9 Treatment Issues Specific to Prisons

In This Chapter...

Overview

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.

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 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/Latino 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/Latino 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 CASA (1998), almost half (43 percent) of those iden-

tified as "regular drug users" in State correctional systems were incarcerated for a violent offense, including murder, manslaughter, rape, robbery, kidnapping, and aggravated assault.

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).

HIV and AIDS

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 yearend 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 1999*b*).

The lifetime incidence of substance abuse or dependence disorders in the prison population is roughly 75 percent.

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 9-1 indicates, the most common reasons listed for the limited availability of treatment were budgetary constraints (71 percent) and space limitations (51 percent).

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 9-2 (see p. 192) summarizes some of these guidelines.

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

Figure 9-1
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.

shame and guilt. Thus, in addition to treating substance abuse and other mental disorders, the consensus panel recommends that 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 post-traumatic 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. For more information on PTSD see the forthcoming TIP

Figure 9-2
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 • Continuity of services across the corrections system	• Individualized treatment plans
Other	• Referrals to community resources upon release (ACA 1990)	• Staff recruitment • Staff training • Sanctions • Program accountability and evaluation (NIC 1991)	• Matching to different levels or types of treatment services • Case management services • Use of cognitive–behavioral, social learning, and self-help approaches • 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.

Substance Abuse and Trauma (CSAT in development *f*), and TIP 42, *Substance Abuse Treatment for Persons With Co-Occurring Disorders* (CSAT 2005*c*).

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 incar-

ceration, 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. For more information on gender-specific issues, see chapter 6 of this TIP and the forthcoming TIPs *Substance Abuse Treatment: Addressing the Specific Needs of Women* (CSAT in development *g*) and *Substance Abuse Treatment and Men's Issues* (CSAT in development *e*).

Men in prisons

The consensus panel suggests that, where possible, programs 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.

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.

Counseling

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. Examples of cognitive–behavioral group interventions include the National Institute of Corrections' *Thinking for a Change* curricula (online at http://www.nicic.gov/t4c), the *Criminal Conduct and Substance Abuse Treatment* (Wanberg and Milkman 1998), and others described in chapter 5 of this TIP.

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. For more information on using family therapy in substance abuse treatment see TIP 39, *Substance Abuse Treatment and Family Therapy* (CSAT 2004).

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

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

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 previous page.) 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 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, the consensus panel believes that 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. The panel feels that the 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.

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 standalone 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.

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.

"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.

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, val-

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.

ues, 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.

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 9-3, program completion also decreased the likelihood of rearrest.

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 non-treatment comparison group (Martin et al. 1995; Nielsen et al. 1996). A followup 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

Figure 9-3
Stay'n Out Program Outcomes

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

Source: Wexler et al. 1988, 1990.

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 decisionmaking 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 followup, 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 followup 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 next page 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.

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

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).

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 appropri-

ate treatment modality, and maximizing success by providing needed aftercare (Burdon et al. 2001). More detailed information on sex offenders is in chapter 5, Major Treatment Issues and Approaches.

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

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 followup interviews, many of the successful program participants mentioned that lifers had been important influences in their recovery (Wexler et al. 1999*a*).

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 previous page) is an example of a treatment approach that can be beneficial to both the aging prison population and its younger peers.

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. TIP 12, *Combining Substance Abuse Treatment With Intermediate Sanctions for Adults in the Criminal Justice System* (CSAT 1994*a*), gives a more detailed overview of sanctions and their effective use.

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. The panel believes that 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.

Disincentives for Inmate Participation

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

- *Increased surveillance on the job and in the treatment program.* This includes the justification for increased urinalysis during treatment and posttreatment 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.

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.

- *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. The consensus panel encourages treatment providers 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

The panel stresses that 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.

Criminal justice personnel should understand the dynamics of substance abuse treatment and its potential to reduce recidivism and relapse.

Further information on gender training is in chapter 6. Two forthcoming TIPs will also provide detailed information on gender training, *Substance Abuse Treatment and Men's Issues* (CSAT in development *f*) and *Substance Abuse Treatment: Addressing the Specific Needs of Women* (CSAT in development *g*).

Recommendations and Further Research

The following are the consensus panel's 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. The consensus panel believes 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 postprison 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.