be returned to jail for detention prior to trial. Successful completion of the treatment or other conditions can mitigate the sentence imposed by the court if the offender is convicted. Ideally, judges should mandate as a condition of release that offenders receive treatment within 24 hours.

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Pretrial Diversion: Treatment in Lieu of Prosecution

In some instances, arrest charges against the defendant are dropped if the person completes treatment. The decision to order treatment as part of pretrial diversion typically, though not always, rests with the prosecutor's office. The prosecutor offers to cease all prosecution of the case if the defendant completes the prescribed treatment regimen. However, if the defendant fails to complete the treatment and to satisfy the other conditions of diversion, he may risk being sentenced more harshly (if prosecution proceeds and a conviction results) than if the individual had never entered the diversion program.

Because pretrial diversion occurs before an individual enters a guilty plea or is convicted by a judge or jury, the defendant is still technically innocent. Anxiety about the outcome of pending charges may motivate those charged to agree to treatment, and many treatment providers view this as an ideal time to intervene and offer the individual an opportunity to participate in treatment.

Plea Bargaining

With court docket overcrowding, plea bargaining is used in a large number of cases. In a plea bargain, defendants are allowed to plead guilty to lesser charges than the charges that they would have had to face at trial. In most cases, especially misdemeanors or low-level or nonviolent felonies, the sentence is agreed to by prosecutor and defense attorney as part of the plea bargaining agreement. So although judges have the power to change the sentence, they generally do not do so except in unusual circumstances.

Incorporation of substance abuse concerns into the plea bargaining process is a key element in strategies to link the justice and treatment systems. A requirement that the defendant enter treatment can be part of the plea bargain. Many systems are finding that getting defendants into treatment at this point is successful because they are ready for services. However, just as overcrowded court dockets force the hand of criminal justice system officials on certain decisions, overcrowded caseloads can make it difficult for treatment programs to accept new clients. In some cases, defendants who are placed on waiting lists for treatment can be involved in substance abuse education or treatment orientation groups, so that they do not lose track of the need for recovery and treatment involvement.

Pretrial Diversion: Probation Before Judgment

Another form of pretrial diversion is Probation Before Judgment. Under this scheme, the defendant is placed on probation (usually unsupervised) and the charges are pending. If the probation is completed successfully (which may include court-ordered treatment) then the charges may be dropped. This happens commonly in regular traffic court but can be used as a mechanism within diversion programs as well.

Advice to the Counselor: **Information Management During the Pretrial Stage**

- Information management is the key to identifying treatment needs and can provide treatment and related services during the pretrial stage more effectively.

- Because of the complexity of the pretrial phase (with many different agencies involved in a short or uncertain time period), it can be difficult to access necessary information on a timely basis. Also, treatment providers may not be permitted to provide certain information regarding clients to criminal justice staff. As a result, the information needed for clinical or case decisions may not be available at the appropriate time.

- Pretrial information about a defendant can be grouped into the following categories:

    - Criminal record
    - Prior compliance with supervision
    - Pretrial evaluation
    - Substance abuse assessment information
    - Substance abuse treatment information
    - Mental health treatment
    - Relevant medical information

Trial and Postverdict Periods

Trial

A trial is a court hearing in which a prosecutor presents a case against the defendant to show that he or she is guilty of a crime. The defendant presents information to support the plea that he or she is not guilty. A judge or jury decides the verdict.

Presentencing

Presentencing is the period after a guilty plea is entered (in cases that are plea bargained) or after a conviction is handed down (in cases that go to trial).

Prior to sentencing, a presentence investigation is usually conducted. The investigation is conducted after the plea is entered or after the conviction is handed down. In some plea-bargained cases, a plea may be withdrawn after the presentence investigation is completed and sentencing recommendations are made. However, in some jurisdictions, the prosecution conducts an investigation prior to making the plea offer, thereby preventing the problem of changes in plea at the sentencing stage.

Many jurisdictions have presentence investigation agencies that specialize in writing the presentence report. Elsewhere, probation officers compile the report. The sentence or penalty handed down by the judge is based on the information compiled in the report. Therefore, with more relevant information available, the judge is better equipped to make an appropriate sentencing decision.

This is another point where linkages between the substance abuse treatment and criminal justice systems are crucial. It is suggested that some sort of preliminary assessment be conducted at this stage, if one has not yet occurred in the earlier stages.

In many States, serious legal constraints preclude sharing information contained in the presentence investigation. In some States, only the judge can see the report—not even the defendant can see it. However, the presentence investigation report may contain information highly relevant to developing a substance abuse treatment plan for the individual. To avoid duplication of efforts in gathering needed information at various stages of the justice-treatment continuum, planners should investigate ways to ensure that critical information follows the individual through the process without breaching confidentiality.

Sentencing

If the verdict is "guilty," either the judge or the jury, depending on the State, determines the sentence or the penalty imposed in the case. In many States, the sentence or penalty is based partially on the information that has been compiled in the presentence investigation report. Increasingly, States are passing laws to ensure that the penalty is based on the offense without regard to information contained in the report. Laws requiring the sentence to be based on fixed criteria are known as *sentencing guidelines*, and their purpose is to eliminate wide judicial discretion that can result in disparate sentences by jurisdiction within a system or even by courtroom. However, these guidelines allow for very little flexibility based on defendant-specific factors such as substance use or mental disorders.

Diversion to Treatment

Much of the substance abuse treatment that occurs in the pretrial setting is in the form of diversion from prosecution into treatment. In other cases, diversion is conducted after conviction but before sentencing. This model is used extensively by drug treatment courts (DTCs) (see description below) and provides safeguards so that prosecutors can effectively reinstate charges for those individuals who are unsuccessfully terminated from diversion programs. Diversion is a "multi-systems collaboration between criminal justice and community-based agencies [that] allows programs to begin to address potential contributing factors to recidivism" (Broner et al. 2002, p. 87). It is a "mechanism to identify those in need of treatment, to broker treatment, housing, medical care, vocational and educational training, and often to remain involved with the individual . . . in the community" (Broner et al. 2002, p. 97). DTCs are a primary mechanism through which offenders are diverted into treatment. Diversion to treatment depends to a large extent on the statutory framework that guides processing defendants and to the prosecutor's approach on resolving cases through placement in treatment.

Drug Treatment Courts

In communities throughout the United States, DTCs are dramatically changing the way the criminal justice system deals with offenders who use drugs. Drug courts and other diversion programs hold considerable promise for engaging and retaining offenders who are involved with drugs in treatment and related services. DTCs share the underlying premise that drug abuse is not simply a criminal justice system problem, but a public health problem. American University's Drug Court Clearinghouse and Technical Assistance Project documents over 1,000 operational drug courts as of December 2003, with many more in the planning process. Preliminary outcome research indicates that DTCs are effective in

engaging and retaining offenders in treatment and can significantly reduce criminal recidivism during program participation and following release from the DTC (Belenko 2001). Successful implementation of DTCs has stimulated the development of several other "specialty court" approaches for substance-involved populations, including DUI/DWI courts, juvenile drug courts, and family drug courts. Each of these specialty courts uses a collaborative rehabilitation team model that involves the judiciary, treatment providers, community supervision, and ancillary community services.

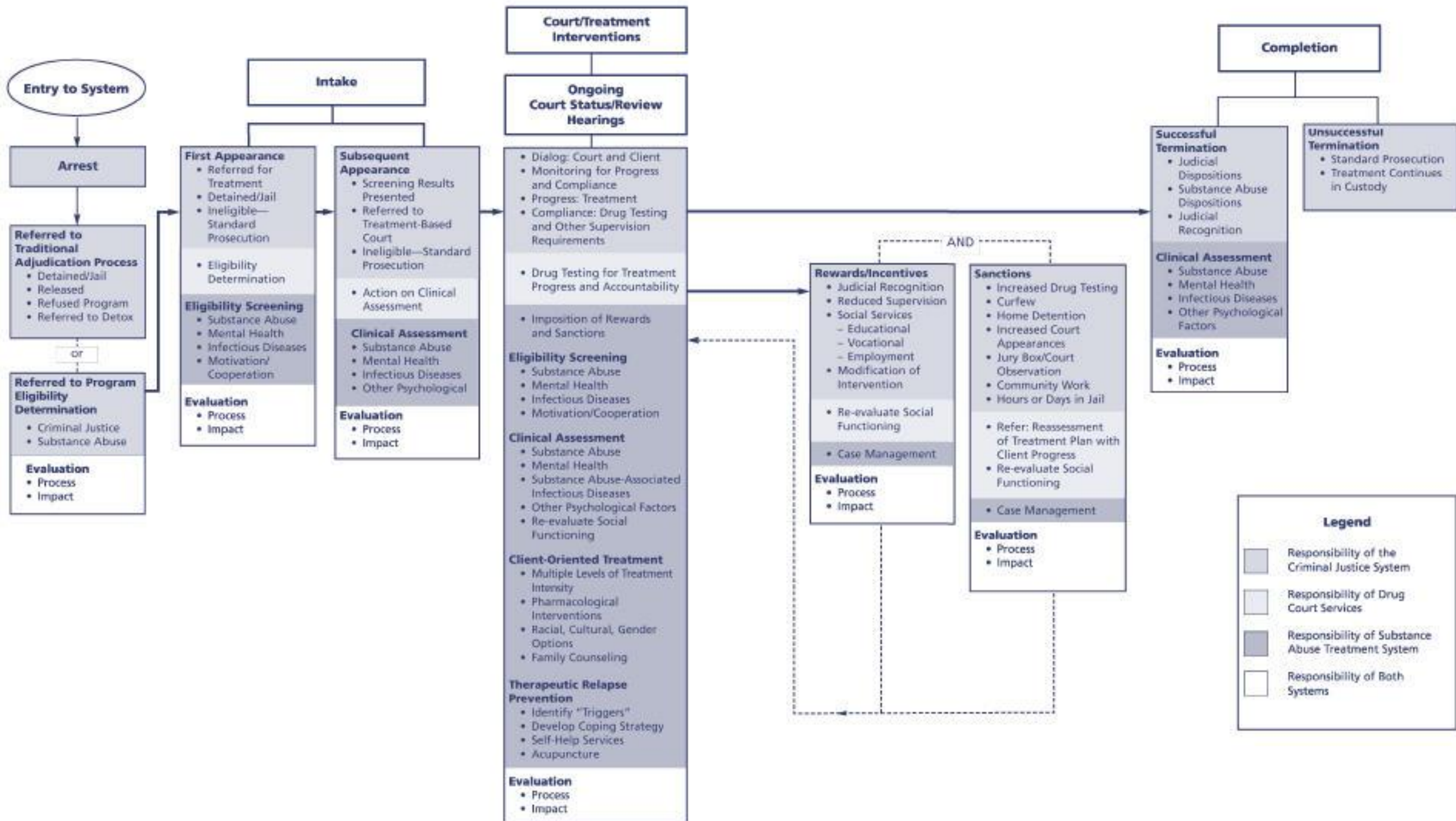
DTCs were established in response to the realization that incarceration for longer periods and under mandatory sentencing laws was not having a significant effect on drug-using behavior. Instead, the courts, jails, and prisons were becoming more and more congested. DTCs provide diversion from jail or prison through expedited involvement in treatment for nonviolent offenders with substance abuse problems. Some drug courts have now expanded their admission criteria to include offenders who have a history of multiple prior offenses related to their substance abuse. Several different diversion models are used by DTCs (some operating within the same jurisdiction), including presentence diversion, processing through postplea or presentence arrangements, and postconviction arrangements. The essential "core" of DTCs is a collaborative partnership between the courts, substance abuse treatment providers, community supervision, and other ancillary services to achieve sustained participation in treatment, coupled with regular oversight and monitoring by the court. In contrast to the adversarial nature of traditional criminal court processing with its focus on prosecution of cases, DTCs feature more of a rehabilitation team approach that couples mandatory treatment involvement with accountability through surveillance, monitoring, and regular feedback to the court and drug court team. Drug courts provide more rigorous supervision and accountability than is provided for offenders on traditional probation.

Typically drug court planning and oversight teams determine the DTC structure, treatment delivery model, and selection of treatment providers. A DTC team consists of judge, prosecutor, defense counsel, treatment provider, corrections personnel, local social service and mental health representatives, and housing authorities to help in the design of the most responsive treatment model possible. Though DTCs vary, the goal is essentially the same: treatment for offenders dependent on drugs instead of incarceration or probation (CSAT 1996; Hora et al. 1999).

Figure 1-1 depicts the role of DTCs in substance abuse treatment and highlights the importance of creating and maintaining cooperative working relationships between the substance abuse treatment and criminal justice systems. It is vital that information flow smoothly among the courts, case management staff, and substance abuse treatment professionals. Judges must have access to evaluation and screening reports, drug screens, and information about the

client's participation in treatment. At the same time, substance abuse treatment counselors, social workers, and mental health professionals involved with the client's case must be aware of any requirements or restraints imposed by the courts. Figure 1-1 also demonstrates the need for evaluation and reevaluation. During the treatment and recovery process, the client's level of functioning, mental health status, and physical condition may change along with his treatment needs. Continual monitoring will allow both systems to tailor treatment to the client's stage of recovery by identifying and addressing emerging health or mental health issues.

Figure 1-1. Substance Abuse Treatment Planning Chart for Treatment-Based Drug Courts



In DTC proceedings, the judge takes an active and leading role in monitoring the offender's progress in the treatment process through mandatory court appearances and data from urinalysis. The judge encourages the offender to stay in treatment through graduated rewards and sanctions. Generally, treatment lasts about a year, although incentives and sanctions can shorten or lengthen this time (Hora et al. 1999).

Treatment through drug courts usually consists of three or four phases:

- Orientation, drug education
- Treatment
- Relapse prevention, educational/vocational services
- Aftercare and transition

A range of treatment interventions is employed in DTCs. Most use a tapered approach that employs intensive outpatient treatment during initial stages of treatment, followed by progressively less intensive involvement in outpatient treatment (e.g., 1–3 times per week) in later stages of the program. In addition to regular involvement in treatment, DTC clients attend regular status hearings in court, receive individual and group counseling, are involved in case management services, are drug tested, and participate in peer support groups and a range of other ancillary services.

10 Key Components of Drug Courts

The following components were developed by a national committee of experts for the Office of Justice Programs, Drug Courts Program Office (National Association of Drug Court Professionals 1997).

1. Drug courts integrate alcohol and drug treatment services with justice system case processing.
2. Using a nonadversarial approach, prosecution and defense counsel promote public safety while protecting participants' due process rights.
3. Eligible participants are identified early and promptly placed in the drug court program.
4. Drug courts provide access to a continuum of alcohol, drug, and related treatment and rehabilitation services.
5. Abstinence is monitored by frequent alcohol and illicit drug testing.
6. A coordinated strategy governs drug court responses to participants' compliance.
7. Ongoing judicial interaction with each drug court participant is essential.
8. Monitoring and evaluating achievement of program goals is necessary to gauge effectiveness.

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9. Continuing interdisciplinary education promotes effective drug court planning, implementation, and operations.
10. Forging partnerships among drug courts, public agencies, and community-based organizations generates local support and enhances drug court program effectiveness.

Other Diversion Models

Treatment Accountability for Safer Communities (formerly Treatment Alternatives to Street Crime) (TASC)

TASC programs focus on providing a bridge between treatment providers and the criminal justice system and offer a range of services, including screening and assessment, referral to community-based services, monitoring of treatment progress and compliance, case management and brokering community services, and court liaison. TASC programs sometimes are embedded with treatment agencies or court services departments, and, in some cases, are freestanding organizations. TASC programs have a long history of collaborative work in the criminal justice system. Early evaluations of TASC programs were generally positive, although limited in scope. An evaluation of five TASC programs (one for juvenile offenders) found mixed results. While TASC programs were consistently successful in identifying offenders who abused drugs and referring those offenders to treatment, three of the sites outperformed the others in at least one measure of subsequent drug use, while results on criminal recidivism were inconclusive. Study authors report that the findings on TASC programs were "consistently favorable," although modest and, in some cases, confined to offenders with more problematic behavior (Anglin et al. 1999).

Diversion programs established through constitutional ballot initiatives

A number of ballot initiatives have been approved by the electorate in Alaska, Arizona, California, Oregon, and other States that have significantly affected the way in which drug offenses are processed in the criminal justice system. Several of these initiatives have focused on use of marijuana for medical purposes and decriminalization of drug possession offenses. Others, such as Proposition 200 in Arizona and Proposition 36 in California, have been more far reaching and require diversion to treatment for nonviolent drug offenders who meet certain eligibility criteria. Similar initiatives are scheduled to appear on the ballot in other States. These ballot initiatives also restrict the use of sanctions (e.g., jail incarceration) that can be applied and provide procedural safeguards to prevent

incarceration. These initiatives have been perceived in some jurisdictions as a direct threat to other existing diversion programs such as drug courts. A preliminary study of the Arizona initiative indicates that significant savings were provided to taxpayers in the form of reduced demand for jail and prison space.

Proposition 36: The Substance Abuse and Crime Prevention Act

In November 2000, California voters approved a ballot initiative, Proposition 36 (Substance Abuse and Crime Prevention Act [SACPA] of 2000). The intent of SACPA was to reserve space in prisons and jails for serious and violent offenders, to increase public safety through reduction of drug-related crime, and to expand treatment and rehabilitation for offenders involved with drugs. The SACPA initiative changes State law to provide substance abuse treatment and community supervision for certain groups of nonviolent drug-involved adult offenders who would otherwise be sentenced to institutional settings or supervision in the community. All offenders charged with nonviolent drug-related offenses are potentially eligible to receive treatment services through the initiative. Offenders who use a firearm during the commission of their offense, who have additional nondrug offenses, or who refuse drug treatment as a condition of probation are ineligible for SACPA participation. The initiative establishes the Substance Abuse Treatment Trust Fund and provided $60 million for fiscal year 2000-2001, and $120 million for each subsequent fiscal year, ending in 2005-2006.

Although the long-term effects of SACPA await examination in the future, early studies provide information about the people being served. Compared to non-Proposition 36 clients in treatment, Proposition 36 clients were more likely to be men in their first treatment episode receiving outpatient services for methamphetamine and marijuana use. They were less likely to use heroin or injection drugs (Hser et al. 2003). Another study indicated that criminal justice clients (whether or not they came from Proposition 36) with high-severity drug abuse were less likely to be admitted to residential programs. Of high-severity outpatient clients, the SACPA clients were more likely to be rearrested for a drug-related offense (Farabee et al. 2004).

Diverting individuals with co-occurring disorders

People with some types of mental disorder are more frequently jailed than sent to hospitals. About three quarters of these individuals also have a substance use disorder (Broner et al. 2001*a*). Their multiple problems present a challenge to criminal justice personnel.

Some of these individuals are good candidates for diversion in the approximately 50 jail-based diversion programs that currently exist. Arrestees with co-occurring disorders can enter a diversion program in either the pre- or postbooking phase. In prebooking diversion, the police officer is the decisionmaker, although few

police departments provide training in specialized responses to those with mental disorders. In postbooking diversion, there is usually screening, mental health evaluation, and negotiation between diversion and legal staff for a diversion rather than prosecution. In some postbooking programs, drug court procedures for case management have been adapted for a population with co-occurring disorders. In others, a "mental health court," based on the drug treatment court model, has been established. These courts focus on the mental disorders rather than on prosecution.

Many of those with co-occurring disorders do not respond well to traditional community interventions; their problems are too complex. It is clear that integrated treatment is more effective than either parallel treatment of mental disorders and a substance use disorder or sequential treatment of the two (Weiss and Najavits 1998). Drake et al. (1998*b*) concluded that treatment outcomes were especially improved when treatment lasts 18 months or longer.

Work by Steadman and colleagues (1995) notes six central features of effective diversion programs for offenders with co-occurring disorders: integrated services, key agency meetings, boundary spanners, strong leadership, early identification, and distinctive case management. Boundary spanners in this context are individuals with knowledge of both criminal justice and treatment systems who can bring the systems together to collaborate on the shared goal of obtaining substance abuse and mental health treatment for an individual who must answer to restrictions set by the criminal justice system.

Driving Under the Influence courts

Recent evaluations of drug court programs throughout the United States (Belenko 2001), which work to rehabilitate drug offenders, reduce recidivism, and save money, indicate that they are achieving their goals. This success has prompted practitioners and various institutions such as the National Association of Drug Court Professionals and the U.S. Department of Justice to discuss the potential benefits of widespread use of Driving Under the Influence (DUI) courts. Although arrests for DUI have been on the decline since 1987, serious, habitual abusers of alcohol remain largely unaffected by stiff criminal penalties and public awareness campaigns to stop drunk driving (National Drug Court Institute 1999).

Similarities between repeat DUI and drug offenders have led many practitioners to believe that DUI or combined DUI/Drug Courts can be effective. Both types of offenders have a serious substance abuse problem and both require treatment, a strong support system, and the ability to overcome denial. However, unlike drug offenders, DUI offenders tend to be employed, and because of their generally more stable family situations, they tend to be able to draw on greater emotional

and financial resources. But perhaps the most significant difference between the two is that DUI offenders usually believe that because the substance they ingest is legal, they do not have a substance abuse problem (National Drug Court Institute 1999).

In November 1998, practitioners from seven legal jurisdictions formed the DUI/Drug Court Advisory Panel at the invitation of the National Drug Court Institute to discuss establishing DUI courts that are modeled after drug courts and/or expanding existing drug courts to include DUI cases.

What Treatment Services Can Reasonably Be Provided in the Pretrial Setting?

The large number of offenders who are supervised in the community, time constraints, supervision issues, and multiple agencies limit the services that can reasonably be provided in the pretrial setting. Below is a general description of intervention strategies and treatment components that can be used in a pretrial setting.

Intervention Strategies

A number of intervention strategies can be adapted to the pretrial setting, as described in the following section. The time required to implement these strategies is necessarily brief.

Brief interventions

For some offenders, especially during the pretrial stage, a brief intervention can determine if treatment is necessary. Addressing a substance use disorder even briefly is preferable to ignoring it. A counselor can use the FRAMES approach or other motivational enhancement strategies, for example.

F*eedback* is given to the individual about personal risk or impairment.

R*esponsibility* for change is placed on the participant.

A*dvice* to change is given by the clinician.

M*enu* of alternative self-help or treatment options is offered to the participant.

E*mpathic* style is used by the counselor.

S*elf-efficacy* or optimistic empowerment is engendered in the participant.

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Behavior contracts

Some treatment programs use contracts with clients that describe precisely what is required of them. For example, offenders may be placed under less restrictive conditions of supervision if they successfully complete a pretrial treatment program. These behavior contracts offer rewards or incentives for specific behaviors. In drug court, individuals move to the next phase only when they complete the requirements in their contracts. Contingency contracts can reduce relapse and improve retention in treatment (Prendergast et al. 1995).

Sliding scale (client fees)

Many drug courts and pretrial diversion programs require participants to pay treatment or diversion fees in order to participate. Often these are based on ability to pay, or clients are allowed to defer some payments until after they become employed, one of the principles being that charging fees gives the offender some "buy-in" to the treatment process.

Treatment Modalities

In addition to previously discussed drug treatment courts and related specialty court/diversion programs, several other types of treatment modalities can be used effectively in pretrial settings.

Sobering stations

Willamette Family Treatment Services in Eugene, Oregon, offers a Sobering Station, a 24-hour facility designed as a safe and clean facility where an individual can be monitored while coming off drugs or alcohol. The service is not detoxification. The individual is housed and monitored until he can leave safely. Those admitted to the Sobering Station are offered detoxification services when appropriate.

Detoxification

Detoxification is the term used to describe the process of withdrawal from alcohol or drugs that cause physical addiction. Detoxification, as the word implies, entails a clearing of "toxins" from the body. The most immediate purpose is to safely alleviate the short-term symptoms of withdrawal from chemical dependence, including physical discomfort.

Detoxification may occur in either an inpatient or an outpatient setting. It involves several procedures for therapeutically supervised withdrawal and abstinence over a short term (usually 5 to 7 days but sometimes up to 21 days), often using pharmacologic treatments to reduce client discomfort and reduce medical complications such as seizures. It is a first step for many clients who will enter

treatment, but it is not synonymous with comprehensive, ongoing treatment. The detoxification process entails more than the removal of alcohol and illicit drugs from the body; it includes a period of psychological readjustment that prepares the individual to enter ongoing treatment.

Withdrawal from certain drugs such as sedative-hypnotics, alcohol, benzodiazepines, and barbiturates can be life threatening. Thus, it is recommended that medical detoxification be provided for these classes of drugs. Though not life threatening, opioid withdrawal should also be treated in order to provide humane conditions to inmates and to avoid the potential for morbidity from dehydration as well as suicide attempts.

Day reporting centers

Day reporting centers are used to monitor the behavior of arrestees in the pretrial setting and of probationers and parolees under community supervision. They provide closer supervision than twice-a-week drug testing, but are less restrictive than residential treatment.

Chicago, Illinois, Day Reporting Center

A day reporting center established in Chicago supervises detainees awaiting trial, ensures appearance in court, and begins to address substance abuse and other service needs. The program consists of a mandatory 15-day orientation phase, from which detainees progress into one of several tracks based on assessed needs. Several challenges in developing the day reporting center include (1) time limitations that restrict the type of interventions that can be provided, (2) facility limitations related to space and treatment activities, and (3) the need to integrate assessment and treatment information within the judicial process and to communicate in a timely manner about security and clinical issues. One interesting outcome related to the day reporting center is that approximately half of participants left the program when they were no longer required by the court to remain, with those leaving no longer involved in community treatment services. Those who completed the orientation phase of the program were more willing to engage in substance abuse treatment. Length of involvement in the day treatment center was associated with reductions in substance abuse (McBride and VanderWaal 1997).

Additional treatment components

The vast majority of offenders processed through the criminal justice system during the pretrial phase have chronic substance problems, as well as high rates of vocational, social service, educational, mental, and physical health needs. The following components can be an important and useful adjunct to standard counseling services offered in the pretrial setting and treatment providers may need to contract these services out on an as-needed basis.

- Vocational training
- Job readiness assessment and preparation
- Liaison with employer
- Literacy assessment and referral
- Anger management training
- Criminal thinking assessment and treatment
- HIV education (sexual health)

Assistance in accessing State or Federal entitlements such as Medicaid; Temporary Assistance for Needy Families; Women, Infants, and Children Program; Food Stamps; and housing programs available for clients willing to enter treatment

These additional services are integral to fostering long-term recovery but they do add cost, more service and supervision layers, and the need for case management. In the long run, however, treatment can save greater costs to the criminal justice, medical, and foster care systems. In a Philadelphia study of Medicaid clients receiving outpatient treatment with "enhanced services" (supplemental health and social services), McLellan and colleagues (1998) found that on almost all outcome measures, the clients receiving the supplemental services showed the best outcomes, including drug and alcohol use.

Use of Sanctions

Judges and prosecutors have seen that sanctions encourage participation in treatment and are necessary to gain public acceptance of treatment in lieu of punishment. Sanctions include a range of measures that focus on holding offenders accountable for their actions. When a system of sanctions is implemented in concert with a sound treatment plan, offenders swiftly experience real consequences of their actions. This accountability is achieved through graduated sanctions. For example, an offender in an outpatient program requires drug testing three times per week. After a first positive drug test, the offender may be required to participate in treatment exercises to address reasons for relapse and may be required to submit to more frequent testing. If the offender continues to test positive, he or she may be required to enroll in more intensive services (e.g., residential treatment). Further, if an offender, who pleaded guilty

and received a deferred jail or prison sentence so that he could enter treatment, continues to fail to comply with his treatment program, despite the imposition of intermediate sanctions, the ultimate sanction of a sentence of incarceration will be imposed. It is important, from a motivational standpoint, that other program participants see what will happen to them (i.e., incarceration) if they fail to comply with their treatment programs.

Other sanctions such as victim impact meetings encourage the offender to recognize how drug-related activities affect the community. If the offender fails to complete the required treatment activities, victim restitution may be imposed as the next level of sanctions. By holding offenders accountable, graduated sanctions can be effective in redirecting individuals away from substance abuse and toward recovery. In general, the availability and use of sanctions tends to strengthen the impact of treatment, just as involvement in treatment tends to strengthen adherence to community supervision arrangements.

Examples of sanctions used in diversion

- *Means-based fines* (also called "day" fines). The total amount of these fines is calibrated to both the severity of the crime and the discretionary income of the offender, with the calibration and calculation established by the court as a whole for all cases in which this type of fine is to be imposed. (This type of fine contrasts with traditional fines that are imposed at the discretion of the judge according to ranges set by the legislature for particular offenses.) Defendants with more income (and/or fewer family obligations) pay a higher overall fine than those with lower incomes (and/or more obligations) for the same crime. This approach to setting the fine amount is typically coupled with expanded payment options and collection procedures that are tighter than usual.

- *Community service*. This is the performance by offenders of services or manual labor for government, private, or nonprofit organizations for a set number of hours with no payment. Community service can be arranged for individuals, case-by-case, or organized by corrections agencies as programs. For example, a group of offenders can serve as a work crew to clean highways or paint buildings.

- *Restitution.* Restitution is the payment by the offender of the costs of the victim's losses or injuries and/or damages to the victim. In some cases, payment is made to a general victim compensation fund; in others, especially where there is no identifiable victim, payment is made to the community as a whole (with the payment going to the municipal or State treasury).

- *Outpatient or residential substance abuse treatment centers*. Both public and private treatment centers may be contracted to provide treatment to offenders, as described in this TIP.

- *Day reporting centers or residential centers for other types of treatment or training*. These centers are established to provide services other than substance abuse treatment. For example, a center may provide skills training to enhance offenders' employability. Offenders must report to the center for a certain number of hours each day, and/or report by phone throughout the day from a job or treatment site, as a means of monitoring.

- *Intensive supervision probation*. The level and types of supervision that are labeled intensive vary widely but usually involve closer supervision and greater reporting requirements than regular probation for offenders. This level can range from more than five contacts per week to fewer than four per month. Supervision usually entails other obligations (to attend school, have a job, participate in treatment, or the like).

- *Intensive supervision parole* has similar requirements and variations but is usually provided by parole agents to offenders who have completed a prison term and who are serving the balance of their sentences in the community.

- *Curfews or house arrest* (with or without electronic monitoring). Offenders are restricted to their homes for various durations of time, ranging from all the time to all times except for work or treatment hours, with a few hours for recreation. Frequently, the curfew or house arrest is enforced by means of an electronic device worn by the offender, which can alert corrections officials to his or her unauthorized absence from the house.

- *Halfway houses or work release centers*. Offenders are restricted to the facility but can leave for work, school, or treatment. The facility is in the community or attached to a jail or similar institution.

- *Brief jail incarceration* (e.g., for 1–3 days). Brief incarceration is often used with offenders who have committed major program infractions in DTCs or in other diversion programs. This provides respite from temptations to use drugs and is useful in reinforcing the importance of sobriety and treatment. In some cases, incarceration can be used counterproductively for DTC or diversion participants if it is lengthy and if it prevents the offender from reengaging in treatment activities.

- *Boot camps*. Typically, a sentence to a boot camp (also called shock incarceration) is for a relatively short time (3 to 6 months). As the name implies, boot camps are characterized by intense regimentation, physical conditioning, manual labor, drill and ceremony, and military-style obedience. Because boot camps are a form of incarceration, some in the criminal justice field reject their inclusion in the category of intermediate sanctions. Others include boot camps because placement in them is intended to take the place of a longer, traditional prison term. Several research studies have shown that boot camps do not significantly reduce criminal recidivism or substance abuse. One potential explanation for these findings is that most boot camps do not provide intensive substance abuse treatment services.

How to use sanctions

Evidence on the usefulness of sanctions from other institutional settings demonstrates several principles.

- The efficacy of a punishment is determined, in large part, by the individual's history and circumstances.
- Sanctions must be of sufficient intensity so the client does not become habituated to threats and punishments, yet not so severe that the judge exhausts all options for sanctions.
- A sanction should be delivered for each infraction.
- To the extent possible, sanctions should be delivered immediately after the undesirable behavior.
- Undesirable behavior must be reliably detected (e.g., through mandatory urinalysis two or three times per week).
- Sanctions must be predictable (by explicit statements of behavioral expectations) and controllable through the individual's actions.
- Behavior does not change by punishment alone; desired behaviors should be rewarded. Desired behaviors include those that are incompatible with drug use, those that are naturally rewarding, and those that are likely to be rewarded by the client's social environment (Marlowe and Kirby 1999). Rewards for positive behavior and behavior change in DTCs include public praise and recognition of achievement by the judge and other staff, reduction of fees or time in the program, small prizes such as key chains or movie tickets, and certificates of phase and program completion.

Treatment Issues

The counselor-client relationship in a pretrial setting raises unique challenges. For one, the role of the counselor can become blurred between therapist and gatekeeper, answerable to both the treatment and the criminal justice communities. In the midst of this role confusion, the client's legal rights need to be carefully guarded.

The discussion below highlights some of the issues counselors operating in a pretrial setting are likely to face.

Importance of Screening

Unpredictability characterizes the hours and days immediately following arrest. The rapidly developing nature of arrest and arraignment creates a challenge for counselors in gaining access to the arrestee. Arrests can occur at odd hours, while assessment staff are unavailable. Interviewing conditions, such as in a police lockup, are less than ideal. Still, detainees should receive screening for substance abuse during the initial intake procedure to determine whether further assessment should be recommended or whether referrals should be made. Prompt screening is also important to identify offenders in need of detoxification services.

It is important for counselors to understand that offenders sometimes sign up for treatment because "it's the thing to do." Accessing drug treatment can help an individual appear more sympathetic in the eyes of the court. Understanding this, some offenders who do not genuinely have a drug or alcohol problem will participate in treatment nonetheless. One example is a drug dealer who does not have a substance use disorder, but earns income from drug trafficking. During assessment the offender may deny using substances. However, once a clinician threatens to send the offender back to the judge, the offender may prudently decide he is boxed into "admitting addiction." In this instance, the offender is simply using common sense to avoid harsher sentencing and improve his chances for leniency in the criminal justice system.

To address this dilemma, treatment counselors should assess collateral evidence of a substance use disorder. Orientation and other "pretreatment" program components are also used to determine individual readiness and commitment to treatment, prior to involvement in more intensive program services. Not every offender is appropriate for treatment. For example, if a counselor assesses an individual who does not have a substance use disorder, the person should be referred back to the judge in order to avoid denying the offender's due process rights, such as the right to a speedy trial. Early drug screening and the use of professional alcohol breathalizers can also be helpful in determining the need for further screening and treatment.

Advice to the Counselor: Operating in a Pretrial Setting

- Counselors must maintain a client's confidentiality. One strategy is to avoid discussing the client's criminal case.
- Counselors should bear firmly in mind that the client is presumed innocent before trial.
- Counselors should be realistic about the responsibilities that a client is capable of handling in pretrial settings. For example, it is unrealistic to believe that a defendant will suddenly become a model citizen, meeting all of his or her responsibilities, simply because of an arrest.
- Counselors should avoid allowing individuals to be inadvertently penalized for enrolling in treatment.
- Counselors should be aware that clients may be more focused on "beating the case" than on recovery.

To better identify individuals with substance abuse problems and to provide informed diversion to treatment services, several jails have implemented a comprehensive screening, and use systematic "case finding" approaches (National GAINS Center 2000; Steadman et al. 1999). In some areas, TASC program staff perform these activities; in others, different types of "boundary spanners" perform these tasks. Generally, these are people who are knowledgeable about criminal justice processing and different community treatment systems and resources.

Meeting Immediate Needs

The pretrial setting can create difficult scheduling problems for clients. Individuals may have lost their jobs because of an arrest, and clients who are employed may wonder how they will hold onto their job if they are required to attend treatment. Counselors tend to believe that putting an individual into treatment is of primary importance during this time period; however, they should be sensitive to the fact that although treatment is critically important, it is not always the client's most pressing priority. This is especially true when weighed against considerations such as displacement from housing and lack of appropriate childcare. Many clients who are navigating more immediate and pressing needs are not ready to engage in the therapeutic process. Effective triage helps to build client trust and lays a foundation for successful engagement in therapy.

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Counselors should prioritize case management services to include the most pressing client needs, such as food, clothing, shelter, and medical treatment. Does the client need detoxification? Are there childcare issues to be resolved? Is the client in need of medication?

Advice to the Counselor: Addressing the Client's Immediate Needs

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- *Detoxification needs:* Screen for the need for detoxification services and refer clients when appropriate. Train staff in signs and symptoms of withdrawal so that staff can detoxify clients from alcohol and drugs.
- *Childcare issues:* Provide on-site childcare at treatment facilities.
- *Potential forfeiture of public housing:* Notify an individual's landlord that the individual is receiving treatment.
- *Transportation needs:* Provide bus tokens, car-service vouchers, and transportation support.
- *Medical needs:* Ensure that medical needs are addressed, including receipt of prescription medicines and screening for infectious diseases.

Maintaining Existing Services

In many U.S. communities, individuals receiving Federal disability supports, such as Medicaid, Social Security Insurance, or Social Security Disability Insurance, often lose their benefits if they are detained in jail. Although Federal regulations do not require these supports to be terminated for jail detainees, misunderstandings regarding policies often result in loss of services. Upon release, these individuals must re-apply for Federal supports, a somewhat lengthy process that often creates a delay in access to community treatment services. A lapse between incarceration and treatment without benefits means that these individuals are often unable to meet their basic subsistence, health, and mental health needs and usually lose any stabilization gained while in jail, bringing them back in contact with the criminal justice system after a short period of time (National GAINS Center 1999*b*). Although Federal policies do not require an individual's benefits to be terminated immediately upon incarceration, they do stipulate a timeframe after which benefits cannot be received. Whether communities suspend or drop an individual's Medicaid benefits depends on the State (National GAINS Center 1999*b*).

In Lane County, Oregon, diverted individuals with co-occurring mental and substance use disorders experienced difficulties in maintaining uninterrupted treatment due to issues with Medicaid and Social Security Insurance benefits. In response, the County raised its concerns with the Oregon Medical Assistance Program director. The State recognized this situation as a continuum-of-care issue for those with short-term stays in the jail. The State adopted the Interim Incarceration Disenrollment Policy, which states that individuals cannot be disenrolled from the Oregon Health Plan during their first 14 days of incarceration (National GAINS Center 1999*b*).

In addition to this policy change, Lane County has coordinated with the local application processing agency for Medicaid and Social Security Insurance. This relationship allows detainees who did not have benefits upon booking or who have been incarcerated longer than 14 days to begin the application process while still in custody. Diversion program participants are now given priority and are able to regain or obtain benefits within a few days (National GAINS Center 1999*b*). The staff of the Lane County diversion program reports that the disenrollment policy has been crucial for offenders and has greatly benefited program participants. Other jail staff members, providers, and advocates are also encouraged to develop a thorough understanding of the rules regarding Federal benefits, and to maintain an open line of communication with the State Medicaid agency and local Social Security office (National GAINS Center 1999*b*).

Protecting Clients' Rights

The client's due-process rights can affect the counselor's role in the pretrial setting. Clients and counselors should not discuss the client's ongoing criminal case. The boundaries of the counselor's responsibilities can begin to blur when clients discuss their criminal cases. Counselors should avoid the situation of being forced to report to a prosecutor something they have been told concerning the client's case.

A memorandum of understanding (MOU) can also protect a client's rights. An MOU signed by the prosecutor will ensure that the prosecuting attorney in the case will not use information gathered during the treatment process against the client. A judicial order attached to such an MOU may carry more weight: If the judge rules that information given to a treatment provider is out of bounds for a prosecutor, the client has that much more assurance that he or she may speak freely to the counselor.

Presumption of Innocence

The issue of presumption of innocence points to an essential difference between the legal and therapeutic cultures. It also poses a challenge for treatment counselors during the pretrial phase. The dilemma is this: For individuals to participate in drug treatment, they must first admit to having a drug problem. As a result, when the crime is possession of drugs, counselors often have a more difficult time presuming a client's innocence.

> *"Presuming their innocence never occurs to me. I'm usually trying to convince the clients they have a problem." —Counselor*

Coercive Power of Treatment Staff

The impact of arrest itself carries trauma, uncertainty, and disruption that are different from being in jail. This uncertainty can either help or hinder counselors who are trying to engage clients in treatment. The aftermath of the arrest often provides additional motivational leverage and counselors can better engage their clients in treatment by assessing this motivation. Are they seeking to avoid prosecution? Do they want to remain in the community? Counselors who perceive clients' motivation and assist them in meeting short-term goals provide strong incentive to engage them in the treatment process. For counselors, the keys to meeting these short-term goals are awareness of resources and the ability to offer them.

Counselors working in the pretrial setting have additional leverage with clients in that they are responsible for making recommendations to the court concerning adherence to and progress in treatment. However, the counselor's role is potentially more adversarial. Self-disclosure to a counselor is not necessarily in the client's best interest. As a result, it may be more difficult to engage the client in an open relationship. The counselor should inform the client at the outset that at some point it may be necessary to report to the court or pretrial supervision staff. The counselor should be absolutely clear about this process, its requirements, and his or her role in relation to the community supervision agency. In some settings, such as drug courts, counselors are part of a multidisciplinary team and play a vital role in case reviews and determining clients' disposition. For example, counselors provide regular and periodic reports regarding client treatment adherence and progress. The judge may defer to the counselor's opinion regarding recommendations for the client's promotion to different phases, or graduation from the program, giving the counselor additional leverage in motivating clients to engage in treatment.

Checks and Balances on a Counselor's Influence

The power of the counselor in pretrial and diversion settings raises several important ethical questions. Should counselors be able to circumvent a client's release conditions? What assurance is provided that counselors will act with fairness and consistency? What measures can be taken to prevent counselors from abusing this power? Should some type of oversight mechanism be established to avoid the potential abuse of power? These types of checks and balances are incorporated within drug treatment courts. For example, team staff meetings provide a forum for discussion to review each case prior to court hearings and to achieve consensus regarding what the judicial and drug court program response will be to infractions or other critical incidents.

Developing Pretrial Treatment Services

Efforts to expand and institutionalize treatment programs in order to make them a standard part of the pretrial criminal justice system often face a number of challenges. In planning such programs, the following strategies may be helpful:

- Increase the number of experienced counselors and trained clinical staff.
- Create special licensing and certification for counselors who provide treatment in the pretrial setting.
- Increase awareness of the importance of the pretrial setting in promoting clients' successful recovery.
- Educate the media concerning the effectiveness, usefulness, and importance of providing treatment in pretrial and diversionary settings.
- Demonstrate that the services provided are effective in reducing substance abuse and recidivism.
- Expand treatment options to include brief interventions and treatment readiness programs.
- Consider the effects of treatment on case processing.
- Include stakeholders from a variety of domains in the planning process.

Baltimore's Response to Drugs and Crime

Since the early 1990s, Baltimore, Maryland's substance abuse prevention and treatment agency, the Board of Directors of Baltimore Substance Abuse Systems, Inc. (BSAS), has faced a crime rate that is double the national average, an increase in the spread of infectious diseases, and economic costs of drug use exceeding $2.5 billion a year. Baltimore's drug problem is among the worst in the Nation. At least 60,000 Baltimore city residents need alcohol and drug treatment (*Smart Steps* 2000).

In its efforts to tie high-quality, readily available treatment to comprehensive wraparound services, BSAS recognizes that outside help is crucial, given the strict limitations on Baltimore's own budget. To aid in this effort, neighborhoods across the city have come together to form a Crime and Drugs Solution Work Group, whose major goal is to improve the quality and quantity of drug treatment. Another organization, the Greater Baltimore Interfaith Clergy Alliance, which represents over 200 congregations in the region, is working to strengthen community-based treatment services in neighborhoods throughout the city. Over the past several years, *The Baltimore Sun*, the city's major newspaper, has editorialized frequently to raise awareness of the need to boost the city's investment in drug treatment. Other local organizations and foundations have advocated more public funding for treatment, and have even contributed their own dollars (*Smart Steps* 2000).

For more information on Baltimore's commitment and approach to improving drug treatment, go to www.drugstrategies.org/Baltimore.

Effective Pretrial and Diversion Programs

To be effective in providing substance abuse treatment, diversion programs need adequate staff resources, training, and coordination, along with program components adapted to criminal justice settings. These recommended elements are discussed in detail below.

Staff resources

Staff for effective programs can include both counseling personnel and individuals in liaison and administrative roles. Counselors can provide information regarding how to access treatment services and available treatment programs. A liaison resource coordinator can disseminate this information, or an administrator can maintain a database of treatment programs, supervise referrals, and provide coordination between treatment and the court. As "boundary spanning" staff members, they can perform the delicate balance between social work, social justice, and social control.

To ensure that trained personnel are available to deliver services on a timely basis, programs could hire additional staff or link to other treatment programs and agencies. For example, treatment providers may not have the ability to offer anger management or literacy training classes in a particular program site. Given the cost of maintaining these specialists, agencies could provide these services through contract vendors. Clinical agencies may also need to contract for backup staff in order to reduce the size of caseloads and to provide 24-hour services for offenders who are arrested and/or processed during "off hours."

Training

Cross-disciplinary training for effective programs emphasizes the importance of substance abuse interventions and criminal justice supervision while making available the information that all staff members need. CSAT has provided technical assistance to States seeking to establish cross-training programs. While early efforts focused on training probation officers and treatment staff, more recent training activities have focused on creating multidisciplinary teams of staff from different systems that collaborate to engage and retain offenders in treatment.

Effective substance abuse treatment is culturally competent. That is, the programs and staff demonstrate behaviors, attitudes, and policies that enable them to work effectively in cross-cultural situations (Cross 1989). Cultural competence is based on understanding and respect for differences among people and groups. It is important to recognize that culture plays a complex role in people's lives and in the development of substance abuse problems and their treatment. Cross-training is an appropriate time to review practical examples of cultural competence in program development and operation. Staff require training in cultural diversity and issues specific to the cultural populations that they serve.

Judges, too, must stay informed about issues in many areas. Organizations such as the American Bar Association, the National Judicial College, the National Association of State Court Judges, the American Judicature Society, and the National Association of State Judicial Educators ensure that judges receive many kinds of information and training.

Coordination

Effective programs include mechanisms for coordination and information exchange between substance abuse and criminal justice agencies (including MOUs, discussed below). For example, individuals need to be screened for diversion, and their treatment histories given; diversion programs often require that specific conditions be met. Both situations entail communication between agencies if the defendant is to receive appropriate treatment.

In addition, the pretrial environment requires coordination in making key clinical decisions, including determination of the treatment intensity, duration, modality, setting, and specific services required. Counselors can work with the court to develop consensus-building approaches to deal with these critical issues that arise during the course of treatment, with the goal of developing mechanisms to advise judges regarding the best course of action for an individual's treatment. Decisions regarding diversion to treatment that provide a balanced consideration of public safety needs are complex when offenders have multiple cases in different courts, including noncriminal systems (e.g., family court, housing court, child welfare cases). Some offenders are already on probation, parole, or other types of supervision when they are arrested. The challenge is then to determine and arrange a hierarchy of services within multiple systems (e.g., criminal justice, treatment, child welfare).

Successful interagency cooperation requires information sharing that is coordinated as quickly as possible. Establishing commonly accepted protocols, such as those required for sharing information, is also useful in promoting this coordination. Case managers who provide wraparound services and work within both the treatment and justice systems are also instrumental in improving interagency coordination and can address critical issues such as insurance coverage and navigating through managed care networks.

Suggestions for Improving the Timing of Treatment

Effective programs work to optimize the timing and sequencing of treatment services. The following approaches can be helpful:

- Provide screening and assessment at the earliest possible point in the justice system.
- Move offenders into treatment as soon as possible.
- Provide several levels of care, including detoxification.
- Develop flexible sanctions so clients who have been unable to access treatment are not punished for this.
- Provide services to increase the offender's motivation to engage in treatment.
- Address the offender's denial.
- Use brief interventions, where appropriate.
- Identify treatment and ancillary resources in the community.

Memorandums of understanding

MOUs are useful for clarifying who has responsibility for various decisions related to sanctions, treatment, and case disposition, and under what conditions these decisions can be modified. Effective programs set up MOUs to establish guidelines and procedures for treating the client, sharing information, and maintaining the confidentiality of information. First, MOUs foster cooperative interagency relationships by ensuring that each component of the treatment system is aware of how the other components will access, share, and use information (Tauber et al. 1999). Second, when participants sign the consent to disclosure (permitting the counselor to share information from the client's treatment), the MOU can be used to explain how information will be distributed to the criminal justice system. (See also www.hipaa.samhsa.gov and CSAT 2004.) The following are recommendations for elements that should be contained in MOUs.

- MOUs typically note that discussions at team meetings are confidential, in part because of legal concerns but also to promote trust and fairness.

- If outsiders are permitted to attend treatment team meetings, the MOU should require them to sign an agreement that they adhere to the confidentiality provisions of the law (redisclosure) and the MOU.

- MOUs should state that the prosecutor's office will not use information obtained in the drug treatment to prosecute the participant, with two exceptions: child neglect or abuse and crimes committed at the treatment center or against treatment personnel. A prosecutor frequently learns of offenses by participants, particularly drug possession offenses. In some cases, an offender who commits a crime may lose eligibility for the drug court program (among other possible consequences) but should not be prosecuted for crimes based on information that was acquired during the drug court proceedings.

- The MOU should describe the conditions under which the information can be shared or held confidential.

- The MOU should encourage the free flow of information within the drug court team to promote the drug court's mission.

- The MOU should include rules governing the storage of, and the access to, written and electronic records. Federal law requires such written policies (Tauber et al. 1999).

Procedures To Serve the Best Interests of the Offender

Even at the pretrial stage, the best interests of the offender may be seen differently by the substance abuse treatment and criminal justice systems. While the former strives to assist offenders in recovery, the emphasis in the criminal justice system is to prevent further illegal actions and ensure compliance with court orders and conditions. A common goal of both programs is to prevent recidivism.

The Paradox of Diversion, Treatment, and Public Safety

Diversionary treatment is perceived as a threat to public safety because offenders are quickly placed back into the community. However, over the long run, diversionary treatment increases public safety because individuals involved in substance abuse treatment are less likely to commit crimes (Belenko 2001).

A central challenge for treatment in the criminal justice setting is determining who has jurisdiction over program violations. Offenders may not know the "rules" or the exact consequences of their actions. Clients may fail to complete obligations in the criminal justice system without violating treatment requirements. The question becomes: Should clinicians report this violation if it could adversely affect the individual's treatment? Does the discretion of the clinician undermine the sanctity of the judicial system? Other concerns include the format of a clinician's report: If a violation occurs, should the report be in a regular general format or an immediate communication?

Sanctions, as well as incentives to engage in treatment, should be described in clear written guidelines. This information should be provided to clients in the presence of their attorneys in order to make certain they understand the sanctions. These guidelines should be grounded in reality. For example, jailing an employed individual can be potentially excessive punishment. The sanctions should be fair, consistent, and involve each of the agencies. Education and cross-training are needed for both criminal justice and treatment professionals in order to ensure that sanctions are provided in a fair, consistent, and timely manner.

How can a public defender convince a client that treatment might be best if it goes against the client's legal interests? The role of the counselor is to engage the client in treatment—but the role of the attorney is to advocate the wisest legal course. The attorney's role becomes more complicated when the need for treatment is identified. Legal counsel traditionally plays the role of gatekeeper,

although negotiating treatment issues in the pretrial setting can call for a different role. Defense counselors need specific training in what can and cannot be achieved in treatment, and the advantages and potential risks related to the clients' enrollment in treatment.

The use of drug testing in the pretrial setting is somewhat controversial. It is argued that because drug use is associated with criminal behavior, those currently using drugs are more likely to commit additional crimes if they are released into the community while awaiting trial, and that these individuals are less likely to appear for trial if they continue to use drugs. Belenko and colleagues (1992) report that drug testing does not appear to be a cost-effective method for predicting which defendants are at risk for pretrial misconduct. Their examination of pretrial drug testing at six sites showed that the testing did not consistently predict pretrial misconduct better than other information available at the time (e.g., prior arrest record, indications of ties to the community).

Belenko and colleagues (1992) make several additional arguments against pretrial drug testing for detainees in the absence of treatment. First, one could argue that judges would be more likely to release detainees if they required periodic drug testing because this condition of release would act as a system for monitoring their behavior. In fact, this has not happened. Second, staff costs and costs for purchasing drug-testing equipment are substantial. Third, the accuracy of drug testing technology is not perfect. False-positive results can have serious consequences for a defendant, and given the number of drug tests an offender is required to take over the course of 6 months, the chances of receiving at least one false-positive result can be significant. Finally, mandatory drug testing raises constitutional issues of due process, self-incrimination, and unnecessary search and seizure.

Pretrial drug testing is considered a search under the Fourth Amendment to the U.S. Constitution. Court rulings have determined that it complies with due process when collection and testing procedures meet the legal test of reasonableness (Bureau of Justice Assistance 1999). From the treatment perspective, however, part of the difficulty with drug testing is that it can only flag the presence or absence of certain drugs. It cannot discriminate between chronic and casual users—between those with a substance use disorder who would benefit from treatment and those who are experimenters.

Drug testing alone does not provide enough information to make decisions about pretrial release or detention or referral for treatment. Rather, these results should be combined with other information available in the pretrial setting or from a thorough clinical assessment. Drug testing is, however, a necessary and useful adjunct for monitoring offenders' compliance with conditions. As an intermediate sanction, drug testing often decreases drug use among offenders. Although drug testing and sanctions alone are limited in what they can provide, there are some individuals who will stop using drugs if they are tested.

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Many clinicians believe that offenders who have not been able to access drug treatment should not be punished for testing positive. Nonetheless, use of drug testing alone without sanctions is sometimes used as an alternative to treatment and may lead to an individual's exclusion from treatment. The Washington, D.C., Drug Court provides drug testing and sanctions without drug treatment. This combination of sanctions without treatment is referred to as the "Coerced Abstinence Model." The D.C. Drug Court does demonstrate reduced recidivism, though the impact on drug use is unclear (Belenko 1990).

Conclusions and Recommendations

- The vast majority of offenders processed through the criminal justice system during the pretrial phase have chronic substance abuse problems, as well as high rates of vocational, social service, educational, mental, and physical health needs.

- The rapid movement of offenders through different points of processing in the criminal justice system complicates delivery of substance abuse treatment services and presents challenges in sharing information and encouraging continuity of involvement in treatment.

- Pretrial services programs face many challenges in identifying and referring offenders in need of treatment. These include providing timely clinical assessment, timely referrals to services, effective monitoring of treatment progress, referral, and case management.

- Pretrial drug testing is unlikely to be more effective than indicators such as the prior arrest record and family or other community ties in predicting pretrial misconduct (Belenko et al. 1992).

- Treatment providers face several challenges in serving pretrial clients. These include developing processes to transfer information between jails, courts, community supervision, and treatment agencies, and strategies to identify and resolve potential conflicts between courts, supervision, and treatment staff related to clinical decision-making, sanctions, and level of supervision.

- Access to effective treatment and other services is sometimes limited for offenders at the pretrial stage.

- Diversion from prosecution and treatment can occur at several points in the criminal justice process and can result in a variety of case dispositions (Anglin et al. 1999; Broner et al. 2002).

- There is a significant need for cross-training of criminal justice and treatment staff, use of culturally sensitive treatment approaches, and for stakeholder involvement in program planning in pretrial and diversion settings.

- Community task forces provide an important mechanism to coordinate activities of various community agencies that are involved in diversion programs.

- To capitalize on the initial and sometimes fleeting interest in personal and lifestyle change that can accompany arrest, individuals in pretrial settings should be screened as soon as possible for substance use disorders, detoxification needs, and other immediate needs.

- Mental health screening and assessment should be conducted as soon as possible after consideration for diversion programs, and when appropriate, clients with mental disorders should be referred to specialized programs that are tailored to address their needs.

- Treatment in pretrial and diversion settings should focus on immediate needs, such as housing, transportation, economic support, and vocational placement and training. Counselors should consider use of brief interventions that are based on early identification of substance abuse treatment and other urgent needs.

- Drug courts and other diversion programs hold considerable promise for engaging and retaining offenders who have substance use disorders and for reducing substance abuse and criminal recidivism during periods of program participation and following program completion.

- Providing access to continuing involvement in community recovery services is essential to maximize the long-term impact of pretrial and diversion programs.

- Diversion programs for those with co-occurring disorders are most effective when they provide integrated treatment for mental disorders and substance use disorders (Broner et al. 2002).

- Few studies have examined treatment services in pretrial and diversionary settings. Further research could help identify and reduce gaps in services, identify beneficial services, inform clinicians regarding useful and effective changes, evaluate program effectiveness, and assist in providing program funding.

- More research is needed to determine the economic costs and benefits of treatment interventions at the pretrial stage. Intensive and long-term programs that target first-time or low-risk offenders are not likely to be cost-effective. At the same time, limited nonintensive interventions for chronic serious offenders are also unlikely to be cost-effective.

Chapter 2:
Treatment Issues Specific to Jails

This chapter addresses treatment options that can be provided for jail inmates with substance use disorders who are incarcerated for relatively short periods of time. This chapter discusses treatment issues specific to jails through an examination of what constitutes a jail, who is incarcerated in jail, how and when substance abuse treatment can be provided, and what types of treatment are effective in this setting. Recommendations are made regarding the treatment services that can be provided within the physical, legal, and policy confines of a jail; and, finally, the treatment interventions that are best suited for brief, short-term, and long-term periods of jail treatment. This is followed by an overview of the larger systems that affect treatment in a jail setting. Lastly, the chapter outlines the research, provides examples of existing programs, and makes recommendations for the treatment of substance abuse in jails and detention centers. It should be noted that this chapter addresses diversion only as it relates to the jail population.

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Definitions

Jails (also called detention centers) house diverse groups of people detained for a wide variety of reasons. Jails confine people during the adjudication process (i.e., arraignment, criminal court, grand jury, hearings, trial, sentencing). These individuals are referred to as detainees and have not yet been sentenced. Jails also confine those sentenced to short-term incarceration (usually 1 year or less) and serve as a holding facility for

- Individuals who have allegedly violated probation, parole, or bail conditions
- Those who are absconding from court-ordered programs or other community placements
- Juveniles who are awaiting transfer to juvenile authorities or adult State prisons
- Inmates awaiting transfer to State, Federal, or other local authorities
- Inmates transferred from overcrowded Federal, State, or other prisons
- Individuals detained by the military
- Those held for protective custody
- People punished for contempt
- Witnesses detained by the court
- People with mental illness pending transfer to appropriate mental health facilities (Harlow 1998)

The approximately 3,365 jails in the United States (Stephan 2001) range in size from small jails located in rural areas to large jails typically located in or near large urban areas. The sociodynamics of jails vary according to size. For example, inmates housed in jails that serve rural communities often are familiar with other inmates, while those incarcerated in large, complex systems have less chance of being housed with someone they know.

Defining a Jail

For the purposes of the Jail Manager Certification Program only, the American Jail Association defines a jail as

1. A county, municipal, or regional facility(ies) that houses pretrial and sentenced inmates and/or an institution that houses pretrial and sentenced inmates where the State is responsible for jail operation(s) (e.g., Alaska, Connecticut, Delaware, Hawaii, Rhode Island, Vermont); and/or a private facility that houses pretrial and sentenced inmates *and* exists to serve the local jail needs of the community in which it operates.

AND/OR

2. A facility that houses only pretrial detainees, regardless of what entity operates it. This includes, but is not limited to, facilities that house people for less than 72 hours (lockups); facilities that house Federal or military custody inmates awaiting trial (e.g., the Immigration and Naturalization Services, U.S. Marshals, Armed Forces); institutions where the State is responsible for the operations of jails, and private facilities.

AND/OR

3. A local government or private facility that houses convicted people who, without this facility's existence, would serve their sentence in the local jurisdiction's jail (e.g., Milwaukee County House of Correction).

A facility is not a jail if its purpose is to house sentenced inmates

- Who are, or who would be under normal circumstances, incarcerated in a State institution
- Who are, or who would be under normal circumstances, incarcerated in a Federal institution

These institutions include State prisons, Federal prisons, Texas State Jails, State work camps, and State boot camps.

Trends

Several recent trends have led to changes in the jail population. Enactment of harsher sentencing laws for drug offenses has led to increases in the number of minority and female inmates. At the same time, significantly reduced funding for the mental health care system has led to an increase in the number of multiproblem inmates (National GAINS Center 2002; Peters 1993; Peters et al. 1997).

As a result of these changes, jails house growing numbers of individuals who have been displaced from traditional societal "safety nets" such as State hospitals. By necessity, jails have enlarged the scope of their mission to serve as community "gatekeepers" in identifying and addressing a range of psychosocial problems, such as HIV/AIDS, domestic violence, educational deficits, homelessness, mental illness, and, increasingly, substance use disorders (Peters and Matthews 2002).

Substance use disorders among the jail population have risen since the 1980s. In 1989, 67 percent of jail inmates had committed a drug offense or used drugs regularly. By May 1998, that number had increased to 70 percent—approximately 7 in 10 jail inmates. An estimated 16 percent committed their offense to obtain money for drugs (Wilson 2000). Increases in jail substance abuse treatment programs have not kept up with this trend (Belenko and Peugh 1998; Peters and Matthews 2002). In recent years, however, levels of substance use and abuse seem to have stabilized or even decreased slightly depending on the substance in question. In 2002, 66 percent of jail inmates reported regular alcohol use (down from 66.3 percent in 1996) and 68.7 percent reported regular illicit drug use (up from 64.2 percent in 1996), with *regular use* defined as use at least once a week for a month or more.

Jails often serve as the first opportunity for offenders to have their substance use disorder and other problems (e.g., other mental disorders) identified, to have their acute needs stabilized (e.g., detoxification from alcohol or opioids), and to receive referrals to in-house or community services (Peters and Matthews 2002). In fact, many offenders' initiation into treatment is in jail (Mumola 1999). Thus, the challenge to jail administrators is two-fold: to recognize the need for treatment and to understand that treatment must vary based on the population (e.g., by culture, average length of stay, type of crimes, psychosocial needs).

Treatment Services in Jails

Findings from several studies indicate the effectiveness of in-jail substance abuse treatment programs in reducing criminal recidivism (Peters and Matthews 2002). Reductions in rearrests for treated inmates range from 5 percent to 25 percent in comparison to untreated inmates, over follow-up periods of 6 months to 5 years. Treated inmates also have a longer duration to rearrest following

release from incarceration, relative to untreated inmates. Other positive outcomes associated with in-jail treatment include reduced rates of relapse among treatment participants (Tucker 1998), lower levels of depression (San Francisco County Sheriff's Office Department 1996), and fewer disciplinary infractions (Tunis et al. 1997). Cost savings associated with jail treatment programs have been reported from $156,000 to $1.4 million per year (Center for Substance Abuse Research 1992; Hughey and Klemke 1996).

Despite the positive outcomes associated with in-jail treatment, two-thirds of jails do not offer treatment (excluding such ancillary services as assessment, self-help groups, and educational programming) (Substance Abuse and Mental Health Services Administration [SAMHSA] 2000). About two-thirds have self-help programs and about 30 percent have detoxification programs. Of jail inmates who reported ever having used drugs, only one in eight had participated in any treatment (even broadly defined) since their admission, and most of those reported were self-help programs (Wilson 2000).

Description of the Population

At midyear 2003, local jails held or supervised 762,672 people, of whom approximately 10 percent (71,371) were outside the jail facility (e.g., under electronic monitoring, in outside treatment programs, on work release, etc.); this figure represented a 3.9 percent increase over the number of inmates held in jail at midyear 2002. Between 1995 and 2003 the number of jail inmates per 100,000 residents increased from 193 to 238, an increase of over 23 percent. More than half of the adult jail inmates (60.6 percent) were not yet convicted of the crime for which they were being held (Harrison and Karberg 2004). According to a 1999 survey of jail inmates, 5 percent were known to be noncitizens (Stephan 2001).

Crimes

Crimes committed, or allegedly committed, by jail inmates are fairly evenly divided between violent offenses (24.4 percent), property offenses (24.4 percent), drug offenses (24.7 percent) and public-order offenses (24.9 percent). The most common offenses are drug trafficking (12.1 percent), assault (11.7 percent) and drug possession (10.8 percent). Compared to other jail inmates, offenders driving while intoxicated are older, better educated, and more likely to be Caucasian and male (Maruschak 1999*a*).

Income and Education

According to 2002 data, approximately 44 percent of jail inmates had not received a GED or graduated from high school. Twenty-nine percent of jail inmates were not working at all at the time of their arrest and only 57.4 percent were employed fulltime. Jail inmates also reported low incomes, with 59 percent reporting monthly incomes of less than $1,000.

Gender

Between midyear 1995 and midyear 2003, the percentage of male inmates dropped from 89.8 percent to 88.1 percent, while the percentage of female inmates rose from 10.2 to 11.9 percent. This means that as of 2003 men were per capita eight times more likely than women to be in a jail. During the year prior to June 30, 2003, the number of female inmates in jail rose 6.3 percent while the number of male inmates increased by 3.7 percent (Harrison and Karberg 2004).

Over 55 percent of jailed women report physical or sexual abuse prior to admission, with 44.9 percent reporting physical abuse and 35.9 percent reporting sexual abuse (James 2004). Women are also more likely to be identified as having mental illness. Approximately 22.7 percent of female inmates and 15.6 percent of male inmates were identified as having mental illness (Ditton 1999). A survey of inmates in State prisons and jails indicated that men with mental illness were twice as likely as other men to report a history of abuse (Ditton 1999).

Offenses vary by gender. For example, women were more likely to be held for drug possession than trafficking, whereas the reverse was true for men; women were also more likely to be held for property offenses than violent offenses, and again the reverse was true for men. However, a greater percentage of women in jail are there for drug offenses. The common offenses for which women in jails were being held in 2002 were drug possession (14.5 percent), fraud (14 percent), drug trafficking (10.9 percent), and larceny/theft (10.3 percent). For men, the most common offenses were drug trafficking (12.3 percent), assault (12.2 percent), drug possession (10.3 percent), and burglary (7.2 percent).

Race and Ethnicity

As of midyear 2003, the largest proportion of jail inmates were Caucasian (43.6 percent) or African American (39.2 percent). African Americans were 5 times more likely than Caucasians and 3 times more likely than Hispanics/Latinos to be in jail (Harrison and Karberg 2004). Caucasian jail inmates reported higher rates of mental illness (21.7 percent) than either African Americans (13.7 percent) or Hispanics/Latinos (11.1 percent) (Ditton 1999). Among convicted jail inmates, Caucasians were more likely to be using alcohol (38.5 percent) and/or illicit drugs (33.2 percent) at the time of their offense than African Americans (29.3 percent and 27.3 percent respectively) or Hispanics/Latinos (30.1 percent and 23.8 percent respectively).

Substance Abuse

A history of drug use is a common characteristic of the jail population, although patterns of use have changed somewhat in recent years. Compared to jail inmates in 1996, inmates in 2002 reported more use of marijuana, depressants, stimulants (other than cocaine), and hallucinogens in the month prior to the

offense and less use of cocaine and heroin/opioids. As noted earlier, in 2002, 66 percent of jail inmates reported regular alcohol use and 68.7 percent reported regular illicit drug use. Approximately 35 percent of all convicted males and 31 percent of females reported that they had been drinking alcohol when they committed their offenses. Of convicted jail inmates who were actively involved with drugs, 72 percent were on criminal justice status at the time of their arrest (i.e., were on probation or parole, had pretrial status, were out on bail, or had escaped) (Wilson 2000).

The percentage of those who participate in substance abuse treatment programs in jails varies widely. The average population is young, male, and, like the general jail population, fairly evenly distributed between African Americans (42 percent) and Caucasians (39 percent). The majority of participants (58 percent) are ordered to treatment programs as a condition of their sentence, and most have prior felony convictions (Peters and Matthews 2002). The percentage of jail inmates who used alcohol or other drugs regularly participating in some type of substance abuse treatment (including self-help group participation) after arrest has increased from 12.3 percent in 1996 to 15.1 percent in 2002 (James 2004). Among inmates jailed for driving while intoxicated (DWI) offenses, only 17 percent are involved in programs such as self-help and educational groups for alcohol abuse, compared with 62 percent of probationers who receive these services. Only 4 percent of those jailed for DWI receive any type of alcohol abuse treatment including detoxification or counseling (Maruschak 1999*a*).

HIV Status

At midyear 2002, 1.3 percent of jail inmates who reported their test results were known to be HIV positive (Maruschak 2004), rates far in excess of those within the general population (Centers for Disease Control and Prevention 2004*a*). Between 1998 and 1999, AIDS-related deaths accounted for 8.5 percent of all deaths in jails making it the third leading cause of death in jails (death by natural causes was the leading cause of death, followed by suicide) (Maruschak 2001). However, the number of AIDS-related deaths in jails decreased from 9 per 100,000 inmates in 2000 to 6 per 100,000 in 2002 (Maruschak 2004).

In 2002, 3 percent of African-American women, 2.9 percent of Hispanic/Latino inmates (both male and female), 1.6 percent of Caucasian women, 1 percent of African-American men, and .6 percent of Caucasian men reported testing positive for HIV. African-American men, however, made up the largest number (163,219) of HIV-positive jail inmates (Maruschak 2004).

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Co-Occurring Mental Disorders

In 1998, an estimated 16 percent of jail inmates reported either a mental disorder or an overnight stay in a mental hospital. Mental illness was most commonly reported by offenders between the ages of 45 and 54, with 23 percent identified as mentally ill (Ditton 1999). Many people with mental illness cycle through jails repeatedly. Individuals with mental illness are admitted to jails at approximately eight times the rate at which they are admitted to public psychiatric hospitals. As a result, there are more people with severe mental illness in U.S. jails than in State hospitals (Torrey et al. 1992). A review of administrative data for jail detainees and inmates in New York City found that approximately 15,000 people with mental health problems cycle through that correctional system and back into the community each year, of which a significant portion have co-occurring disorders (Lamon et al. 2002). The Urban Justice Center, a New York City advocacy group, reported that detainees and inmates with mental illness spend significantly more time incarcerated—an average of 215 days versus 42 days—when compared to those not identified as mentally ill (Winerip 1999). One study found that homelessness is strongly associated with mental illness among jail inmates: half of the ever-homeless sample of inmates in the New York City correctional system responded positively to at least one mental illness screening question (Michaels et al. 1992). Of those, many, if not most, are repeat offenders.

According to the research collected and reported by the National GAINS Center (2002), 6.4 percent of male and 12.2 percent of female jail detainees have severe mental illness. Among male detainees at intake, 2.7 percent meet the criteria for schizophrenia/schizophreniform disorder, 1.4 percent for mania, and 3.9 percent for major depressions. Among female detainees, 2.0 percent meet the criteria for schizophrenia/schizophreniform disorder, 1.4 percent for mania, and 10.5 percent for major depression. Twenty-nine percent of male and 53 percent of female jail detainees have a substance use disorder, and both male and female detainees have a 72 percent rate of both mental illness and substance use disorders (National GAINS Center 2002). Inmates with both disorders are significantly more likely to have multiple problems in terms of employment, family relations, and health, and are at greater risk for not complying with treatment, rearrest, homelessness, violence, and suicidal behavior when compared to those without this combination of disorders (Borum et al. 1997; Peters et al. 1992; RachBeisel et al. 1999; Steadman et al. 1998; Swartz and Lurigio 1999). In a study of 204 pretrial jail detainees in substance abuse treatment in a Chicago jail, more than half met the lifetime criteria for at least one mental disorder, and the lifetime rates of serious mental illness were higher than those reported in the general jail population. Individuals with co-occurring disorders were also more likely to have been arrested for property offenses; to be dependent on alcohol, marijuana, or PCP; and to have more than one psychiatric disorder. Moreover, the study revealed a correlation between severe mental illness, antisocial personality disorder, and drug abuse (Swartz and Lurigio 1999).

Key Issues Related to Treatment

Several factors affect the availability and effectiveness of treatment in jails. Treatment, if available at all, may not be offered to those in need because the methods for screening and selecting treatment participants may not be comprehensive. For some inmates, the length of jail stay may be too short for substance abuse interventions. Others, especially those in pretrial status, may decline to participate. Even when services are available, they are not always responsive to the inmates' psychological, social, medical, and mental health needs, and some inmates have special needs that are too complex to be addressed fully in brief or short-term treatment.

This section addresses factors unique to jails that can impact the availability and/or effectiveness of treatment.

Public Perceptions About Jails

Although jails are designed to improve public safety and to provide punishment through the short-term detention of defendants and convicted inmates, they are sometimes perceived negatively by the public. A negative perception can affect the morale and attitudes of jail staff, particularly relating to treatment services. The community may not realize that jails hold a significant number of individuals who are arrested for low-level, nonviolent charges; that many offenses committed by jail inmates are related to their substance abuse and/or mental health problems; and that most will return to their community within a short amount of time.

Through their work with local community agencies, treatment staff can assist in dispelling misperceptions and increase the sense of inclusion of the jail as part of the community's network of services. Because of their involvement with individuals who often cycle through a variety of community services and agencies, jails are ideally situated to develop partnerships to improve community services. Many jails have worked to establish "beachheads" to develop healthcare services, prevention and education programs, and vocational services, particularly for "high-risk" groups such as the homeless, those with HIV/AIDS, and inmates with co-occurring mental disorders. Jails can serve a pivotal role in engaging family members, peers, and community organizations in supporting substance abuse treatment and the recovery efforts of inmates who are enrolled in treatment services. Jails can also help facilitate partnerships between community groups and local corrections for the purpose of identifying, treating, and referring (through diversion or aftercare) inmates with substance use disorders, and reinforce the concept that "treatment works."

Time Constraints

One of the most serious challenges for substance abuse treatment in jails is the small amount of time available, both in terms of scheduling treatment and in terms of the duration of jail incarceration (Leukefeld and Tims 1992). Many pretrial inmates are housed in jail for only short periods of time. Time constraints are a particularly significant factor given that research shows a correlation between treatment effectiveness and length of time spent in treatment (Swartz et al. 1996).

A jail must operate on a schedule that includes periods of time during which inmates are locked-in for inmate count for meals or other structured activities (e.g., work). Thus, despite the importance of time spent in treatment, programs must compete for the inmate's time. Some jails offer evening programming, but this is sometimes difficult to arrange and substantially increases staffing costs. Due to scheduling constraints within jails, an inmate may have to decide between enrolling in a treatment or an educational program.

Also, offenders are confined to the jail for limited, and often uncertain, lengths of time. This is particularly true for unsentenced, pretrial inmates who may be released from jail unpredictably following a court hearing. Ideally, treatment programming can be developed according to a modular structure that accommodates differing time lengths and goals—from initial engagement and education to developing skills and completing steps.

Environmental Issues

A large number of people enter jails both as visitors and as service providers. While reach-in from the community and visits from family should not be discouraged, coordinating and overseeing such activities is time consuming for staff who may need to spend time processing and escorting visitors that could otherwise be spent with clients. Treatment providers who visit clients from outside the institution may also find a significant portion of their time on the premises taken up with waiting and processing.

Jails also maintain a classification-based system that is typically based on security needs and bed/space availability, and which may or may not coincide with an inmate's treatment needs. Many small, rural, or older jails in particular have environments and structures that are not conducive to treatment: They were built to detain, house, and process inmates, and not to provide screening, assessment, or treatment services. There may not be individual interview or treatment space available, and group treatment space may also be scarce. If activity space is available, educational, work, religious, and treatment programs

often compete for this space, and the amount of treatment programming is often compromised. Architecturally, jail activity rooms and housing units are not soundproof. Noise can provide distraction from treatment activities and can be a source of stress for both clients and treatment providers.

Suggestions for Dedicated Program Space

The effectiveness of substance abuse treatment services would be significantly enhanced by dedicated program space in jails that is isolated from general housing units. Dedicated staff office space would optimally be provided in an area within or adjacent to the isolated treatment unit. The benefits of providing dedicated treatment space include the following:

- Privacy in conducting treatment and staff meetings
- Reduced competition for treatment program space
- More readily available staff
- Reduction of issues related to inmate movement and coordination

Finding space that is private and that provides security for both staff and inmates is a challenge. While corrections and treatment staff may find joint solutions, informing clients of these limitations is important. The counselor should also be aware of the limitations this may create for discussing certain issues or engaging particular populations (e.g., detainees with certain charges, certain trauma events, severe mental illness), or even for conducting a thorough assessment. Privacy is also hampered by the fact that an inmate is never alone; there is electronic surveillance in jails as well as security personnel and other inmates.

Gang Affiliation

The counselor should be aware of the jail's policies and programs regarding gang affiliation, including rules regarding who should participate in certain groups and activities or which actions may lead to an administrative or new criminal charge during detention. Knowledge of the gangs in the jail may allow the counselor to foresee which activities could be used to inflame rival gangs, to set clear group rules for activities, and to clearly define the counselor's role of balancing security and facility rules with good treatment practices, thereby avoiding sending mixed messages to the inmate or placing him- or herself at odds with corrections.

Stress Related to Incarceration

A number of issues beyond the individual's readiness for treatment can affect his engagement in the treatment process within a jail setting. Many stressors are present in jails, including trauma related to the recent arrest, uncertainty of the legal situation, and possible loss of a job or custody of children. Counselors are in a position to assist the client in developing coping mechanisms to address

substance abuse issues within the context of multiple internal and external stressors, to clarify which issues can be addressed while incarcerated within the bounds of certain timeframes, and to make referrals to other jail or community services to address non-substance-abuse-related issues and to facilitate continuity of treatment from jail into the community (e.g., legal and medical problems, education, vocational training or work programs, diversion or aftercare programs).

Advice to the Counselor: Jailed Clients

- Counselors should be aware of gang affiliations as well as the jail's policy regarding who should participate in certain groups. This knowledge may allow the counselor to foresee which activities could be used to inflame gang rivalries, set clear group rules for activities, and balance security with good treatment practices.

Issues Related to Justice System Processing and Legal Representation

The legal process can understandably confuse detainees, and either this disorientation can persist for a lengthy period (e.g., during adjournments, plea bargaining, competency processes, or diversion planning), or the status of the case can rapidly shift and the detainee may be suddenly released from jail. Often there is little communication between the court, jail staff, and treatment staff, which has direct impact on the therapeutic relationship, as the detainee's legal status is a major concern.

Defense attorneys do not always visit clients while they are in jail, with brief visits often occurring at court prior to the stressful and sometimes confusing court proceedings. Further, for those detainees who reach out to peers for support, information is often inaccurate and can increase their sense of urgency and hopelessness. Due to the wide variety of populations incarcerated in jails, detainees may learn about scenarios that are not relevant to their own case processes.

Attorneys do not always recognize the benefits of treatment and may not encourage the inmate's involvement in treatment. For example, due to heavy caseloads, many public defenders do not take the time to advise clients about how treatment could benefit them. In some jurisdictions, the appointed defense counsel may not be from the public defender's office and may not be aware of diversionary or other treatment options. Despite the presence of substance abuse problems, defense counsel may in some cases be reluctant to advise their client to voluntarily submit to treatment due to conditions of supervision that are

likely to lead to sanctions and incarceration. The flow of information between legal and treatment professionals can also be problematic, related to the types of information that counselors can provide to their clients' attorneys, whether counselors can testify in court, and the types of legal information that the treatment provider needs for purposes of counseling.

Confidentiality

Substance abuse treatment programs should establish clear guidelines regarding the type of information that may be disclosed after an offender has signed a proper consent form. The Federal confidentiality laws and regulations protect any information about an offender if the offender has applied for or received any substance abuse-related services from a program covered by the law. Programs included are those that specialize, in whole or in part, in providing treatment, counseling, and/or assessment and referral services for offenders with alcohol or other drug problems. A different confidentiality issue can arise in small, rural jails, where inmates and officers often know each other. Residents with substance use disorders are well known, and it is difficult to keep confidential the fact that someone is receiving treatment.

Counselor-Client Issues

Given the complexity of the environment and issues needing to be addressed, it is useful for the counselor to clearly describe his role and limitations related to that role, the structure of the proposed treatment, and the various options available. For instance, the counselor should explain whether he or she will become involved in legal, family, medical, disciplinary, or other issues. The counselor should describe the potential treatment options, how these options may or may not impact the client's problems, and what other types of treatment or interventions may be needed to address the client's problems that are not offered within a jail setting. While the client's reactions to this information may initially vary from rage to indifference to relief, offering ways to cope with limitations and stressors is more useful than initially placating the client. The counselor should be aware of the protections and limits to protections that informed consent may have.

Supervision and training

Supervision and ongoing participation in training are essential for jail treatment counselors, given the complexity of issues, presenting symptoms, and behaviors related to the inmate population, and the limitations to the physical structure and environment of the jail. Supervision can support the counselor and help clarify the different systems' demands, potential personal reactions to these demands, and personal reactions to the clients themselves. These clarifications help

determine when these issues should be part of or separate from the treatment and which issues should be addressed systemically. Support and continued professional development can reduce therapist burnout and increase treatment efficacy.

What Treatment Services Can Reasonably Be Provided in a Jail Setting?

There have been several efforts to develop guidelines for jail-based treatment programs that describe model treatment approaches and minimum standards of care. For example, the Office for Treatment Improvement (now the Center for Substance Abuse Treatment [CSAT]) convened a "Criminal Justice Treatment Evaluation Meeting" in 1992 to identify critical elements of jail-based substance abuse treatment programs and jail treatment guidelines. There is still a need, however, for more specific guidelines that can be operationalized by local jails. The American Correctional Association (ACA) and the National Commission on Correctional Health Care (NCCHC) have standards related to jails, but they are extremely limited in the area of substance use, and far less specific and detailed than those developed for mental health services in jail. No specific guidelines have been adopted for substance abuse treatment in jail, nor do existing standards account for the elaborate contextual and environmental factors affecting treatment in jail settings.

There is currently no single prototype for jail substance abuse treatment programs, but rather a range of available programs that vary in content and intensity according to the inmates' length of stay (Leukefeld and Tims 1992; Peters and Matthews 2002). Some detainees are in jail less than a week, during which they may receive only assessment and referral, whereas others are serving a sentence in a jail setting. Several different durations of treatment are discussed in this section to examine the range of treatment options that might be provided in jail. This section recommends a framework by which to identify priority treatment services, given a defined period of time available to provide treatment services for inmates. For purposes of this section, "brief" treatment is defined as up to 30 days, "short-term" treatment is defined as from 1 to 3 months, and "long-term" treatment is defined as 3 months and longer. Regardless of the duration of treatment, however, the goal should always be to engage clients so that treatment and recovery can continue when they leave jail.

Treatment intensity and duration are increased with length of stay, as is the scope of topics that can be addressed. More intensive treatment services are often necessary, given that the substance abusing lifestyle has taken years to develop and cannot be altered in just a few weeks. Figure 2-1 outlines optimal treatment components that might be deployed at each level, followed by a more detailed explanation of each. Each successive level of treatment in this layered approach includes service components from previous levels.

Figure 2-1. Treatment Components

Brief	Short-term		Long-term
Level I (1 to 4 weeks)	**Level II (4 to 12 weeks)**		**Level III (3 months or more)**
Motivational interviewing	Relapse prevention	Communication skills	Employment counseling
Orientation to treatment/ treatment planning, and substance abuse education	12-Step programs	Dealing with domestic violence	Therapeutic community
Information on available community resources	Basic cognitive skills	Anger management	Family mapping and social networks
			Following through on 12 steps
Facilitating access to community services	Identity and culture	Problem solving	Continued stabilization
Community linkage and transition services	Strengths building	Social skills training	Cultural factors
Psychotropic medication: education and compliance			Criminal thinking

Regardless of the duration of treatment, complicating factors for those in jail include co-occurring medical problems and histories of physical and sexual abuse, unstable relationships and social support structures, poverty, homelessness, gender, and cultural differences, among others. Combinations of factors can interact differently with any of these subpopulations, have implications for treatment strategies, and have an impact on treatment outcomes. Consequently, when designing or adapting treatment programs, it is important to factor in these variables along with the substance choice patterns of use and types of previous treatment and services.

Level I: Brief Treatment

Some offenders may be identified within a short period of jail detention for involvement in community diversion programs that include participation in treatment. For many other inmates who are incarcerated 30 days or less, case management, referral, and brief interventions can be provided. Brief treatment usually focuses on supplying information and making referrals.

Motivational enhancement therapy and motivational interviewing

Motivational enhancement approaches help clients to address their ambivalence about involvement in substance abuse treatment, and to identify methods of dealing with this ambivalence. The goal of this process is to engage inmates in a discussion of the treatment process and their potential reasons for changing substance abuse behavior and to help inmates develop their own rationale for changing this behavior. This approach is designed to help counselors work with clients who are ambivalent about treatment, in denial about their circumstances, and resistant to change.

In Project MATCH, the largest clinical trial ever conducted to compare different alcohol treatment approaches, a four-session motivational enhancement therapy yielded long-term overall outcomes that were similar to those of other, more intensive outpatient methods. Further, the results of this study strongly suggested that motivational interviewing could be applied across cultural and economic groups.

Enhancing detainees' motivation for change and increasing their receptivity to substance abuse treatment can be effective in this setting as well. For example, materials developed at Texas Christian University include a board game called Downward Spiral, which helps clients examine the consequences of substance abuse. Other useful exercises include the Decision Matrix, which looks at advantages and disadvantages of continued substance use from the client's perspective and at the benefits of choosing to discontinue use. This helps identify functional aspects of their substance use (e.g., socialization, reduction of negative emotions) that sustain patterns of use, and that may serve as barriers to continued abstinence and involvement in treatment.

Substance abuse education

Because inmates may not have examined the negative health consequences related to substance abuse, an educational component can inform and possibly change risky behaviors. Films, presentations, and literature can be used to present this education. The ultimate goal of treatment is abstinence, but people who have abused substances long-term have had difficulty successfully addressing issues such as boredom, anxiety, social discomfort, and being ostracized by family and peers.

A Voice of Experience

I believe that jail administrators have an obligation to provide the programs by which inmates can better themselves, and this includes alcohol and drug abuse programs. But in South Carolina—and only in South Carolina—anyone sentenced to more than 90 days, with the exception of family court, goes to State prison. The rest come here. Consequently, with this small average length of stay, it's very difficult to justify the significant commitment of resources that are needed with such a revolving door atmosphere.

—Mark F. Fitzgibbons,

CJM

Director, Buford County (SC) Detention Center

Information on available community resources

Community resource information ranges from how to obtain a restraining order to what community organizations offer substance abuse treatment. Counselors in the pretrial setting need to be aware of their community's resources in order to assist their clients after release. Many of these individuals will be released back to the community with their numerous needs unchanged and/or unmet. Clients can be referred to Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) groups, and counselors can provide help with finding job training programs, general educational programs, clothing, food, and public assistance. Before this information is presented to inmates, however, counselors must check to see that an agency will accept referrals from the criminal justice system, and assess eligibility criteria. Some programs have developed resource directories with descriptions of community services programs and relevant contact information.

Facilitating access to community services

Incentives can be established for substance abuse treatment staff to enter jails to work with inmates enrolled in treatment. One step is to develop contract language that identifies jail inmates as a priority group to receive publicly funded substance abuse treatment services. Another is to establish funding for health benefits. In New York City, for example, an inmate's Medicaid eligibility in a community program can be reinstated while the inmate is still in jail so the paperwork is ready when that inmate is released; a similar system has also been developed for establishing temporary Medicaid coverage. Some community organizations may be less resistant to taking on former inmates as clients if these individuals are receiving Medicaid support. Once a health problem or mental illness is identified, Medicaid may be needed in order to cover treatment in the community for those affected.

Community linkage and transition services

Offenders who abuse substances are perhaps at their most vulnerable when they are making the transition back to the community. The treatment system needs to plan for an inmate or detainee who is leaving the jail, and the community needs to be prepared to receive the individual. Case managers or other types of "boundary spanner" staff are particularly trained to manage these transitions. They are cross-trained in issues related to the mental health, substance abuse, and criminal justice systems, and will help to facilitate aftercare or diversion (Steadman et al. 1995; Taxman 1998).

These staff members can handle multiple tasks—from being advocates to understanding the available community resources and linking exiting inmates to those resources. The most common types of linkage and transition services provided by jail substance abuse treatment programs are assessment of aftercare needs, discharge planning, placement planning, and coordination with community treatment agencies (Peters and Matthews 2002). Jail aftercare coordinators or treatment counselors, community resource coordinators, or case managers often provide these services. Specialized reintegration programs are often helpful in developing postrelease plans related to housing, aftercare, relapse prevention, and employment.

While the goal of treatment is to help an inmate to abstain from substance use, the reality is that inmates are at high risk for relapse and in some cases overdose upon their release from jail. Overdose prevention efforts prior to release can prevent deaths, especially for inmates who have been off the streets for a period of time. Counselors should provide inmates with information about the decreased tolerance that results from abstinence.

A Voice of Experience

Since 1993, the Clark County (NV) Drug Court's 1,725 graduates have experienced only a 17 percent recidivism rate—as compared with the 80 percent recidivism rate of people addicted to drugs who are released from jails or prisons. According to our drug court judge, this is the best method so far to treat people addicted to drugs. I agree. To have an impact on substance abuse in the jail population, an approach of long-term, high-quality treatment with community follow-up is the answer.

—Captain Marilyn

Rogan

Clark County (NV) Detention Center

Psychotropic and other medications: Education and adherence

Many inmates will benefit from education regarding psychoactive medications, how they work, the reason for certain medication schedules, flexibility in dosage, side effects and how to manage these, and the relationship between mental and substance use disorders and noncompliance with medications and decreased efficacy of medications. Clients should understand the distinction between psychotropic medication and substances of abuse but also be informed about which medications can be addictive. This type of education also provides a venue for discussing the relationship of mental disorder symptoms and the potential sense of stigma associated with mental health problems and ongoing medication regimens.

For a significant number of inmates with a history of opioid abuse, review of existing opioid substitution medications will also be quite useful, including methadone, levo-alpha-acetyl-methadol, buprenorphine, and other medications used in detoxification from or reduction of opioid use. There has not been widespread use of these medications in jails, primarily because they are seen as potential sources of contraband, prolonging physical dependence on opioids, and requiring specialized medical supervision.

A Voice of Experience

I am a psychologist working in a jail. We learned that our policy of stopping methadone "cold turkey" resulted in a very high frequency of booking recidivist inmates on drug charges related to heroin. So, working with our County Executive, we stopped withdrawing and stopped the practice of "stopping" on Sundays. Now, if someone comes in, they continue, and we encourage agencies to send their case manager into the jail and make plans for the inmate's release, so there is no gap . . . What we've noticed is—we have very, very few bookings of individuals who were taking methadone. But we haven't reached the point of initiating methadone treatment—that would be our next step. And I think that would be a great idea, because everybody is so happy with what we've been doing.

—Lawrence W. Smith, Ph.D.

Psychiatric Services Administrator

King County (WA) Department of Adult and Juvenile Detention

Level II: Short-Term Treatment

Level II, short-term treatment (approximately 4 - 12 weeks in duration) enables greater depth of involvement in the treatment process. Short-term treatment is built upon the previously described basic Level I services. Level II or short-term treatment interventions provide more focus on coping skills to prevent substance use and sustain recovery.

Substance cravings, urges, and relapse prevention

Inmates learn about actions that can trigger their substance cravings and how cravings and urges are tied into relapse prevention. They can also complete exercises to identify personal "substance use triggers" and review strategies for avoiding and dealing with these triggers. For example, group discussion may focus on what inmates may expect when returning to their families, who may not fully support their involvement in recovery. While support from non-substance-using family members can be an enormous contribution to help the client stay clean and sober after release, reunification with family members is often accompanied by stress related to the family's distrust and anger over the offender's past substance use, unresolved conflicts with the partner or spouse, shifting parental roles, and added financial obligations (Peters 1993). Returning to live with family members who actively use substances or who condone substance use within the home creates additional high-risk situations for the offender. In some cases, return to the home environment can trigger a relapse. Counselors should assess the home situation and possibly examine alternative housing arrangements. Counselors may instruct clients that certain areas of town (e.g., drug neighborhoods) are "no-fly" zones and that they will be violating conditions of their treatment program and/or supervision if they frequent those parts of town.

Self-help programs

Level II treatment is an opportunity for inmates to learn about self-help programs and their availability in the community. While not typically considered substance abuse treatment, such groups as NA and AA provide a valuable and accessible source of peer support for inmates returning to the community.

In the past several years, new case law has found that AA and NA are essentially religious-based treatment programs (*Griffin v. Coughlin* 1996; *Kerr v. Farrey* 1996; *Warner v. Orange County* 1999). While many States continue to sentence offenders to AA or NA, in at least one State (New York), the court has found that doing so is a violation of the first amendment. Authorities may be able to resolve this issue, however, by either removing these coercive requirements or by incorporating nonreligious alternatives (Cohen 2000).

Some jails offer alternative types of peer support groups, such as SMART Recovery, which is based on cognitive-behavioral principles of Rational Emotive Behavioral Therapy. While licensed professionals in the community sometimes organize such groups, it is individuals in recovery who lead them.

Basic cognitive skills

Cognitive skills training helps inmates correct thoughts that can lead to criminal behavior and substance abuse. These interventions help inmates understand the relationship between thoughts, emotions, and behaviors, and strategies to address maladaptive thought processes that can lead to interpersonal conflict, emotional disturbance, and aggressive and violent behavior. Cognitive skills learned in jail treatment programs are often generalizable to other settings, including work, school, and relationships with significant others and family members.

Strengths building

Strengths building identifies and uses the assets that clients bring to the treatment program to improve their chances for successful recovery. Counselors can examine interactive ways for participants to recognize their strengths, for example, by having inmates write something positive about each group member, then by identifying characteristics of themselves they think are good, and considering how they can build on those strengths in the future.

Researchers at Texas Christian University (TCU) have developed a series of readiness and induction interventions that incorporate a strengths-building strategy (Dees et al. 2000). These interventions give participants unique opportunities to define their roles in treatment and to discover their positive personal strengths and hidden cognitive potentials. In Tower of Strengths intervention, for example, participants examine their strengths and those they most wish to have. These activities are suitable for use in custody or community settings, and can be used in groups of up to 35 participants or in individual counseling.

The TCU readiness and induction interventions were designed specifically to overcome problems often encountered in working with those mandated to treatment. They address the distorted and negative expectations about treatment common among clients in criminal justice programs, and their lack of self-confidence resulting from personal failures, educational and vocational deficiencies, and poor coping skills.

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Communication skills

This type of intervention can improve interpersonal skills and increase assertiveness with key family members, significant others, and individuals at work. Key activities often address effective means of expressing anger and other negative emotions, dealing with conflict situations, and dealing with problems that arise in personal relationships, whether at work or in the home.

Anger management

These activities can help inmates recognize when they feel angry, identify some of the causes of their anger, and learn to use alternative problem solving techniques to help manage their anger. These interventions are also helpful in understanding the connection between anger and substance abuse, given that poorly managed anger often precipitates substance abuse.

Domestic violence

In these cases, short-term strategies are developed to maintain personal safety for victims of domestic violence and protect children, and longer term solutions are considered that involve legal and law enforcement action. Having staff who are aware of available community shelter and domestic abuse counseling services is also helpful.

Problem Solving

These skills allow people to address and solve their own everyday problems in a rational manner by defining those problems and examining potential solutions. Inmates can begin by talking about problems they have encountered in the past, how they tried to solve them, and whether their efforts succeeded or failed. Then they can examine problems they have solved in a positive manner. Inmates learn how to select a solution rationally, instead of emotionally or acting out immediately. This requires that they learn how to take time to look at a problem, weigh the advantages of alternate solutions, and anticipate their effects.

Discussions involving real incidents of problem solving can help inmates articulate methods of problem solving that typically produce success. For example, a client might describe an argument with his employer, and how he or she intentionally arrived 15 minutes late to work the next day. If that individual's response did not improve the situation, others in the group might indicate what they would do when faced with a similar situation: "I would avoid the situation," "I'd try to ignore him," "When he asked me something, I'd get defensive." The purpose of this exercise is to identify effective ways to proceed. An effective response that could result in desirable responses and outcomes might be, "I went

in to ask my boss if I could speak with him for a minute, apologized, gave him the reason for the tardiness, and made a commitment not to have this happen again." This approach is most effective when counselors make use of real-life issues, role-playing, and group interaction.

Social skills training

Social skills training can be provided independently or as part of modules related to problem solving and anger management. This training can help inmates deal appropriately with coworkers, family members, and friends. The process includes acquiring and rehearsing drug-free and prosocial skills to deal with interpersonal problems faced during recovery. Key components include communication skills, assertiveness, skills for developing and sustaining interpersonal relationships, and specific drug coping skills to handle high-risk interpersonal situations. Other areas include conflict management and learning interpersonal skills related to work, family, and community settings.

A Voice of Experience

Long-term actions, started in jails, which include voluntary acceptance of behavior altering elements, can be effective. They must include abusive substance abstinence, the unburdening of the conscience, and the concept of continuity of care. Treatment must have a solid aftercare component that provides social, family, and community lifestyle changes that encompass jobs as well as education. It must also include daily reinforcement of positive behavior and a new look at life, itself, from a healthy attitude, to be successful. When those actions encompass such a program, success of the individual is possible and productive life skills can be achieved.

—Tim Ryan

Santa Clara County (CA) Department of Correction

President-Elect, American Jail Association

Level III: Long-Term Treatment

When inmates are incarcerated more than 90 days, more treatment time is available to build on the tools provided in short-term treatment and aid the inmate in the transition back to the community. Level III or long-term treatment approaches include components similar to those found in residential treatment in many community-based programs. These interventions are designed to delve more deeply into personal values, belief systems, and issues related to cultural and family background that have supported a substance abuse lifestyle.

Employment counseling

Employment counseling, which can examine an inmate's employment skills and include skills testing, can be incorporated into work release or furlough. Counselors should provide pre-employment training (e.g., communication skills with employers, responsibility, punctuality) and résumé writing. To elicit information to strengthen their résumés, clinicians can ask such questions as what have clients done as a volunteer, community member, or in jail that contributes to their employment opportunities rather than considering only traditional work experience. Counselors can help their clients develop action plans for obtaining employment after release.

Building a therapeutic community

Limited duration therapeutic communities have been established in some jail programs. For a more complete discussion of therapeutic communities, see Chapter 3, *Issues Specific to Treatment in Prisons*.

A Voice of Experience

Both short-term and long-term substance abuse treatment programs in jails are most effective when accompanied by aftercare within the community upon release. Inmates will readily volunteer to participate in treatment programs within the confines of the jail. However, few inmates will participate in voluntary post-release care. To be effective, the post-release aftercare should be mandatory with ongoing monitoring and testing by drug courts.

—Terry L. Bunn, CJM

Chief Deputy, Custody Operations

Santa Barbara County (CA) Sheriff's Department

Family mapping and social networks

Family mapping is a structured approach to examine the family network and background. The purpose is to look at the family and try to understand its criminal and/or substance use history and how the family adapted over the years in an effort to maintain stability. The inmate looks beyond his or her immediate family to grandparents, aunts, and uncles because many criminal and substance-using behaviors run in families and move across generations. This close examination helps people understand how and why substance abuse and other maladaptive behaviors exist in their family.

Female inmates, in particular, remain part of their community even while in jail and continue to establish social relationships and maintain social supports. However, while in jail they encounter significant problems in maintaining family contact and support, such as having their children searched for contraband, limits on visitation, glass barriers between mother and child, and having staff members monitor the visits, which often have a negative impact on family relationships. For some issues related to the family, it is important to have the family present.

There are innovative jail programs that work with the inmate and child welfare agency to create specific visit times for father or mother, caseworker, and child in order to streamline visit procedures for agencies (City of New York 2001). Such models may be able to be used for other types of family meetings.

Co-occurring disorders

Longer term treatment provides the opportunity for learning about the interrelated nature of substance abuse and mental disorders, including events leading up to relapse of mental disorders, such as discontinuation of psychiatric medication. Other key interventions include psychiatric consultation to review medications, education regarding mental disorders, and development of transition plans for follow-up mental health and substance abuse services in the community.

Criminal thinking

Many inmates have developed ingrained patterns of thinking that contribute to poor interpersonal relationships and lead to conflict with others and involvement in criminal behavior. Inmates frequently do not see the connection between their criminal behavior and these patterns of thinking or belief systems. By identifying and challenging maladaptive criminal thinking patterns such as generalizations, absolutes, exaggerations, and lies, offenders can become more critical in their thinking and question the thoughts that lead to their criminal behaviors. A number of structured curricula have been developed for this purpose that blend cognitive and behavioral approaches that are consonant with other skills approaches used in jail-based substance abuse treatment programs.

Coordination of Jail Treatment Services

In order to operate a successful jail drug treatment program, cooperation is needed between funding sources, the community, substance abuse counselors, criminal justice personnel, outside agencies, and the offender, among others. This section highlights some of the potential barriers involved in coordinating jail treatment services, then discusses a number of possible solutions to barriers that are frequently encountered while implementing these services.

Barriers to Treatment

A number of factors at work in the jail setting have the potential to interfere with effective treatment:

- Lack of funding for services
- Absence of administrative support for developing comprehensive treatment programming
- Tensions between substance abuse and criminal justice systems, which have overlapping but distinctive concerns (e.g., rehabilitation and substance abuse treatment versus safety, control, and punishment)
- Physical space and environment that are not conducive to treatment
- Competing institutional program activities
- Difficulties in developing mechanisms for sharing information between treatment providers and criminal justice staff
- Confidentiality issues and the need to share information
- Lack of case management or continuing care
- Lack of detoxification services
- Detoxification symptoms mistaken for mental illness
- Lack of methadone tapered doses for inmates enrolled in methadone treatment programs prior to relapse
- Bringing in family members for family reunification or family therapy without careful security screening

- HIV/AIDS and sexually transmitted diseases among inmates
- Inability to provide HIV/AIDS educational materials
- Institutional restrictions related to video equipment, TVs, VCRs (for video playback of practice job interviews)
- Difficulties implementing community in-reach for supplemental as well as basic treatment services
- Treatment providers' reluctance to work in jails

The competing goals of the criminal justice and treatment systems can sometimes pose problems, though the systems share many of the same objectives. Figure 2-2 highlights the specific goals of correctional and treatment systems within jail settings and the shared goals of these systems.

Figure 2-2. Goals of the Treatment and Corrections Systems in the Jail Setting

Goals of Treatment System	Goals of Corrections System	Shared Goals
Behavior change	Safety of inmates	Reducing crime
Public health	Safety of jail personnel	Reducing substance use
Rehabilitation	Punishment	Reducing violence
Long-term good of individual and family	Safety of community	Changing behaviors

Limited resources

The limited amount of funding provided for treatment in many jails reflects underlying community attitudes and beliefs. These include the belief that providing services, including treatment, runs counter to a jail's "purpose" of punishment and may interfere with management. There is also a general lack of knowledge of the impact that treatment can have on crime. Few are aware of the multiple problems that exist in those served by jails, the fluidity of this population between the jail and the community, and the lack of systematic interventions that would stop the expensive jail-streets-jail cycle. Further, the struggle for jail treatment resources may mirror the underfunding of treatment in the community. Jail treatment programs may even compete with, or be viewed as competing with, community resources.

If a community surveys the needs of its jail population, scarce treatment resources can be allocated in a way that is most effective. Jails with adequate resources can develop both specialized and generalized substance abuse treatment services. Jails with fewer resources may choose to divide resources between identification and referral to community programs for inmates who have various co-occurring disorders and problems (e.g., people with severe mental illness, the homeless), and providing traditional treatment services to inmates whose primary problem is their substance use disorder.

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To more efficiently focus limited resources, jail-based substance abuse treatment programs have clear goals and objectives tied to reasonable outcomes, given the limitations imposed by the correctional setting. For example, if the goal of jail treatment is to reduce inmates' negative health consequences related to their substance abuse (e.g., HIV risk), the program would be constructed somewhat differently than if the goal were for maintenance of sustained abstinence following release from custody. Jail treatment programs have found it useful to enlist the help of multiple stakeholder groups that can offer additional resources both in the institution and during transition to the community.

Solutions for Coordinating Jail-Based Treatment Services

There are a number of ways substance abuse treatment providers can work to improve services for people in jails and overcome the barriers described above. These are discussed in the sections that follow.

<u>Prioritizing substance abuse treatment for traditional versus special needs populations</u>

Because of scarce resources, many jails find that they must prioritize how to allocate treatment services for inmates with differing levels of treatment needs. One major issue is whether to target populations that require specialized care and that are at greater risk for relapse, criminal recidivism, and high utilization of community services (e.g., chronically mentally ill, mentally retarded, or homeless inmates) or to focus resources on inmates with more traditional substance abuse treatment needs. There are advantages and disadvantages related to targeting one group in favor of another. Jails need to assess their own resources available for treatment and the scope of subpopulations with special treatment needs to devise a plan that ideally would address the needs of both groups. Figure 2-3 compares the advantages and disadvantages of prioritizing substance abuse treatment services for traditional and special needs populations.

Figure 2-3. Targeted Treatment for Specific Populations versus Mainstream Treatment for Larger Populations

Treatment for Specific Populations		Mainstream Treatment	
Advantages	**Disadvantages**	**Advantages**	**Disadvantages**
Can increase outreach to detainees and inmates otherwise not identified or provided with treatment	Comprehensive multi-problem screenings and assessments are costly	Rapid identification of detainees through charge category or urine testing	Possibly less effective because intensity of treatment is not matched to inmates' needs
Can reduce correctional officer and inmate injuries by providing stabilization and observation of potentially volatile inmates	Committed space and specially trained professional staff are more expensive and could reduce resources to general substance abuse population	Interventions reach more inmates	Less effective without discrete program space and experienced, trained staff
Makes more beds available through reduced cycling of "high-risk" inmates	Requires more aftercare planning staff and coordination with community agency visits	Focuses more resources on substance abuse treatment	Not as effective with special needs populations who need more intensive services
Allows for creation of aftercare and community linkages for special populations		Allows for direct aftercare and diversion linkage to reduce negative outcomes and increase positive gains	Requires aftercare planning staff, coordination with community agencies, and coordination with courts, and may increase officer time for court transportation and staffing agency visits

Promote understanding of institutional security rules and confidentiality requirements

An incomplete understanding of the rules related to confidentiality of substance abuse treatment information and to the security guidelines within the institution may lead to conflict between correctional and treatment staff and may reduce the effectiveness and credibility of the treatment program. For example, counselors may unwittingly bring materials into the jail for treatment purposes that could be considered contraband by security staff or may make promises to inmates regarding scheduled activities, visitation, telephone calls, or other privileges that are not allowed. A thorough awareness of the rules allows the treatment program staff to anticipate these difficulties and develop creative solutions. Treatment counselors should be invited, and be willing, to participate in training related to security guidelines and methods. Treatment supervisors could also offer support by advising counselors on techniques for handling safety concerns and conflict with security staff. Finally, treatment and jail supervisory staff can use cross-disciplinary meetings and cross-training activities to jointly address and solve potential areas of conflict related to housing assignments, scheduling, reviewing responses to critical incidents (e.g., dealing with contraband), information sharing, and other aspects of program development.

Advice to the Counselor: Cross-Training

- Treatment and corrections staff should learn from each other.
- Counselors in correctional settings can benefit from training in security guidelines, and learning about inmate behavior and attitudes.
- Correctional staff can benefit from training in working with specific populations, components of substance abuse treatment, and their role in shaping a therapeutic environment.

Improve coordination of information systems

A lack of coordinated information can be a problem for detainees involved in multiple systems. Several nonproprietary computerized management information systems have been developed for this purpose. This software allows efficient, timely, and continuous care through treatment matching and follow-up and may also include data on drug test results. One model, based on the University of Maryland's High Intensity Drug Trafficking Area Automated Treatment Tracking Software (HIDTA-HATTS), enables substance abuse treatment and criminal justice personnel to access the same information in making decisions about the client (Taxman and Sherman 1998). Other proprietary models based on drug courts have expanded their applications to include mental health screens and assessments. Still other jurisdictions have developed mechanisms to share mental health and substance abuse database information between the

correctional institution and the community managed care provider (e.g., National GAINS Center 1999*c*). Each jurisdiction involved in developing these types of management information systems has worked out informed consent and differential confidentiality issues for information sharing. The models cited have also developed their work in the context of multisystem collaboration and at times through formal consensus-building processes between the key stakeholders relevant to ensure continuity of treatment (Broner et al. 2001*b*).

Educate staff regarding pharmacotherapies

Some jail administrators resist using pharmacotherapy because they are philosophically opposed to administering medication (e.g., methadone, psychiatric medications) to people with substance abuse problems, but most jails administer a range of psychiatric medications for inmates with mental disorders. Most of these medications are not addictive and do not present a risk for distribution as contraband within the institution. However, relatively few jails provide medication-assisted treatment for opioids and other drugs. Figure 3-4 describes some of the advantages and disadvantages of medication use, for inmates enrolled in jail substance abuse treatment programs.

Figure 3-4. Varied Opinions Regarding Medication Use for Inmates in Jail Treatment Programs

Advantages	Disadvantages
Provides continuous treatment from community to jail, and jail to community	Belief that "drugs" should not be tolerated in jails
Reduces cravings	Medications used to combat withdrawal may be used as contraband
Provides a humane response to treating symptoms of withdrawal and addiction	May lead to inmates' selling or trading the medication within the population
Medications are constantly being developed and improved that can benefit inmates with substance abuse and mental health problems	Side effects are not always known
Benefits of treating medical problems (substance use disorders) medically	Benefits to learning to deal with problems without drugs

Resolves/improves symptoms of mental illness and allows the dually diagnosed individual to focus on substance abuse issues	Some medications (e.g., benzodiazepines) can be addictive

There are legitimate concerns regarding the use of some medications in jails, particularly when there are not adequate healthcare staff available to monitor and supervise medication use. Pharmacological treatments used in jails should be monitored by a qualified physician or nurse practitioner. Project KEEP is an example of a program that integrates pharmacological treatments with a jail environment (see text box below).

Project KEEP

A significant increase in the number of drug-related arrests in the New York Metropolitan area in 1987 led to overcrowding and unrest at the Correctional Facility on Riker's Island. In response, researchers developed a program that serves as both a methadone program and an AIDS prevention initiative. Called KEEP (Key Extended Entry Program), the program enables opioid-dependent offenders who are charged with misdemeanors to be maintained on a stable dose of methadone during their stay at Riker's, and then receive a referral at release to a participating community methadone program. KEEP, intended to be a route into long-term community drug treatment, aims to break the cycle of illicit drug use and criminal recidivism. It was one of the first methadone treatment programs of its kind in the United States for incarcerated persons addicted to heroin (Tomasino et al. 2001). This program allows for a humane detoxification for offenders who desire it upon entry to jail, and it allows new patients to enroll in maintenance and to receive treatment in the community. Finally, and most importantly, it provides a continuity of care upon release from jail to people enrolled in methadone therapy prior to arrest.

Seventy-four to 80 percent of methadone treatment patients discharged to the community, mostly to outpatient KEEP programs, report to their designated program. Recidivism rates show that 79 percent of KEEP patients were re-incarcerated only once or twice during a recent 11-year period. KEEP data indicate the importance of administering sufficient blocking doses of methadone to patients in outpatient treatment centers in order to eliminate heroin craving and to maintain the patients in treatment. About 6 percent of KEEP patients are at a higher risk for recidivism (e.g., those with co-occurring disorders) and require specialized treatment (Tomasino et al. 2001).

Provide for staff development

Many front-line jails require that staff have only a GED or high school diploma and no criminal record. While correctional staff receive extensive security training, training is not always provided in working with specific populations and substance abuse treatment. Cross-training is an effective approach to have correctional and treatment staff learn from each other about key issues related to institutional security and rehabilitation. Correctional officers can benefit from learning about the length, course, and components of substance abuse treatment; effective communication strategies with treatment staff regarding inmate behavior and attitudes; involvement in treatment team, group meetings, and other unit activities; and their role in shaping a therapeutic environment. Treatment staff can benefit from training related to security guidelines, effective communication with corrections staff regarding inmate behavior, contraband and other security infractions, and their role in maintaining the security of the housing unit and the jail. Both corrections and treatment staff can be productively involved in identifying critical incidents that may occur within the jail treatment unit, the type of information that needs to be shared between treatment and corrections staff, and methods of resolving these situations.

Instituting treatment programs within jails creates a unique opportunity for treatment staff to collaborate with jail staff in developing in-service training programs and to encourage certification and degree training at local universities. For instance, New York City offers incentives and tuition reimbursement for city employees for both undergraduate and graduate training, along with a forensic certificate, through the New York University school of social work. Flexible job scheduling could help many employees improve their education, and providing course work for credit at the job site would allow jail personnel to work toward undergraduate or graduate degrees. Another option is to set aside time for career development on the job—with a few hours per week to take a class that will not only help their job performance, but will also aid their career progress.

Developing community and correctional partnerships

Creating partnerships between the jail and the community can allow for the development or enhancement of both in-jail treatment programs and coordination of offenders' transition into community diversion and aftercare/reentry programs. Such a model of cooperation and collaboration exists in many jails in the areas of education and health care or in some jails for diversion and aftercare of those with substance use disorders or other mental disorders (Broner et al. 2002 *a*; Steadman et al. 1995). Such partnerships allow for the extension rather than duplication of an array of community resources to address many of this population's substance abuse, mental health, medical, vocational, educational, and social service needs.

On the other hand, coordinating the visits of large numbers of community volunteers can create both a security and staffing burden for the jail. Concerns include staffing patterns, security, contraband monitoring, coordinating schedules, staff time, escorting inmates to their group room and back, and escorting visitors. Therefore, arranging for services from the outside produces an additional workload for jail administrators that may in itself be a barrier. To overcome these problems, shared funding and community organizations' budgeting for jail officers' time could be employed. To find a compatible blend of needs and concerns on both sides, there must be a planning structure for community volunteers and jail administrators to facilitate communication and resolve problems.

Creating linkages between jail treatment and diversion and reentry court programs

Although typically operated by the criminal courts, drug treatment courts (DTCs) have formed productive partnerships with local jails in many jurisdictions (Tauber and Huddleston 1999). The first phase of treatment in some drug court programs is completed in jail, with intensive services provided that focus on a comprehensive psychosocial assessment, substance abuse education, and engagement in and orientation to treatment. In other drug court programs, an initial in-jail treatment component is optional, depending on the severity of drug treatment needs and the importance of a secure treatment setting. Jail treatment is also used with inmates who are awaiting placement in drug court treatment programs in the community. Another major function of jail treatment programs is to provide more intensive services on a short-term basis for drug court participants who relapse or commit other major infractions. In these cases, jail programs can serve as a therapeutic sanction to remove an individual from salient relapse cues (such as drug-using peers), to provide detoxification as needed, and to reengage individuals in their recovery programs. Many drug courts use progressive sanctions that provide an escalating number of days in jail (e.g., 2, 4, 7) for designated program infractions. In some cases, drug courts have provided longer jail sentences, although the therapeutic effects of these sanctions are unclear.

Several drug courts have established a coordinated reentry approach with in-jail treatment programs (Huddleston 1998; Tauber and Huddleston 1999). Each of these partnerships is characterized by significant flexibility in addressing the individual needs of drug court participants. Many of these drug courts also continue to monitor participants who are placed both in custodial and noncustodial settings. For instance, two drug court and jail treatment partnerships (Los Angeles County and San Bernardino County, California, and Uinta County, Wyoming), place offenders in the jail treatment program as the first phase of drug court. In the San Bernardino drug court, participants are given job assignments within the jail that allow for attendance in treatment groups and classes. In Los Angeles County, a separate housing unit is reserved for drug

court treatment and receives referrals from several drug courts in the county. One Los Angeles drug court, designed for probation violators (one of 11 drug courts in the county), requires 3 months in-jail treatment prior to completing subsequent phases of the program. In Uinta County, Wyoming, drug court participants who have been unsuccessful in court-ordered treatment are placed in a 6-week jail treatment program as the first phase of drug court involvement. While they are in the jail treatment program, participants in Uinta County are required to appear in drug court once weekly for status hearings.

In Broward County, Florida, the DTC refers participants to a 90-day jail treatment program if they have not successfully completed other less intensive approaches (e.g., outpatient treatment) (Tauber and Huddleston 1999). Individuals sentenced to jail prior to involvement in the Broward County drug court are also referred to the jail treatment program to engage them in treatment quickly. The drug court then monitors their progress in the jail treatment program and provides a reentry mechanism upon their transfer to the drug court program.

In New Castle County, Delaware, the DTC has combined both short-term (6 months) and long-term (11–18 months) custodial substance abuse treatment with continued care upon rearrest for probation violators who have committed new felony-level offenses. The court monitors the individual's progress through the prison- or jail-based treatment and develops a reentry treatment plan based on input from team members. This has had a positive effect on reducing recidivism (Statistical Analysis Center 1998).

Several other drug court and jail treatment partnerships offer unique elements. In Los Angeles County drug courts, participants who are transferring from the jail treatment unit to community settings can use transition housing. In San Bernardino County, a comprehensive assessment is provided after 10 weeks of treatment in the jail program and is provided to the drug court judge before status hearings. This assessment serves as the basis for the court's decision to order continued in-jail treatment, placement in a community residential treatment program, or placement in a community outpatient program. In New Haven, Connecticut, the drug court judge orders jail sentences as a sanction and requests on an individual basis that drug court participants receive priority access to drug treatment and self-help groups during the ensuing period of jail incarceration (Huddleston 1998).

Examples of Jail Treatment Programs

Several innovative components and unique features of metropolitan jail substance abuse treatment programs are described in this section.

Multnomah County Sheriff's Office In-Jail Intervention Program (Portland, Oregon)

- Offers a specialized co-occurring mental disorders emphasis and features domestic violence services and a relapse prevention track.
- Provides acupuncture treatment to assist inmates in dealing with cravings and withdrawal symptoms during the initial stage of treatment.
- Offers an intensive short-term treatment program (22 days, 50 hours per week, 1:7 staffing ratio) with significant emphasis on aftercare linkage.
- Provides transition and linkage services, which includes driving inmates to community treatment providers (often residential services), as needed, and picking up medications and refilling prescriptions prior to the aftercare placement.
- Coordinates with community treatment providers to share information about aftercare treatment plans and other records.
- Plans aftercare programs that include case management and client needs assessment.
- Offers a treatment curriculum shaped in part by results of satisfaction surveys administered to inmates.

King County Jail System, North Rehabilitation Facility, Stages of Change Program (Seattle, Washington)

- Provides an integrated system of "wraparound" treatment services.
- Partially funded through work contracts.
- County's Department of Public Health manages the jail.
- Offers screening and triage for inmates placed in the jail for more than 1 week.
- Provides individual sessions with counselors.
- Offers acupuncture services.
- Assigns all inmates to jobs that have the potential of developing employment skills.

Philadelphia Prison System OPTIONS Program (Philadelphia, Pennsylvania)

- Provides gender-specific programming for women.
- Provides relapse prevention services, combined with modules on the "psychology of achievement" and entrepreneurship training, using motivational and action-oriented strategies of Fortune 500 companies.
- Integrates family therapy sessions in which families come into the jail.
- Program staff make home visits.

- Program staff use videotaped material from jail and home-base settings for inmates and their families.
- Provides aftercare follow-up services.

Wayne County Jail Target Cities Jail-Based Substance Abuse Treatment Program (Detroit, Michigan)

- Diverts nonviolent prison inmates to complete short-term jail treatment services, followed by involvement in community treatment.
- Reduces the need for prison space through cost-effective diversion approach.
- Addresses parenting skills and parental financial responsibility for family members.
- Uses feedback from an external evaluator to intensify services during the first 3−4 weeks of program involvement, the period in which many participants historically drop out.
- Offers an "Alumni Success" group for program participants.

Walden House and the San Francisco Sheriff's Office SISTER Project (San Francisco, California)

- Prepares incarcerated women for life after their release to prevent relapse.
- Encourages women to make productive use of their time in this 30- to 45-day program.
- Offers a 6-week academic course that provides women with information about college admission and financial aid.
- Provides five-stage testing for GED (high school equivalency) weekly, and holds cap and gown ceremony for graduates.
- Introduces women to a variety of potential job options and helps them to prepare their resumes in a computer class.
- Counsels women on how to keep a job after securing it.
- Prepares women for treatment and places them in community-based programs after their release (Chadwick 2001).

Research Related to Jail Treatment

A survey of metropolitan jail treatment programs indicates that many jails have several treatment phases and endorse more than one therapeutic orientation (Peters and May 1992). More than half of the jail programs surveyed included 12-Step groups, cognitive-behavioral groups, and relapse prevention programs. Many jail treatment programs have developed specialized tracks for such groups as juveniles charged as adults, those with co-occurring disorders, groups for people arrested for driving under the influence, and blended groups for domestic violence and substance abuse (Peters and Mathews 2002).

Outcomes of Jail Treatment

Jail treatment programs often are dependent on local resources or knowledge, rather than on consistent best practice models for this setting. While outcome studies are few and limited in scope, the therapeutic community model shows promise even for short-term stays. In particular, the Amity/Pima County Substance Abuse Treatment Jail Project, funded by the U.S. Bureau of Justice Assistance in the late 1980s, demonstrated the efficacy of drug treatment in a correctional setting (Pima County Sheriff's Department 1988). Moreover, a number of studies demonstrate reduced rearrest and reconviction rates, longer time to rearrest, and fewer arrests during follow-up for those participating in in-jail drug treatment (Peters and Matthews 2002).

Effects of Treatment Duration

Studies investigating the effects of duration of jail substance abuse treatment indicate that recidivism rates are related to the length of treatment, up to an optimal duration of 91–150 days (Swartz et al. 1996). Successful treatment outcomes have been reported for jail programs of 1.5–5 months duration. Involvement in aftercare treatment services following release from jail has also been found to reduce criminal recidivism (San Francisco County Sheriff's Office Department 1996; Swartz et al. 1996). Offenders released from jail are more likely to participate in aftercare treatment if they have previously been involved in a jail treatment program (Taxman and Spinner 1997).

Predictors of Treatment Outcomes

A number of studies have examined predictors of jail treatment outcomes—what elements help people finish treatment ("completers") and what elements militate against completion ("noncompleters"). The most important predictor in one study examining rearrest during a 1-year follow-up period was the number of lifetime arrests, although other psychological indicators and living arrangements were also found to be predictors (Peters et al. 1993). A similar study (Peters et al. 1999) found that cocaine users were less likely to complete a treatment program than alcohol or marijuana users. Other factors predicting noncompletion were lack of a high school diploma, living outside a parent's home, lack of full-time employment, and having been arrested for charges other than drug possession. It is likely that similar factors may influence retention in jail treatment programs, although more research is needed in this area.

Importance of Aftercare

Unfortunately, a majority of released detainees are not linked to aftercare services or treatment and the majority of jails do not use diversion resources such as drug courts. Treatment mandated by drug courts is associated with decreased recidivism, increased treatment retention, and better aftercare linkages (Leukefeld and Tims 1988). Tunis and colleagues (1997) found that drug treatment programs in jails provide a "behavioral management tool" that results in fewer behavioral problems, especially physical violence. However, effects of the program on recidivism rates were modest in the year after release. Inmates participated in the treatment on a voluntary basis in the programs they studied, which consisted of counseling and self-help groups and aftercare opportunities in the community were extremely limited. Additional training for correctional staff could have increased their support for aftercare.

Recommendations for Treatment Providers

- To maximize the benefits of substance abuse services, treatment staff working with clients in jails should consider the following recommendations:
- Recognize that many people in the community frequently move back and forth from community to jail and that triage and referral to services can be critical.
- For individuals in community treatment agencies, make staff available to provide services in jails and share expertise through training and consultation with jail treatment staff.
- Provide ongoing consultation to jail administrators and other jail staff about substance abuse issues, and work to establish a continuum of services in the jail and community for people with substance abuse problems.
- Develop treatment approaches that are targeted to recognized special populations, such as those described in this chapter.
- Assist in conducting periodic quality assessment reviews.
- Employ evidence-based practices such as motivational enhancement techniques, cognitive-behavioral interventions, relapse prevention, contingency management, and therapeutic communities.

Chapter 3:
Treatment Issues Specific to Prisons

The unique characteristics of prisons have important implications for treating clients in this setting. Though by no means exhaustive, this chapter highlights the most salient issues affecting the delivery of effective treatment to a variety of populations within the prison system. It describes the prison population as of 2003, reviews the treatment services available and key issues affecting treatment in this setting, and considers the question, "what treatment services can reasonably be provided in the prison setting?" The prison therapeutic community (TC) model is explored in depth and examples of in-prison TCs are described. The chapter also looks at the treatment options available for certain specific populations and at systems issues that affect all clients in prison settings. The chapter concludes with some general recommendations for substance abuse treatment in prisons.

Overview

- **Description of the Population**
  - Gender
  - Race and Ethnicity
  - Substance Abuse
  - Mental Illness
  - Communicable Diseases
- **Treatment Services in Prisons**
- **Key Issues Affecting Treatment in Prison Settings**
  - Trauma and Hopelessness
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- **What Treatment Services Can Reasonably Be Provided in the Prison Setting?**
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  - Staff Training and Cross-Training
- **Recommendations and Further Research**
  - Recommendations
  - Further Research

Description of the Population

Prisons differ from jails in that inmates generally are serving longer periods of time (1 year or longer) and the offenders have often committed serious or repeated crimes. Prisons and jails both vary in size, but prisons are unique in that they are separated by function and inmate classification. Types of prisons include

- Intake facilities (processing centers for inmates receiving orientation, medical examinations, and psychological assessment)
- Community facilities (halfway houses, work farms, prerelease centers, transitional living facilities, low-security programs for nonviolent inmates)
- Minimum security prisons (dormitory style housing for inmates classified as the lowest risk levels serving relatively short sentences for nonviolent crimes)
- Medium security prisons (higher security risks such as those with a history of violence)
- Maximum security prisons (most restrictive prisons for violent inmates and those posing the highest security risks)
- Multi-use prisons (inmates of different security classifications generally used in States with smaller prison populations)
- Specialty prisons (for inmates with special needs, such as people with mental illness, physical disabilities, or HIV/AIDS) (National Center on Addiction and Substance Abuse [CASA] 1998).

At the end of 2003, State and Federal prisons in the United States housed a total of 1,470,045 inmates. This meant that there were approximately 482 sentenced inmates for every 100,000 United States residents. About 1 in every 109 men and 1 out of every 1,613 women were incarcerated by State or Federal authorities. The Nation's prison population grew 2.1 percent in 2003 (Harrison and Beck 2004).

The percentage of prison inmates incarcerated for parole violations has decreased in recent years. Between 1990 and 1998, the number of people in prison for parole violations increased by 54 percent, but since 1998 the number of parole violators has increased less than 1 percent (Harrison and Karberg 2004).

Gender

Since 1995, the rate of incarceration of women incarceration in prisons has increased at a higher rate (5 percent on average) than that of men (3.3 percent). In 2003, the number of women in State or Federal prisons increased by 3.6 percent, while the number of men in those institutions increased by 2 percent. Women accounted for 6.9 percent of all inmates in State and Federal prisons as of yearend 2003, an increase from 5.7 percent of all inmates in 1990 (Harrison and Beck 2004).

Race and Ethnicity

Although the total number of sentenced inmates increased greatly over the past decade, only a slight variance existed in the racial and ethnic composition of the inmate population. At yearend 2003, African-American males (586,300) outnumbered Caucasian males (454,300) and Hispanic males (251,900) among inmates with sentences of more than 1 year. African-American inmates represented an estimated 44 percent of all inmates with sentences of more than 1 year, while Caucasian inmates accounted for 35 percent and Hispanic inmates, 19 percent. More than 9 percent of all African-American men between the ages of 25 and 29 were in prison in 2003 (Harrison and Beck 2004).

Substance Abuse

The lifetime incidence of substance abuse or dependence disorders in the prison population is roughly 75 percent (Peters et al. 1998). In 2001, 20 percent of State prison inmates were incarcerated for drug-related offenses (Harrison and Beck 2003).

In a 1997 Bureau of Justice Statistics survey, approximately half of all State and Federal inmates reported that they had used drugs in the month before their offense, and over three-quarters indicated that they had used drugs during their lifetime (Mumola 1999). Almost one in three prisoners said they had committed their current offense while under the influence of drugs, and about one in six had committed their offense to get money for drugs. In addition, a quarter of State and a sixth of Federal prisoners had experienced problems consistent with a history of alcohol abuse or dependence. Drug offenders accounted for more than half the total increase in parole violators returned to State prisons (Beck 2000*b*).

Offenders who use drugs are more likely to commit violent crimes. In a report by the National Center on Addiction and Substance Abuse (CASA) (1998), almost half (43 percent) of those identified as "regular drug users" in State correctional systems were incarcerated for a violent offense, including murder, manslaughter, rape, robbery, kidnapping, and aggravated assault.

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Mental Illness

At midyear 1998, 16 percent of State prisoners and 7 percent of Federal inmates reported having a mental condition (Ditton 1999). As of 2000, 13 percent of State prison inmates (approximately 79 percent of those with mental disorders) were receiving some type of regular counseling or therapy from a trained professional. Approximately 10 percent of all inmates in State prisons were receiving psychotropic medication (Beck and Maruschak 2001).

According to 1998 data, State prison inmates who reported having a mental condition were more likely than other inmates to be incarcerated for a violent offense (53 percent compared to 46 percent). They were also more likely than other inmates to be under the influence of alcohol or illicit substances at the time of the current offense (59 percent versus 51 percent), and more than twice as likely as other inmates to have been homeless within the previous 12 months (20 percent compared to 9 percent) (Ditton 1999). Approximately 78 percent of females and 33 percent of males in State prisons who have a mental illness reported they had been physically or sexually abused at some point in their lives (Ditton 1999).

Many offenders in State or Federal prisons who had a mental illness reported negative life experiences related to drinking, including losing a job, getting arrested, and getting into a fight. Inmates with a mental illness were also more likely than others to be under the influence of alcohol or drugs while committing their offense; 60 percent of State prisoners who had a mental illness compared to 51 percent of other inmates were under the influence when they committed their offense (Ditton 1999).

Communicable Diseases

Many offenders in State and Federal prisons have poor general health. Their access to and use of healthcare services may have been limited, and behaviors such as intravenous drug injection and unsafe sex may have exposed them to communicable diseases. Prisoners have disproportionate rates of HIV, hepatitis C (HVC), sexually transmitted diseases, and tuberculosis (TB) (Hammett 1998; HIV and Hepatitis Education Prison Project 2002; Maruschak 2004).

<u>HIV and AIDS</u>

The number of all State and Federal prison inmates with HIV infection is estimated to be nearly six times higher than that of the general population (Hammett 1998). In recent years, the rate of infection has decreased somewhat for the general prison population. The number of prisoners known to be infected with HIV was down from 2.2 percent in 1998 to 1.9 percent at year-end 2002. The number of State and Federal prison inmates known to have AIDs also

decreased from 5,754 reported cases in 2001 to 5,643 in 2002 (Maruschak 2004). As in the general population, HIV infection rates were higher for racial minorities. In 1997, of all State prison inmates, 2.8 percent of African American inmates and 2.5 percent of Hispanic/Latino inmates, compared to 1.4 percent of Caucasian inmates, reported to survey interviewers that they were HIV positive (Maruschak 1999b).

Hepatitis C

Many inmates also have HVC. According to the HIV and Hepatitis Education Prison Project (2002), the rate of HCV infection is 10 times higher than that of HIV—an estimated 17 percent of inmates, nearly 10 times higher than the estimates for the general population. Like HIV infection, rates are higher among incarcerated women. Nationally, HVC is about a third higher in incarcerated women than incarcerated men.

Tuberculosis

Rates of TB are also higher among State and Federal inmates than in the general population. Wilcock and colleagues (1996) note that many men who eventually enter prison are at risk even before they are incarcerated. Poverty, poor living conditions, substance abuse, and HIV/AIDS put them at increased risk. Once in prison, these offenders are at risk for contracting TB, as prisons present optimal conditions for the spread of TB. According to 2003 data, nationwide 3.2 percent of residents of correctional facilities had TB (Centers for Disease Control and Prevention 2004*b*). A 1994 study of 25 State and Federal inmates by Wilcock and colleagues (1996) reported that 5,609 inmates who did not test positive for TB when entering prisons did so 2 years later.

Treatment Services in Prisons

The need for prison-based substance abuse treatment is profound. Lo and Stephens (2000) examined treatment needs of Ohio offenders entering the State prison system. More than half were dependent on at least one substance, and 10 percent were dependent on at least two. Treatment for cocaine and marijuana dependence was most urgently needed. Young minority males were most likely to be dependent on marijuana; females were more likely to be dependent on cocaine and opioids than males. Nearly 60 percent of respondents said that treatment would be of use to them.

Despite this need, in 1997 only 1 in 8 State prisoners and 1 in 10 Federal prisoners reported that they have participated in drug treatment programs since entering prison (Mumola 1999). In 1996, a CASA survey of prison facilities indicated that three quarters of State inmates needed substance abuse

treatment, though less than a quarter of State inmates received it (CASA 1998). As Figure 3-1 indicates, the most common reasons listed for the limited availability of treatment were budgetary constraints (71 percent) and space limitations (51 percent).

Figure 3-1. Reasons for Limitations to Providing Treatment to Prison Inmates

Reason	Percentage
Budgetary constraints	71
Space limitations	51
Limited number of counselors	39
Lack of volunteer participants	18
Frequent movement of inmates	12
General correction problems	8
Problems with aftercare provision	4
Legislative barriers	2

Source: CASA 1998.

Various organizations and agencies have developed, or are in the process of developing, guidelines for substance abuse treatment in correctional facilities, including the American Correctional Association (ACA) in conjunction with Therapeutic Communities of America, the National Institute of Corrections (NIC), and the Center for Substance Abuse Treatment (CSAT). Figure 3-2 summarizes some of these guidelines.

Figure 3-2. Guidelines for Substance Abuse Treatment in Correctional Facilities

	ACA	NIC	CSAT
Screening and assessment	Diagnosis of chemical dependency by a physician and determination of whether that individual requires pharmacologically supported care	Screening and assessment	Standardized screening and assessment
Treatment plans	Individualized treatment plans	Development of comprehensive treatment services	Individualized treatment plans
		Continuity of services across the corrections system	
Other	Referrals to community resources upon release (ACA 1990)	Staff recruitment	Matching to different levels or types of treatment services
		Staff training	Case management services
		Sanctions	Use of cognitive-behavioral, social learning, and self-help approaches
		Program accountability & evaluation	Inclusion of relapse prevention training
			Use of self-help groups
			Use of therapeutic communities
			Provision for isolated treatment units
			In-prison drug testing
			Continuity of services
			Program evaluation
			Cross-training of staff

Sources: ACA 1990; CSAT 1993; NIC 1991.

Although the extent to which State prison systems have adopted these professional guidelines is unclear, they provide a standard against which treatment programs can be measured (Peters and Steinberg 2000).

Key Issues Affecting Treatment in Prison Settings

Incarcerated prisoners are marked by considerable diversity, yet they share a common experience of incarceration. Prisons can be violent, harsh, psychologically damaging environments; incarcerated people live in an environment that is both depersonalizing and dehumanizing. Moreover, the social stigma associated with incarceration, combined with the depersonalizing effects of imprisonment, may result in a sense of hopelessness and powerlessness, as well as deeply internalized shame and guilt. Thus, in addition to treating substance abuse and other mental disorders, in-prison treatment also address the trauma of the incarceration itself as well as a prison culture that conflicts with treatment goals.

Trauma and Hopelessness

Inmates' responses to prison environments vary, but virtually all will experience some degree of trauma and hopelessness. Derosia (1998) conducted a review of the literature and determined that the inmates who were most likely to have difficulty coping in prison

- Have unstable family, living, work, and/or education histories
- Are single, young, and male
- Exhibit histories of chronic substance abuse or psychological problems

When accompanied by violence and exploitation from other inmates or custodial staff, the sense of trauma and hopelessness can be magnified. Sexual assaults are particularly devastating, with a series of accompanying medical, psychological, and social costs (Dumond 2000).

Even for inmates who do not suffer abuse or exploitation while in prison, the trauma of incarceration alone may worsen existing posttraumatic stress disorder (PTSD) or create PTSD-like symptoms. Markers of PTSD include

- Irritability
- Hypervigilance
- Sleep difficulties
- Restricted range of affect
- Feelings of detachment
- Flashbacks and/or nightmares of traumatic incidents (American Psychiatric Association 2000)

Counselors should be able to recognize these symptoms and encourage clients to talk about their feelings related to the incarceration. Counselors should be especially aware of signs of suicidal ideation.

Inmate Identity and Culture

It is difficult to describe one type of "criminal" identity that is shared by all offenders. A more common problem is, perhaps, the lack of identity and accompanying hopelessness that many offenders face. Some offenders feel relatively little anxiety regarding their incarceration, and many believe that being in prison and participating in prison culture are the norm. Others feel they are the victims of society, and still others take pride in belonging to an alternative culture (e.g., the drug culture, a gang) and being outside the majority culture.

Unlike jail detainees, who are likely to be incarcerated for short terms, prisoners often learn to identify as inmates as a matter of survival. In part, this is a result of institutional pressures on them, and partly it is the result of interactions with other inmates who have accepted the role or persona of a prisoner. In prisons, as opposed to jails, there are many more people who are accustomed to the setting and who take the attitude that it is "no big deal." The assumption of an identity as an inmate is an issue of survival for most offenders. The hardened demeanor and "macho" attitude adopted as part of the inmate culture can discourage offenders from participating in treatment. Treatment is often perceived as a sign of "weakness" within the inmate culture, and inmates who enroll in treatment are often characterized by other prisoners as too weak to "handle their drugs" in the community.

Gender-Specific Issues

Gender in particular is a defining category for treatment and recovery in prison settings. Populations are segregated by gender so that in addition to the difference in psychosocial issues facing male and female inmates, the character and experience of men's and women's prisons are widely divergent. Programs must be attuned to the differences inherent in treating men and women within a prison setting.

<u>Men in prisons</u>

Where possible, programs should provide specific groups and educational curricula that emphasize the gender-specific aspects of treatment. For example, issues related to relationships and to fatherhood should be explored. Fathers may be encouraged to participate in parenting education, with an emphasis on responsibilities and the impact of neglect, anger, and abuse on children.

Employing both male and female counselors is helpful in an all-male program, as male inmates may be less guarded and confrontational with female staff. Treatment staff also should focus on gender dynamics that affect many male participants' willingness to assess honestly their own conduct, typically including behaviors such as avoiding responsibility, excessively blaming others, and repressing feelings.

For many incarcerated men, learning to express anger in healthy and constructive ways is vital. Many male offenders have been perpetrators of domestic and/or sexual violence and/or have gotten into trouble because of fighting or assaults. Violence prevention groups may help participants explore thoughts, feelings, and behaviors that are often the underpinnings of violent behavior and sexual aggression—issues such as a lack of empathy, narcissism, anger management problems, an overblown sense of entitlement, and the lack of effective thinking skills and sense of self-efficacy.

Research shows that sexual offenders may be at greater risk for violent assaults by other offenders (Brady 1993). By taking a "scattershot" approach that treats all participants as if they have a history of violence or sexual offenses, rather than singling out specific individuals, treatment providers can address latent and manifest coercive behavior focusing attention on specific individuals.

Women in prisons

Incarcerated women typically have a constellation of high-risk environmental, medical, and mental health issues as well as behaviors associated with continued or renewed substance abuse (CSAT 1999*b*). In the prison environment, these factors can operate as influences to relapse. They include antisocial behavior, emotional problems, the trauma of imprisonment, and the separation of the inmate from her family and loved ones, especially children. Problematic behaviors and the attitudes that influence them have been developed over many years and often have their roots in childhood trauma. Often, the trauma and related negative influences of imprisonment counteract the value of services provided by the in-prison treatment provider. Imprisonment also disrupts family life and social relationships, thereby interfering with female inmates' roles as wife/partner, mother, sister, aunt, and daughter. Women inmates' identities in most cases are tied to one or more of these roles. For some women, interference with these roles produces stress because of the loss of affection and security normally provided by their families, which can also trigger substance abuse.

Women's Intensive Treatment Program

National Institute on Drug Abuse (NIDA)-sponsored research indicates that three frequent treatable problem areas in women's lives are substance abuse, recurring criminal behavior, and personality disorder. The Women's Intensive Treatment Program at the Maryland Correctional Institution—Women (MCI-W) was initiated to address these problem areas and to provide more intensive treatment alternatives (Richards et al. 2003).

The 9-month residential program is composed of individualized treatment planning, focused treatment modules, and work or school. It is geared toward offenders with 3 years remaining to serve, whose psychopathy is not too severe for the program, and who, after screening, are considered able to benefit from treatment. Modules include anger management, moral problem solving, addiction awareness, relapse prevention, early memories, trauma recovery, social skills, and empowerment.

Six key treatment principles guide the treatment process:

- Clear focus on public safety, which guides all treatment decisions and effective teamwork with other MCI-W departments
- Attunement to the particular needs of female inmates (e.g., unique pathways to crime, trauma histories) is critical
- Assessment-driven treatment planning, which avoids a "one-size-fits-all" approach in favor of individualized planning
- Dual diagnosis programming for the approximately 70 percent of women with mental illness
- A minimum stay of 6 months
- The use of motivational enhancement techniques
- Women may create intimate relationships and family groupings to meet their relational and emotional needs. It is important that in-prison treatment programs work with female participants to help create healthy prosocial relationships to meet these needs. Female inmates can draw the strength to change in a new peer group, rather than feel pressure from their old peer group to conform by engaging in drug-taking or criminal behavior. Additionally, a strong core of female staff provides opportunities for role modeling and for developing healthy noncoercive relationships with inmate participants.

What Treatment Services Can Reasonably Be Provided in the Prison Setting?

Because the prison population tends to be incarcerated for longer periods than jail inmates, treatment possibilities in a prison setting are more extensive, depending on funding and other factors. Counselors and prison administrators may establish programs that are long term and comprehensive. Substance abuse issues may be addressed along with behavioral, emotional, and psychological problems. Ideally, prisoners have the opportunity to abstain from substances and learn new behaviors before release.

Treatment Intensity

Treatment in a prison setting can vary greatly in the setting and intensity of the program. On the most intense end of the spectrum, the TC is a treatment model that attempts to create a 24-hour, 7-day-a-week treatment environment that integrates community, work, counseling, and education activities. Ideally, the program activities take place apart from the general prison population. Complete isolation from the general population is somewhat unusual, however.

Less intensive treatment programs may simply deliver counseling, education, and other treatment services in a manner similar to outpatient programs. Inmates live in the general population and have assignments or appointments for services. Examples include weekly or twice-weekly individual therapy, weekly group therapy, or a combination of the two in association with self-help activities.

Regardless of whether treatment occurs in a TC or as isolated outpatient sessions, intensity generally decreases over time as the individual meets treatment goals and moves through the stages of recovery.

Treatment Components

In-prison treatment incorporates several different models, approaches, and philosophies for the treatment of substance use disorders, as described in the following section.

<u>Counseling</u>

In its prison study, CASA found that 65 percent of prisons provide substance abuse counseling. Of those, 98 percent offered group counseling and 84 percent offered individual counseling. Nearly one-quarter (24 percent) of State inmates and 16 percent of Federal inmates participated in group counseling while incarcerated (CASA 1998).

Group counseling

As the most common treatment method, group counseling seeks to address the underlying psychological and behavioral problems that contribute to substance abuse by promoting self-awareness and behavioral change through interactions with peers (CASA 1998). Although the intensity and duration of group therapy can vary, trained professionals typically lead groups of 8 to 10 inmates several times a week with the expectation that participants will commit to and engage in meaningful change in an emotionally safe environment. Group sessions typically range from 1 to 2 hours in length.

Cognitive-behavioral groups

Substance abuse treatment programs in correctional settings should be organized according to empirically supported approaches (i.e., those based on social learning, cognitive-behavioral models, skills training, and family systems) (Cullen and Gendreau 1989). Programs based on nondirective approaches or medical models or those focusing on punishment or deterrence have not been shown to be effective (Peters and Steinberg 2000). Cognitive programs include such strategies as "problem solving, negotiation, skills training, interpersonal skills training, rational-emotive therapy (REBT), role-playing and modeling, or cognitively mediated behavior modification" (Izzo and Ross 1990, p. 139).

Cognitive/behavioral/social learning models emphasize interventions that assist the offender in changing criminal beliefs and values. Such interventions concentrate on the effects of thoughts and emotions on behaviors, and include strategies (e.g., behavioral contracting) that promote prosocial behavior and accountability through a system of incentives and sanctions.

In REBT, the client's thinking patterns are also the focus of attention. Individuals who abuse substances tend to think automatically, in rigid terms, and with overgeneralizations. Rationalizations are also commonly used by offenders to justify maladaptive behaviors, including substance abuse and a range of other criminal behaviors. Clients are taught to be aware of their thinking patterns and to challenge their assumptions. Once these errors in a client's thinking are pointed out, they can be changed. Correcting the client's thoughts can lead to exploration of alternative behaviors and attitudes that do not involve substances.

Specialty groups

Specialized treatment groups are often organized around a shared life experience (e.g., children of alcoholics, incest survivors, people with AIDS) or common problem (anger management, parenting, stress reduction, or prerelease planning). Specialty groups offer a chance to work on specific issues that may be

impeding other treatment initiatives or require special attention not readily available in the regular program. Two types of specialty groups are briefly described below.

- *Anger management groups.* Anger management groups are widely used in drug treatment programs. They are especially helpful for inmates who are either passive and nonassertive or express anger in an explosive fashion. By careful analysis of emotional reactions to painful and threatening experiences, treatment staff help the inmate learn to manage anger in a more socially acceptable manner. For example, inmates may feel incapable of expressing negative feelings verbally. Instead of responding appropriately to a provocation, they allow feelings to build up, which leads to a delayed explosive reaction. Learning to express angry feelings verbally and in an appropriate manner helps inmates feel more competent about interpersonal relationships.

- *Parenting groups.* Very successful groups have been organized around parenting issues. Although the perspective may differ for females and males, bonds to children can help motivate the recovery process for both genders and can contribute to a successful re-entry into the community. Practitioners have found that both men and women need to focus on developing parenting skills and overcoming patterns of neglect, abandonment, and abuse. As a result of parenting work, some program participants have tried to find their children and establish relationships with them upon release to the community. The process of becoming a responsible parent can be a critical component in the recovery process.

Family counseling

Family therapy is a systems approach that often focuses on large family networks. Family and friends can play critical roles in motivating individuals with drug problems to enter and stay in treatment. When possible, involvement of a family member in an individual's treatment program can help prepare the individual for parole. Often caution needs to be exercised when involving families of offenders because of high degrees of antisocial behavior and psychological disturbance.

Individual counseling

Individual counseling is an important part of substance abuse treatment. Counselors may operate from many different philosophical and theoretical orientations and employ a variety of therapeutic approaches in individual therapy. The common feature of such sessions is that inmates in a private consultation

are free to explore more sensitive issues, which they might not be ready to discuss in a group. Individual sessions also provide a place where a counselor can coach inmates on relapse prevention techniques such as how to recognize specific high-risk situations, personal cues, and other warning signs of relapse.

Like group counseling, individual therapy strives to help offenders develop and maintain an enhanced self-image and accept personal responsibility (CASA 1998). It can act as an important adjunct to group therapy. Additionally, skilled psychologists and social workers who offer individual therapy to offenders play a role in the development and review of a client's treatment plan.

Self-help groups

Self-help groups, found in a majority of State and Federal prisons, are frequently a crucial component of recovery and can provide a great deal of support to recovering offenders. Self-help groups provide peer support and may serve as therapeutic bridges from incarceration to the community.

Self-help programs were founded by individuals who found conventional help inadequate or unavailable. These individuals shared common problems and a personal commitment to do something about their condition. Self-help programs are not considered "services," which require client dependence on providers. Instead, they are programs based on a philosophy of self-responsibility. The philosophy involves a powerful belief system that requires individuals to commit to their own healing. For many, this approach has proven inspiring and successful.

A major focus of the self-help approach is altering the fundamental beliefs and overall lifestyles of participants. By taking responsibility for their own problems, individuals can gain control over their situation and develop a new sense of self-respect and competence. Recovering role models provide support and guidance. The entire approach can result in far-reaching changes in personal lifestyles and social relationships. In general, the self-help movement successfully instills the more positive aspects of individualism—self-reliance and responsibility—while also stressing the importance of group effort in overcoming common problems.

The concept of empowerment is perhaps the most central to understand the positive effects of self-help groups. (For other benefits, see below.) Self-help processes are geared to invoke and develop a sense of personal power among members. Empowerment can be derived from a "higher power," from the group, or entirely from within the individual, where the idea of "bottom line" responsibility for the conditions of one's life teaches members that they have the power to alter their lives and living conditions. Self-help groups also encourage members to use their personal strength to enable others to feel less helpless. This, in turn, enhances the power of the helper. Since self-help programs are peer centered, they encourage mutual support and offer many opportunities for leadership.

The Benefits of Self-Help Groups

- Support for substance abuse treatment and recovery
- Peer support
- Healthy peer interaction
- Therapeutic bridges between the criminal justice system and the community
- Crisis prevention and management
- Personal growth

The best known self-help groups are Alcoholics Anonymous (AA) and Narcotics Anonymous (NA). However, other self-help groups may be appropriate, depending on the offender's beliefs, needs, and interests. Other groups include Survivors of Incest Anonymous, Secular Organizations for Sobriety (SOS), religious groups, women's groups, and veteran support groups. One survey found that 74 percent of prison facilities offered self-help programs of various types. Of those, AA had the strongest representation (in 95 percent of those facilities), followed by NA (in 85 percent). Less than one third offered other types of self-help programs. Because of the lack of empirical evidence about the effectiveness of self-help programs in reducing recidivism and relapse, these groups are best viewed as support activities that can enhance more structured and intense treatment interventions (CASA 1998).

At times compulsory self-help group attendance is used as a sanction. Compulsory use of any treatment or supportive service as a sanction is ill advised and can be detrimental to other treatment efforts. Moreover, the constitutionality of mandatory participation in spiritual-based groups has been challenged. When compulsory attendance is a part of the treatment, secular alternatives should be made available.

Educational and vocational training

Educational and vocational training, in addition to attention to psychosocial and behavioral needs, is a critical dimension that helps offenders become responsible family members, employees, and community members. The acquisition of skills such as basic literacy, GED certification, and life skills can improve employment opportunities and improve self-esteem. Such enhancements also can help keep inmates from returning to substance-using subcultures and ways of life. These services are generally provided by the prison and must be closely coordinated and monitored by the treatment staff as part of case management function.

Advice to the Counselor: Prison Treatment Approaches

- Treatment in prison environments should be organized according to empirically supported approaches, such as social learning, cognitive-behavioral models, skills training, and family systems.
- Nondirective approaches, some medical models, and those focusing on punishment or deterrence have not been shown to be effective.

Therapeutic Techniques

Specific therapeutic techniques can be especially helpful in treating the prison population. As discussed below, role-playing and video feedback can help offenders improve awareness of how others experience and perceive their behavior. Other models that have received increased attention include motivational interviewing, faith-based initiatives, token economy models, and the resurgence of a more traditional medical-pharmacological model that includes the development of medications to remove the organic effects of cocaine (i.e., craving-based treatment interventions). Typically, therapeutic techniques are not used as stand alone interventions but rather blended into a treatment approach or model that addresses multiple needs with multiple techniques. Also, evaluation studies usually test the efficacy of program models such as the TC and rarely test the effectiveness of individual treatment techniques. However, the following interventions have been widely used in correctional treatment and have gained clinical validity among many practitioners.

Role playing

Role playing exercises have been used with incarcerated populations since the 1950s, particularly in residential treatment settings. These exercises take advantage of the fact that inmates are experienced at playing roles negatively and direct that skill toward a positive end. Prior to participation in guided role playing, inmates learn the rules and purpose of this technique. This approach has been particularly effective with perpetrators of violence, as these individuals often remove themselves emotionally from their victims. Using role play, inmates often take turns acting as both victims and perpetrators. Destructive behavior patterns, frequently rooted in childhood, can be evoked and re-experienced. This process helps the individual understand old patterns to avoid repeating them. Roles can also be reversed so that perpetrators experience the emotions and thoughts of their victims. Habitual offenders typically feel remorse not for the crime committed but for being caught. Experience of appropriate guilt and desires to make restitution for their crimes are major goals of role playing exercises.

Video feedback

Video feedback can be a valuable therapeutic tool in correctional rehabilitation. Video feedback allows inmates to "see themselves as others see them." For example, viewing a tape of their intake interview helps inmates cut through denial as a result of witnessing their own body postures, gestures, and facial expressions. Video sessions can also help inmates identify different behavior patterns, attitudes, and self-images. Inmates who have spent their lives on the streets may change their self-perception by seeing themselves in a video, perhaps dressed in a suit, speaking and behaving differently than before. Watching tapes of group sessions and of other activities, inmates can begin to view themselves differently. This is especially valuable for those with poor self-images. Inmates may have no access to visual images of themselves, since full-length mirrors are not typically available in jail or prisons. Lacking important information for forming an accurate self-image, an inmate's problem may be less a matter of poor self-image than of no self-image. In such cases, videotapes can play an important role in treatment.

"Blended" approaches

The "blended model" recognizes that a melding of different approaches and techniques can prove effective in prison-based treatment. More subtly, the corrections environment itself already incorporates a blended approach, simply because the nature of prisons requires adaptation of existing structural and security concerns.

Blended approaches expand in-prison treatment offerings to include more innovative techniques and treatment modalities. These require creativity, the imaginative use of available resources, proper identification of inmate problem severity (i.e., the more severe the inmate's problem, the more intensive the treatment services), support for programming, adequate physical plant and design, attention to the impact of activities on classification and movement, cost, monitoring, and continued professional development of correctional staff.

One example of a blended approach program is the Residential Substance Abuse Treatment located at the South Idaho Correctional Institution. It offers a combination of three treatment strategies, including cognitive-behavioral and 12-Step programming set within a TC (Stohr et al. 2001). A unique feature is its target population: parole violators who abuse substances. Using qualitative and quantitative data collection techniques, an initial evaluation team determined it to be sound in content and service delivery.

In-Prison Therapeutic Communities

Offshoots of the mental health and self-help approaches, TCs are among the most successful in-prison treatment programs. Because of the intensity of treatment, TCs are preferable for the placement of offenders who are assessed as substance dependent. The Federal Bureau of Prisons and State systems in California, Delaware, New York, Oregon, and Texas, among others, have well-established TC programs in place.

Surveys of the membership of Therapeutic Communities of America (Melnick and DeLeon 1999) and the residential TC programs in the Drug Abuse Treatment Outcome Survey (De Leon 2000; Melnick and De Leon 1999) show high levels of agreement among TCs as to the nature of the essential treatment elements including the treatment approach, the role of the community as a therapeutic agent, the use of educational and work activities, the formal elements of TC treatment, and the TC process. The standards have undergone field testing conducted by the Therapeutic Communities of America and the Office of National Drug Control Policy. The more than 120 revised standards cover 11 domains, from theoretical basis and administration to staffing, stages of treatment, and aftercare. These are available at www.whitehousedrugpolicy.gov/national_assembly/publications/therap_comm/therap_comm.pdf.

Goals

The core beliefs and practices of the TC have been described in the literature (Bell 1994; De Leon and Rosenthal 1989; De Leon 1997, 2000; Kooyman 1986; Sugarman 1986; Wexler 1995; Wexler and Williams 1986). The general goals of TCs are (1) decline in or abstinence from substance use, (2) cessation of criminal behavior, (3) employment and/or school enrollment, and (4) successful social adjustment. Prison TCs maintain a high level of control over their participants, and treatment goals are always secondary to security.

Structure

Although there is some variation in the structure of these programs, most are a minimum of 6 months in duration and consist of three or four stages:

- Orientation to acquaint inmates with the rules of the TC and establish routines
- Group and individual counseling to work on issues of recovery
- Maintaining recovery and relapse prevention
- Reentry planning (Peters and Steinberg 2000)

There is also evidence that prison-based TC programs may provide their best results for those whose residency extends from 9 to 12 months (Wexler et al. 1990). Relapse can be relatively high, however, if there is no continuity of care provided after release from custody. Research has clearly shown that aftercare in the community is essential to prevent relapse and recidivism (Knight et al. 1999*b*; Martin et al. 1999; Wexler et al. 1999*a*). One study found that offenders who were in treatment for 12 to 15 months while in prison, combined with 6 months of aftercare, were more than twice as likely to be drug-free 18 months after release than offenders who received prison-based treatment alone (Inciardi 1996). Offenders who receive aftercare are also less likely to be rearrested in the 18 months after their release than offenders who receive only in-prison treatment (71 and 48 percent, respectively).

Components

The TC's daily regimen involves the resident in a variety of work, educational, therapeutic, recreational, and community activities. Main program components are

- Community meetings, events, and ceremonies
- Seminars
- Group encounters
- Group therapy
- Individual counseling (both from staff and peers)
- Tutorial learning sessions
- Remedial and formal education classes
- Client job-work responsibilities

Explicit treatment phases that are designed to provide incremental degrees of psychological and social learning

TCs differ from self-help groups, such as AA, in that they are structured, hierarchical, and highly intense intervention programs while AA provides peer support only. The TC treatment experience promotes a sense of camaraderie, safety, and communication as keys to transformation from degradation to dignity. One of the most complex treatment models to implement and operate in a prison, TCs require significant changes in the norms, values, and culture of the environment and a great deal of commitment and cooperation from prison administration and staff to properly structure and control that environment.

While residents must take responsibility for their own recovery process, treatment staff, including ex-offenders, act as role models and provide support and guidance. Individual counseling, encounter groups, peer pressure, role models, and a system of incentives and sanctions form the core of treatment interventions

in a TC. Residents of the community must live together, participate in groups, and study together. In the process, inmates learn to control their behavior, become more honest with themselves and others, and develop self-reliance and responsibility.

TCs are most often implemented in a residential structure isolated from the general population to provide enough safety and sense of belonging to begin the process of change. States of anxiety, secrecy, fear, and alienation—conditions permeating the antisocial inmate subculture of the general prison population—are antithetical to positive change. In fact, separation from the prison subculture during treatment has been found to be most conducive to achieving major changes in attitudes and behavior. However, the safe TC environment, coupled with gains in interpersonal skills, helps offenders relate to the general prison population with the inner strength needed to combat the negative cues of the prison environment.

Practitioners note that there can be no "watchers" in a TC, only active participants. TCs demand the participation of the inmates in the emotional, physical, and intellectual work required for the process of change and personal growth. Work in a TC, as a part of treatment, involves an increasing set of responsibilities designed to build self-confidence and coping skills. As active participants in their own recovery process, inmates learn self-sufficiency and competence. Practitioners often cite an old maxim that captures the essence of the TC philosophy: "Give people a fish and they have food for a day. Teach them to fish and they can obtain food for a lifetime."

TCs depend on the staff and participants' community-building capabilities. The degree and intensity of confrontation with participants tends to correspond to the strength of the supportive atmosphere of the program. Confrontation in prison, for example, may be less intense than in a community-based environment, since confrontation can be a threat to prisoner codes of acceptable behavior. The success of the TC also depends on the collaboration between treatment and corrections staff in classification of inmates who are appropriately assessed and placed in treatment as well as in the delivery of sanctions and removal from the treatment unit.

Program Elements of a TC

Rod Mullen, founder of the Amity prison TC program, has attempted to define the program elements needed for a TC and suggests that programs that do not meet this standard be identified simply as "residential" to avoid indiscriminate use of the TC identification:

- Twenty-five to 50 percent of the staff should have a substance abuse history and at least 2 years of continual sobriety.
- The program must emphasize peer leadership and a structure of peer responsibilities and authority.
- The program must have a defined structure of community ceremonies that occur daily (as well as at other intervals), which reinforce the beliefs and mission of the community.
- Regular encounter groups are held for all participants and confidentiality of the group is a paramount community value.
- All staff members participate in community activities.
- The emphasis of the community is on the healthy, positive development of all aspects of its members.

Successful Prison-Based TC Programs

The TC is widely recognized as an effective approach that is highly intensive in nature and scope, deals effectively with issues related to implementation and maintenance, and addresses many of the more important treatment issues. Some examples of successful in-prison TC programs are described below along with references that provide further information.

Stay'n Out in New York

The Stay'n Out program was implemented in July 1977 as a modified hierarchical TC. Stay'n Out began at a time when many other in-prison TC programs were closing. Program capacity was 120 inmates at the time this research was conducted. Residents lived in two housing units segregated from the rest of the prison population. They had contact with prisoners in the general population only when off the TC unit (e.g., at the cafeteria, infirmary, library). The Stay'n Out staff comprised mostly persons in recovery with TC experience.

The results of a 3-year outcome study of the Stay'n Out prison TC indicate that this program is effective in reducing recidivism rates (Wexler et al. 1988, 1990). As summarized in Figure 3-3, program completion also decreased the likelihood of rearrest.

Figure 3-3. Stay'n Out Program Outcomes

Rearrest	Male Graduates	Males with No Treatment	Female Graduates	Females with No Treatment
	27 percent	41 percent	18 percent	24 percent

Source: Wexler et al. 1988, 1990.

Research also found a strong relationship between time spent in the program and treatment outcomes. For male inmates who participated in Stay'n Out, the percentage of those who had no parole infractions during community supervision rose from 50 percent for those who remained less than 3 months, to almost 80 percent for parolees who were in the program between 9 and 12 months while in prison. Similar findings were obtained for the females, although the percentages of those discharged positively from parole were higher than for their male counterparts (79 percent for females in treatment less than 3 months, 92 percent for the 9 to 12 month group) (Wexler et al. 1988, 1990).

Delaware KEY-CREST programs

The KEY-CREST programs, evaluated by the Center for Drug and Alcohol Studies at the University of Delaware, represent a treatment continuum that mirrors the offenders' custody status (Inciardi et al. 1997). Prisoners with a history of drug-related problems are identified and referred to the KEY TC program. Following prison release, parolees then go to the CREST program, a TC-based work-release program. Six-month postrelease relapse and recidivism rates for graduates of both KEY and CREST were significantly lower than for program dropouts and a nontreatment comparison group (Martin et al. 1995; Nielsen et al. 1996). A follow-up study at 18 months showed that among those who completed both the prison-based and the work-release aftercare programs, fewer used drugs and were rearrested compared with an untreated comparison group (Inciardi et al. 1997). Outcomes at 3 years were similar, although somewhat attenuated (Martin et al. 1999). A recent study by the Delaware Sentencing Accountability Commission has confirmed the positive results (SENTAC 2002).

Amity prison TC

Originally established as a demonstration project funded by the California Department of Corrections in 1989, the Amity TC is located at R.J. Donovan Correctional Facility in San Diego, a medium security prison. (See Graham and Wexler 1997 and Winnett et al. 1992 for detailed program descriptions.) The prison houses approximately 4,000 men in five self-contained living areas. All aspects of daily living (e.g., housing, education, work, etc.) are accommodated within the confines of the prison. One 200-man housing unit is designated for Amity project occupancy. The men residing in the unit participate in daily programming conducted in two trailers located near the housing unit.

The program uses a three-phase treatment process (DeLeon 1995; DeLeon and Rosenthal 1989; Wexler and Williams 1986). The initial phase (2 to 3 months) includes orientation, clinical assessment of resident needs and problem areas, and planning interventions and treatment goals. Most residents are assigned to prison industry jobs and given limited responsibility for the maintenance of the TC. During the second phase of treatment (5 to 6 months), residents are provided opportunities to earn positions of increased responsibility by showing greater involvement in the program and by focusing on emotional issues. Encounter groups and counseling sessions address self-discipline, self-worth, self-awareness, respect for authority, and acceptance of guidance for problem areas. During the reentry phase (1 to 3 months), residents strengthen their planning and decision-making skills and work with program and parole staff to prepare for their return to the community.

Upon release from prison, graduates of the Amity prison TC may elect to participate in a community-based TC treatment program for up to 1 year. Residents at this Amity Aftercare TC have responsibility for maintaining this facility (under staff supervision) and continuing the program curriculum. The aftercare TC also provides services for the wives and children of residents.

An evaluation conducted by the Center for Therapeutic Research at the National Development and Research Institutes, Inc., assessed 36-month recidivism outcomes for a prison TC program with aftercare using an intent-to-treat design with random assignment. Outcomes for 478 felons at 36 months replicated findings of an earlier report on 12- and 24-month outcomes, showing the best outcomes for those who completed both in-prison and aftercare TC programs (Wexler et al. 1999*a*). For those who completed the TC aftercare program, 27 percent had been reincarcerated at a 36-month follow-up, compared to 75 percent for the other groups. Researchers also noted a significant positive relationship between the amount of time spent in treatment and the time until return for the parolees who recidivated. However, the reduced recidivism rates for in-prison treatment at 12 and 24 months were not maintained at 36 months (Wexler et al. 1999*b*).

Texas Kyle New Vision Program

The Kyle New Vision program was the first in-prison TC (ITC) developed under 1991 State legislation that outlined plans for several corrections-based substance abuse treatment facilities in Texas (Eisenberg and Fabelo 1996). It is a 500-bed facility that provides treatment to inmates during their final 9 months in prison. After release, parolees are mandated to attend 3 months of residential aftercare in a transitional TC (TTC), followed by up to another year of supervised outpatient aftercare. An evaluation conducted by the Institute for Behavioral Research at Texas Christian University revealed that 3 percent of those who completed both ITC and TTC programs were rearrested within 6 months of their release from prison, compared to 15 percent of those who only completed the ITC and 16 percent of an untreated comparison group (Knight et al. 1997). Furthermore, results from hair specimens collected during a 6-month follow-up indicated that fewer of those who completed both the ITC and TTC tested positive for cocaine (the primary drug of choice for those in the sample), compared to those who completed only the ITC and a comparison group (Knight et al. 1998). A recently completed study showed that TTC completion following the ITC was the strongest predictor of remaining arrest-free for 2 years following release from prison. Aftercare completion was strongly associated with parolee success (Hiller et al. 1999*a*). A 3-year outcome study revealed that high-severity aftercare completers recidivated only half as often as those in the aftercare dropout and comparison groups. These results indicate that intensive treatment can be effective when it is integrated with aftercare and that the benefits of intensive treatment are most apparent for offenders with more serious crime and drug-related problems (Knight et al. 1999*b*).

Federal Bureau of Prisons

While not technically a TC program, the Federal Bureau of Prisons offers voluntary residential treatment programs, or Drug Abuse Programs (DAPs), for alcohol and drug problems that use some of the features of the TC model. Inmates participate in a total of 500 hours of treatment over a 9-month period and programs have 1 staff member for every 24 inmates. Program goals are to identify, confront, and alter the attitudes, values, and thinking patterns that led to criminal behavior and substance abuse. This is accomplished through a unit-based approach (whereby program participants are segregated from the general population to build a treatment community), and also through standardized program content that includes 450 hours of programming using modules devoted to a variety of subject areas. Though initially implemented without incentives, the passage of time saw the introduction of financial achievement awards; consideration for a full 6 months in a halfway house for successful DAP program completion; and tangible benefits such as shirts, caps, and pens with program logos. The passage of the Violent Crime Control and Law Enforcement Act of 1994 allowed eligible inmates with successful completion rates to reduce as much as a year from their statutory release dates.

The second component is graduate maintenance, an 8-week program for those who completed the initial component. Skills are reinforced from the first component and transition plans are initiated. The third and final component, aftercare, provides services from completion of graduate maintenance to release from department custody. This component attempts to reinforce attitudinal and behavioral changes that occurred during the first three phases. Transition plans are regularly reviewed, placements for inmates in community-based programs are completed, and tracking occurs for all inmates at regular intervals.

Specific Populations in Prisons

Co-Occurring Substance Use and Other Mental Disorders

Despite the high incidence of co-occurring mental and substance use disorders, few programs for inmates with co-occurring mental and substance use disorders currently operate in prisons. Edens and colleagues (1997) found fewer than 10 operational programs that were designed for this population (see below for a description of one such program), although several State correctional systems reported that similar programs were being planned. A number of common elements of these programs included phased program interventions, a focus on destigmatizing mental disorders, the use of psychoeducational interventions, involvement of mental health staff in major program activities, and the use of relapse prevention approaches.

San Carlos Correctional Facility—A TC Modified for Offenders With Mental Illness

In response to the increasing number of inmates with co-occurring substance use and other mental disorders, the Colorado Department of Corrections contracted with a private not-for-profit agency to develop the Personal Reflections Therapeutic Community program at the San Carlos Correctional Facility in Pueblo (Sacks et al. 2001). Based on evidence of the effectiveness of the TC approach for co-occurring disorders implemented in a community-based setting (De Leon et al. 2000), the San Carlos program, a Modified Therapeutic Community (MTC), uses TC principles and methods as the foundation for recovery. Modifications from traditional TCs include smaller caseloads, shortened and simplified meetings, and minimized confrontation. In addition, the MTC contains components to address criminal thinking and to provide medication education.

- The goal of the program is to use a positive peer culture to foster personal change and to reduce the incidence of return to a criminal lifestyle. The inmates progress through program stages, typically moving from orientation to primary treatment ("family" phase) and then preparation for re-entry to the community at large. Upper level inmates in the MTC program function as a positive peer leadership group, or "structure," to guide and support newer members as they begin to develop and apply new values, beliefs, and skills to their daily lives. Thus the San Carlos TC, modified for the mentally ill population, functions as a healthy family for its members, reinforcing affiliation with the recovery community.
- A NIDA-funded evaluation of MTCs showed significantly better outcomes on self-reported crime and arrests for the MTC group as compared to standard mental health and nontreatment groups. The best outcome was for the MTC group that also received TC aftercare. In response to such results, a CSAT Community Action grant supported an initiative to improve services for released offenders with histories of substance abuse and severe and persistent mental illness (Wexler 2001). Preliminary cost analysis indicates that the incremental (or additional) costs of prison MTC programs for offenders with co-occurring disorders are low compared to both the overall costs of incarceration and the additional cost of services for people with co-occurring disorders in the general prison population (Sacks et al. 2001).

Sex Offenders

In 1999, nearly 9 percent, or 100,800, of the 1.2 million inmates in State prisons were incarcerated on sex-related offenses: 2.6 percent (29,600) for rape and 6.2 percent (71,200) for other sexual assault (Burdon et al. 2001). Among incarcerated sex offenders, two of every three have a history of alcohol or substance use, abuse, or dependence (Peugh and Belenko 2001).

Given their prevalence in the prison population, as well as the high rate of substance abuse, in-prison substance abuse treatment programs are likely to be treating a number of sex offenders. Burdon and colleagues (2001) identified several barriers to successful treatment of sex offenders in correctional institutions:

Stigma. Sex offenders are perceived as occupying the lowest possible rung within the prison social hierarchy, not only among inmates, but also among custodial and often treatment staff. This leads to extreme secrecy and fear of self-disclosure based on a legitimate fear for their own safety.

Untrained and inexperienced staff. Most treatment staff members in prison-based substance abuse programs lack the requisite knowledge to work effectively with sex offenders. This can be remedied in part by recruiting and hiring individuals with advanced degrees or special certification, although it will entail increased treatment costs associated with compensation to ensure their longevity.

Institutional policies against disclosure. Strict prohibitions against disclosing inmate offense and conviction information means that staff are unable to identify which inmates are sex offenders.

Lack of a formal process for identifying clinical sex offenders. The different classifications of those who have committed sex-related offenses and those diagnosed with sex-related disorders makes identification more difficult for providers. Currently, the sole criterion for identification is the inmate's criminal record. Because some individuals are likely to be recommended for highly specialized treatment and may not need it, this criterion may result in an inefficient use of resources.

One proposed model is to provide effective treatment by differentiating between legal and clinical offenders and then offering treatment to clinical sex offenders. Steps in this process include identifying those sex offenders suitable for treatment, identifying the appropriate treatment modality, and maximizing success by providing needed aftercare (Burdon et al. 2001).

Older Inmates

In recent years, the number of inmates in State and Federal prisons aged 55 and older has increased dramatically. Between 1995 and 2003 that number has increased approximately 85 percent, so that as of 2004 there were 27,700 prison inmates over the age of 55 (Harrison and Beck 2004). Many, though not all, of these inmates have spent much of their lives in prison. The 1994 Crime Bill ratifying the "three strikes and you're out" provision could increase these numbers substantially as it becomes a more fully utilized sentencing option.

As a distinct cultural subgroup, lifers have spent much of their adulthood in "total institution" environments with unique features. Among them are the physical barriers to the outside world, the development of a unique way of life, or "prison culture," which precludes "normal" interactions and social activities found on the "outside." This stressful, unnatural situation can produce what Goffman (1961) termed "disculturation," wherein prison rules and mores have outweighed those of the outside world. Over prolonged periods, the implications for inmate self-concept and autonomy may be more pronounced.

Additional "disculturative" changes can occur relating to family, employment, and sexual identity. Although all inmates face these challenges upon incarceration, the aging inmate faces the imminent probability that a traditional life cycle will be seriously altered. "Time that might have been spent in courtship, marriage,

raising children, career, education, travel, pursuit of personal talents, and activities with friends never can be re-established" (LaMere et al. 1996, p. 27). The usual milestones to measure success and adult rites of passage are systematically denied the aging inmate, thus producing a sense of social disconnection. One of the best ways to engage elderly inmates is to involve them in helping other inmates. The program at the R.J. Donovan Correctional Facility (see below) is an example of a treatment approach that can be beneficial to both the aging prison population and its younger peers.

Use of "Lifers" as Peer Counselors at Amity

In 1990, the Amity prison TC at the R.J. Donovan Correctional Facility, a medium security facility, began to accept offenders who were under life sentences (i.e., "lifers") as counselors in its substance abuse treatment program. It remains one of a handful of programs in the country to do so.

- Lifers were accepted as members of the counseling staff because they could provide stability to the program and ensure its continuity. They are available to program participants 24 hours a day, unlike staff from outside the prison, and can have a vital role in keeping a community alive and helping to hold its members responsible for their behavior. Because these are individuals who have considerable respect in the prison community, they are able to help keep participants in the program safe and out of situations that can cause them trouble.
- The program is selective about who can become a counselor; all counselors have to be graduates of the program and then complete a 2-year internship. They must be individuals who have the respect of their peers and demonstrate high levels of motivation. The program also ensures that this group represents the racial demographics of the prison population.
- Programs that are considering using lifers should already have trained staff who are experienced working with this particular subpopulation. The culture of lifers is unique within the prison system, and the problems they face are also often different. These are individuals whose home, for much (if not all) of the rest of their lives is the prison. Becoming a counselor enables lifers to make personal restitution for past acts by helping others, which they may never have the opportunity to do so outside the prison environment. During follow-up interviews, many of the successful program participants mentioned that lifers had been important influences in their recovery (Wexler et al. 1999*a*).

Systems Issues

Coerced Treatment

In prison, coerced treatment may come as a result of a sentence mandating treatment or as a result of a prison policy mandating treatment for inmates identified as having substance use disorders. Still, prison-based programs generally do not have significant incentives for parolees or probationers who enter treatment as a means to avoid prison. Research indicates that treatment adherence and outcomes are the same among those coerced into treatment and those who entered treatment voluntarily (Miller and Flaherty 2000). In terms of prison-based treatment programs, Wexler and colleagues (1996) reported that these programs are often the *only* (emphasis added) treatment opportunities for offenders. Two key issues regarding treatment of offenders are time spent in treatment and engagement in the process. Coerced treatment can force inmates to begin a treatment episode, but the program must be able to engage them in a meaningful rehabilitation process. The longer the inmate remains in treatment, the greater the likelihood for success (Hubbard et al. 1988; Simpson 1984; Wexler 1988). Without treatment, the likelihood of continued drug use and criminality after release increases considerably (Lipton 1994).

Sanctions and Incentives

A hierarchy of specific sanctions (that notes the type and duration of each sanction) can be used in conjunction with treatment incentives and rewards to improve treatment outcomes.

Offenders need to be responsible to their individual treatment plans and held accountable to the treatment program's rules. They must know the consequences of noncompliance and poor progress and understand that treatment programs have certain unbreakable or "cardinal" rules (e.g., no violence or intimidation). The penalties for breaking rules that are intended to guide behavior can include dismissal from the program or revocation of privileges. Sanctions should be applied consistently for positive drug tests, no-shows for treatment, prohibited behavior, or broken program rules. Penalties should be specifically spelled out, so there is no doubt in the client's mind regarding the consequences of specific misbehavior. Accountability also includes objective measures and monitoring as a basis for measuring the client's progress and determining the need for reassessment. Rule infractions (other than "cardinal rules") are best seen as opportunities to learn more appropriate and effective behaviors. This treatment or learning perspective is in contrast to the traditional correctional view of adjudication and punishment. It is important to provide opportunities for "failed" clients to reapply to the program when possible. Often, a program failure can be a learning experience that leads to increased motivation and desire for a "second chance." Given that addiction is a chronic, recurring condition, multiple treatment episodes are more the norm than the exception.

Just as sanctions clearly establish a series of consequences for designated behaviors, incentives should be offered to inmates who adhere to the program rules, to recognize small accomplishments. Possible incentives include:

- Recognition ceremonies
- Awards
- Preferred meals
- Special desserts
- T-shirts, coffee mugs, or other small gifts
- Modified uniforms (which contributes to a positive environment)
- Deviations from the standard curriculum including seminars, music, and sports
- Financial rewards
- Increased privileges
- Safe housing units
- Additional recreation time
- Positive parole board review
- Return of children to their mothers

Wherever possible, problems of attrition and noncompliance should be anticipated early enough in the treatment process to avert them. Coordination and communication between the treatment counselor and criminal justice staff are crucial in this process. For example, the treatment counselor can use a proactive attitude and alert the criminal justice representative when noncompliance occurs, long before a client is actually expelled from a program, if it appears that a situation leading to this outcome is developing. It is also helpful if the treatment counselor and criminal justice representative discuss certain general trends in advance. Such particulars as retention rates, the most likely dropout points, and relapse rates in various stages of treatment can be used to alert case managers in other systems to potential problem periods and when they are likely to occur.

Advice to the Counselor: **Heading Off Noncompliance**

- Counselors can take a proactive attitude and alert the criminal justice representative when noncompliance occurs before a client is expelled from a program.
- The treatment counselor and criminal justice representative can identify the most likely program dropout points to alert case managers to potential problems in the system.

Disincentives for Inmate Participation

Despite these incentives, there are factors—both perceived by the inmate and inherent in the system—that may discourage involvement in a residential treatment program:

- *Increased surveillance on the job and in the treatment program.* This includes the justification for increased urinanalysis during treatment and post treatment phases.
- *The requirement and pressure to stop using drugs.* Although prevalence levels are lower in prison than the general population, there is still substance use and when enrolled in treatment, the offender must confront the necessity of having to stop using drugs.
- *Loss of relationships.* Women especially may resist treatment because they have the perception that participation could result in the loss of in-prison intimate relationships.
- *Loss of income.* Often it is a requirement to give up prison jobs in order to enter treatment.
- *Peer (or yard) pressure.* Offenders can face physical threats of violence if they participate in treatment.
- *Lack of treatment continuum.* Intensive treatment inside the prison is of limited use if there are no services available upon release. Furthermore, it is critically important to build upon previous treatment rather than forcing a newly released inmate graduate to start over in the community program.
- *Treatment length and modality.* If treatment is not linked to inmates' needs, inmates are more likely to drop out. For example, often an offender who has serious substance abuse problems and is in need of a structured environment is placed in a 12-Step program on a voluntary basis, whereas a person who only occasionally uses substances is inappropriately placed in a long-term TC or other residential program.
- *Lack of desire to help one another.* For many offenders, the key to doing prison time is to get through it without any extra output of energy to help others (e.g., "I'm doing my time. I'm not doing his time."). It is not selfishness per se but rather part of prison culture.
- *Limited treatment resources.* There are often problems associated with convincing inmates to engage in treatment. One problem is the lack of trained staff and available modalities. Additionally, treatment programs often do not offer incentives. In fact, some incentives (e.g., work furloughs) are removed, which acts as a disincentive to enter treatment.
- *Stigma.* Many inmates want treatment, but do not necessarily want to be put in programs that may cause them to have low status in the inmate culture.

- *Mandatory sentences that prohibit early release.* Increasingly, in an effort to appear ever tougher on crime, politicians and policymakers are removing early release opportunities by legislating mandatory sentences that require inmates to serve their full terms, reducing or eliminating good time credits, or being more stringent in Parole Board decisions. Without the incentive of early release, inmates are less likely to voluntarily enter and remain in prison treatment programs.

Staff Training and Cross-Training

Cross-training for both criminal justice and substance abuse treatment staff can improve the effectiveness of program administration (Farabee et al. 1999). Treatment providers and custody staff often become familiar with the philosophy, approach, goals, objectives, language, and boundaries of both systems. Treatment providers need to understand the operational responsibilities of the justice system, the importance of public safety, and the security concerns that are at the heart of criminal justice. Criminal justice personnel should understand the dynamics of substance abuse treatment and its potential to reduce recidivism and relapse. Without these training safeguards in place, the custody concerns of the correctional facility will often overwhelm the concerns of the treatment program (Farabee et al. 1999). Some of the training issues include confidentiality, relapse prevention, infectious diseases, co-occurring disorders, and cultural competence.

Other concerns regarding recruitment and training of staff include the difficulty of hiring qualified staff in the remote areas where prisons are built; the lack of experience in criminal justice settings on the part of most counselors; and the perennial concern about high turnover rates and the lack of experienced counselors, especially given the limited ability to hire individuals in recovery as counselors (Farabee et al. 1999). In addition, Department of Corrections contracts frequently have restrictions based on criminal history that narrow the eligible pool of employment applicants.

Gender-specific training

Training should review the latest theories and findings on men's and women's issues in treatment. For counselors working with men, special focus should be on anger management and relational violence. Staff should learn theories of male development and explore key issues influencing men's substance abuse—societal gender roles, family, relationships, rage and violence, abuse and trauma, and educational and vocational issues. In addition, staff need to become familiar with the prison culture specific to the program's geographic location, for example, race and gang issues, "the convict code," and prison slang. Knowledge and understanding about these issues ensures greater impact and provides staff deeper insight into incarcerated men's barriers to recovery.

Staff working with incarcerated women should be familiar with theories of female development and consider ways that treatment programs can address the central importance of relationships for women. Training should also explore key issues influencing women's substance abuse—family, parenting, relationships, self-sufficiency and life skills, anxiety and depression, grief and loss, abuse and trauma, educational and vocational issues, and societal gender roles. Expertise in these areas will help develop a quality program focused on helping incarcerated women recover and successfully re-enter their communities.

Recommendations and Further Research

The following are recommendations regarding treatment in prisons:

Recommendations

- In-prison treatment for substance abuse can reduce recidivism.
- In general, treatment programs based on social learning, cognitive-behavioral models, skills training, and family systems approaches are more effective than nondirective programs or those using punishment or deterrence.
- Successful programs provide a variety of intensive services that use several approaches and create a prosocial environment.
- Nine to 12 months of treatment in a TC is the recommended duration for reducing recidivism, although a noticeable improvement in recidivism is noted after 3 months.
- To sustain the gains achieved in in-prison TCs requires supervision in an aftercare program in the community.
- TCs can be adapted to make them more appropriate for female inmates.
- Quality assurance models are needed for assessing prison treatment.
- The needs of incarcerated women (and their children) have to be better understood, with an emphasis on reintegrating the family when appropriate and developing marketable skills.
- As the number of people with co-existing substance use and other mental disorders in prisons expands, treatment models that integrate the best mental health and substance abuse treatment practices need to be developed and tested.

- The mental health and substance abuse literature on co-occurring disorders has identified the modified TC as a promising treatment model.

- Issues of aftercare and continuity of care are especially relevant to offenders with co-occurring disorders, who are particularly in need of continuing treatment to stabilize their positive gains and to promote integration with the mainstream community.

- Restructuring the prison environment to address education and employment, particularly for inmates with longer sentences, can dramatically improve prison security, programming, and outcomes.

- Providers should develop innovative aftercare programs that incorporate recovery, employment, and educational best practice. Continuity of vocational goals should be identified early on and followed throughout the various phases of client reintegration from prison to community residential and aftercare outpatient treatment.

Further Research

In-prison substance abuse treatment, particularly when followed by community-based continuing care, has been credited with reducing short-term recidivism and relapse rates among offenders who are involved with illicit drugs. More recently, the sustained effects on longer-term outcomes have been documented by studies conducted in California, Delaware, and Texas. There is a growing credibility of the idea that "treatment works," which is replacing the older belief that "nothing works" in prison rehabilitation.

However, the benefits of treatment can vary greatly depending on the inmate being treated and the services being provided. It is critical that research now focus on determining which inmates benefit the most from the different types of treatment programs being offered in prison. For example, should intensive treatment programs such as TCs give admission priority to inmates with the most severe problems? Are better educated inmates best treated with a cognitive-behavioral approach? Is it better to develop stand-alone in-prison treatment facilities?

There is considerable research that shows that at least 3 months of community treatment and 9–12 months of prison treatment are needed to produce significant improvement and reductions in recidivism and relapse. The critical need for adequate treatment duration has been demonstrated. What is not known is whether post prison treatment alone can be effective and how much time in aftercare following prison treatment is needed. Currently, in-prison drug

treatment programs vary considerably in length: from 4 months to 2 years. Also, given the importance of aftercare, can similar outcomes be obtained with a shorter duration in-prison treatment program if inmates are mandated to a comprehensive postrelease aftercare program?

Treatment and aftercare research questions

- A clear understanding of the treatment "black box" remains elusive; models that describe effective treatment processes need to be developed and tested.
- The organizational and system dimensions of treatment need to be studied and understood to foster the implementation and maintenance of treatment networks within complex correctional systems.
- Researchers should examine the contribution of pharmacotherapy to treatment outcomes among prisoners.
- Although prison evaluation studies of women have shown positive treatment effects, more research is needed to study treatment engagement, process, and costs versus benefits for this population.
- Consideration needs to be given as to whether aftercare alone is capable of significantly reducing recidivism and relapse following prison.
- Researchers should investigate the effect of shorter term prison treatment with and without aftercare.
- Researchers should consider the optimum combination of duration of both in-prison and aftercare treatment.
- Researchers need to determine what the best treatment models are for dealing with the inherent geographic dispersion of offenders after their release from prison.
- Research is needed to evaluate the costs and cost-benefits of prison treatment and aftercare.

Chapter 4:
Treatment for Offenders under Community Supervision

Substance abuse treatment for parolees and probationers differs from treatment for people in jail or prison. Although their freedom is curtailed, they have greater access to drugs and alcohol than the incarcerated population, and hence more opportunities to relapse. Moreover, securing basic needs such as food and shelter is often of paramount importance, especially for parolees attempting to reintegrate into society.

After describing the population under discussion in this chapter, the text takes up levels of supervision and treatment. Next, the discussion provides a broad look at the services needed by probationers and parolees and examines the treatment issues that are specific to offenders under community supervision. The chapter then suggests strategies that are helpful in improving collaboration between the substance abuse treatment and criminal justice systems. Finally, the chapter presents descriptions of sample programs.

Overview

- **The Population**
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  - The Amity Project
  - Breaking the Cycle
  - Probationers in Recovery
  - KEY-CREST
  - Special Offender Services Program
- **Conclusions and Recommendations**

The Population

Both parolees and probationers are under community supervision; nonetheless, they represent different ends of the criminal justice continuum. Whereas parolees and mandatory releasees are serving a term of conditional supervised release following a prison term, probationers are under community supervision instead of a prison or jail term.

Despite their differences, parolees and probationers often share a history of drug or alcohol use. Approximately two thirds of probationers can be characterized as alcohol- or drug-involved offenders (Mumola and Bonczar 1998), while almost 74 percent of State prisoners expected to be released between 2000 and 2001 were drug- or alcohol-involved (Beck 2000*c*). Parolees and probationers also are alike in that their freedom is conditional; both groups must meet certain conditions in order to avoid incarceration or reincarceration. Often, treatment for drug or alcohol dependence is one of those conditions.

The number of people under community supervision has increased over the past decade. More than 4.8 million individuals were under community supervision in 2003, compared to 3.8 million in 1995. The parole population has been the slowest growing since 1995, with an average annual rate of 1.7 percent; however

between 2002 and 2003, the growth rate nearly doubled to 3.1 percent (Glaze and Palla 2004).

Despite the shared experience of individuals under community supervision, as Figure 4-1 indicates, parolees and probationers differ considerably.

Figure 4-1. Comparison of Probationers and Parolees

	Probationers	Parolees
Number	4,073,987	774,588
Gender	77 percent male 23 percent female	87 percent male 13 percent female
Race/Ethnicity African American	30 percent	41 percent
Hispanic/Latino (can be of any race)	12 percent	18 percent
Caucasian	56 percent	40 percent
Crimes	24 percent for drug law violation 17 percent for driving while intoxicated	40 percent for drug offenses 24 percent for violent offenses
Drug or alcohol involved	83 percent (based on State prisoners expected to be released by the end of 1999)	74 percent (based on State prisoners expected to be released between 2000 and 2001)
Mental illness	13.8 percent	14.3 percent
Parole/probation violations led to incarceration/reincarceration	17 percent incarcerated	42 percent reincarcerated
Drug/alcohol treatment as condition of release	41 percent	N/A
Mandatory drug testing	32.5 percent	N/A

Sources: Beck 2000*b* ; Ditton 1999; Glaze and Palla 2004; Hughes et al. 2001; Mumola 1998; Office of National Drug Control Policy (ONDCP) 2003.

Levels of Supervision

While both probationers and parolees are under community supervision, the level of supervision varies according to individual circumstances. These differences are described below.

Intensive Supervision

Intensive supervision generally involves frequent contact with supervising officers, frequent random drug testing, strict enforcement of probation or parole conditions, and community service. The level and type of supervision that are labeled intensive vary widely but usually require closer supervision and greater reporting requirements than regular probation. Contacts can range from more than five per week to fewer than four per month. Conditions usually include having a job or attending school, and participating in treatment. Intensive supervision parole has similar requirements and variations for offenders completing their sentences in the community.

Intermediate Supervision

Compared to traditional supervision, intermediate supervision can include increased drug testing, short jail stays, increased reporting to criminal justice staff, referral to day reporting centers, attending 12-Step meetings, community service requirement, curfews, work release centers, electronic monitoring, and more frequent home visits.

Treatment Levels and Treatment Components

Placement of offenders under community supervision will depend on a number of factors, including the duration and severity of the offender's substance use as well as the crimes committed. The level of treatment services recommended for the offender should be individualized and based on a multidimensional, diagnostically driven assessment; clinical judgment; and availability of resources in a given community.

Residential

Residential treatment for those supervised in the community incorporates several approaches involving cooperative living for people receiving treatment. The most used residential model is the therapeutic community (TC), which provides a well-controlled, 24-hour, structured treatment environment.

Some programs provide services for 8 or more hours a day, 5–7 days a week, with clinical staff available days and evenings. Other residential programs are recovery homes for employed offender-clients, with evening and weekend

treatment and limited onsite staff. Facilities may include hospitals or hospital-based programs, institutional housing, sections of apartment complexes, and dormitory-like residences.

Most residential treatment programs use a group-centered approach to create an environment that duplicates certain aspects of a family and makes clients accountable to their peers. Residents collaborate on chores, laundry, and meal preparation with the aim of participation in problem solving, goal setting, and improving cooperation and communication skills. Residential treatment should be followed by continued care in an outpatient setting.

Dallas County Judicial Treatment Center: A Sample Community-Based Substance Abuse Treatment Program

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Dallas County, Texas, established a residential substance abuse treatment program for probationers to relieve prison overcrowding. Based on a modified therapeutic community with a 12-Step component, it included basic substance abuse treatment, life-skills training, drug education, and group counseling. After 1 year, arrests for program graduates were one half of those for probationers who were expelled or transferred. Those who participated in a residential aftercare program had even lower arrest rates (Knight and Hiller 1997).

Outpatient

Outpatient treatment for probationers and parolees can be provided to many more offenders for the same level of funding as residential treatment. It ranges from traditional outpatient services provided by treatment professionals in regularly scheduled sessions in a group or individual setting, to intensive outpatient treatment several hours per week. Because outpatient treatment tends to be more intense in community settings than in correctional institutions, offenders may be receiving more intense treatment than during incarceration. Intensive outpatient treatment includes day or evening programs in which clients engage in a full spectrum of services while living at home or in a special residence.

Within a treatment continuum, intensity decreases over time as the individual meets treatment goals. Offenders may initially be placed in residential settings, followed by intensive outpatient treatment and continuing care. With institution-based treatment as a foundation, outpatient services in the community can help offenders to continue working on their problems and developing social and work skills in group processes familiar to them from their earlier treatment experience.

Halfway Houses

Halfway houses are transitional facilities where clients are involved in schoolwork, work, training, and other activities that do not necessarily include any drug abuse treatment when run by the criminal justice system. The halfway house can be a step up to greater liberty (i.e., for a person released from prison) or a step down for an offender in need of greater supervision (i.e., for a person who violated probation requirements). Some clients need halfway houses that can help them stabilize or maintain recovery as they enter society. Usually these programs provide individual counseling along with group, family, or couples therapy. Offenders can leave the facility for work, school, or therapy but are otherwise restricted to the halfway house, which is in the community but can be attached to a jail or other correctional institution. House responsibilities are shared and rules must be followed. The length of stay may be related to sentence length and depend on individual progress toward specific goals.

Day Reporting

Day reporting centers are facilities to which offenders must report in person or by phone from a job or treatment site as part of their larger supervision plan. The regular reporting back to probation or parole officers mandated under this intermediate sanction is aimed at monitoring offender movements or incapacitating them. Reporting must be done at specified times, often throughout the day. Day centers may include assessment for special needs and such services as anger management, drug testing, General Equivalency Exam (GED) preparation, drug and medical/mental health treatment, violence prevention, community service, and vocational training.

Some day centers primarily function as staging areas from which offenders are sent out in work crews to perform manual labor in the community: cleaning highways, painting schools, etc. Others offer chiefly educational opportunities. In many jurisdictions, day centers have become day treatment centers whose primary mission is to provide outpatient alcohol and drug abuse treatment of various intensities. Public or private treatment agencies or correctional agency staff may provide the treatment.

Salt Lake City, Utah: A Sample Day Reporting Center

The day reporting center in Salt Lake City, Utah, has been operating since 1994. It serves high-risk/high-need offenders who abuse substances and who have had technical violations or committed new offenses while on probation or parole. Program activities are designed to reduce recidivism and enhance recovery by improving coping skills, preventing relapse, improving job and employment skills, and promoting a smooth reentry to the community. A study of offenders who attended and were discharged from the program during a 1-year period showed that these individuals had fewer property crime offenses, fewer criminal charges, and less substance use in their first year after discharge. A longer stay was associated with better positive outcomes up to 120 days, after which the effect diminished (Bureau of Justice Assistance 2000).

Treatment Components

Substance abuse is a chronic, relapsing disorder influenced by numerous interacting biological, psychological, and social factors. To provide treatment addressing these factors, a full range of services should be available, which might include components from the following list:

- Screening and assessments—medical, psychiatric, and substance abuse
- Detoxification
- Medical assessment—pregnancy tests and treatment for HIV and AIDS, other sexually transmitted diseases, and tuberculosis
- Full-range medical treatment
- Treatment planning—medical, psychiatric, and substance abuse
- Counseling—group, individual, family, couples
- Residential treatment for substance abuse
- Substance abuse education—didactic lectures, interactive groups, videos, reading assignments, and journal-writing assignments
- Relapse prevention services
- Crisis intervention
- Drug testing and monitoring
- Self-help education and support
- HIV/AIDS education, testing, and counseling
- Comprehensive pregnancy management—prenatal care and parenting classes and/or childbirth classes
- Mental health services—medications when indicated
- Social and other support services for the offender and family members
- Vocational and educational training
- Family services unrelated to substance abuse treatment

- Assistance in managing entitlements (e.g., food stamps, veterans benefits)
- Acupuncture and other nontraditional adjuncts
- Housing assistance

Additional services may be needed to address sexual abuse, child abuse, domestic violence, victimization, guilt and remorse, and family problems. These can be coordinated on an individual basis through case management and collaboration among system practitioners.

What Treatment Services Can Reasonably Be Provided for People Under Community Supervision?

Parolees and probationers receive similar services in community supervision. This section highlights recommended treatment options for both populations.

Basic Needs

Parolees and probationers often cannot meet their basic needs. In some situations, treatment cannot begin until such fundamental needs as housing and employment are met. In other cases, such as when the client cannot maintain prolonged abstinence or when detoxification is needed, the client should be engaged in treatment before he or she receives assistance in locating housing or a job.

Housing

A lack of housing for offenders under community corrections supervision is a major problem in most jurisdictions; yet stable living arrangements are crucial to treatment. Available housing often is inconvenient to jobs, public transportation routes, community social services, or other agencies and includes drug-involved family members and/or friends. Sometimes a halfway house, a "sober house," or recovery house are better alternatives than the offender-client's home. Attention to residential resources for clients should be a critical factor in case planning by corrections supervisors. Probation and parole officers should be required to visit and evaluate client residences promptly.

Reintegration with Family Members and Social Support

The offender's home environment often is not helpful for encouraging adherence to treatment. Treatment providers should explore the family's dynamics promptly during a home visit and make alternative living arrangements if the environment threatens to undermine treatment progress. Negative family dynamics take many forms. The offender may be the scapegoat for family problems, making his or her return to the home counterproductive. Also, other family members may be actively using drugs or involved in criminal activities.

Domestic violence and child abuse situations present additional issues, including the personal safety of family members. To determine how healthy the home is, counselors need to make frequent home visits. Generally, community corrections supervisors assess levels of safety in the home when there is a question, although there are some substance abuse treatment programs that also perform this function.

To supplement the support an offender may be receiving from family members, the treatment plan should include recreational opportunities and other outlets to build healthy social relationships.

Vocational Training and Employment

Although highly important to an offender's recovery, vocational training and employment can create problems when they are mandated by the community supervision agency before the offender has been engaged in treatment. If the client has not undergone treatment, there is a high risk that money earned will be spent on drugs or alcohol. Another common result of mandating employment before treatment is that the offender may lose his or her job because of behavior related to substance abuse. Achieving and maintaining abstinence depends on structured, phased programming. Vocational training should occur before employment to enable the offender to retain a job or obtain a better one. Wexler (2001*a*) suggests beginning vocational training at the start of treatment rather than introducing it at the end. Integrating vocational assessment, counseling, training, placement, and follow-up throughout treatment is a challenge and requires consistent collaboration within and outside of agencies. However, actuating vocational treatment goals can serve as the matrix holding all other goals of reintegration into the community.

Case Management

Case management is the process of linking the offender with appropriate resources, tracking his or her progress through required programs, reporting this information to supervising authorities, and monitoring court-imposed conditions when requested. It should provide the following functions for offender-clients:

- Assessment of the client's strengths, weaknesses, needs, and ability to remain crime- and drug-free
- Planning for treatment services and fulfillment of criminal justice obligations, such as restitution, community service, or regular contacts with probation officers or other criminal justice officials
- Brokering treatment and other services and ensuring continuity as the client moves along criminal justice and treatment continuums
- Monitoring and reporting progress

- Providing client support, such as identifying problems and advocating with legal, social service, and medical systems in response to needs
- Monitoring urinalysis, breath analysis, or other chemical testing for substance use

Case management tests the ability of the criminal justice and treatment systems to work collaboratively and is based on two types of agreement: the agreement between the client and the two systems laying out protocols and consequences of infractions, and the agreement between the two agencies, a memorandum of understanding (MOU) that defines how each will manage the caseload of offender-clients in the jurisdiction. There can be one or two case managers representing each system. If two case managers are involved, they must coordinate efforts, working to encourage a multidisciplinary response that takes advantage of a wide range of treatment and rehabilitation options.

Relapse Prevention

When an offender experiences relapse, it is crucial to gauge the seriousness of the "slip" to determine appropriate interventions. One positive urine test or one drink after a long abstinence should not be viewed as failure but as a signal for stepped-up treatment and closer monitoring. Because resumption of drug abuse can lead to resumption of criminal activity, graduated sanctions for relapses should be specified in the treatment plan. It is essential that personnel from both the criminal justice and treatment systems agree to the range of responses and times when certain responses are appropriate. Repeated relapses must trigger consequences based on danger to the community and the offender's treatment progress.

The rate of relapse is high among offenders, and relapse prevention training must be provided at the beginning of and throughout treatment, and stressed prior to release. Personal relapse plans should be developed for all parolees receiving treatment. Relapse prevention skills should be part of each offender-client's treatment plan, addressing how clients can refuse drugs and identify and manage triggers for craving. When relapse occurs, clients must be helped to understand it is part of the recovery process, rather than a personal failure, so they can rededicate themselves to success. If properly handled, relapse can lead to increased motivation for recovery, strengthening an individual's knowledge of his or her limitations, the dangers of stressors, and awareness of what could be lost by leaving the treatment process.

In negotiating the MOUs, treatment and criminal justice officials need to collaborate and must support sanctions consistent with treatment so that relapse is not simply punished as a criminal offense. Criminal justice decision makers at all levels, including judges and court personnel, should be aware that relapse is a characteristic feature of substance use disorder that must be anticipated, prevented, and addressed. Sanction possibilities include

- House arrest
- Assignment to halfway house
- More frequent drug testing
- Electronic monitoring
- Day treatment
- Brief jail stays
- Assignment of community service hours

Advice to the Counselor: **Recommended Treatment Services for People Under Community Supervision**

- Help the client address basic needs, such as housing or employment.
- A client's living arrangements are crucial to treatment. Counselors should be aware of residential resources and collaborate with corrections supervisors and probation and parole officers on finding appropriate housing for clients if needed.
- A client's treatment plan should include recreational opportunities and other outlets to help them build healthy social relationships in addition to the support clients may be receiving from their family.
- Try to start vocational training for clients at the beginning of substance abuse treatment rather than at the end of treatment.
- Case management is an opportunity for the criminal justice and substance abuse treatment systems to collaborate to take advantage of a wide range of treatment and rehabilitation options for clients.
- Relapse prevention skills should be part of each offender treatment plan, and personal relapse prevention plans should be developed for all parolees receiving treatment. These plans address how clients can refuse drugs, identify triggers, and manage cravings.
- One positive urine test or one drink after a long abstinence should not be viewed as a failure but as a signal for stepped-up treatment and closer monitoring.
- Graduated sanctions for relapses should be specified in the treatment plan because resumption of drug abuse can lead to resumption of criminal activity.

Treatment Issues for People Under Community Supervision

The point at which an individual acknowledges the need for drug treatment varies by personal circumstance. What is a crisis for one person is not a crisis for another. However, at a number of junctures many offenders indicate readiness to accept substance abuse treatment. These include the point of arrest, the point of release back to the community, any point at which there is a diversion decision, sentencing, after certain periods of incarceration, on entering probation, or when there is a choice between entering a residential treatment program or a jail. Other critical choice points include changes in one's social position in the community or personal crises such as the death of a loved one, loss of a job, or suicide attempt.

Because of the diversity of offenders under community supervision, treatment issues vary widely. A parolee recently released after a 20-year sentence will, for example, have different issues and needs than a probationer who has spent minimal time in a correctional facility and who has more immediate ties to the community. Still, there are treatment issues that are common to both parolees and probationers. This section addresses those issues. Treatment issues unique to probationers and parolees are addressed in separate sections.

Self-Esteem and Identity

Shame and stigma are tremendous obstacles for offenders to overcome after an arrest or in making the transition between incarceration and the community. One effective approach to overcoming this stigma involves encouraging offender-clients to become active as volunteers in support of a community activity. Providing an opportunity for individuals to make a positive contribution to the community—to "give back"—may reduce feelings of alienation and build self-regard.

Stories abound of ex-offenders who experienced a successful recovery from substance use disorders through inspirational interventions and became mentors to young people, playing key roles in steering them toward law-abiding lives. Successful programs recognize the importance of building the client's sense of worthiness. Program success also depends on the quality of the staff, the treatment approach, and individual client motivation. Given the critical importance of self-esteem to recovery, training in developing client self-esteem should be mandatory for community corrections personnel.

At the same time, self-esteem is not always a useful treatment target or goal with offenders. Feelings of shame and stigma are sometimes missing, especially in those having antisocial traits and psychopathy. Targeting self-esteem without also increasing sense of personal responsibility and empathy for others may only result in a more confident criminal. Community service serves to reconnect the offender with the community and allows for retribution.

Financial Concerns

Many offenders have multiple financial responsibilities—child support, family obligations, job requirements, restitution, and treatment schedule—which can be major obstacles to successful treatment. A client burdened with overwhelming responsibilities sometimes gives up, saying, "I just couldn't handle it." Criminal justice and treatment professionals need to plan realistic requirements for individuals under community supervision.

Some communities have recognized the obstacles and stress presented by competing assignments and schedules imposed on offenders, which often necessitate expensive and time-consuming travel between sites. On Maryland's Eastern Shore, Tyson's Food, a major chicken producer, has given parole officers an office on-site at the processing plant so that employees do not need to miss work to meet reporting requirements. Drug courts impose numerous reporting responsibilities, but officials can make a reasonable attempt to accommodate the logistics of offenders' job, treatment, and family responsibilities.

Barriers to Treatment

Probationers and parolees may live in fear of the system; their freedom is conditional, and a mistake is likely to lead to reincarceration. Among the many internal barriers that can inhibit treatment success for offender-clients are

- A history of failure
- Alienation from and cynicism about the social structures and governmental agencies that typically have had a major impact on them
- A sense of hopelessness that anything can make a difference in their lives
- A culturally supported belief that treatment is for weak people
- The perception that treatment is further punishment

Those working with probationers and parolees need training to address each of these barriers. It is important for professionals working with offenders under community supervision to learn that offenders often do not realize that the goal of community corrections is to prevent them from being reincarcerated. Another treatment component should address the realities of incarceration and the impact of being a felon. Offenders being supervised in the community need to be informed of what they stand to lose by violating supervision requirements.

Motivation for Treatment

Establishing an offender's motivation to change is an essential first step in substance abuse treatment. It cannot be skipped. Generally, clients lack focus or goals, which must be established to permit motivation. Those working with probationers and parolees need to be familiar with techniques of motivation and how to create and/or support the offender's desire to break a pattern of criminality. Without genuine motivation on the part of the offender-client, treatment problems can be guaranteed. Clients need to feel hope and counselors need to plan a continuum of events that can begin to generate hope. During early stages of treatment, the offender-client should be oriented toward small accomplishments.

Flexibility on the part of community corrections officials is important. Both treatment programs and corrections agencies can work together to build opportunities for success—keeping an appointment, having a clean urine test, or completing homework—small, structured steps that clients can take with relative ease and derive confidence from as they progress. When the client completes one goal, the provider should be ready to suggest the next. Incentives can be built into the system as well. For example, the more frequent the negative drug test results, the less frequent the mandatory testing.

Those who abuse substances often are gifted manipulators with long histories of manipulative behavior in many systems. They may be able to simulate motivation but lack any real emotional investment in changing behavior. Clear, consistent, and uniform messages promote recovery and prevent the two systems from being used against one another. If the word "on the street" is that staff can be manipulated, treatment providers will face an uphill battle with many clients.

Motivational interviewing is one of the most frequently used strategies for enhancing motivation. The technique assumes the client's ambivalence about change and produces cognitive dissonance by eliciting the negative consequences of the addictive behavior. Motivational interviewing has been effective in the treatment of alcoholism (Bien et al. 1993; Galbraith 1989; Miller and Rollnick 1991) and methadone treatment for opioid abuse (Saunders et al. 1995; Van Bilsen and Van Emst 1986).

Negative Counselor Attitudes

Treatment is impeded when counselors have a negative perception of the client's desire to change, believe there is a poor prognosis for recovery, or are reluctant to serve offenders in general. Clients easily pick up on a provider's negative attitude, which often confirms their own feelings about the futility of attempts to

give up drugs. The cross-training of professionals helps build an understanding of offender-clients' needs and potential, but professionals in both systems must acknowledge that the very nature of substance abuse means that maintaining recovery is a long-term goal.

Lifestyle Changes

The kinds of changes community corrections professionals ask drug offenders to undertake are extraordinarily challenging and difficult to contemplate on a personal level. Many offenders have had limited experience with success and few opportunities to test their ability to succeed. A drug court or prison may be the first setting in which some offenders have a genuine chance to discover the capacity to change their lifestyles.

A counselor who is a role model of courage or compassion can often be very effective in persuading clients to reevaluate their lifestyles. On the other hand, counselors should also be prepared for setbacks, lapses, and slow progress, as offenders come to terms with the extent of lifestyle change that is being asked of them.

Self-Help Groups

Self-help groups frequently are a crucial component in recovery; they can provide peer support and nurture positive change. As bridges between incarceration and community, they can help with crises and personal growth. Probation and parole officers often advise clients to attend well-known programs like Alcoholics Anonymous or Narcotics Anonymous, saying, "Don't take my word. I'm not the expert. Listen to the folks who've been there." Other self-help groups may be appropriate depending on a client's beliefs, needs, and interests, such as Survivors of Incest Anonymous, Secular Organizations for Sobriety, church or feminist groups, or veteran organizations. Practitioners need to remember, however, that although self-help groups are not a substitute for counseling, they can be an important adjunct to it.

Adherence to Supervision Conditions

Both parole and probation officers need to be attuned to treatment needs, the dynamics of substance use disorders, and the changes required to maximize an offender-client's chance to succeed. Training needs to be provided to them on how to craft requirements that support a client's potential for success. Flexibility must be built into the requirements, given the complex pressures on most offenders in the community. Cross-training is necessary to facilitate information sharing among the entire range of professionals involved from presentence to probation or parole. While public safety is always a priority, training for probation and parole officers should emphasize that the offender's long-term treatment will bring sustained improvements in public safety.

Revocations because of technical violations of probation or parole requirements are a major barrier to completion of successful treatment. Required expectations for offender behavior need to be realistic. Cross-training can be helpful in fostering a shared vision of success. Such training should have specific goals. For example, training for probation officers working with drug offenders could include education on what treatment is and is not. Generic models of treatment should be presented. Similarly, treatment professionals working with drug offenders should be trained on the role of parole and probation in the criminal justice system. Probation and parole are frequently the most misunderstood element of the system, considered to be "law enforcement" by treatment professionals and "social work" by law enforcement. Often the breakdowns in communication between probation, parole, and treatment professionals are the result of a lack of understanding of each other's roles.

Vulnerability to Relapse

Both parole and probation officers, who may have a supportive role before the client enters treatment, are likely to move into supervisory mode once treatment is underway to reduce public safety and liability risks. Zero tolerance and "three strikes" policies make it difficult for officers to overlook drug lapses and contradict knowledge that substance use disorder is a chronic disease. Relapse is not necessarily a failure. The common belief that treatment does not work is often based on the fact that most people recovering from substance use disorders relapse from time to time.

Roles as Workers and Taxpayers

Not only have arrests and imprisonment removed many young men and increasing numbers of young women from their communities and families, the majority have no financial resources to cushion their return. Their length of time away from the job world and lack of skills or experience to enter the marketplace leave many offenders low on the job ladder and further unable to support families or meet social expectations. Simply having a job, and particularly paying taxes, can be a completely foreign experience for many offenders. If parole or probation reporting and other multiple requirements are inflexible, they can prevent clients from being able to earn a living and contribute as tax-paying citizens.

Increasingly, vocational training, GED programs, and job readiness training are being added to treatment. If programs do not offer these services, they can link to community agencies that can provide them. Offenders need specific preparation for responding to a prospective employer's questions about their past. Lying is often a first choice, given the prospect that admitting to a criminal history will likely bar them from the job. A felon may be legally obligated to disclose a criminal past.

Advice to the Counselor: Treatment Issues for People Under Community Supervision

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- Counselors can help offenders overcome the stigma of past incarceration by encouraging them to become active as volunteers in support of a community activity.
- For some clients financial stresses can be an obstacle to successful treatment. Counselors can work with criminal justice personnel to help plan realistic financial requirements for clients.
- Counselors need to help clients address any internal barriers clients may be experiencing, such as a history of failure, sense of hopelessness, or the perception that treatment is further punishment. Counselors can help offenders understand that the goal of community corrections is to prevent them from being reincarcerated.
- An essential first step for treatment is to establish a client's motivation to change. Counselors should be familiar with motivational techniques (such as motivational interviewing) and how to create or enhance a client's desire to break a pattern of criminality.
- Counselors should be careful not to project negative attitudes, which might be picked up by clients and reinforce their feelings of futility about substance abuse treatment.
- Being a role model of courage or compassion can be effective in persuading clients to reevaluate their lifestyles and make positive changes.
- Self-help groups can be a crucial component in a client's recovery by providing peer support and nurturing positive feelings.
- Counselors can help clients applying for employment prepare for responding to a prospective employer's questions about their past.

Treatment for Specific Populations

Both probationers and parolees with substance use disorders are likely to have additional treatment needs. Model programs described at the end of this chapter include comprehensive services to address a range of issues. This section briefly highlights the treatment issues of specific populations.

People with co-occurring disorders

Of the 74 percent of probationers and parolees identified as having drug and/or alcohol problems, 11.4 percent were also identified as having mental illness (Beck 2000*c*). The prevalence of co-occurring disorders among these populations means that many offenders will need assistance with their mental illness as well as their drug or alcohol problems. Treatment for co-occurring mental disorders should be tailored to the particular treatment plan, and revised according to ongoing assessment. Coordinated (integrated when possible) services are especially important for offenders with mental illness. An example of one model for treating offenders with mental illness is highlighted below.

PACT (Programs for Assertive Community Treatment)

The PACT model targets individuals with severe and persistent mental illness (which may include schizophrenia and other psychotic disorders, bipolar disorder and severe and recurrent depressive disorders, and occasionally severe personality disorders or severe anxiety disorders). Many if not most PACT clients have co-occurring addictive disorders, medical problems, and more than one psychiatric illness. The hallmark of PACT is low caseload size (15 clients per staff person) and an integrated team approach that includes people with medical, psychiatric, nursing, social work, psychology, case management, addictions, and other expertise who view the clients as a shared responsibility. Typically these programs will follow the client across locations. They do outreach into homeless shelters and street locations, they work with other providers when the client is hospitalized, and they will work with jails to advocate for good treatment.

Research indicates that PACT is effective in reducing hospital recidivism and, less consistently, in improving other client outcomes (Drake et al. 1998*a* ; Wingerson and Ries 1999). Another study compared a PACT with a standard case management approach at 3-year follow-up. The results indicated that the PACT adapted for clients with co-occurring disorders produced greater improvements on measures of quality of life and clinician ratings of alcohol use and substance abuse (McHugo et al. 1999).

The National GAINS Center for People with Co-occurring Disorders in the Justice System provides an online information source of value to those who work with offenders. The GAINS Center collects and analyzes information, and develops materials specifically for people who work with offenders with mental illness, and provides technical assistance to help localities plan, implement, and operate appropriate, cost-effective programs. For further information go to www.gainsctr.com/.

Female clients and children

Nearly a million women were on probation in 2003, and nearly 100,000 were on parole (Glaze and Palla 2004). Women under community supervision accounted for 85 percent of females in the criminal justice system in 1998. About 45 percent of women whose parole ended in 1996 were back in prison or had absconded. Women who successfully finished parole were incarcerated for an average of 15 months and on parole for an additional 20 months (Greenfeld and Snell 1999).

Mothers who are to be incarcerated often lose custody of their children because of neglect and/or abuse, but the loss of children is extremely difficult for them to accept. If children are removed, criminal justice and treatment providers need to consider providing assistance for dealing with grief and loss. A client who has demonstrated a sustained period of sobriety during treatment should be considered for a phased return of her children. Mothers reentering the community from correctional institutions are likely to have a difficult time reuniting with their children. They and their children should work with family service agencies on reunification issues, when appropriate.

Clients with HIV/AIDS or other illnesses

Offenders face additional challenges when they are unable to work because of illness. Access to medical help is essential. Comprehensive assistance to offenders should include prevention education, medical and social service support, grief counseling, and other psychological services. Services should include infectious disease risk assessment and screening, medical interventions such as primary care, and family counseling. Continuing care should include follow-up and hospice care. Case managers can assist in coordinating care for such infectious diseases as HIV, hepatitis C, tuberculosis, and sexually transmitted diseases.

Treatment Issues Specific to People on Parole

Prisoners released into the community face a sometimes bewildering transition. Nearly 80 percent of prisoners returning to the community are released on parole under conditional release (Petersilia 2000). A successful transition from offender to citizen often depends on successful treatment. Successful treatment helps individuals to be more realistic about their strengths and weaknesses, more skilled and willing to endure obstacles encountered in maintaining a job or obtaining an education, and more confident about meeting family and work responsibilities.

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Continuum of Care

Because substance use disorders are long-term, relapsing illnesses, a crucial aspect for reentry is to develop and sustain an integrated continuum of care between substance abuse treatment providers, the parole officer, and social service agencies that can assist the inmate's reintegration into the community. Ideally, cross-system integration for offender transitional services contributes to cost benefits as a result of reduced recidivism (Inciardi 1996; National Institute of Justice 1995; Swartz et al. 1996). However, the parolee does not exist in a discrete, well-coordinated system, but rather in a cluster of independent agencies and entities with separate justice responsibilities. Some entities collaborate closely; others do not. Most operate under separate funding streams, with differing organizational missions that may or may not share philosophical orientations toward public safety and offender rehabilitation. Boundary spanners and case managers can sometimes help maintain continuity.

Aftercare and Continuing Care

Several studies have supported the long-term efficacy of post prison aftercare and treatment services in the reduction of recidivism and relapse. For example, Wexler (1995) found that those who participated in prison- and community-based therapeutic community treatment committed fewer crimes than their counterparts who did not receive aftercare services. Inciardi (1996) reported similar findings: lower rates of drug use and recidivism than those enrolled only in institutional treatment programs.

Residential aftercare contributes to improved post prison outcomes. For optimal results, the offender should remain in treatment in the community. Studies show, for example, that the most effective treatment lasts a minimum of 3-6 months, and outcomes improve with additional time in treatment. This is true for all treatment modalities and particularly for treatment of offenders (Hubbard et al. 1988; Simpson 1984; Wexler 1988).

Case Management

Case management is the crucial function that links the offender with appropriate resources, tracks progress, reports information to supervisors, and monitors conditions imposed by the supervising agency. These activities take place within the context of an ongoing relationship with the client. The goal of case management is continuity of treatment, which, for the offender in transition, can be defined as the ongoing assessment and identification of needs and the provision of treatment without gaps in services or supervision. Accountability is an important element of a transition plan, and case management includes coordinating the use of sanctions and incentives among the criminal justice, substance abuse treatment, and possibly other systems.

Ideally, case management activities should begin in the institution before release and continue without interruption throughout the transition period and into the community. Reassessments should be conducted at various stages throughout the incarceration and community release process. These periodic assessments should form the basis for ongoing case management and service delivery.

Ancillary services are needed before and after release to prepare the offender for the return to family, employment, and the community. Studies (Knight et al. 1999*a* ; Martin et al. 1999; Wexler et al. 1999*b*) have revealed the importance of aftercare for the maintenance of treatment effects. Foremost among needs for ancillary services are drug-free housing or other living arrangements, employment, family support, transportation, education, and primary health care. Others include literacy training, HIV/AIDS education, and prosocial support networks (Belenko and Peugh 1998; Hiller et al. 1999*b*). Offenders may need help learning basic life skills such as budgeting, using public transportation, and parenting. Improving clients' likelihood of obtaining a job through GED preparation, enrollment in an educational program, vocational training, or job-seeking skills classes increases their chances of success after release.

This array of services reflects the multiple psychosocial needs of offenders and takes into account the likelihood that they may experience periods of relapse, requiring more intensive levels of treatment and supervision. Other needs are training to improve interpersonal skills within families and among peers and training in anger management to learn new methods for resolving conflicts. Family members should be involved whenever possible, and participation in self-help groups should be encouraged.

Recidivism

Parole failures now account for 35 percent of all prison admissions. Two-thirds of all parolees are rearrested within 3 years (Petersilia 2000), many on technical revocations, but most rearrests occur in the first 6 months. Offenders with mental illness are especially likely to be rearrested.

Given the importance of aftercare in the reduction of recidivism, several Federal and State Initiatives have sought to provide integrative treatment. One such program, the Serious and Violent Offender Reentry Initiative, is highlighted below.

Serious and Violent Offender Reentry Initiative

In conjunction with several Federal partners, the U.S. Department of Justice, Office of Justice Programs, created a comprehensive program to reduce violent crime by helping high-risk offenders prepare for reentry to society. The Initiative provides funding for the development, implementation, and enhancement of reentry programs. Programs funded under the Initiative will be tailored to address the three phases of reentry:

- *Phase 1 – Protect and Prepare*. Institution-based programs will provide services to prepare the offender for reentry, including education, mental health and substance abuse treatment, job training mentoring, and diagnostic and risk assessment.
- *Phase 2 – Control and Restore.* These community-based transition programs will assist offenders prior to and immediately following their release by providing education, monitoring, mentoring, life skills training, assessment, job skills development, and mental health and substance abuse treatment.
- *Phase 3 – Sustain and Support.* In this phase, community-based, long-term support programs help offenders who have successfully completed their criminal justice supervision to connect with social services agencies and community-based organizations that provide ongoing services.

Further information on the Serious and Violent Offender Reentry Initiative is available at the Office of Justice Programs Web site: www.ojp.usdoj.gov/reentry/learn.html.

Advice to the Counselor: Treatment Issues for People on Parole

- Counselors can collaborate with parole officers and social service agencies to assist a client's reintegration into the community and help maintain the continuity of services.
- Counselors can help clients with securing post prison aftercare and treatment services, which have been shown to reduce recidivism and relapse.
- Ancillary services (e.g., drug-free housing, employment, family support, transportation, education, health care) are needed before and after release from prison to prepare the client for return to the community.

Treatment Issues Specific to Probationers

Compared to parolees, probationers are less likely to have spent extended time in a correctional facility, and their ties to the community are relatively intact. The latter is both a benefit and a detriment in terms of substance abuse. On the one hand, offenders on probation may have the support of their families and their communities. They may be able to maintain some consistency in their employment, their residence, and their family lives. On the other hand, probationers face a more immediate return to the surroundings and influences associated with their drug or alcohol use. For example, the offender with alcohol dependence is likely to return to the same neighborhood with the same bars, liquor stores, and friends.

As with parolees, in order to be effective treatment must necessarily focus on changing ingrained patterns of behavior and thinking and avoiding the people, places, and things that the offender associates with drug or alcohol use. Unlike people on parole, however, the issue is not so much to reintegrate into society, but rather to learn new ways to live in that society. Much of the information presented in Chapter 2 is also applicable to probationers, since many probationers have been sentenced through drug courts.

Strategies for Improving System Collaboration

Initiatives such as cross-training, coordinated and comprehensive planning, and follow-up interdisciplinary meetings can help justice and treatment system partners to develop a shared, client-centered mission and a coordinated response. Figure 4-2 provides an example of how the goals of the treatment and criminal justice systems can be viewed as similar, although on the surface they appear disparate.

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Figure 4-2. Paradigm of Collaboration

Goals of Treatment System	Goals of Supervision System	Shared Goals
Reduce recidivism/criminal behavior.	Reduce recidivism/criminal behavior.	Minimize risk to public.
Provide evaluation and treatment services.	Maximize the use of databases on the offender.	Obtain adherence to treatment plan and abstinence from substance use.
Practice social skills.	Enhance supervision.	Alleviate symptoms of illness.
Develop working alliance.	Rely on third party expertise.	Promote successful community reintegration with the goal of abstinence.
Prevent secondary pathology.	Focus on public safety.	Encourage family/social support.
Collaborate/consult with other providers.	Respond to court mandates.	Support employment efforts.
Honor confidentiality.		

Memorandum of Understanding

When a substance abuse treatment program and a criminal justice agency collaborate, an MOU will outline the objectives of each partner, the expectations each partner has about the obligations of the other, and communications between the program and the criminal justice agency. For programs treating offenders, it is crucial to identify who will make certain decisions and what kinds of information will be reported. For example, will the program or the criminal justice agency decide when an offender's relapse into alcohol or drug use will be handled as a violation of the conditions of probation? How detailed are the program's reports to the criminal justice agency? Matters such as these can be resolved upfront between the program and criminal justice agency. An MOU or letter of agreement makes explicit the responsibilities agreed upon by each system.

Information-Sharing and Confidentiality Issues

To develop effective treatment plans that respond to individual needs and problems, community-based organizations need information from the paroling institution about the offender's previous substance abuse treatment. Obtaining such information often is problematic because of ethical considerations about client privacy and Federal laws guaranteeing strict confidentiality of information about all people receiving substance abuse prevention, assessment, and treatment services.

Program Violations

Ideally, program violations should be addressed in the context of treatment needs before legal sanctions are considered, depending on the severity of the violation. However, this is realistic only if the supervising agent and the provider of care agree on how to make it work; it is not realistic if there is not a solid agreement between the two systems. When possible, this understanding can be established by an initial agreement between the offender-client's probation or parole officer and treatment provider.

Personnel and Training

While some States do not require licensing for treatment providers, it is undesirable to have unaccredited, unlicensed people providing treatment. Individuals providing treatment to offender populations should meet minimum standards of recognized accrediting authorities in addition to receiving specialized training in substance use disorders and relapse prevention. Special attention needs to be paid to the training of recovering staff who are essential counseling resources for therapeutic communities and other programming. Their credibility with clients and role modeling potential cannot be underestimated. Programs that include opportunities for clients to begin counselor training while in custody enrich programs and offer increased hope for participants. However, careful guidelines are needed concerning crime-free and sober years, in addition to other standard professional counselor requirements.

Whenever possible, training should be carried out across criminal justice and substance abuse treatment systems and should integrate personnel from both. The curriculum should cover needs and approaches to specific populations in the jurisdiction, such as women, minorities, those with co-occurring mental disorders, and clients with special needs, and incorporate input from each of these groups to ensure the training's relevance, accuracy, and sensitivity. General topics to consider include

- A broad overview of how each system works
- Common ground shared by substance abuse treatment and criminal justice systems

- Education on the language and jargon of the systems so that providers understand each other's language
- Clarification of system roles and personnel roles within each system
- Ways in which the two systems can communicate, work together, and manage conflicts
- Cultural competence issues
- Confidentiality requirements
- Effective case management for the offender-client
- Rationales for intermediate sanctions programs for drug offenders
- Eligibility requirements for intermediate sanctions programs and how they can be applied to individual cases
- Reporting requirements and agreements
- Pharmacotherapy

Participants in training for this type of community supervision program should include

- Judges
- Prosecutors
- Probation and parole officers
- Treatment program administrators
- Counselors
- Public treatment-funding agencies
- Defense attorneys
- Ancillary program staff

Special presentations can be made to policymakers (e.g., State and local legislators or advisors to the State or county) that focus more on systems and legislative issues.

Sample Programs

The Amity Project

The Amity Project was a collaboration between Amity, Inc., and the Pima County, Arizona, Department of Probation and funded by The Center for Substance Abuse Treatment, U.S. Department of Health and Human Services, in 1990. The program targeted offenders who were at high risk of having their probation revoked because of their substance abuse. By incorporating the key elements of a therapeutic community into a day and evening program, the unique structure escalated sanctions, including urine screens and varying supervision levels, case management, educational and vocational training, family support and counseling, coordination of medical services, and intensive aftercare. After 2 years, drug use relapses among probationers declined, positive urine screens decreased by

more than 50 percent in the first year, and job placement increased. Because of the success of the employment component, the project had to extend its activities to nights and weekends to accommodate the employed offenders. The program ended when funding was not renewed, despite its promising start (Healey 1999).

Breaking the Cycle

A joint project of the ONDCP and the National Institute of Justice, U.S. Department of Justice, Breaking the Cycle is designed to interrupt the downward spiral of drug use, crime, imprisonment, and recidivism and is currently being tested by three adult justice systems nationwide. The goal of the program is to reduce drug use and crime through increased collaboration between justice system practitioners and treatment providers. The Breaking the Cycle model encourages a change in the way both systems respond to offenders who use drugs and includes the following initiatives:

- Drug testing of all arrestees before the initial court hearing
- Placement of people who use drugs in appropriate treatment and monitoring programs
- Intensive pretrial and post-sentence case management
- Appropriate, graduated sanctions and incentives to address offender behavior
- Judicial oversight of offender compliance (National Institute of Justice 2001)

Probationers in Recovery

An intensive probation program in San Diego County, California, Probationers in Recovery requires offenders to participate in intensive drug treatment and drug testing. The program has made a strong effort to combine substance abuse treatment with the heightened surveillance of intensive supervision. The program targets high-risk offenders and excludes people with psychotic disorders and excessive criminal or violent histories. The requirements for program completion are comparatively high, including self-help, group and individual therapy, job club, drug education, social skills development, and life skills components lasting a minimum of 6 months (Curtis et al. 1994).

KEY-CREST

Located in Wilmington, Delaware, KEY-CREST has an in-prison therapeutic community, and a 6-month residential, community-based TC with a work release program for inmates with histories of substance abuse. The program includes an aftercare stage, where clients are under community supervision. Data from a 3-year follow-up indicate that the group in aftercare shows the most powerful effects of the earlier treatment (Martin et al. 1999).

Special Offender Services Program

One model program for the treatment of offenders who have developmental disabilities or at least three deficits in essential adaptive skills or behaviors was developed in the mid-1980s by Lancaster County, Pennsylvania. This program, known as Special Offenders Services (SOS), helps qualified offenders who have been placed on probation or parole. SOS works in a number of areas to help this group by educating criminal justice personnel, facilitating the use of social services (through case management), building client self-esteem (which it does by rewarding small successes and not placing unreasonable demands on its clients), educating clients about their rights and responsibilities, and providing skills training in areas such as recreational activities (since many offenders who are cognitively challenged may not know how to spend their free time). The program's success is demonstrated by the extremely low recidivism rate of its clients, which, as of 1992, was only 5 percent (Wood and White 1992).

Conclusions and Recommendations

- Offenders can be effectively controlled and managed by a combination of treatment and surveillance while on probation at a far lower cost than if they are in jail or prison.
- Offenders under community supervision who have substance use disorders need services from multiple systems. Services should be accessible on an as-needed basis to ensure positive outcomes and smooth transitions.
- Cross-training of probation and parole officers, case managers, and substance abuse counselors is vital for the delivery of coordinated services.
- Community supervision should be based on the recognition that relapses are unavoidable and not necessarily indicative of failure. Intensification in the level of supervision should be matched by an intensification of the level of treatment. Likewise, the intensity of supervision should decrease over time as the individual meets treatment goals.
- Probationers who have avoided incarceration should receive education on the realities of incarceration and the impact of being a felon on the offenders' lives.
- Ideally, case management activities for parolees should begin in the institution before release and continue throughout the transition period for a minimum of 3 months of treatment after release.

- Reassessment should be conducted throughout the period of community supervision.

- All residential treatment should be followed by continued care in an outpatient setting.

- Optimally, probation and parole officers should visit and assess the client's residence and place of employment periodically in the course of community supervision.

- Vocational programming should be ongoing and integrated with substance abuse treatment.

- Community supervision staff should be involved in treatment planning and treatment team activities whenever possible, particularly when issues of sanctions and placement in community treatment are reviewed.

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Appendix B: Post Test and Evaluation for
Treatment Needs and Strategies for individuals in Various Criminal Justice Settings

Directions: To receive credits for this course, you are required to take a post test and receive a passing score. We have set a minimum standard of 80% as the passing score to assure the highest standard of knowledge retention and understanding. The test is comprised of multiple choice and/or true/false questions that will investigate your knowledge and understanding of the materials found in this CEU Matrix – The Institute for Addiction and Criminal Justice distance learning course.

After you complete your reading and review of this material, you will need to answer each of the test questions. Then, submit your test to us for processing. This can be done in any **one** of the following manners:

1. *Submit your test via the Internet.* All of our tests are posted electronically, allowing immediate test results and quicker processing. First, you may want to answer your post test questions using the answer sheet found at the end of this appendix. Then, return to your browser and go to the Student Center located at:

   http://www.ceumatrix.com/studentcenter

   Once there, log in as a Returning Customer using your Email Address and Password. Then click on 'Take Exam' and you will be presented with the electronic exam.

   To take the exam, simply select from the choices of "a" through "e" for each multiple choice question. For true/false questions, select either "a" for true, or "b" for false. Once you are done, simply click on the submit button at the bottom of the page. Your exam will be graded and you will receive your results immediately. If your score is 80% or greater, you will receive a link to the course evaluation. , which is the final step in the process. Once you submit the evaluation, you will receive a link to the Certificate of Completion. This is the final step in the process, and you may save and / or print your Certificate of Completion.

   If, however, you do not achieve a passing score of at least 80%, you will need to review the course material and return to the Student Center to resubmit your answers.

   OR

2. *Submit your test by mail using the answer sheet found at the end of this package.* First, complete the cover page that will identify the course and provide us with the information that will be included in your Certificate of Completion. Then, answer each of the questions by selecting the best response available and marking your answers on the sheet. The final step is to complete the course evaluation (most certifying bodies require a course evaluation before certificates of completion can be issued). Once completed, mail the information, answer and evaluation sheets to this address:

   CEU Matrix - The Institute for Addiction and Criminal Justice Studies
   P.O. Box 2000
   Georgetown, TX 78627

   Once we receive your exam and evaluation sheets, we will grade your test and notify you of the results.

   If successful, you will be able to access your Certificate of Completion and print it. Access your browser and go to the Student Center located at:

   http://www.ceumatrix.com/studentcenter

   Once there, log in as a Returning Customer using your Email Address and Password. Then click on 'Certificate' and you will be presented with a download of your Certificate of Completion that you may save / and or print. If you would rather have your Certificate of Completion mailed to you, please let us know when you mail your exam and evaluation sheets; or contact us at ceumatrix@ceumatrix.com or 800.421.4609.

   If you do not obtain the required 80% score, we will provide you with feedback and instructions for retesting.

   OR

3. *Submit your test by fax.* Simply follow the instructions above, but rather than mailing your sheets, fax them to us at **((512) 863-2231**.

If you have any difficulty with this process, or need assistance, please e-mail us at **ceumatrix@ceumatrix.com** and ask for help.

Answer the following questions by selecting the most appropriate response.

1. Drug Abuse Monitoring Program (ADAM) data of women arrestees revealed that the predominant drug detected was:

   a. heroin.
   b. methamphetamines.
   c. marijuana.
   d. cocaine.
   e. None of the above

2. Nationally, _______% of all arrestees test positive for an illicit drug.

   a. 25%
   b. 50%
   c. 65%
   d. 80%

3. The majority of drug offenders are supervised in the community following their arrests.

   a. True
   b. False

4. Arrest offers the first opportunity for the individual to voluntarily choose to enter substance abuse treatment.

   a. True
   b. False

5. Agreeing to enter substance abuse treatment may be part of which of the following judicial processes?

   a. Pretrial Diversion
   b. Pretrial conditional release
   c. Plea Bargain
   d. Sentencing
   e. All of the above

6. Persons with co-occurring disorders are most effectively treated by sequential programs that first deal with the substance abuse problems.

   a. True
   b. False

7. Persons with knowledge of both criminal justice and treatment systems who encourage collaboration between substance abuse and mental health services are called:

    a. case managers.
    b. boundary spanners.
    c. dual disorders specialists.
    d. dreamers.

8. Unlike drug offenders, DUI offenders tend to:

    a. be less likely to see that they have a substance abuse problem.
    b. have more stable family situations.
    c. draw on greater emotional and financial resources.
    d. be employed.
    e. All of the above

9. Withdrawal from all of the following drugs except ________ can be life threatening.

    a. opioids
    b. alcohol
    c. barbiturates
    d. benzodiazepines
    e. sedative-hypnotics

10. Sobering centers provide medically supervised detox services in a safe setting.

    True
    False

11. During the pretrial period, counselors should be aware of:

    a. protecting client confidentiality and other rights.
    b. the client's varying abilities to handle everything going on his or her life.
    c. the client probably being more focused on avoiding the consequences of the charges than on recovery.
    d. the client's presumption of innocence.
    e. All of the above

12. Effective programs set up ____________ to establish guidelines and procedures for treating the client, sharing information, and maintaining the confidentiality of information.

    a. treatment plans
    b. Memoranda of Understanding (MOUs)
    c. Releases of Information (ROIs)
    d. court orders
    e. None of the above

13. Diversionary treatment is perceived as a threat to public safety because offenders are quickly placed back into the community.

    a. True
    b. False

14. Belenko and colleagues (1992) reported that drug testing during the pretrial period was cost-effective and consistently predicted pretrial misconduct better than other available information.

    a. True
    b. False

15. Jail-based treatment must be based on which of the following?

    a. Average length of stay
    b. Types of crimes
    c. Psychosocial needs
    d. Culture
    e. All of the above

16. According to Ditton's 1999 and James' 2004 surveys, jailed women report or exhibit all of the following EXCEPT:

    a. physical abuse history (44.9%).
    b. sexual abuse history (35.9%).
    c. lower percentage of drug offenses than men.
    d. a higher incidence of mental illness than male inmates (22.7%).
    e. higher percentage of property offenses than men.

17. Individuals with mental illness are admitted to jails at approximately eight times the rate at which they are admitted to public psychiatric hospitals.

    a. True
    b. False

18. The single biggest barrier to jail-based treatment is:

    a. lack of time available for participation in and scheduling of treatment.
    b. lack of funding.
    c. no effective treatment has been found for incarcerated individuals.
    d. gang threats.

19. ACA and NCCHC have adopted no specific guidelines for substance abuse treatment in jail settings.

    a. True
    b. False

20. An intervention that helps inmates understand the relationship between thoughts, emotions, and behaviors and to correct thoughts that can lead to criminal behavior and substance abuse is:

    a. Motivational Enhancement.
    b. Dialectical Behavior Therapy.
    c. Social Skills Training.
    d. Cognitive Skills Training.
    e. Problem-solving Skills.

21. Long Term (Level III) Treatment using components similar to those found in community based programs are utilized for inmates incarcerated for:

    a. less than 90 days.
    b. more than 90 days.
    c. more than 180 days.
    d. more than 1 year.

22. Both short-term and long-term substance abuse treatment programs in jails are most effective when accompanied by:

    a. supportive medications such as disulfiram.
    b. aftercare within the community upon release.
    c. supportive employment and job placement.
    d. intensive parole services.

23. ____________ is a structured approach to examine the family network and background, including patterns of criminal activity and substance abuse.

    a. Family mapping
    b. Genome mapping
    c. Transgenerational Linking
    d. Historical tracing

24. Creating partnerships with the community makes additional resources available, but coordinating the visits of community volunteers to jails poses potential problems with:

    a. staffing patterns, including staff time.
    b. security.
    c. contraband monitoring.
    d. additional administrative coordination.
    e. All of the above

25. Peters *et al* found that cocaine users were more likely to complete a treatment program than alcohol or marijuana users.

    a. True
    b. False

26. Prisons differ from jails in that:

    a. inmates generally are serving longer period of time (over 1 year).
    b. prisons are larger facilities.
    c. prisons are separated by function and inmate classification.
    d. A and C are both correct
    e. B and C are both correct

27. Peters also found the lifetime incidence of substance abuse or dependence disorders in the prison population to be approximately:

    a. 25%.
    b. 50%.
    c. 75%.
    d. 90%.

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28. Although the total number of sentenced inmates increased greatly over the past decade, there was only a slight variance in the racial and ethnic composition of the inmate population.

    a. True
    b. False

29. According to 1998 data, state prison inmates with reported mental conditions were more likely to have all the following characteristics except for:

    a. having been homeless within the past 12 months.
    b. having been hospitalized within the past 12 months.
    c. having been under the influence at the time of the offense.
    d. having been incarcerated for a violent offense.

30. Rates of HIV infection and Hepatitis C are higher for incarcerated women than for incarcerated men.

    a. True
    b. False

31. In addition to treating substance abuse and other mental disorders, in-prison treatment also addresses the trauma of the incarceration itself as well as a prison culture that conflicts with treatment goals.

32. Counselors should be able to recognize the APA's symptoms of Post Traumatic Stress Disorder (PTSD) that includes which of the following?

    a. Feelings of detachment
    b. Hypervigilance
    c. Sleep difficulties
    d. Irritability
    e. All of the above are correct responses

33. Gender-specific treatment issues for incarcerated men include:

    a. violence prevention.
    b. money management.
    c. healthy relationships.
    d. A and B
    e. A and C

34. Cognitive therapies address substance abusers' errors in thinking that include all EXCEPT which of the following?

    a. Premeditation
    b. Rationalizations
    c. Automatic thinking
    d. Overgeneralization

35. Probably the most central concept of self-help groups is:

    a. group support.
    b. crisis management.
    c. Empowerment.
    d. making amends.

36. ____________is a treatment approach that is structured, hierarchical, and highly intense.

    a. Psycho-rehabilitation
    b. Peer Support
    c. Didactic Behavior Therapy
    d. Therapeutic Community

37. Separation from the prison subculture during TC treatment has been found to be most conducive to achieving major changes in attitudes and behavior.

    a. True
    b. False

38. Women in prison may create intimate relationships and family groupings to meet their relational and emotional needs.

    a. True
    b. False

39. An example of a Therapeutic Community for inmates with co-occurring disorders is the:

    a. Personal Reflections Therapeutic Community program.
    b. Kyle New Vision program.
    c. Amity Therapeutic Community.
    d. Stay'n Out prison TC.

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40. Between 1995 and 2003, the number of ________________in State and Federal prison increased by 85%:

    a. sex offenders
    b. female inmates
    c. inmates aged 55 and over
    d. persons with co-occurring disorders

41. Sanctions for violations of treatment program rules should be:

    a. specifically spelled out.
    b. opportunities for learning.
    c. applied consistently.
    d. balanced with incentives.
    e. All of the above

42. Attrition and non-compliance can be decreased if counselors and staff address individual attitudes and behaviors early enough in the treatment process to avert them.

    a. True
    b. False

43. Criminal justice personnel should receive training on issues related to substance abuse use including:

    a. cultural competence.
    b. confidentiality.
    c. infections diseases.
    d. co-occurring disorders.
    e. All of the above

44. Recruitment of counselors in the criminal justice system is complicated by the limited ability to hire individuals in recovery.

    a. True
    b. False

45. The recommended duration for participation in a Therapeutic Community is:

    a. 3-6 months.
    b. 6-9 months.
    c. 9-12 months.
    d. 12-18 months.

46. Issues of aftercare and continuity of care to maintain recovery are especially relevant to:

    a. women inmates.
    b. sex offenders.
    c. inmates over the age of 55.
    d. inmates with co-occurring disorders.
    e. None of the above are correct responses

47. Which of the following is not a true statement about community supervision?

    a. A higher percentage of violations resulted in re-incarcerations than incarcerations
    b. There are nearly 4 million persons under community supervision
    c. A higher percentage of probationers have drug or alcohol involvement than parolees.
    d. Caucasians represent the largest group of probationers.

48. Outpatient community treatment tends to be more intense than treatment during incarceration.

    a. True
    b. False

49. An officer's evaluation of a client's proposed residence after release is a critical factor in case planning.

    a. True
    b. False

50. Case management includes which of the following functions?

    a. Monitoring court imposed conditions when requested
    b. Tracking progress through required programs
    c. Linking the offender with appropriate resources
    d. Reporting the information to supervising authorities
    e. All of the above

51. Zero tolerance and "three strikes" policies support the substance abuse recovery process.

    a. True
    b. False

52. Offenders need specific preparation for responding to a prospective employer's questions about their past.

    a. True
    b. False

53. Which of the following statements are female clients is/are true?

    a. The majority of women in the criminal justice system are under community supervision.
    b. Nearly three million women were under community supervision in 2003.
    c. Mothers who are incarcerated need special assistance with grief and loss.
    d. A and B are correct responses
    e. A and C are correct responses

54. Facts concerning recidivism include all of the following EXCEPT:

    a. most re-arrests occur in the first 6 months after release.
    b. offenders with mental illness are especially likely to be rearrested.
    c. aftercare is an important factor in the reduction of recidivism.
    d. parole failures account for 35 percent of all prison admissions
    e. two thirds of women parolees successfully complete supervision without incident.

55. Minimizing risk to the public is obviously a higher supervision system priority than a treatment system priority.

    a. True
    b. False

56. Honoring confidentiality is obviously a higher treatment system priority than a supervision system priority.

    a. True
    b. False

57. The Breaking the Cycle model employs all of the following EXCEPT:

    a. judicial oversight of offender compliance
    b. drug testing of all arrestees before the initial court hearing
    c. an integrated dual disorders treatment program
    d. intensive case management

58. Coordinated case management, treatment, and community supervision is often less cost effective than incarceration.

    a. True
    b. False

59. Probationers:

    a. should be intensively supervised until they prove they are compliant.
    b. should be incarcerated after the first relapse.
    c. should be educated about the realities of incarceration and its impact.
    d. should only find jobs that don't interfere with frequent probation meetings and treatment requirements.

60. The benefit of in-prison treatment is that there are clear concepts and philosophies of what modalities work and don't work for incarcerated individuals.

    a. True
    b. False

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Fax/Mail Answer Sheet
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Test results for the course "Treatment Needs and Strategies for Individuals in Various Criminal Justice Setting

If you submit your test results online, you do not need to return this form.

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You will receive notification of your score within 48 business hours of our receipt of the answer sheet. If you do not pass the exam, you will receive instructions at that time.

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Course: Treatment Needs and Strategies for Individuals in Various Criminal Justice Settings

1. [A] [B] [C] [D] [E]	11. [A] [B] [C] [D] [E]	21. [A] [B] [C] [D] [E]
2. [A] [B] [C] [D] [E]	12. [A] [B] [C] [D] [E]	22. [A] [B] [C] [D] [E]
3. [A] [B] [C] [D] [E]	13. [A] [B] [C] [D] [E]	23. [A] [B] [C] [D] [E]
4. [A] [B] [C] [D] [E]	14. [A] [B] [C] [D] [E]	24. [A] [B] [C] [D] [E]
5. [A] [B] [C] [D] [E]	15. [A] [B] [C] [D] [E]	25. [A] [B] [C] [D] [E]
6. [A] [B] [C] [D] [E]	16. [A] [B] [C] [D] [E]	26. [A] [B] [C] [D] [E]
7. [A] [B] [C] [D] [E]	17. [A] [B] [C] [D] [E]	27. [A] [B] [C] [D] [E]
8. [A] [B] [C] [D] [E]	18. [A] [B] [C] [D] [E]	28. [A] [B] [C] [D] [E]
9. [A] [B] [C] [D] [E]	19. [A] [B] [C] [D] [E]	29. [A] [B] [C] [D] [E]
10. [A] [B] [C] [D] [E]	20. [A] [B] [C] [D] [E]	30. [A] [B] [C] [D] [E]

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31. [A] [B] [C] [D] [E]	41. [A] [B] [C] [D] [E]	51. [A] [B] [C] [D] [E]
32. [A] [B] [C] [D] [E]	42. [A] [B] [C] [D] [E]	52. [A] [B] [C] [D] [E]
33. [A] [B] [C] [D] [E]	43. [A] [B] [C] [D] [E]	53. [A] [B] [C] [D] [E]
34. [A] [B] [C] [D] [E]	44. [A] [B] [C] [D] [E]	54. [A] [B] [C] [D] [E]
35. [A] [B] [C] [D] [E]	45. [A] [B] [C] [D] [E]	55. [A] [B] [C] [D] [E]
36. [A] [B] [C] [D] [E]	46. [A] [B] [C] [D] [E]	56. [A] [B] [C] [D] [E]
37. [A] [B] [C] [D] [E]	47. [A] [B] [C] [D] [E]	57. [A] [B] [C] [D] [E]
38. [A] [B] [C] [D] [E]	48. [A] [B] [C] [D] [E]	58. [A] [B] [C] [D] [E]
39. [A] [B] [C] [D] [E]	49. [A] [B] [C] [D] [E]	59. [A] [B] [C] [D] [E]
40. [A] [B] [C] [D] [E]	50. [A] [B] [C] [D] [E]	60. [A] [B] [C] [D] [E]

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Information was interesting	☐ Start Over ☐ Good ☐ Excellent	☐ Needs work ☐ Very Good
Information will be useful in my work	☐ Start Over ☐ Good ☐ Excellent	☐ Needs work ☐ Very Good
Format of course was clear	☐ Start Over ☐ Good ☐ Excellent	☐ Needs work ☐ Very Good
POST TEST		
Questions covered course materials	☐ Start Over ☐ Good ☐ Excellent	☐ Needs work ☐ Very Good
Questions were clear	☐ Start Over ☐ Good ☐ Excellent	☐ Needs work ☐ Very Good
Answer sheet was easy to use	☐ Start Over ☐ Good ☐ Excellent	☐ Needs work ☐ Very Good

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