Substance Abuse Treatment
For Adults in the Criminal Justice System

A Treatment Improvement Protocol

TIP 44

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Treatment
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Roger H. Peters, Ph.D.
Consensus Panel Co-Chair

Harry K. Wexler, Ph.D.
Consensus Panel Co-Chair

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Center for Substance Abuse Treatment

1 Choke Cherry Road
Rockville, MD 20857

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Practice Improvement Branch, Division of Services Improvement, Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, 1 Choke Cherry Road, Rockville, MD 20857.

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What Is a TIP?

Treatment Improvement Protocols (TIPs), developed by the Center for Substance Abuse Treatment (CSAT), part of the Substance Abuse and Mental Health Services Administration (SAMHSA) within the U.S. Department of Health and Human Services (DHHS), are best-practice guidelines for the treatment of substance use disorders. CSAT draws on the experience and knowledge of clinical, research, and administrative experts to produce the TIPs, which are distributed to facilities and individuals across the country. The audience for the TIPs is expanding beyond public and private treatment facilities to include practitioners in mental health, criminal justice, primary care, and other healthcare and social service settings.

CSAT's Knowledge Application Program (KAP) expert panel, a distinguished group of experts on substance use disorders and professionals in such related fields as primary care, mental health, and social services, works with the State Alcohol and Drug Abuse Directors to generate topics for the TIPs. Topics are based on the field's current needs for information and guidance.

After selecting a topic, CSAT invites staff from pertinent Federal agencies and national organizations to be members of a resource panel that recommends specific areas of focus as well as resources that should be considered in developing the content for the TIP. These recommendations are communicated to a consensus panel composed of experts on the topic who have been nominated by their peers. This consensus panel participates in a series of discussions. The information and recommendations on which they reach consensus form the foundation of the TIP. The members of each consensus panel represent substance abuse treatment programs, hospitals, community health centers, counseling programs, criminal justice and child welfare agencies, and private practitioners. A panel chair (or co-chairs) ensures that the contents of the TIP mirror the results of the group's collaboration.

A large and diverse group of experts closely reviews the draft document. Once the changes recommended by these field reviewers have been incor-

porated, the TIP is prepared for publication, in print and online. The TIPs can be accessed via the Internet at www.kap.samhsa.gov. The online TIPs are consistently updated and provide the field with state-of-the-art information.

While each TIP strives to include an evidence base for the practices it recommends, CSAT recognizes that the field of substance abuse treatment is evolving, and research frequently lags behind the innovations pioneered in the field. A major goal of each TIP is to convey "front-line" information quickly but responsibly. For this reason, recommendations proffered in the TIP are attributed to either Panelists' clinical experience or the literature. If research supports a particular approach, citations are provided.

This TIP, *Substance Abuse Treatment for Adults in the Criminal Justice System*, revises and supersedes TIP 7, *Screening and Assessment for Alcohol and Other Drug Abuse Among Adults in the Criminal Justice System*, TIP 12, *Combining Substance Abuse Treatment With Intermediate Sanctions for Adults in the Criminal Justice System*, and TIP 17, *Planning for Alcohol and Other Drug Abuse Treatment for Adults in the Criminal Justice System*. The revised TIP provides the current clinical evidence-based guidelines, tools, and resources necessary to help substance abuse counselors treat clients involved with the criminal justice system.

Consensus Panel

Co-Chair

Roger H. Peters, Ph.D.
Professor
Department of Law and Mental Health
Florida Mental Health Institute
University of South Florida
Tampa, Florida

Co-Chair

Harry K. Wexler, Ph.D.
Senior Principal Investigator
National Development and Research Institute, Inc.
New York, New York

Workgroup Leaders

Steven R. Belenko, Ph.D.
National Center on Addiction and Substance Abuse
Columbia University
New York, New York

Nahama Broner, Ph.D.
Senior Research Psychologist
Center for Crime, Violence and Justice Research
New York, New York

Christopher J. Geiger
Vice President/Director of Criminal Justice Programs
Walden House, Inc.
San Francisco, California

Kevin Knight, Ph.D.
Research Scientist
Texas Christian University
Fort Worth, Texas

Michael D. Link, M.C.J.
Chief
Division of Treatment and Planning
Ohio Department of Alcohol and Drug Addiction Services
Columbus, Ohio

Henry Jay Richards, Ph.D.
Associate Professor
University of Washington
Seattle, Washington

Sally J. Stevens, Ph.D.
Research Professor
Social and Behavioral Sciences
Southwest Institute for Research on Women
University of Arizona
Tucson, Arizona

Panelists

Elaine Abraham
Program Developer/Consultant
National Development and Research, Inc.
Chula Vista, California

E. Bernard Anderson, Jr., M.S., M.A., NCAC, ICADC, CCS
Regional Administrator
Correctional Treatment
Florida Addictions and Correctional Treatment Services, Inc.
Tallahassee, Florida

Annabelle Casas-Mendoza, M.A.
Family Treatment Drug Court
65th District Court
El Paso, Texas

Deion Cash
Executive Director
Community Treatment & Correction Center, Inc.
Canton, Ohio

Kimberly S. Hee, M.A.
Grants Program Specialist
Office of the Mayor
Criminal Justice Planning
Los Angeles, California

Mack Jenkins, B.A.
Division Director
Adult Court Services
Orange County Probation Department
Santa Ana, California

Carl G. Leukefeld, D.S.W.
Director
Center on Drug and Alcohol Research
University of Kentucky
Lexington, Kentucky

Erik J. Roskes, M.D.
Director
Forensic Treatment and Correctional Services
School of Medicine
Springfield Hospital Center
Sykesville, Maryland

KAP Expert Panel and Federal Government Participants

Barry S. Brown, Ph.D.
Adjunct Professor
University of North Carolina at Wilmington
Carolina Beach, North Carolina

Jacqueline Butler, M.S.W., LISW, LPCC, CCDC III, CJS
Professor of Clinical Psychiatry
College of Medicine
University of Cincinnati
Cincinnati, Ohio

Deion Cash
Executive Director
Community Treatment and Correction Center, Inc.
Canton, Ohio

Debra A. Claymore, M.Ed.Adm.
Owner/Chief Executive Officer
WC Consulting, LLC
Loveland, Colorado

Carlo C. DiClemente, Ph.D.
Chair
Department of Psychology
University of Maryland Baltimore County
Baltimore, Maryland

Catherine E. Dube, Ed.D.
Independent Consultant
Brown University
Providence, Rhode Island

Jerry P. Flanzer, D.S.W., LCSW, CAC
Chief, Services
Division of Clinical and Services Research
National Institute on Drug Abuse
Bethesda, Maryland

Michael Galer, D.B.A.
Chairman of the Graduate School of Business
University of Phoenix—Greater Boston Campus
Braintree, Massachusetts

Renata J. Henry, M.Ed.
Director
Division of Alcoholism, Drug Abuse, and Mental Health
Delaware Department of Health and Social Services
New Castle, Delaware

Joel Hochberg, M.A.
President
Asher & Partners
Los Angeles, California

Jack Hollis, Ph.D.
Associate Director
Center for Health Research
Kaiser Permanente
Portland, Oregon

Mary Beth Johnson, M.S.W.
Director
Addiction Technology Transfer Center
University of Missouri—Kansas City
Kansas City, Missouri

Eduardo Lopez, B.S.
Executive Producer
EVS Communications
Washington, DC

Holly A. Massett, Ph.D.
Academy for Educational Development
Washington, DC

Diane Miller
Chief
Scientific Communications Branch
National Institute on Alcohol Abuse
and Alcoholism
Bethesda, Maryland

Harry B. Montoya, M.A.
President/Chief Executive Officer
Hands Across Cultures
Espanola, New Mexico

Richard K. Ries, M.D.
Director/Professor
Outpatient Mental Health Services
Dual Disorder Programs
Seattle, Washington

Gloria M. Rodriguez, D.S.W.
Research Scientist
Division of Addiction Services
NJ Department of Health and Senior Services
Trenton, New Jersey

Everett Rogers, Ph.D.
Center for Communications Programs
Johns Hopkins University
Baltimore, Maryland

Jean R. Slutsky, P.A., M.S.P.H.
Senior Health Policy Analyst
Agency for Healthcare Research & Quality
Rockville, Maryland

Nedra Klein Weinreich, M.S.
President
Weinreich Communications
Canoga Park, California

Clarissa Wittenberg
Director
Office of Communications and
Public Liaison
National Institute of Mental Health
Kensington, Maryland

Consulting Members

Paul Purnell, M.A.
Social Solutions, L.L.C.
Potomac, Maryland

Scott Ratzan, M.D., M.P.A., M.A.
Academy for Educational Development
Washington, DC

Thomas W. Valente, Ph.D.
Director, Master of Public Health Program
Department of Preventive
Medicine
School of Medicine
University of Southern California
Alhambra, California

Patricia A. Wright, Ed.D.
Independent Consultant
Baltimore, Maryland

Foreword

The Treatment Improvement Protocol (TIP) series supports SAMHSA's mission of building resilience and facilitating recovery for people with or at risk for mental or substance use disorders by providing best-practices guidance to clinicians, program administrators, and payors to improve the quality and effectiveness of service delivery, and, thereby promote recovery. TIPs are the result of careful consideration of all relevant clinical and health services research findings, demonstration experience, and implementation requirements. A panel of non-Federal clinical researchers, clinicians, program administrators, and client advocates debates and discusses its particular areas of expertise until it reaches a consensus on best practices. This panel's work is then reviewed and critiqued by field reviewers.

The talent, dedication, and hard work that TIPs panelists and reviewers bring to this highly participatory process have helped to bridge the gap between the promise of research and the needs of practicing clinicians and administrators to serve, in the most scientifically sound and effective ways, people who abuse substances. We are grateful to all who have joined with us to contribute to advances in the substance abuse treatment field.

Charles G. Curie, M.A., A.C.S.W.
Administrator
Substance Abuse and Mental Health Services Administration

H. Westley Clark, M.D., J.D., M.P.H., CAS, FASAM
Director
Center for Substance Abuse Treatment
Substance Abuse and Mental Health Services Administration

Executive Summary

For men and women whose struggle with substance abuse brings them into contact with the legal system, the personal losses can be enormous: families can break apart, health deteriorates, freedom is restricted, and far too often, lives are lost. But this is just the beginning of the potential devastation. Personal costs to the victims of crime are immeasurable. The effects of every theft, burglary, and violent crime reverberate throughout the whole community. Economic losses include the costs of arresting, processing, and incarcerating offenders, as well as the costs of police protection, increased insurance rates, and property losses.

Strong empirical evidence over the past few decades consistently has shown that substance abuse treatment reduces crime. For many people in need of alcohol and drug treatment, contact with the criminal justice system is their first opportunity for treatment. A substance use disorder may be recognized and diagnosed for the first time, and legal incentives to enter substance abuse treatment sometimes motivate the individual to begin recovery. For other offenders, arrest and incarceration are part of a recurring cycle of drug abuse and crime. Ingrained patterns of maladaptive coping skills, criminal values and beliefs, and a lack of job skills may require a more intensive treatment approach, particularly among offenders with a prolonged history of substance abuse and crime.

This TIP was developed to provide recommendations and best practice guidelines to counselors and administrators based on the research literature and the experience of seasoned treatment professionals. It covers the full range of criminal justice settings and all the phases through which an individual progresses in the criminal justice system. It addresses both clinical and programmatic areas of treatment. The consensus panel defined the areas highlighted below as important in efforts to achieve the treatment objectives of recovery and a life in the community for everyone.

Screening and Assessment

A vital first step in providing substance abuse treatment to people under criminal justice supervision is to identify offenders in need of treatment. In the criminal justice system, screening often is equated with "eligibility," and assessment often is equated with "suitability." To do this effectively, the consensus panel recommends that protocols be developed to determine which offenders need substance abuse treatment, assess the extent of their treatment needs, and ensure that they receive the treatment they need. Obtaining accurate and reliable information during screening and assessment can be a challenge; offenders do not always accurately report drug or alcohol problems. Other collateral sources of information (e.g., drug test results, correctional records) can be combined with self-report information to make referral decisions. For example, in many correctional facilities, urine tests are used to flag the need for treatment—even when an offender denies recent substance abuse.

Many offenders who abuse substances have co-occurring mental disorders that can make treatment more complex. They should therefore be screened for other psychological or emotional problems. Offenders who are initially assessed as having symptoms of co-occurring disorders should be evaluated over an extended period of time to determine whether these symptoms resolve in the absence of substance use.

A significant number of offenders who abuse substances also have histories of trauma and physical or sexual abuse. Screening and assessment of a history of physical and sexual abuse should be conducted routinely, particularly in settings that include female offenders. Staff training is needed to develop effective interviewing approaches related to the history of abuse, counseling approaches for addressing abuse and trauma issues, and in making referrals to mental health services.

Triage and Placement in Treatment Services

Information obtained in screening and assessment is used to place offenders in the treatment program that is best suited to their needs. More offenders can receive appropriate treatment if a range of substance abuse treatment options is provided in criminal justice settings, particularly in institutions and community settings where offenders are supervised for long periods of time. In addition to key information regarding substance abuse problems, risk for criminal recidivism, and mental health problems, triage and placement decisions also should consider the offender's motivation and readiness for change, the length of sentence or incarceration, history of previous treatment, violence potential, and other related security or management issues. The consensus panel recommends that in general, offenders who have moderate-to-high levels of substance abuse problems and criminal risk should be prioritized for placement in substance abuse treatment services, rather than in other types of institutional programs.

Treatment Planning

After placement, a treatment plan is developed that specifies which services the offender-client needs, at what level of intensity, and which of the available resources (e.g., personal, program-based, or criminal justice) will be most beneficial. The treatment plan takes into consideration the severity of substance abuse-related problems and the presence of co-occurring mental disorders because these influence the treatment approach. Also important are factors such as criminal attitudes and psychopathy, which may suggest persistent criminality unrelated to the need to maintain a drug habit. The degree to which an individual is motivated and ready for change is another critical factor that will determine whether motivational enhancement interventions, sanctions, or more self-directed treatments are appropriate. Finally, personal strengths are taken into

account in planning. The offender should be involved in the treatment planning process.

The most effective treatment programs have the resources necessary for comprehensive assessment and treatment planning activities including adequate staffing, clerical support, and access to computers and management information systems that contain information regarding the offender. Mechanisms for sharing information among agencies will expedite treatment as clients move through the criminal justice system. For example, monitoring, consultation, and written agreements are needed to define the types of information that will be shared, with whom, and under what circumstances. Procedures that ensure the smooth and timely flow of relevant information will enable staff to proceed with treatment without interruption. Effective management information systems allow for access to clinical information as well as other offender data. At the same time, however, confidentiality regulations require that clinical information be maintained separately from the corrections or supervision case files, and access to clinical files be restricted to staff who have primary clinical responsibilities.

Major Treatment Issues and Approaches

Clients under criminal justice supervision share many of the same clinical issues faced by others receiving substance abuse treatment, but some are unique. For example, many offenders have problems with the very issues that brought them to the attention of law enforcement, particularly, criminal thinking and values. These clients often have problems dealing with anger and hostility and have the stigma of being criminals, along with the guilt and shame that accompany this stigma. Their identity as criminals may need to be offset by exposure to more prosocial values and identities such as those of family member and wage earner.

Adapting Offender Treatment for Specific Populations

General clinical strategies for working with offender-clients include interventions to address criminal thinking and to provide basic problemsolving skills; however, substance abuse treatment approaches should be modified to meet specific client needs. Because of their histories or life experiences, certain populations are recognized as having somewhat different treatment needs. For example, people from cultural minorities have had different stresses from those in the majority culture. Women are more likely to have been traumatized by physical and sexual abuse than men and to have urgent concerns about their children. Offenders with co-occurring substance use and mental disorders need help that integrates treatment for both. Other groups with specific needs include older adults, violent offenders, people with disabilities, and sex offenders.

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, problemsolving, 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.

Key Issues Related to Program Development

Offender-clients will best be served by substance abuse treatment and criminal justice systems that are working together to help them in recovery and in becoming law-abiding citizens. This requires leaders in both systems who promote their mutual goals, endorsement for mutual goals from leaders, clarification of the goals, and recruitment of stakeholders in pursuit of the goals. The challenge for substance abuse treatment practitioners and criminal justice professionals is to work together to provide a coordinated response to ensure that offenders' needs are addressed while protecting public safety.

1 Introduction

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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])

Overview

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 followup 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.

In response to research demonstrating the success of treatment in reducing criminal activity as well as the cost benefits of such treatment, policymakers over the past two decades have implemented a wide variety of strategies at the Federal, State, and local levels. These initiatives are aimed at improving the availability and quality of treatment for offenders. Drug Courts—courts with special unified dockets for individuals charged with crimes who are drug or alcohol involved—serve to divert offenders with substance use disorders away from the criminal justice system into a supervised treatment plan or to incorporate a coerced treatment plan as part of a judicial sentence. Other programs have been established for people with special needs, including individuals with co-occurring mental disorders. At the same time, other initiatives have increased funding for people already in prisons and jails. Examples of such initiatives include

- Project REFORM and later Project RECOVERY. These programs, funded in the late 1980s by the Bureau of Justice Assistance (BJA) and in the early 1990s by CSAT, provided technical assistance to 20 States in planning and developing substance abuse programming for prisoners with substance abuse problems (Wexler 1995).
- Residential Substance Abuse Treatment for State Prisoners Formula Grant Program. This program funds States seeking to develop comprehensive approaches to treatment for offenders who abuse substances, including intensive programs for inmates and relapse prevention training. Further information is available at www.cfda.gov.
- The National Drug Control Strategy, prepared annually by the Office of National Drug Control Policy (1997, 1998, 1999, 2000, 2001). This program has encouraged the development of treatment and rehabilitation services for offenders who use drugs (e.g., Treatment Accountability for Safer Communities, formerly Treatment Alternatives to Street Crime; drug court programs; prison treatment programs). For further information, go to www.whitehousedrugpolicy.gov/.
- The BJA, Office of Justice Programs, U.S. Department of Justice. Formerly known as the Drug Courts Program Office, established to administer the drug court grant program, the BJA provides financial and technical assistance, training, and programmatic guidance for drug courts throughout the country. BJA offers grants that enable communities to develop, implement, or improve drug courts. Information is available at www.ojp.usdoj.gov/BJA/.
- The Serious and Violent Offender Reentry Initiative. In conjunction with several Federal partners, the U.S. Department of Justice is spearheading this initiative to

provide funding to promote successful reintegration of serious, high-risk offenders into the community. The Initiative seeks to address all obstacles to successful reentry, including substance abuse. Information is available online at www.ojp.usdoj.gov/reentry/learn.html.

In part because of initiatives such as these, the availability of substance abuse treatment for criminal offenders is on the rise. After 3 years of decline in the mid-1990s, the number of inmates in drug treatment programs began rising again in 1997 and 1998 (Corrections Yearbook 1998). A report based on a 1997 nationwide survey of Federal and State correctional facilities (Office of Applied Studies 2000) indicates that 93.8 percent of Federal prisons and 56.3 percent of State prisons provide some form of substance abuse treatment.

Although an increasing number of prisons offer some form of treatment, the actual number of programs and slots remains limited (National Center on Addiction and Substance Abuse at Columbia University 1998; Peters and Matthews 2002). For example, although more than half of prison inmates have a lifetime prevalence of drug use disorders (Peters et al. 1998), fewer than 15 percent of inmates receive substance abuse treatment services while in prison (Mumola 1999; Simpson et al. 1999*b*). Moreover, while the number of substance abuse programs for offenders is on the rise, so too is the number of offenders in need of services. Substance abuse treatment services for offenders have not kept pace with the growing need for these services (Belenko and Peugh 1998; Simpson et al. 1999*b*).

This TIP highlights some of the best practices and innovative programs created to treat offenders. It describes the unique needs of offenders with substance abuse and dependence disorders. Finally, it addresses the challenges counselors and criminal justice personnel are likely to face at every stage of the criminal justice continuum.

The Purpose of This TIP

This TIP updates and combines three TIPs originally published in 1994 and 1995: TIP 7, *Screening and Assessment for Alcohol and Other Drug Abuse Among Adults in the Criminal Justice System* (CSAT 1994*d*); TIP 12, *Combining Substance Abuse Treatment With Intermediate Sanctions for Adults in the Criminal Justice System* (CSAT 1994*a*); and TIP 17, *Planning for Alcohol and Other Drug Abuse Treatment for Adults in the Criminal Justice System* (CSAT 1995*b*).

One consistent research finding is that involvement in substance abuse treatment reduces recidivism for offenders who use drugs.

The new TIP presents clinical guidelines to assist counselors in dealing with problems that routinely arise because of their clients' status in the criminal justice system. These clients have multiple needs; they often have poor health, have histories of trauma, lack job and communication skills, and have educational deficits. A special feature throughout the TIP—"Advice to the Counselor"—provides the TIP's most direct and accessible guidance for the counselor. Readers with basic backgrounds, such as addiction counselors or other practitioners, can study these boxes first for the most immediate practical guidance. In particular, the Advice to the Counselor boxes provide a distillation of what the counselor needs to know and what steps to take, which can be followed by a more detailed reading of the relevant material in the section or chapter.

The events of September 11, 2001, dramatically altered the political climate of our Nation and caused a shift in focus from the "tough on drugs" policies previously in place

to the war on terrorism. These changes have impacted both the sanctions against people in the criminal justice system and the availability of substance abuse treatment for those populations. While it is beyond the scope of this TIP to address the implications of these shifts or to predict their ultimate outcomes, the core content of this document reflects the current best practices for providing substance abuse treatment for adults in the criminal justice system.

This TIP aims to provide tools and resources to increase the availability and improve the quality of substance abuse treatment to criminal justice clients. It should assist the criminal justice system in meeting the challenges of working with offenders with substance use disorders and encourage the implementation of evidence-based clinical approaches to treatment.

Other guiding principles of this publication are to

- Provide the relevant information that will inform and enable treatment providers to feel more confident in their approach to offender and ex-offender populations.
- Help people in community treatment understand the criminal justice system and how it works in step with their treatment services.
- Encourage collaboration between the criminal justice and treatment communities.
- Help readers understand the multiple perspectives that often lead to confusion and misunderstandings—public safety versus public health, treatment versus corrections, differing client needs, issues of culture and society, and local characteristics of the criminal justice system.
- Provide practical solutions and approaches to complex problems.

Key Definitions

In this TIP, the term "substance abuse" is used to denote both *substance abuse* and *substance dependence* as they are defined by the *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition, Text Revision (DSM-IV-TR) (American Psychiatric Association 2000). This term was chosen partly because substance abuse treatment professionals commonly use the term "substance abuse" to describe any excessive use of addictive substances. Readers should attend to the context in which the term occurs to determine the possible range of meanings it covers; in most cases, however, the term will refer to all varieties of substance use disorders described by DSM-IV-TR.

According to DSM-IV-TR, *substance abuse* is a maladaptive pattern of substance use marked by recurrent and significant negative consequences related to the repeated use of substances. *Substance dependence* is defined as a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual is continuing use of the substance despite significant substance-related problems. A person experiencing substance dependence shows "a pattern of repeated self-administration that usually results in tolerance, withdrawal, and compulsive drug-taking behavior" (p. 192). A diagnosis of substance dependence can be applied to every class of substances except caffeine.

Treatment is defined according to the Institute of Medicine (IOM 1990), as cited in CSAT's National Treatment Plan Initiative (CSAT 2000*a*, *b*):

> Treatment refers to the broad range of [primary and supportive] services—including identification, brief intervention, assessment, diagnosis, counseling, medical services, psychiatric services, psychological services, social services, and followup—provided for people with alcohol [and/or drug] problems. The overall goal of treatment is to reduce or eliminate the use of alcohol [and/or drugs] as a contributing factor to physical, psychological, and social dysfunction and to arrest,

retard, or reverse the progress of any associated problems (CSAT 2000*a*, p. 7).

The *criminal justice system,* as discussed in this TIP, includes four subsystems: pretrial and diversion settings, jails and detention centers, prisons (State and Federal), and community supervision settings. Definitions of other terms relevant to criminal justice and substance abuse treatment are given in appendix B, Glossary.

For the purposes of this TIP, an *offender* is a person who has been arrested, charged with a crime, or convicted of a crime and under the supervision of the criminal justice system.

Audience for This TIP

This TIP is written primarily for substance abuse counselors and clinicians who treat clients involved in the criminal justice system or who are under full or partial supervision and for administrators whose programs serve clients under criminal justice supervision. It also will be useful for counselors who work in correctional institutions and those in community agencies with clients on probation, parole, or pretrial release.

Others who work in the criminal justice system may also find this TIP helpful. This includes judges and prosecutors; probation and parole officers, case managers, public defenders and other criminal defense attorneys; jail, detention center, and prison personnel; and people working in pretrial/diversion and in probation and parole settings.

Program developers and grant writers will find that this TIP provides information about a variety of programs and resources. Finally, this TIP is of value to anyone concerned with reducing overcrowding in correctional facilities, addressing the crimes committed by untreated drug-involved offenders, and meeting the challenges that these offenders face on their journey toward recovery.

Contents of This TIP

The chapters that follow will focus on the following areas:

- Chapter 2 focuses on screening and assessment of criminal justice clients in the relevant domains. It includes a discussion of special concerns (e.g., gender and sexual orientation, literacy, a client's primary language, and learning disabilities) and specific populations. See also appendix C, which contains more information on screening and assessment instruments.
- Although it is recognized that treatment can be effective, it is also clear that different treatment approaches may work better with some clients than with others. Chapter 3 discusses triage and placement in treatment services and reviews the complex area of treatment matching.
- Chapter 4 discusses the available treatment options in the criminal justice system. It also presents guidelines for developing treatment plans.
- Chapter 5 addresses the major treatment issues for offenders who use substances. These include a wide range of themes, including engagement and retention, stigma and shame, the client–counselor relationship, and major treatment levels (e.g., residential, nonresidential, outpatient, community supervised, and self-help and other ancillary services).

This TIP aims to provide tools and resources to increase the availability and improve the quality of substance abuse treatment to criminal justice clients.

- Chapter 6 describes treatment issues and approaches for special populations for whom modifications in treatment may be appropriate: people of ethnic and racial minorities, women, violent offenders, people with disabilities, older inmates, people with co-occurring substance use and mental disorders, and sex offenders, among others.
- Chapters 7 through 10 describe the specific treatment needs and strategies for individuals in particular criminal justice settings. Chapter 7 addresses treatment provided in diversion and other pretrial settings. Chapter 8 provides a detailed discussion of treatment for offenders in jails and detention centers, while chapter 9 focuses on offenders in prison. Chapter 10 outlines treatment for people under community supervision.
- Finally, chapter 11 discusses the issues related to program development.

2 Screening and Assessment

In This Chapter...

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Screening Guidelines

Assessment Guidelines

Key Issues Related to Screening and Assessment

Areas To Address in Screening and Assessment

Selection and Implementation of Instruments

Screening and Assessment Considerations for Specific Populations

Integrated Screening and Assessment—Sample Approaches

Conclusions and Recommendations

Overview

Screening and in-depth assessment are important first steps in the substance abuse treatment process; currently no comprehensive national guidelines for screening and assessment approaches exist in the criminal justice system. In the absence of such guidelines, information in this chapter can help clinicians and counselors develop effective screening and referral protocols that will enable them to

- Screen out offenders who do not need substance abuse treatment.
- Assess the extent of offenders' treatment needs in order to make appropriate referrals.
- Ensure that offenders receive the treatment that they need, rather than being released into the community with a high probability of re-offending.

This chapter addresses the issues relevant to screening and assessment and makes recommendations for the appropriate use of screening and assessment tools in specific settings. For information on how to use screening and assessment to match the offender to services and to identify an appropriate treatment plan, see chapters 3 and 4. For more information on specific screening and assessment instruments see appendix C.

Definitions of Terms

Information gathered during screening and assessment plays an important role in identifying offender needs and making appropriate referrals for services. Throughout this TIP, the following definitions are used for screening, assessment, and related terms in the criminal justice setting:

- *Screening*—A process for evaluating someone for the possible presence of a particular problem. The screening process does not necessarily identify what kind of problem the person might have or how serious it might be but determines whether or not further assessment is warranted. Screening does not typically include assignment of DSM-

IV-TR (*Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition, Text Revision [American Psychiatric Association {APA} 2000]) diagnoses of alcohol or drug abuse or dependence and may only identify DSM-related problem areas. During the screening process staff members use instruments that are limited in focus, simple in format, quick to administer, and usually able to be administered by nonprofessional staff. There are seldom any legal or professional restraints on who can be trained to conduct a screening.

- *Assessment*—A process for defining the nature of a problem and developing specific treatment recommendations for addressing the problem. A basic *assessment* consists of gathering key information and engaging in a process with the client that enables the counselor to understand the client's readiness for change, problem areas, any diagnosis(es), disabilities, and strengths. The assessment process typically requires trained professionals to administer and interpret results, based on their experience and training. A clinical diagnosis has important legal ramifications since judges tend to rely on assessments to identify an offender's needs and risks, and to determine the offender's disposition.

In correctional settings, "screening" and "assessment" are equated with "eligibility" and "suitability," respectively. "Eligibility" is determined in pretrial and jail settings by screening for offenders who may need substance abuse treatment. "Suitability" for placement in one of several different levels of treatment services is determined by an assessment to help identify key psychosocial problems related to referral to treatment and/or supervision. Accordingly, the following considerations are suggested:

- *Eligibility*—Does the offender meet the system's criteria for receiving treatment services? A quick screen, typically applicable in prisons and community corrections settings, can determine whether a person warrants assessment to determine if that person has a drug or alcohol problem.
- *Suitability*—Is the offender suitable for the type of program services that are available? An assessment can determine whether the offender is capable of benefiting from treatment or responding to a particular intervention. The question of suitability arises once it has been determined that offenders meet the eligibility criteria for receiving services.

In essence, screening and assessment vary based on the goals of the evaluation and the setting where they are used. For drug court and jail settings, a source for operational treatment and criminal justice definitions is the article "Guideline for Drug Courts on

Common Myths About Screening and Assessment

Following are several common myths about substance abuse screening and assessment, and the facts that debunk those myths.

- *Myth:* Screening and assessment are no better than intuition in detecting a person's need for treatment.
- *Fact:* Objective screening and assessment measures can result in treatment that is better targeted to a client's needs, resulting in better outcomes.
- *Myth:* Only a single screening is needed to place people in different levels of treatment services.
- *Fact:* Accurate evaluation requires a battery of assessment instruments that examine how substance use has affected all the domains of the client's life. When treatment options are severely limited, however, a basic screening may be sufficient to determine both eligibility and suitability for treatment.

- *Myth:* Untrained professionals can conduct screening and assessments.
- *Fact:* Although some screenings can be administered and scored without significant training, placement decisions are greatly improved when they are made by professionally trained staff. This includes staff with relevant certification in substance abuse treatment, those with advanced professional degrees, and those with specialized training in the use of particular screening and assessment instruments. For those screening and assessment approaches that require an interview with the offender, specialized training is also needed in basic counseling techniques such as rapport building and reflective listening. Use of trained professional staff in the triage and placement process helps to minimize the number of inappropriate referrals for treatment.
- *Myth:* Screening and assessment are always compromised because you cannot trust self-report information from offenders.
- *Fact:* Research generally validates the reliability, and to some degree, the validity of information obtained through self-reports. Collateral sources such as the offender's family and friends can improve the reliability of the information gathered (or "the full picture"). Offenders do supply a certain amount of misinformation in some settings to avoid unwanted consequences, however.
- *Myth:* All screening and assessment instruments are equally effective.
- *Fact:* Research shows significant variability in the reliability and validity of different instruments with different populations.
- *Myth:* Because an instrument is widely used, it must be effective.
- *Fact:* Many highly marketed and widely used instruments do not have a research base supporting the validity of their use. In fact, some of the widely marketed and used instruments have been shown to be less effective than those available in the public domain.
- *Myth:* Screening and assessment should not examine the history of physical and sexual abuse and related trauma because this may aggravate the offender's level of stress and psychological instability, and staff may not be able to deal effectively with the consequences.
- *Fact:* Screening and assessment of all forms of abuse is essential for both male and female offenders, because it is now recognized that the effects of trauma contribute to many mental disorders. Clinical outcomes are likely to be compromised if these abuse and trauma issues are not explored, and if strategies addressing these issues are not developed and integrated into treatment plans for mental and substance use disorders. However, it is important to emphasize that in screening for a history of trauma it can be damaging to ask the client to describe traumatic events in detail. To screen, it is important to limit questioning to very brief and general questions, such as "Have you ever experienced childhood physical abuse? Sexual abuse? A serious accident? Violence or the threat of it? Have there been experiences in your life that were so traumatic they left you unable to cope with day-to-day life?"

Screening and Assessment" (Peters and Peyton 1998).

Screening Guidelines

This section presents broad guidelines and considerations for developing an effective screening protocol. (See section below for additional guidelines related to assessment protocols.)

More specific guidelines based on the criminal justice setting and the characteristics of the population are discussed in later sections.

When creating a screening protocol, counselors will need to ask the following questions:

- What is the purpose of the screening?
- What screening tools will be used and under what circumstances?

Purpose of Screening

The first issue to consider is the purpose of the screening. In addition to screening for drug use, counselors may consider screening for other problem areas. For example, given that many infectious diseases are associated with the use of drugs (Varghese and Fields 1999), health screening can be important in identifying offenders in need of healthcare services to ensure that clients receive needed medication and to prevent the spread of disease. Screening to identify special needs for offenders with co-occurring mental problems can improve the effectiveness of treatment. It can identify individuals who may pose a threat to themselves or others, prevent crises, and promote immediate intervention. Screening content should identify key issues that need to be addressed in placing offenders in treatment. Content can be specific to several domains, including substance use, criminal, physical health, mental health, and special considerations. Figure 2-1 summarizes the information relevant to each domain.

Screening guidelines will vary by setting. A professional screening of an individual who has just been arrested will include different questions and require different information than a long-term prisoner being considered for parole. For a probationer, screening might be used to determine the appropriate level of supervision; a jail inmate may be screened to assess his or her suitability for treatment. Figure 2-2 (see p. 12) highlights the different screening considerations for each setting.

Selection of Screening Tools

In addition to identifying the purpose of screening, the protocol should also identify the screening tools to be used and the conditions under which they are used. Basic information can be acquired from any number of sources, including

- Booking records
- Self-report/interview information
- Results of instruments and surveys administered
- Past correctional records (presentence investigations)
- Past treatment records
- Police reports
- Correctional staff reports (for bail hearings, early release)
- Prior offense records (for driving under the influence [DUI], possession, trafficking)
- Emergency medical reports
- Drug test results (from examination of hair, sweat, urinalysis, Breathalyzer®)

Some jurisdictions may be required to use a particular instrument or information source to gather information consistently from all offenders, even though corroborative information, such as urine test results, is often available. Such universal screenings can help route nonviolent, low-risk offenders to treatment placements in the community so that recovery can begin. A more detailed discussion of selection of screening instruments is provided later in this chapter.

Assessment Guidelines

The goal of assessment is to gather enough information about clients to describe how the treatment system can address their substance abuse problems and the impact of those problems. An assessment examines how the offender's emotional and physical health, social roles, and employment could be affected by substance abuse (Center for Substance Abuse Treatment [CSAT] 1994*a*). In addition, assessments can help identify the factors that could prompt a return to drug use or criminal behavior. These include lack of social support networks, unstable employment history, poor health, criminality, unresolved legal problems, inadequate housing, lack of motivation to change, a history of physical and sexual abuse, mental illness, learning disabilities, and other social and psychological factors. These factors need to be carefully examined during assessment to plan for potential gaps

Figure 2-1
Screening Guidelines by Domain

Domain	Information
Substance Use	• Substance use history • Motivation and desire for treatment • Severity and frequency of use • Detoxification needs, acute intoxication • Treatment history (e.g., number and type of episodes, outcomes)
Criminal Involvement	• Criminal thinking • Current offense(s) • Prior charges • Prior convictions • Age at first offense • Type of offense(s) • Number of incarcerations • Prior successful completion of probation or parole drug use offenses • Prior involvement in diversionary programs • History of diagnosis of any personality disorder
Health	• Intoxication, infectious disease (tuberculosis, hepatitis, sexually transmitted diseases, HIV status) • Pregnancy • General health • Acute conditions
Mental Health	• Suicidality • History of treatment and prior diagnosis • Past diagnoses • Treatment outcome • Current and past medications • Acute symptoms • Psychopathy
Special Considerations	• Educational level • Reading level/literacy • Language/cultural barriers • Physical disability • Developmental disability • Learning disability • Health and biomedical record • Housing • Dependents/family issues • History of abuse (victim and/or perpetrator), including trauma experienced as a result of physical and sexual abuse

Figure 2-2
Screening Guidelines by Setting

Setting	Purpose	Special Considerations
Jails	• For early identification, if getting out of jail early • To determine eligibility for drug courts and pretrial diversion programs • For diversion to specialized mental health courts or programs focused on behavioral problems • To determine behavioral management problems and acute needs (including crisis intervention) • To identify suitability for placement in jail treatment programs • For classification to different housing units	Look for previous correctional substance abuse treatment, readiness for treatment, past institutional behavior problems, prior correctional treatment, and court orders.
Prisons	• To match time left to serve with time for receiving treatment or for custody level classification • To identify suitability for placement in prison treatment programs	Look at prison record, treatment history (including treatment for issues other than substance abuse), and behavior.
Pretrial and Community Supervision	• To determine the need for housing, transportation, employment, or economic benefits • To identify suitability for placement in community treatment programs • To assess for public safety risk and level of supervision needed, pursuant to consideration for placement in diversion programs	Look for community or corrections records or collateral information (e.g., information from family members).

in services that can affect relapse and criminal recidivism.

While assessments are more comprehensive than screenings, their depth and scope varies across settings according to the following factors:

- Amount of time available to conduct the assessment
- Physical setting of assessment (e.g., holding pen, booking room, medical unit, reception center, lockup, community/corrections office)
- Factors influencing the confidentiality or privacy of the assessment process and the uses of assessment findings
- Availability of qualified staff, caseload volume, and interagency cooperation
- Availability of financial resources (e.g., staffing, type of assessment chosen)
- Availability of treatment options in the community
- Number of sources of information

The instruments and sources of information used during an assessment are determined by the purpose of the assessment. Jurisdictions may elect the quickest and most efficient approach to assess who goes into treatment. In other cases, the court may want the greatest amount of information available about an

offender. In this case, in addition to police, corrections, and medical records, an assessment should include family and other collateral sources for historical information.

The following guidelines pertain to assessment protocols:

- *Purpose*—In pretrial or diversion settings, assess for linkage to the community and placement to different types of services.
- *Content*—In all settings, deepen the information obtained from previous screenings (psychopathy, antisocial).
- *Source*—In pretrial or diversion settings, seek more expansive collateral information from family and social service staff. In jails, prisons, or community supervision settings, correctional officers and/or collateral offenders may be additional sources of information.

Once a screening has identified the need for treatment, assessments should be conducted before offenders are given permanent placements. Assessments feed into treatment planning, decisions about treatment intensity and services needed (e.g., treatment planning and matching), and re-entry and continuing care plans.

Advice to the Counselor: Screening and Assessment

- It is critical to administer screening and assessment instruments in a way that encourages honesty. Offenders often think the results of these screenings will be used against them and may try to skew the results to influence the outcome of a trial.
- The consequences of honest or dishonest responses should be clarified with the offender.
- Counselors should use available collateral information, such as drug testing results, to verify the accuracy of the information.

Key Issues Related to Screening and Assessment

The distinctions between screening and assessment are defined above. This section highlights key issues relevant to both.

Accuracy of Information

Accuracy of screening and assessment information is clearly dependent on the honesty of the offender. It is critical to administer screening and assessment instruments in a way that encourages honest answers. The consequences of honest and dishonest responses should be clarified, and the setting for the screening can be important in this regard (Knight et al. 2002). Some factors that contribute to greater accuracy of responses include using collateral information, using concurrent drug testing, and reviewing with the offender the purposes of information obtained during screening and assessment.

In some contexts (e.g., pretrial and presentence settings), offenders are often concerned that screening and assessment results will be used against them; for example to coerce them into a long-term treatment program. The individual may also want to avoid being labeled as having an addiction problem. Conversely, an offender may purposely try to skew the results to influence the outcome of trial, sentencing, or placement in custody and/or treatment settings. It is important for those administering screening and assessment to recognize the factors that may influence the accurate disclosure of information, and to craft their findings accordingly.

Unless potential concerns related to the screening and assessment process are addressed directly, it is unlikely that screening and assessment results will provide an

accurate picture of the offender's substance abuse problems and treatment needs. Offenders should be briefed in advance regarding who will have access to screening and assessment information and how the information will be used. Counselors and criminal justice professionals should also clearly indicate their own role in the information gathering process. It may also help to address myths regarding court-ordered or other mandated treatment and treatment program requirements, and to describe the benefits of participating in treatment. Counselors working in criminal justice settings should also be aware of issues related to confidentiality and informed consent in the context of screening and assessment (see CSAT 2004 and www.hipaa.samhsa.gov).

Continuity of Information

Screening and assessment are not single events but continuous processes that can be repeated by a variety of professionals in a variety of settings (CSAT 1994*a*). Efforts should be made to ensure the continuity of the information and to preserve the rights of the client. Ongoing communication and data sharing are important aspects of the screening and assessment process. Substance abuse treatment and criminal justice system staff, at all points in the process, need to pass on information obtained from substance abuse screening and assessment. Key information can be summarized and consolidated using a brief format, but this information should be maintained in a case file—even if a client does not go on to criminal prosecution—so that it can be used in case of subsequent arrest. It is helpful to standardize the format used to document screening and assessment information so that staff can be trained to more readily access, interpret, and communicate this information (CSAT 1994*a*).

Effective treatment programs require assessment and coordination between substance abuse treatment and criminal justice programs and an understanding of the goals of both systems. Coordination also leverages the scarce resources for substance abuse treatment (CSAT 1994*a*). To encourage a team approach to treatment, assessment, referral, and case management, the consensus panel recommends that the two systems develop or strengthen arrangements that support linkages at the institutional and procedural levels. In addition, cross-training can promote the use of screening and assessment results and can reduce duplication of efforts (CSAT 1994*a*).

Systemwide Information Sharing

Frequently, those in the criminal justice system who conduct initial substance abuse screening and assessment maintain the information, while others who have contact with the offender later in the course of criminal justice processing have to rescreen or reassess the individual. (See CSAT 2004 and www.hipaa.samhsa.gov for information about confidentiality and certain restrictions regarding sharing of information.) The use of multilevel agreements to share information is one approach that can minimize duplication of screening and assessment activities. One way to achieve this is to convene stakeholder meetings with representatives from all of the involved agencies in the system to develop these agreements. The benefits of multilevel agreements tend to be quite persuasive. Following are two examples:

- Agency A is spending $15 per drug screen in addition to staff time. If that agency works out an implementation plan with Agency B, both agencies can share the information, avoiding the unnecessary costs of duplicating tests.
- Hospitals that have laboratory test results can add them to a database to confirm or refute self-report information.

At each stage of the criminal justice process there can be individuals or agencies that do not support sharing of substance abuse

screening and assessment information. These groups have legitimate concerns that need to be expressed, and they need to be brought into the decisionmaking process as full stakeholders. Jurisdictions that establish interagency agreements can preserve limited staff time and resources and help avoid unexpected resistance to systemwide sharing of screening and assessment information at any stage in the criminal justice process. See the text box below for examples of programs that have developed multilevel agreements for sharing information systemwide.

Examples of Multilevel Agreements for Systemwide Sharing of Information

Developing multilevel agreements is a difficult task and can take years to complete. Large criminal justice systems will clearly benefit from having an intermediary case management or placement system to increase communication and coordination between in-custody programs, community-based providers, and parole offices. Below are several working models of multilevel agreements for systemwide sharing of information.

Lane County, Oregon

Lane County uses client consent and a multilevel agreement between agencies to facilitate sharing of information. In this model, the client and agencies must agree up front if someone wants shared access to information. A correctional/mental health official developed a screening and reporting system where every person in jail is screened for drugs, risk, and mental health with a brief instrument. The screening information is available systemwide (i.e., jail, diversion, and community programs), including a tear-off copy for mental health information (National GAINS Center 2000).

High Intensity Drug Trafficking Areas Automated Tracking System

The University of Maryland developed a nonproprietary Management Information System (MIS) called HATS, the HIDTA [High Intensity Drug Trafficking Areas] Automated Tracking System, that links substance abuse treatment, mental health, juvenile, and community information. HIDTA is a program within the Office of National Drug Control Policy that coordinates drug control efforts in 28 regions around the country. A layered set of informed consent agreements is used to provide different access levels to different stakeholders (e.g., judges, parole, treatment programs). Users gain HATS access by signing an agreement to share any improvements made to the system, to benefit all stakeholders. The MIS is in use from coast to coast as a seamless care screening, assessment, case matching, and monitoring database (Taxman and Sherman 1998). For more information, go to the Washington/Baltimore HIDTA HATS site at www.hidta.org.

Maricopa County, Arizona

Maricopa County has a data-link feed between the jail and behavioral health authority to determine whether offenders entering jail have a previous record of mental health services or substance abuse treatment (National GAINS Center 1999c). (See also chapter 8.)

Examples of Multilevel Agreements for Systemwide Sharing of Information (continued)

Orange County Probation Department

As part of the implementation of Proposition 36, the Orange County (California) Probation Department developed an MIS that links the Drug and Alcohol Division of the County Health Care Agency (HCA) with myriad treatment providers in the county. The law requires that the offender have an assessment and be referred to treatment within 7 days of sentencing. In processing offenders, the Probation Department conducts an initial assessment, while the HCA conducts a clinical assessment to determine the appropriate treatment level. On receiving the case from the court, the Probation Department sends a referral through the system to HCA, who then completes the assessment, selects a provider, and sends a notice through the system to the selected provider. The system then allows the provider to send periodic progress reports to the Probation Department, including when release of information forms have been signed, assessment levels, drug test results, and progress in treatment (Orange County Probation Department 2002).

The Need To Rescreen and Reassess

There are many reasons to rescreen and reassess. Offenders who may fear the consequences of self-disclosing substance abuse problems in one setting (e.g., pretrial detention) may be more open to discussing their need for treatment at a later stage (e.g., community supervision or prison).

Offenders' motivation for treatment may change over time; for example, as they become more familiar with peer mentors, counseling staff, program expectations, and their own self-defeating behaviors from the past. Another example is participants in drug courts who initially appear resistant to treatment during status hearings and who are unresponsive to early efforts by the judge and/or treatment counselors to instill motivation (e.g., through praise, use of sanctions, and engagement in more intensive treatment), but who later surprise program staff by their progress toward recovery over the course of a year or more of program participation. For these individuals, assessment may reflect a gradual process of uncovering reasons to quit their substance use, and identifying strengths that can be built on during treatment. Another key reason for conducting multiple screenings and assessments over time is that previous information obtained may become outdated and may not include recent events that are relevant to treatment, such as relapse episodes, undetected mental disorders, or domestic violence.

Advice to the Counselor: The Need To Rescreen

- An offender's motivation and willingness to enter treatment may change over time. Those who fear the consequences of self-disclosing substance abuse in a pretrial setting may be more open to discussing their need for treatment while under community supervision or in prison. Others who initially appear resistant to treatment may later surprise program staff by their progress toward recovery.
- Multiple assessments may uncover an offender's reason to quit substance use and identify strengths that can be built on during treatment.

Timing of Screening and Assessment

In some criminal justice settings only a single screening is needed, due to limited treatment options available or to the fact that assessment will be provided at a later stage. This screening is typically focused on issues related to eligibility criteria and suitability for treatment. In cases in which several treatment options and sufficient time are available, screening is often followed by a more comprehensive assessment.

Although screening is usually conducted as early as possible after the offender's entrance into the criminal justice system, assessment may be delayed due to the offender's sentence length, anticipated date of enrollment in substance abuse treatment services, and other factors. For example, most prison treatment programs provide services for inmates who are serving the last 24 months of their sentence, and routinely wait to provide a comprehensive assessment until the inmate is nearing the enrollment date for treatment services.

When Is a Formal Diagnosis Necessary?

When identified with a diagnosis that will follow them throughout the system or even their lifetime (if entered into the criminal justice system's computer), people sometimes feel labeled and stigmatized. This is particularly true of diagnoses related to mental disorders. Because symptoms of mental disorders are often mimicked by recent drug or alcohol use, or withdrawal from these substances, it is particularly important to defer diagnosis until an adequate assessment period is provided under conditions of abstinence. A "people first" description such as "offender who uses drugs" is preferable to the label "drug user." Moreover, diagnostic classification can sometimes preclude offenders from receiving needed services. For example, a mental disorder diagnosis can preclude access to substance abuse services. Likewise, a substance abuse diagnosis can preclude access to mental health services, resulting in no services being rendered. A substance abuse diagnosis can also limit an offender's access to certain work assignments or vocational training.

To avoid these problems, formal diagnoses should be made based on sound clinical practice. A formal diagnosis may be required when

- Reimbursement for services requires it (e.g., Medicaid or Medicare reimbursement is not possible without a DSM-IV-TR code).
- Pharmacological intervention is suggested (e.g., methadone, Antabuse).
- Potential psychiatric concerns emerge (e.g., when the counselor is trying to rule out substance abuse or when symptoms may be drug-induced, organic, or psychiatric).
- The counselor needs to clarify co-occurring disorders that affect treatment decisions.
- The information is for research or evaluation purposes.

Drug Testing

Drug testing is frequently used as a screening device in community-based and institutional settings. For example, in pretrial settings drug testing is used to identify and monitor drug use and to reduce the number of rearrests among defendants (Bureau of Justice Assistance 1999). A major objective of pretrial drug testing is to offer courts alternatives to either detention or unsupervised release during the pretrial period. In community settings drug testing provides a powerful tool for treatment staff, the courts, and community supervision staff to monitor and address relapse episodes and treatment progress. In institutional settings, drug testing is helpful in monitoring abstinence and can serve as an "early warning" device in detecting problems among therapeutic residential programs. In all settings, drug testing serves both as a deterrent to use and as a strong incentive for offenders to remain abstinent.

Because of advancements in drug testing technologies, drug testing can easily be incorporated into the pretrial risk assessment process. For instance, using hand-held devices, commercial laboratories can conduct analyses of urine, perspiration, and hair to identify the presence of a variety of drugs. Pretrial screening for five drugs can cost anywhere from $5 to $120 (Henry and Clark 1999). However, protocols for collecting, testing, and disposing of specimens must be carefully observed to preserve the chain of evidence in the pretrial setting. Counselors should ensure that the rights of detainees and offenders are not violated (see chapter 7).

Areas To Address in Screening and Assessment

This section describes the key areas that the consensus panel felt were important for effective screening and assessment.

Substance Abuse History

Key areas addressed during substance abuse screening and assessment are reviewed in several published TIPs, including numbers 7, *Screening and Assessment for Alcohol and Other Drug Abuse Among Adults in the Criminal Justice System* (CSAT 1994*d*); 11, *Simple Screening Instruments for Outreach for Alcohol and Other Drug Abuse and Infectious Diseases* (CSAT 1994*e*); 31, *Screening and Assessing Adolescents for Substance Use Disorders* (CSAT 1999*c*); and 42, *Substance Abuse Treatment for Persons With Co-Occurring Disorders* (CSAT 2005*c*). Major topics covered during screening and assessment include observable signs and symptoms of alcohol or drug use, signs of acute drug or alcohol intoxication and withdrawal effects, drug tolerance effects, negative consequences associated with substance abuse, the self-reported history of substance abuse, age and pattern of first substance abuse, recent patterns of use, drug(s) of choice, and motivation for using substances. A full examination is made of the prior involvement in treatment, both in criminal justice and non–criminal-justice settings. Family history of substance abuse is also important, including current patterns of abuse by family members who have contact with the offender.

Screening instruments

The effectiveness of substance abuse assessment and screening instruments may vary according to the criminal justice setting and the goals of gathering information in that setting. For example, in one study (Peters et al. 2000), eight different substance abuse screening instruments were examined for use among male prisoners. Each of the instruments was found to have adequate test–retest reliability (the extent to which the scores are the same on two administrations of the instrument with the same people), although the validity of the instruments varied, as described later in this section. The screening instruments examined in the study included the following:

- Alcohol Dependence Scale (ADS)
- Addiction Severity Index (ASI)–Alcohol Use subscale (ASI-Alcohol)
- ASI–Drug Use subscale (ASI-Drug)
- Drug Abuse Screening Test (DAST-20)
- Michigan Alcoholism Screening Test (MAST short version)
- Substance Abuse Subtle Screening Inventory-2 (SASSI-2)
- Simple Screening Instrument for Substance Abuse (SSI-SA)
- TCU Drug Screen (TCUDS) (Knight et al. 2002)

However, these instruments varied considerably in sensitivity, specificity, and positive predictive value with different subpopulations (see appendix B for definitions of terms). For example, the SASSI-2 had significantly lower positive predictive value for African Americans than for Caucasians and Hispanics/Latinos (Peters et al. 2000). Figure 2-3 lists

Figure 2-3
Recommended Substance Abuse Screening Instruments

Instrument	Purpose	Description
Alcohol Dependence Scale (ADS)	A 25-item instrument developed to screen for alcohol dependence symptoms; performs adequately in community and institutional settings	The ADS (Skinner and Horn 1984) can be coupled with the ASI-Drug Use section to provide an effective screen for alcohol and drug use problems among offenders. For more information on the ADS, contact the Center for Addiction and Mental Health (formerly the Addiction Research Foundation) at (800) 661-1111. The ASI is reprinted in TIP 7, *Screening and Assessment for Alcohol and Other Drug Abuse Among Adults in the Criminal Justice System* (CSAT 1994*e*).
Simple Screening Instrument for Substance Abuse (SSI-SA)	A 16-item screening instrument that examines symptoms of both alcohol and drug dependence	An expert panel developed the SSI-SA as a tool for outreach workers. The SSI-SA, which can be administered without training, includes items related to alcohol and drug use, preoccupation and loss of control, adverse consequences of use, problem recognition, and tolerance and withdrawal effects. The SSI-SA is fully described in TIP 11, *Simple Screening Instruments for Outreach for Alcohol and Other Drug Abuse and Infectious Diseases* (CSAT 1994*f*) and is reproduced along with instructions in TIP 42, *Substance Abuse Treatment for Persons With Co-Occurring Disorders* (CSAT 2005*c*).
TCU Drug Screen (TCUDS)	A 15-item substance abuse diagnostic screen	The TCU Drug Screen is completed by the offender and serves to quickly identify individuals who report heavy drug use or dependency (based on the DSM-IV-TR and the National Institute of Mental Health Diagnostic Interview Schedule) and who therefore might be eligible for treatment. For more information regarding the TCUDS and other related instruments go to www.ibr.tcu.edu.

Source: Peters et al. 2000.

recommendations for brief screening instruments based on this research (refer also to appendix C for the administration time and uses of specific instruments).

Findings indicated that either the TCUDS or a combination of the ADS and ASI-Drug screen should be used in situations in which it is important to reduce inappropriate referrals to substance abuse treatment. These instruments may be particularly useful for treatment programs that have limited "slots" available and significant consequences for mismatching offenders to the program (e.g., therapeutic communities or other residential programs). The SSI-SA is recommended for use in situations in which it is desirable to identify the largest number of offenders who need treatment (Peters et al. 2000). Some correctional systems have begun to use the SSI-SA for initial screening at the time of prison admission, with conducting additional assessment later to verify the need for treatment and to determine the specific level of services needed.

In conducting screening and assessment with female offenders, counselors may want to

consider use of the Alcohol Use Disorders Identification Test (AUDIT) and the Tolerance, Worried, Eye Openers, Amnesia, Kut Down test (TWEAK), both of which were developed for women and are more sensitive than the CAGE. The AUDIT and TWEAK also provide equivalent sensitivity in African Americans and Caucasians. For screening of alcohol problems among female offenders, counselors may also want to consider use of the Rapid Alcohol Problems Screen (RAPS), which has been shown to be more sensitive than other measures with African-American, Hispanic, and Caucasian women (Cherpitel 1997). See appendix C for information on how to obtain these instruments.

Assessment instruments

A wide variety of substance abuse assessment instruments is available for use in the criminal justice system. The most commonly used assessment instrument is the ASI (McLellan et al. 1980, 1992), which is used for screening, assessment, and treatment planning. The ASI was supported by the National Institute on Drug Abuse and is reproduced in TIP 7, *Screening and Assessment for Alcohol and Other Drug Abuse Among Adults in the Criminal Justice System* (CSAT 1994*e*), and TIP 38, *Integrating Substance Abuse Treatment and Vocational Services* (CSAT 2000*c*). The instrument provides a structured interview format to examine seven areas of functioning that are commonly affected by substance abuse, including drug/alcohol use, family/social relationships, employment/support status, and mental health status. Many agencies, including those in criminal justice settings, have adapted modified versions of the ASI for use as a substance abuse screening instrument. Two separate sections of the ASI that examine drug and alcohol use are frequently used as screening instruments.

A positive feature of the ASI is that it has been validated for use in criminal justice populations (McLellan et al. 1985, 1992; Peters et al. 2000). For example, the ASI is highly correlated with objective indicators of addiction severity. The ASI is also one of the few instruments that measure several different functional aspects of psychosocial functioning related to substance abuse and provide a concise estimate of the history of substance abuse as well as recent use. The instrument provides severity ratings in each functional area assessed, which are useful both clinically and for research purposes. In using the ASI for assessment, significant training is needed to administer and score the instrument. The interview version of the ASI requires 45–75 minutes to administer, although the alcohol and drug use sections require considerably less time. A self-report version of the ASI was developed that has been shown to be a reliable and accurate alternative to the counselor-administered instrument (Butler et al. 1998, 2001).

Detoxification Needs

Screening should address current evidence of intoxication, dependence, overdose, and withdrawal. This is particularly relevant in community corrections and jail settings, in which there may be significant periods of substance abuse that precede contact with the criminal justice system. Criminal justice and treatment staff should be trained to detect signs and symptoms of substance abuse and to refer clients to medical staff to assist in cases of acute intoxication. Once an individual is referred for detoxification, medical staff should perform a comprehensive assessment to determine the level of prior and recent use, and the level of substance abuse or dependence.

Safe withdrawal from substances such as stimulants, cocaine, hallucinogens, and inhalants can be achieved with psychological support, symptomatic treatment, and periodic reassessments by healthcare providers. Frequent clinical assessments, along with appropriate treatment adjustments, are also important since the intensity of withdrawal cannot always be predicted accurately (Federal Bureau of Prisons 2000). Some substances, such as alcohol, sedative-hypnotics,

and anxiolytics, can produce dangerous withdrawal syndromes once physiological dependence has developed. Offenders who have severe and life-threatening symptoms of intoxication or withdrawal should be placed immediately under medical supervision. The Federal Bureau of Prisons (2000) recommends that "inmates presenting with alcohol intoxication should be presumed to have alcohol dependence until proven otherwise" (p. 8).

Not all substances of abuse produce clinically significant withdrawal syndromes, but abstinence generally results in some psychological changes. Offenders should thus be reassessed often. Substance abuse may mask co-occurring mental disorders, such as depression, or symptoms of mental illness may disappear when the offender is not using. In some cases, withdrawal may cause symptoms of mental disorders that can be identified and treated.

For more information on the signs and symptoms of intoxication and withdrawal and the treatment of individuals undergoing detoxification, see the forthcoming TIP *Detoxification and Substance Abuse Treatment* (CSAT in development *a*). The *Federal Bureau of Prisons Clinical Practice Guidelines: Detoxification of Chemically Dependent Inmates, December, 2000* can be accessed online at www.nicic.org/pubs/2000/016554.pdf.

Physical Health Conditions

Besides the potential need for detoxification services, screening should also address significant medical conditions that may affect the offender's involvement in treatment, such as physical disabilities, tuberculosis, hepatitis, HIV/AIDS, and other debilitating diseases.

Readiness for Treatment

In addition to examining the severity of substance abuse problems, it is helpful to know whether a client is receptive to treatment and is committed to recovery goals. Readiness for treatment provides an important indicator regarding where the substance abuse treatment should begin.

Readiness for treatment is not always clearly defined or apparent at the onset of treatment. Most clients do not volunteer for treatment and experience significant ambivalence about the process and level of commitment required. For years, treatment professionals and paraprofessionals believed that a person needed to "hit bottom" to be ready for change. Today, it is recognized that people can be ready for treatment without "hitting bottom" and that many people can receive benefits from treatment even if they are not completely ready. For example, motivational interviewing (MI) techniques (discussed in detail in TIP 35, *Enhancing Motivation for Change in Substance Abuse Treatment* [CSAT 1999*b*]) can be used to help clients resolve their ambivalence toward treatment and toward making changes in their lives. MI provides an empathic, supportive, and directive counseling style that attempts to persuade

Advice to the Counselor: Screening for Detoxification

- Screening forms should note evidence of intoxication, dependence, overdose, and withdrawal. This is particularly important in community corrections and jail settings, in which there may be significant periods of substance abuse that precede contact with the criminal justice system.
- Besides the potential need for detoxification services, screening should address conditions that may affect the offender's involvement in treatment, such as physical disabilities.
- It is helpful to note whether a client is receptive to treatment and may be committed to recovery (readiness to change).

and guide the client toward change rather than to create motivation through confrontation of the client's substance abuse problems and labeling the client as an "addict."

Many individuals who successfully recovered from substance abuse problems were coerced into treatment, either by family, employers, or the criminal justice system. Coerced treatment by the criminal justice system has been shown to be at least as effective as non-coerced treatment, when time in treatment is held constant (CSAT 1994*a*; De Leon 1988; Hubbard et al. 1988). Coercion can come from multiple sources. Many offenders reported that pressures from "psychological, financial, social, familial, and medical domains" had more influence in their decision to enter treatment than did the legal system (Marlowe et al. 1996, p. 81). However, their decision to stay in treatment is more often based on motivational readiness (Knight et al. 2000) and external leverage. Thus, for clients with low internal motivation, coercive interventions may help to increase their readiness for treatment. Excluding people as "unready" or "unmotivated" would exclude the vast majority of clients and would mean that treatment and recovery would never begin for many (CSAT 1994*a*). For example, Alcoholics Anonymous counsels people who abuse alcohol to "bring the body, and the mind will follow," believing that motivational readiness will grow as the program takes hold.

An individual's readiness for change is one of the most important factors that substance abuse counselors and clinicians should examine during the screening and assessment process, and has been found to be predictive of treatment retention and other outcomes. Studies have shown that initial motivation for treatment influences enrollment in post-release treatment services (DeLeon et al. 2000; Simpson and Joe 1993). Several treatment interventions (e.g., MI, motivational enhancement therapy) (Miller and Rollnick 2002) have been developed to explore and enhance readiness for treatment. Many substance abuse programs in the criminal justice system include a "pre-treatment," or "readiness" phase designed to address the needs of offenders not yet committed to recovery goals and ongoing involvement in treatment. This initial phase of treatment addresses offenders' goals, expectations, and motivation for change. This intervention helps identify offenders who are ready for more intensive treatment services that require full participation in activities designed to encourage changes in attitudes and behaviors.

Assessing readiness includes obtaining information about clients' awareness of a substance problem, their ability to acknowledge their need for help, their willingness to accept help, their perception of how others feel about their need for help, and whether they have taken steps to change on their own (Wanberg and Milkman 1998). Generally, clients can be considered "ready" for treatment if they want to abstain from substance abuse, see treatment as a means to become drug- or alcohol-free, and recognize the difficulty in abstaining from substance abuse without professional assistance (CSAT 1994*a*). Figure 2-4 describes several brief instruments that can be used to assess readiness for treatment. For more detailed information on this topic, see TIP 35, *Enhancing Motivation for Change in Substance Abuse Treatment* (CSAT 1999*b*). See also chapter 3 for a discussion of the stages of change model.

Co-Occurring Disorders

A substantial percentage of those under criminal justice supervision have one or more co-occurring mental disorders in addition to their substance use disorder. There were an estimated 283,800 incarcerated individuals in 1998 who had a major mental disorder, including 16 percent of State prison inmates, 7 percent of Federal prison inmates, and 16 percent of jail inmates (Ditton 1999). Of all of these individuals, 49–65 percent were under the influence of drugs or alcohol at the time of their offense, and 24–38 percent had a history of alcohol dependence. Because individuals often require therapeutic intervention for

Figure 2-4
Instruments for Evaluating Readiness for Treatment

Instrument	Description
The University of Rhode Island Change Assessment Scale (URICA)	URICA was developed to assess stage of change. The instrument is known to be valid with different populations in a variety of settings. El-Bassel and colleagues have determined that URICA is useful, reliable, and valid among incarcerated women who use drugs (el-Bassel et al. 1998). The URICA and other similar instruments are reprinted in TIP 35, *Enhancing Motivation for Change in Substance Abuse Treatment* (CSAT 1999*b*).
The TCU Treatment Motivation Scales	The TCU Treatment Motivation Scales can be used to track the stages of change in treatment motivation. For further information, go to www.ibr.tcu.edu.
The Circumstances, Motivation, Readiness, and Suitability Scales (CMRS)	The CMRS scales were designed to predict retention based on dynamic client factors related to seeking and remaining in treatment (DeLeon et al. 1994). The Circumstances scale is defined as the external pressure to engage and remain in treatment. The Motivation scale is defined as the internal pressure to change; the Readiness scale is defined as the perceived need for treatment; and the Suitability scale is defined as the individual's perception of the treatment modality or setting as appropriate for himself. A prison version has been developed. A revised version of the CMRS, the CMR, is also available. The CMR is copyrighted and can be obtained by contacting the National Development and Research Institute, Inc., 71 W. 23rd Street, 8th Floor, New York, New York 10010, or mail@ndri.org.
Stages of Change, Readiness, and Treatment Eagerness Scale (SOCRATES)	SOCRATES includes items specifically focused on alcohol abuse and can be used as a starting point for discussion. A Spanish translation is available. The SOCRATES and other similar instruments are reprinted in TIP 35, E*nhancing Motivation for Change in Substance Abuse Treatment* (CSAT 1999*b*).

co-occurring disorders, accurate screening and assessment are of particular importance.

Much of the literature related to co-occurring disorders in the criminal justice system has focused on the most severe mental disorders (e.g., schizophrenia, bipolar disorder, and major depression) (Broner et al. 2002). However, less severe disorders (e.g., anxiety, phobia disorders, and posttraumatic stress disorder [PTSD], along with less severe depression, attention deficit disorders, and various types of personality disorders) are also common among offenders with substance use and mental disorders, and can affect treatment outcomes (Broner et al. 2002; Haywood et al. 2000; Henderson 1998; Peters and Hills 1997, 1999; Teplin et al. 1996).

An important first step in treating offenders with co-occurring disorders is to develop a systematic approach to screen and assess for these disorders. Relatively few jurisdictions systematically screen for mental health problems or co-occurring disorders upon arrest, prior to or following the arraignment process, or upon entrance into the jails. Despite the high prevalence of co-occurring disorders, these disorders are not always detected from the individual's arrest charge or mental status during booking. Unless the screening process is systematic, the target population may not be identified. As a result, many individuals are not diverted into specialized programs or provided effective discharge planning—strategies that are likely to reduce recidivism (Broner et al. 2001*a*).

Steps for Assessing the Interactive Effects of Co-Occurring Disorders

1. Assess the significance of the substance use disorder. Obtain a chronological history describing the onset of mental disorder and substance abuse symptoms.
   - Determine whether mental disorder symptoms occur only in the context of substance abuse.
   - Determine whether ongoing abstinence leads to rapid and full resolution of mental disorder symptoms.
2. Determine the duration of the current period of abstinence.
   - If there has not been a 4–6 week period of abstinence, repeat assessment and diagnosis after such a period, depending on clinical judgment about the particular drug abuse history and the offender's physical status.
3. Reassess mental disorder symptoms at the end of 4–6 weeks of abstinence or at any time such symptoms appear or change.
4. If mental disorder symptoms are fully resolved, consider referral for traditional substance abuse treatment; if not, consider referral for mental health or specialized co-occurring disorders services.
5. Provide ongoing reevaluation of the offender's mental disorder symptoms and progress in treatment.

Screening and assessment for co-occurring disorders should occur soon after entry into involvement in the criminal justice system. Many individuals who are screened or assessed in court, community corrections, or jail settings may be under the influence of alcohol or drugs and may need to be detoxified before determining whether they have co-occurring disorders. Acute symptoms of alcohol or drug use and residual effects of detoxification can mimic a wide variety of mental disorders, including anxiety, bipolar disorder, depression, and schizophrenia. Most prison inmates screened for co-occurring disorders will have been detoxified by the time of admission to treatment, although chronic residual side effects of drug use may cloud the initial symptom picture. It is therefore important to identify patterns of recent substance abuse and to observe mental health symptoms over time to see if they resolve as the individual detoxifies. It is often useful to defer diagnosis (or to provide a provisional diagnosis, if needed) until the interactive effects of co-occurring disorders can be determined.

No single instrument can adequately screen for all mental and substance use disorders, particularly given the constraints of length, cost, and required training—but a combination of instruments can be used (Peters and Hills 1999). The choice of substance abuse screening instruments should be based on the purpose of the screening, ethnic or racial characteristics, language spoken, and gender (Broner et al. 2002). Figure 2-5 provides a list and description of instruments used to screen and assess for mental disorders.

Broner and colleagues recommend the Mini-International Neuropsychiatric Interview for mental disorder screening in court-based diversion programs (without the Antisocial Personality Disorder and Substance and Alcohol Abuse modules and with a substance use rule-out question added to reduce false-positives). Several sources recommend the TCUDS, SSI, or ADS/ASI combination for substance abuse screening among offenders with mental health problems (Broner et al. 2001*a*; Peters and Bartoi 1997). For assessment of psychiatric disorders, Broner and

Figure 2-5
Instruments for Screening and Assessing Mental Disorders

Instrument	Description
Beck Depression Inventory II (BDI-II) (Beck et al. 1996)	• A 21-item self-report of symptoms that screens for symptoms of depression. • Requires no significant training to administer. • Found to be the most effective instrument in detecting depression among individuals who abuse alcohol (Weiss and Mirin 1989). • Should not be used as a sole indicator of depression but in conjunction with other instruments (Weiss and Mirin 1989; Willenbring 1986).
Brief Symptom Inventory (BSI) (Derogatis 1975*a*)	• A short form of the Symptom Checklist 90 - Revised (SCL-90-R). • Comprising 53 items, including three global indices of psychopathology (General Severity Index, Positive Symptom Total, Positive Symptom Distress Index) and nine primary psychiatric symptom dimensions. • Quick to administer and requires no significant training to administer. • Only a 6th grade reading level is required. • May be most useful as a general indicator of psychopathology (Boulet and Boss 1991).
General Behavior Inventory (GBI) (Depue and Klein 1988)	• A 73-item self-report instrument that examines mood disorders. • Requires no significant training to administer. • Differentiates between unipolar and bipolar depression.
Hamilton Depression Scale (HAM-D) (Hamilton 1960)	• A 17-item scale completed by an interviewer based on self-report information. • Examines several key elements of depression, including sleep disturbance, somatization, anxiety-depression, and apathy. • Requires training to administer.
Mental Health Screening Form-III (MHSF-III) (Carroll and McGinley 2001)	• Eighteen simple questions designed to screen for present or past symptoms of most of the main mental disorders. • A "rough" screening device and asks only one question for each disorder for which it attempts to screen. • Reproduced in TIP 42, *Substance Abuse Treatment for Persons With Co-Occurring Disorders* (CSAT 2005*c*).
Millon Clinical Multiaxial Inventory (MCMI-III) (Millon 1983; Millon et al. 1994)	• A self-report measure with several subscales. • Useful in assessing Axis II (personality) disorders that may affect involvement in treatment. • Includes the Drug Abuse Scale (DAS), an instrument designed to measure personality characteristics often associated with drug abuse (Calsyn and Saxon 1989).

Figure 2-5 (continued)
Instruments for Screening and Assessing Mental Disorders

Instrument	Description
Minnesota Multiphasic Personality Inventory (MMPI-2) (Butcher et al. 2001)	• A self-report measure with 567 items, 10 main clinical scales, and 10 supplementary scales. • A restandardized version of the MMPI. • Frequently used in correctional settings for classification and assignment to housing or inmate programs, and to predict an inmate's response to placement in a correctional setting. • Useful in identifying characteristics of antisocial personality disorder. • Designed to identify psychopathology and not to identify substance use disorders.
Personality Assessment Inventory (PAI) (Morey 1991)	• A self-report measure with 344 items and 22 scales. • Eleven clinical scales include separate measures of alcohol problems and drug problems. • Five treatment scales are also provided in the PAI.
Referral Decision Scale (RDS) (Teplin and Swartz 1989)	• A 14-item measure of mental disorder symptoms developed to identify mental health problems. • Developed and validated in a criminal justice setting. • Found to be useful in detecting the presence of major mental illness among jail inmates. • Requires no training to administer. • Self-administered. • Examines only a few mental disorders (depression, bipolar disorder, schizophrenia).
Symptom Checklist 90 - Revised (SCL-90-R) (Derogatis 1975*b*)	• A 90-item, multidimensional self-report inventory designed to assess recently experienced physical and psychological distress. • Requires no training to administer. • Self-administered. • Short amount of time to administer. • Frequently used in criminal justice settings. • Covers a wide range of symptom dimensions that include somatization, obsessive-compulsive, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, and psychoticism.

colleagues recommend the Structured Clinical Interview for DSM-IV (SCID) (Broner et al. 2001*a*). Refer to appendix C for these and other examples of instruments that are recommended for use with specific populations. For more information on screening for co-occurring disorders see chapter 4 of TIP 42, *Substance Abuse Treatment for Persons With Co-Occurring Disorders* (CSAT 2005*c*).

History of Trauma

Rates of trauma in men and women entering the criminal justice system are higher than are rates found in community samples. For

Advice to the Counselor: Screening for Co-Occurring Disorders

- Screening and assessment for co-occurring disorders should occur on entry into the criminal justice system, given the high prevalence of co-occurring disorders in this population.
- Individuals in community corrections or jail settings may need to be detoxified before screening for co-occurring disorders. The acute symptoms of alcohol or drug use and the residual effects of detoxification can mimic a wide variety of mental disorders, including anxiety, bipolar disorder, depression, and schizophrenia.

example, Teplin et al. (1996) found that 34 percent of female jail inmates had PTSD. According to the DSM-IV-TR, trauma is defined by two characteristics:

1. A person experiences, witnesses, or is threatened by physical harm.
2. The person's response to the event includes "intense fear, helplessness or horror" (APA 2000*a*, p. 463).

This definition highlights that trauma is not simply an event of a particular type but includes a subjective dimension in that the person's response to the event is powerfully negative. For example, one person may survive a car accident and not react with "fear, helplessness, or horror," while another person does experience such feelings.

Among female State prisoners, 40–80 percent report a history of emotional, physical, or sexual abuse (Bloom et al. 1994; Snell 1994). Female prison inmates are three times more likely to report a history of any abuse and six times more likely to report a history of sexual abuse in comparison to male inmates. A history of physical or sexual abuse has been linked to many types of mental disorders, including PTSD, depression and suicidal behavior, and borderline personality disorder and other personality disorders (Spielvogel and Floyd 1997).

Despite high rates of physical and sexual abuse among offenders, screening and assessment in the criminal justice system has not historically addressed these issues, nor have treatment services been provided in jail, prison, or community settings. There are many compelling reasons to address abuse and trauma issues during screening and assessment in the criminal justice system. For many offenders, the guilt, shame, and low self-esteem related to their trauma history may lead to social isolation and may reduce participation in treatment activities. For example, given the close relationship between past physical or sexual abuse and substance abuse, treatment that does not address one of the "root" contributors to substance abuse may be perceived as unimportant or irrelevant and may not provide sufficient incentives for the offender to change his or her attitudes and behavior. The offender's resulting lack of engagement in program services may be misinterpreted as resistance to treatment or lack of motivation rather than to psychological issues related to abuse and trauma. Forced abstinence during jail or prison may also deprive offenders of their primary means of coping with negative emotions related to past abuse and trauma (i.e., use of drugs and alcohol). When this coping mechanism is no longer available, many offenders are left vulnerable and may begin to exhibit symptoms of depression and other mental disorders that can interfere with treatment. If unaddressed, past trauma can also trigger substance abuse relapse (during or after treatment), through emotional, physical, or situational cues associated with prior abuse experiences.

Only trained counselors should inquire about abuse and trauma issues. The counselor should be prepared for how to respond to self-disclosed experiences related to physical and sexual abuse and how to provide referral for services. In most substance abuse settings,

the goal of screening or an intake interview is not to compile detailed and comprehensive information regarding past trauma, but to identify that the offender has a history of trauma for purposes of treatment planning, triage, and referral for more intensive services. As a result, counselors should be familiar with and have ready access to resources (e.g., counselors with mental health training, liaisons from women's shelters and treatment programs) to refer persons who wish to discuss their histories of trauma in more detail.

Although clinicians are sometimes concerned about addressing material that is potentially uncomfortable or even overwhelming for either the client or themselves, these adverse consequences are rarely experienced when these issues are raised by well-trained staff. In fact, offenders are typically relieved to talk frankly about their abuse and trauma experience, albeit in an appropriately limited fashion. Indepth discussion of the specific events surrounding traumatic experiences is typically conducted in followup individual or

Screening and Assessment of Abuse and Trauma History

Structured interview assessments

- Trauma Assessment & Treatment Resource Book
  New York State Office of Mental Health's Trauma Initiative
  Design Center
  44 Holland Ave
  Albany, NY 12229
  Fax requests: (518) 473-2684
- The Integrated Biopsychosocial Assessment that includes trauma history questions in an assessment form appropriate for a mental health or substance abuse setting. Available from:

  Colleen Clark, Ph.D.
  Louis de la Parte Florida Mental Health Institute
  13301 Bruce B. Downs Blvd./ MHC 1345
  Tampa, FL 33612-3899
  Requests by e-mail: Cclark@ fmhi.usf.edu

Self-report instruments

- The Traumatic Antecedent Questionnaire (TAQ) (van der Kolk 1992). A widely used measure of lifetime experiences of trauma in 10 domains, i.e., physical, sexual, witnessing trauma, etc.
- The Dissociative Experiences Scale (DES) (Bernstein and Putnam 1986). A self-report measure examining several domains of dissociative phenomena, often sequelae of trauma, i.e., amnesia, identity alterations, spontaneous trance states, etc.
- The Clinician Administered PTSD Scale (CAPS) (Blake et al. 1998). A clinician-administered scale that provides an accurate diagnosis of PTSD.
- The Trauma Symptom Inventory (TSI) (Briere 1995). A 100-item self-report instrument that evaluates symptoms in adults that may have arisen from childhood or adult traumatic experiences. Includes 10 clinical scales and 3 validity scales. An alternate version (TSI-A) includes no references to sexual issues. The companion Trauma Symptom Checklist 40 (Briere 1995; Briere and Runtz 1989) is a 40-item instrument that contains 6 sub-scales. Items are rated on a 4-point scale covering frequency over the past 2 months.
- Posttraumatic Disorder Scale (PTDS) (Foa et al. 1993). Measures trauma history and specific symptoms associated with posttraumatic stress disorder.

group treatment sessions that specifically address this topic area. Treatment for trauma issues progresses in stages, with early treatment goals focused on issues of ensuring safety in relationships, the place of residence, and in the workplace. Later work explores issues of recovery and reconciliation, if appropriate. This later work is frequently conducted by therapists with advanced degrees and in most cases is not appropriately addressed by paraprofessional staff.

Most commonly, assessment of trauma has been conducted through a clinical interview. In these settings, it is preferable to use standardized questions that avoid the use of terms such as "abuse," "trauma," or "perpetrator" and that instead focus on description of specific events or experiences.

Sample interview questions could include:

- Were you ever hit or punished in ways that left bruises, burns, or cuts? Were you ever threatened with knives or guns? Were you ever made to go without eating? Did you ever witness anyone else getting hurt? Did you ever have to be taken from your parents' care?
- As a child, did you have any sexual experiences? With whom and for how long did this go on? Were you ever threatened about it? Were any photos taken? Did any of these experiences lead to medical or other problems? Do you have any recurrent memories of these events now?
- Are you safe in your current relationship? Has your safety ever been threatened in any of your adult relationships? Have you been punched, shoved, or hit? Did you ever seek any medical help as a result? Have you talked to people about these experiences? (Spielvogel and Floyd 1997).

For more information on this topic see also TIP 25, *Substance Abuse Treatment and Domestic Violence* (CSAT 1997*b*), TIP 36, *Substance Abuse Treatment for Persons With Child Abuse and Neglect Issues* (CSAT 2000*d*), and the forthcoming TIP *Substance Abuse and Trauma* (CSAT in development *f*).

Psychopathy and Risk for Violence and Recidivism

A number of criminogenic "risk factors" are often assessed in justice settings to determine eligibility for admission to substance abuse treatment programs and community release (e.g., parole), and for placement in institutional housing or in different levels of supervision (Borum 1996; Douglas and Webster 1999; Otto 2000). This information is particularly helpful to identify offenders likely to be disruptive in treatment programs, to be rearrested, or to commit violent crimes after release from institutions. Risk factors can be categorized as static or dynamic. Static risk factors are those that cannot change, such as gender and race, or are relatively enduring traits such as the diagnosis of a mental disorder, criminal history, family history, and the characteristics of the offender's victims. Dynamic risk factors are those likely to change over time and that change according to the client's environment, social situation, or experiences, such as drug use or homelessness. Following is a discussion of the risk fac-

Advice to the Counselor: Screening for Trauma

- Trained counselors are best equipped to inquire about abuse and trauma issues. Offenders who have experienced abuse or trauma and who are undergoing forced abstinence while in jail or prison may be deprived of their primary means of coping with the negative emotions related to past trauma. These offenders may begin to exhibit signs of depression or other mental disorders that can interfere with treatment.
- Counselors should be familiar with and have ready access to resources to refer persons who wish to discuss their histories of trauma in more detail.

tors for psychopathy and for violence and recidivism.

Psychopathy

One stable risk factor often found among offenders with substance use disorders is psychopathy and the closely related antisocial personality disorder defined in the DSM-IV classification system. Personality disorders are persistent and pervasive patterns of maladaptive behavior that are usually exhibited early in life. Historically, many terms have been used to describe personality disorders that involve criminogenic characteristics. Four closely linked terms are "sociopath" (and the trait of sociopathy), "antisocial personality" (and antisocial traits), "dissocial personality" (dissocial behavioral traits), and "psychopathic personality disorder" (psychopathy or psychopathic traits). Whereas the first three formulations of criminogenic personality types focus on social deficits and mild emotional and cognitive problems resulting in impulsivity and poor school achievement, psychopathy focuses on primary and severe deficits in attachment and interpersonal bonding, lack of empathy for others' experiences, lack of remorse, and shallow emotional functioning. These relatively stable traits are thought to have a biological basis. As previously indicated, psychopathy is related to the DSM-IV antisocial personality disorder but represents a more extreme version of that disorder. Some would argue that psychopathy represents a distinct diagnostic group. From 40 to 60 percent of male prison inmates meet the criteria for antisocial personality disorder, whereas only 10 to 20 percent of male prison inmates meet the criteria for psychopathy (Hare et al. 1991).

Psychopathy is an important predictor of treatment dropout, level of involvement in violence, and criminal justice recidivism (Hart et al. 1994; Hemphill et al. 1998; Ogloff et al. 1990; Rice et al. 1992). Offenders identified as having a high degree of psychopathy may require specialized, more structured treatment approaches, although there is not a large body of evidence describing effective therapeutic interventions that have been applied to this population. Assessment for psychopathy is often used in criminal justice settings to rule out individuals for treatment involvement, particularly if there are not sufficiently structured treatment programs available.

Few short screening instruments exist for psychopathy because of the complexity of dimensions that need to be examined. The most widely used instrument to identify psychopathy is the Hare Psychopathy Checklist-Revised (PCL-R) (Hare 1998*b*; Hare et al. 1991; Hart et al. 1994). The PCL-R is considered the "gold standard" for measuring psychopathy. It requires a significant amount of time to review archival information and to conduct an interview. A shorter screening version of this instrument—the PCL-SV—has also been developed for use with this population and validated in substance abuse treatment settings (Hart et al. 1995). Another shorter (60-item) measure, the Self-Report Psychopathy (SRP) instrument, has been developed for use in criminal justice settings by the author of the PCL-R.

Several other short self-report screening instruments for psychopathy have been developed but have yet to be fully validated with criminal justice populations. These include the Psychopathic Personality

Advice to the Counselor: Screening for Psychopathy

- Psychopathy is an important predictor of treatment dropout, level of involvement in violence, and criminal justice recidivism. Offenders identified as having a high degree of psychopathy may require specialized, more structured treatment approaches, although there is not a large body of evidence describing effective therapeutic interventions for this population.

Inventory (Lilienfeld and Andrews 1996), the Psychopathy Q-Sort (Reise and Oliver 1994; Reise and Wink 1995), and the Levenson Self-Report Psychopathy Scale (Brinkley et al. 2001; Levenson et al. 1995). A number of other screening and assessment instruments examine personality features related, but not identical, to psychopathy (Zimmerman 2000), as described in Figure 2-6 on the next page.

Violence and recidivism

Although psychopathy may be the single most important risk factor for criminal recidivism, other risk factors are important to assess among offenders with substance abuse problems. Even offenders determined to have low levels of psychopathy may still be at high risk for violence or recidivism due to other risk factors. Other major risk factors for violence and criminal recidivism include

- Antisocial attitudes
- Criminal peers
- Prior history of crime and violence, and early age at time of first offense/violent act
- Active symptoms of severe mental illness
- Impulsivity
- Environmental stress
- Treatment nonadherence
- Personality disorders (generally)

A number of environmental stressors can lead to renewed substance use and risk for recidivism when offenders are released from custody or when their daily structure and level of supervision is reduced (Peters 1993; Wanberg and Milkman 1998). During these transitions, many offenders face employment and financial problems, and few have family or social supports. Meanwhile, there are immediate demands to organize daily activities, develop and maintain constructive relationships, manage personal or household finances and problems, and participate in community supervision. Many offenders involved with drugs have never learned the requisite skills to accomplish these tasks, and some rapidly return to substance abuse in the absence of opportunities to learn and rehearse those skills.

Many offenders have long histories of psychosocial problems that have contributed to their substance abuse and criminal involvement. These include interpersonal difficulties with family members, difficulties in sustaining long-term relationships, emotional and psychological difficulties, difficulties in managing anger and stress, educational and vocational skills deficits, and employment problems (Belenko and Peugh 1998; Peters 1993). Offenders do not typically plan or seek out addictive lifestyles or relapse. Rather, it is their lack of planning, personal objectives, and self-monitoring that leads to substance abuse or dependence or relapse. The lack of basic coping skills to manage life and social pressures further contributes to the risk for relapse and recidivism.

Reunification with family members is often accompanied by stress related to the family's distrust and anger over offenders' past drug use, unresolved conflicts with the partner or spouse, shifting parental roles, and added financial obligations, as well as drug use in the family or neighborhood. Elements of community supervision can also increase an offender's stress during re-entry to the community. These include drug testing, use of house arrest, and other surveillance or reporting activities, as well as the offender's recognition of the significant level of effort and adherence required by community supervision programs. The community's ongoing leverage to maintain the offender's involvement in treatment following release from custody or other secure settings can be a further stressor (U.S. Department of Justice 1991). Figure 2-6 (next page) provides descriptions of three general assessment instruments related to the risk for violence and recidivism.

Figure 2-6
Instruments Examining Psychopathy and Risk for Violence and Recidivism

	Instruments	Description
Psychopathy assessment instruments	Psychopathy Checklist – Revised (PCL-R)	• A 20-item assessment measure that requires use of a semi-structured interview and review of archival records. • Requires 90–120 minutes for the interview section and 60 minutes for the collateral records review. • Measures the extent to which individuals exhibit psychopathic features on a 40-point scale, with a cutoff score of approximately 30 indicating psychopathy. • Has considerable validation for use with offenders and is highly predictive of violence and criminal recidivism.
	Psychopathy Checklist – Screening Version (PCL-SV)	• A 12-item measure examining the same construct of psychopathy as the PCL-R. • Requires 45 minutes for the interview section and 30 minutes for the collateral records review. • Scored on a 24-point scale with a cutoff of approximately 18 indicating psychopathy.
Other instruments related to psychopathy	Carlton Psychological Survey	• Used as an intake screening in correctional settings. • Contains scale scores for five categories: antisocial tendencies, chemical abuse, self-depreciation, thought disturbance, and validity. • Especially useful for those with low education and literacy as it requires only a 4th-grade reading level.
	Jesness Inventory	• Examines moral development throughout the life span.
	Paulus Deception Scales	• Gauges the extent of deception provided through offenders' self-report.
	Millon Clinical Multi-Axial Inventory-III (MCMI-III)	• Provides an assessment of personality disorders and psychopathy. • Correctional version of the MCMI-III provides early identification of substance abuse and mental health problems. • The 175-question test takes 25 minutes to complete. • Spanish versions available (Millon et al. 2002).
	Minnesota Multiphasic Personality Inventory (MMPI-2)	• A self-report objective assessment measure with 567 items, 10 main clinical scales, and 10 supplementary scales (Hathaway and McKinley 1989). • The Psychopathic Deviate Scale on the MMPI identifies individuals with psychopathic and antisocial features. • Frequently used in criminal justice settings (particularly in prisons) for classification and assignment to housing or offender programs and to predict an offender's response to placement in prison setting. • MMPI subtypes described by Megargee et al. (1979) are often used to identify offenders who require more intensive supervision and structured program activities.

Figure 2-6 (continued)
Instruments Examining Psychopathy and Risk for Violence and Recidivism

	Instruments	Description
Other instruments related to psychopathy	Personality Assessment Instrument (PAI)	• Self-report instrument for assessing traits associated with psychopathy. • Includes 344 items and requires 50–60 minutes to administer. • Contains scales for Negative Impression Management, Malingering, and Defensiveness (Morey and Lanier 1998). • The Antisocial Features (ANT) scale is the most highly correlated with psychopathy and focuses on antisocial behaviors, egocentricity, and stimulation-seeking.
General assessment instruments related to the risk for violence and recidivism	Level of Service Inventory (LSI) - Revised	• A 54-point scale used to predict the chances of criminal recidivism or supervision failure among offenders. • Useful for identifying those in need of more intensive levels of treatment, placement in halfway houses, and level of supervision and security classification (Andrews and Bonta 1995). • Used by jurisdictions to support an increase or decrease in the level of community supervision. • Includes assessment of drug use and is sometimes used in tandem with substance abuse treatment decisions.
	Historical, Clinical, Risk Management (HCR-20)	• Provides a comprehensive risk assessment based on historical, clinical, and risk management assessments. • Composed of static and dynamic factors with information derived from clinical interview, standardized assessment (e.g., the PCL-R or PCL-SV), and collateral sources. • Includes three sections—10 historical items, 5 clinical items, and 5 risk management items—with a final risk rating of low, medium, or high (Webster et al. 1997, 2000).
	The Violence Risk Appraisal Guide (VRAG) (Harris et al. 1993)	• An assessment tool for predicting violent recidivism. • Is an actuarial measure based on 12 objective variables that are linked to recidivism. • Requires interview and archival review, and incorporates results of diagnostic testing, IQ testing, the PCL-R, criminal history, and indicators of adult adjustment.

Selection and Implementation of Instruments

Using well-accepted and standardized instruments can bring uniformity, quality control, and structure to the process. Some instruments may be more appropriate than others for particular purposes (CSAT 1994*a*), depending on the information needed for treatment decisions. For example, some instruments focus on drug dependence and not abuse, some identify those for whom specific treatment options are appropriate, and

some are validated for use with criminal justice populations.

The appropriateness of particular instruments depends on the type of client being referred to a specific criminal justice program and the goals related to program admission. For instance, drug education programs are generally provided to a wide number of offenders, and a substance abuse screen that tends to be overly inclusive for this intervention might be preferred to a more exclusive screen. On the other hand, because of the limited access to treatment for offenders with co-occurring substance use and mental disorders, screening for mental disorders as well as for drug use problems may need to be conservative to avoid referring someone who does not need services. Therefore, flexibility in developing screening and assessment approaches is needed, depending on specific program parameters (e.g., type of staff, client goals and needs).

This section describes the various factors that the consensus panel thinks are important in the selection of screening and assessment instruments, including length, cost, window of detection, interview versus self-administered instruments, staff training required, literacy, language, and computerization.

What Guidelines Are Available Regarding the Effectiveness of Instruments?

Screening and assessment instruments vary considerably in their ability to detect substance use disorders and in the coverage of related areas such as mental health and other health issues, family and social functioning, and employment. The consensus panel believes that several guidelines should be considered when selecting substance abuse instruments for a particular criminal justice setting, in addition to the time and cost of administration. These guidelines, also known as "psychometric properties," are often described in research reports examining a particular instrument or in manuals that accompany the instruments. Five major statistical guidelines are used to gauge an instrument's accuracy for use with client populations:

- *Overall accuracy*—the extent to which the instrument classifies respondents correctly.
- *Sensitivity*—the extent to which the instrument accurately identifies those with substance use disorders (true positives).
- *Specificity*—the extent to which the instrument accurately identifies those without substance use disorders (true negatives).
- *Positive predictive value*—the proportion of offenders identified by the instrument as having substance abuse problems, compared to the total number having substance abuse problems.
- *Negative predictive value*—the proportion of offenders identified by the instrument as not having substance abuse problems, compared to the total number not having substance abuse problems.

Psychometric information helps counselors decide the usefulness of a screening instrument in a specific criminal justice setting. Questions counselors should ask include

- Are there normative scores for the population?
- Does the research show the instrument is valid for use with offenders and for relevant ethnic/cultural groups represented?
- Is it better to err on the side of false-positive or false-negative results? In other words, a decision must be made about whether to err on the side of sending someone to treatment who does not need it or not sending someone who does need it.

Length

Another critical factor that enters into the choice of a substance abuse screening instrument is how long it takes to administer. Although many drug use assessments are well designed and serve as broad sorting tools for treatment and intervention, they tend to take longer to administer than correctional agen-

cies can afford (Knight et al. 2002). Rather, correctional systems usually have a short period of time to determine which of a large number of offenders need treatment. For example, the Program and Services Division of the Texas Department of Criminal Justice coordinates a drug abuse screening and treatment referral process for several hundred inmates monthly. The division lacks the staff, time, or financial resources to administer lengthy individual interviews for each new admission. Therefore, simple logic dictates that an instrument should not be used if it takes longer to administer than the staff time available.

Cost

The cost of instruments varies according to whether they are publicly or commercially available, whether the instrument is computerized, and the unit costs per administration that are assigned by the publisher. There are several screening and assessment instruments available at no cost in the public domain. Other commercially available instruments are available that can often be administered for $1 to $5 per unit. (See appendix C.)

Window of Detection

Questions phrased to ask about a relatively short window of detection—focusing on current rather than lifetime alcohol and drug problems—are recommended for screening (Cherpitel 1997; Knight et al. 2002) because there is a greater chance of obtaining valid responses. However, shorter detection windows could be too restrictive, and some who need treatment could be overlooked (e.g., offenders who abstained from substances while awaiting trial).

Interview Versus Self-Administered Instruments

The method used to administer an assessment instrument has implications for staffing, language, literacy, and reading level. A face-to-face interview can ensure that the respondent understands the items and answers them, but it is more time consuming and costly. The interview, which may be broken into several sessions, might be more appropriate for those with physical or cognitive disabilities. If cost is a concern, self-administered instruments could be used. Use of small-group interviews is another less costly alternative to individual interviews (Broome et al. 1996*b*).

Research suggests that the reliability of the administration method varies by setting and the content evaluated (Broner et al. 2002; Broome et al. 1996*b*; Knight et al. 1998). The method chosen (e.g., interview or self-administered) also affects the amount of training required to administer the screening.

> Correctional staff members who have been trained to administer an instrument can, in turn, train others to use it.

Staff Training Required

Training will have a major impact on instrument selection. Logically, if resources for intensive training are not available, instruments should be selected that do not require interpretation. Although most screening instruments do not require substantial staff training, some, such as the SASSI, may require more training than others. Further, even when little training is required, such as for the CAGE or interview-based instruments, the level of training can influence the validity of results. For assessment instruments such as the ASI, training may have a significant impact on the interpretation of results, administration of the instrument, and development of basic counseling techniques related to engaging clients, eliciting problems, interviewing strategies, and dealing with resistance.

Even with qualified staff, extensive training may be difficult to implement. Choosing a brief, easily administered screening instrument that requires little staff training can solve these difficulties. In some instances, correctional staff members who have been trained to administer an instrument can, in turn, train others to use it (Knight et al. 2002).

Literacy

A brief screening for literacy is recommended if it is suspected that a client may not be able to complete a paper-and-pencil test. The Slosson Oral Reading Test–Revised (www.slosson.com) may be useful if a counselor wants to know whether a client can read at a particular grade level. It is important to note, however, that a client's inability to read or write does not mean he or she cannot take an active part in the assessment. Rather, the counselor can substitute an interview for a paper-and-pencil assessment and a thumbprint for a signature.

Language

Optimally, the instrument chosen should be written in the individual's language of choice, whether English or another language. However, it should not be assumed that individuals who can speak a particular language can also read that language, or any other. To that end, the client may need to communicate in "street language." In this case, the counselor should mirror and leverage whatever vocabulary the client uses. Professional or clinical jargon should be avoided (CSAT 1994*a*).

Translating an instrument on the fly, such as for the Hispanic/Latino population, will greatly reduce the reliability and validity of screening results. Each population has different usages of language; misunderstandings and inaccuracies can impact engagement in treatment and client motivation for change.

Computerization

Some instruments allow screening through computerization (e.g., ASI). Computerization can reduce the personnel time needed to conduct screening and assessment but can also reduce the comprehensiveness of information gathered compared to clinical interviews. Research indicates that a computerized version of the ASI provides good reliability and validity for use with substance-involved clients (Butler et al. 1998, 2001). One report (Budman 2002) concluded that the computerized ASI is "more reliable, faster to administer, more accepted by patients, and more cost-effective" in comparison to the interview version of the ASI. While computerization can decrease the effort and time required for scoring, it can be an obstacle for offenders who are unfamiliar with computer technology and introduces added up-front and ongoing costs.

Screening and Assessment Considerations for Specific Populations

Within different treatment settings in the criminal justice system, screening and assessment instruments and procedures are sometimes altered to address the unique needs of specific clinical populations, such as ethnic and cultural minorities, women, and offenders with co-occurring disorders. For example, there is a growing recognition that instruments vary in their ability to detect substance abuse and other problems among these specific populations and that in some cases new instruments need to be developed. A related concern is that if a screening or assessment instrument is substantially modified for use with specific populations, research is needed to validate the effectiveness of the new instrument in that setting. Another concern is that if items are added or deleted, this may affect

the overall scoring of the instrument. The following section presents issues to consider when screening and assessing specific populations and suggests strategies for modifications to instruments and procedures.

Racial and Ethnic Minorities

When the counselor and the offender are from different racial or ethnic groups, the potential for misunderstanding is considerable. These differences can affect the staff's ability to assess client needs and/or to recommend culturally competent services for clients from other cultures and can jeopardize the client's chances for treatment success. The sources of misunderstanding originate in culture, socioeconomic class, and language (Sue and Sue 1999), as well as in race, gender (Broner et al. 2001*a*), literacy, and physical or cognitive inability to respond to the instrument (CSAT 1994*a*).

A general introduction to a screening or assessment could include statements about the effects of substance abuse on society or on the client's culture, along with information about the purpose of the process. Counselors should ask clients directly about how they view or describe themselves and their preferred usage of terms such as black, African American, person of color, Hispanic, Latino, Chicana, Pacific Islander, gay, homosexual, or lesbian. Counselors should also be aware of general cultural beliefs and expectations. For example, screening American-Indian populations can prove difficult because gaining trust is sometimes a challenge. Moreover, some tribal cultures dictate silence about substance abuse issues. As a result, a screening that detects the need for further assessment brings the stigma of losing dignity in the tribe. American-Indian men and women may also be the victims of other types of abuse that can impede the screening and assessment process. Further barriers of language, literacy, and comprehension are also present in this population (Sue and Sue 1999).

It may be necessary for a counselor to modify screening and assessment instruments to be sensitive to cultural differences. Individuals interested in modifying instruments should consult the research literature to identify adaptations that have already been developed and validated or new scales that have been adapted for the instruments. For example, several adaptations of the ASI have been developed for use with American Indians (Carise et al. 1998) and with women (CSAT 1997*c*). Also, new intake and followup scales have been developed for the ASI (Alterman et al. 1998). Counselors are encouraged to determine whether norms for an instrument make sense with the population they are testing. If the recognized criterion score results in too many individuals being excluded from treatment, perhaps the counselor should consider lowering it. (See also the forthcoming TIP *Improving Cultural Competence in Substance Abuse Treatment* [CSAT in development *b*].)

Women respond differently to the screening process than men, and a longer, more flexible format is often useful.

Women

Counselors also need to be aware of special issues in screening and assessing female offenders. Women respond differently to the screening process than men (Kassebaum 1999), and a longer, more flexible format is often useful, particularly to explore unanticipated areas that may arise. Females are more likely than males to have a co-occurring mental disorder and trauma-related problems. In addition, they are more likely to be affected by poverty, abuse histories, unstable social supports, and medical problems (el-Bassel et al. 1996; Fullilove et al. 1993; Haywood et al.

2000; Henderson 1998; Jacobson and Herald 1990; Jordan et al. 1996; Richie and Johnsen 1996; Teplin et al. 1996). In addition, many have lost custody of their children as a result of incarceration. Important counseling and treatment approaches for women are described in CSAT's Technical Assistance Publication (TAP) 23, *Substance Abuse Treatment for Women Offenders: Guide to Promising Practices* (Kassebaum 1999), and the forthcoming TIP *Substance Abuse Treatment: Addressing the Specific Needs of Women* (CSAT in development *g*). Additional guidelines for screening and assessment of trauma history among female offenders are discussed earlier in this chapter.

Most substance abuse screening and assessment instruments were developed and tested in male populations. Those working with female offenders should carefully review screening and assessment instruments to examine whether they have included content that is relevant to female offenders, such as information related to custody of children and parenting, history of physical and sexual abuse, and symptoms of trauma. Test instruments should be examined to determine if they were developed and normed using female populations, and if not, whether there are other instruments that may be more suitable for this population. One example of an instrument that has been tested with both male and female populations is the TCUDS II, which has been found to have good reliability for both genders (Knight 2001). Other screening instruments such as TWEAK have been developed specifically for women.

Offenders With Co-Occurring Mental Disorders

As noted previously, specialized screening and assessment approaches are needed for offenders with co-occurring disorders. Integrated screening and assessment approaches should be used to determine the scope, symptoms, and consequences (e.g., level of cognitive and intellectual functioning) of mental and substance use disorders and to examine the relationship between these disorders and criminal behavior. Because of the high rates of co-occurring disorders among offenders in criminal justice settings, identification of a single disorder (i.e., either mental health or substance use) should immediately trigger screening for the other type of disorder. Somewhat longer periods of screening and assessment may be needed for offenders with cognitive deficits (e.g., limited attention span) related to their mental disorders. Counselors may need to allow breaks during interview sessions, move at a slower pace during the interview, and obtain collateral information to verify key information related to mental disorder symptoms, treatment and medication use, and interactive effects of co-occurring disorders.

Depending on the criminal justice setting, screening may include a brief interview, use of self-report instruments, and review of archival records. A number of short self-report instruments are also available to examine the presence of mental disorder symptoms (Peters and

Advice to the Counselor: Screening Specific Populations

- It may be necessary for a counselor to modify screening and assessment instruments to be sensitive to cultural and other differences.
- Women respond differently to the screening process than men, and a longer, more flexible form is often useful to explore unanticipated areas that may arise.
- Many adaptations have already been developed and validated. For instance, new versions of the ASI have been developed for use among American Indians and with women.
- Counselors interested in modifying instruments should consult the research literature to identify new adaptations or scales for existing instruments.

Bartoi 1997). A mental status examination is also provided during many screenings for co-occurring disorders. In addition to examining key symptoms, mental health treatment history, and family history of mental disorder, it is helpful to assess the interactive effects of both disorders to determine whether there is an independent mental disorder, or if mental disorder symptoms are present only when the offender uses drugs or alcohol.

Screening for suicidal thoughts and behavior should occur on an ongoing basis for all offenders with co-occurring disorders in the criminal justice system. This screening is particularly important for offenders with severe depression or schizophrenia and individuals who are experiencing stimulant withdrawal. Suicide screening should be conducted at the time of transfer to new institutions, or at different stages in the justice system (e.g., arrest, pretrial diversion, probation). All suicidal behavior should be taken seriously and assessed promptly to identify the types of services needed. For more information see TIP 42, *Substance Abuse Treatment for Persons With Co-Occurring Disorders* (CSAT 2005*c*).

Integrated Screening and Assessment—Sample Approaches

Programs often integrate a variety of screening and assessment instruments to place clients in the most appropriate treatment program. Several sample models of integrated screening and assessment implementations are described below.

Colorado Department of Corrections (CDOC)

Colorado has a unique screening and assessment approach applied to offenders in both prison and community settings. All inmates transferred to CDOC for supervision receive a comprehensive screening and assessment for substance abuse problems, including the Alcohol and Substance Use Screening and the Level of Service Inventory–Revised (LSI-R). Based on the instruments, an extensive treatment matching approach places offenders in correctional settings where intensity varies from no treatment to therapeutic communities. The treatment matching approach defines key criteria for admission to each level of correctional treatment services based on the history of involvement in correctional treatment, individual motivation, social support, living arrangements (if in noninstitutional settings), level of mental disorder and substance abuse symptoms, substance dependence symptoms, and other factors (O'Keefe 2000).

Florida Department of Corrections (FDOC)

Florida has developed an integrated screening and assessment system for all inmates entering its reception centers. The system uses the SSI-SA coupled with a records review (e.g., referrals from drug courts, history of DUI or drug offenses, FDOC treatment history) and a self-report gathered from interviews during the reception process. Responses from the various sources are weighted and then used to determine the offender's needed intensity of treatment and placement. Those inmates placed in services are administered a further assessment on transfer to a permanent institution, including the ASI and other psychosocial information. Key screening and assessment information is computerized and available to treatment, classification, and probation and parole staff (U.S. Department of Justice 1991).

Jacksonville, Florida, Adult Drug Court Programs

This jurisdiction takes an integrated approach to screening and assessment that blends information from screening instruments, interviews, and archived records. For example, in the Jacksonville Adult Drug Court program, offenders are first inter-

viewed and offered treatment by their attorneys and the public defender. After that, several steps are followed:

1. Treatment Accountability for Safer Communities (TASC) screens every offender in the program (either in jail or in the TASC office) for the likelihood of substance abuse or dependency, using the agency's screening form, coupled with a commercially available screen.
2. For offenders with substance use disorders, the need for treatment is evaluated using section 1 of the American Society of Addiction Medicine (ASAM) *Patient Placement Criteria*, Second Edition, Revised (PPC-2R) (ASAM 2001).
3. For offenders who need treatment, placement criteria are assessed with the other sections of the ASAM PPC-2R, which include prior treatment history; biomedical, emotional, and behavioral conditions and complications; treatment acceptance/resistance; relapse and continued use potential, and recovery environment.
4. For offenders placed in treatment, a DSM-IV diagnosis is provided.

All screening and assessment information, the offender's treatment progress, and program evaluation and monitoring data are stored in an MIS that is available to drug court staff, including the drug court judge who can access key information such as recent drug test results during drug court status hearings. The MIS was developed by the drug court staff, court technology staff, and the City of Jacksonville. A juvenile MIS is being developed (Cooper 2002).

Orange County, California, Drug Court Program

Orange County targets nonviolent offenders charged with possession or being under the influence of illicit drugs, first determining the offender's eligibility and suitability for the Drug Court Program. To determine eligibility for the Drug Court Program, the district attorney's office flags offenders charged with possession or being under the influence. Then, probation staff reviews prior arrest history and interviews the offender about substance abuse history and willingness and ability to comply with program requirements. Finally, clinical staff from the program's treatment providers complete a screening interview.

Eligible candidates are given a predetermined period of time in which to either plead guilty or opt into the treatment program. When candidates opt for treatment, suitability is then determined. This entails a full assessment, including a complete review of criminal history, the circumstances surrounding the charged offense, the results of any prior interactions with the criminal justice system, and a risk/needs assessment (with the National Institute of Corrections' version of the LSI) to assess treatment needs and risk of reoffense. Finally, clinical staff conducts an ASI and a full psychosocial history to determine the offender's motivation for treatment, desire for change, emotional stability, and ability to comply with program requirements. The program runs for 18 months, with reassessments every 6 months to re-evaluate risk/needs scores (again using the LSI). The new scores are then used by the Drug Court Team (e.g., clinical staff, judge) to adjust supervision and treatment strategies.

Conclusions and Recommendations

The consensus panel believes that the following are important points and recommendations about screening and assessment for criminal justice populations:

- An effective screening and assessment approach will encourage appropriate referral of offenders to different levels of treatment and will reduce the likelihood that offenders are released to the community without treatment (see chapter 3 for related discussion).

- Appropriate assessment for substance abuse treatment in criminal justice settings examines the substance abuse history, psychopathy and related risk factors, history of mental health problems, and other psychosocial areas that are affected by substance abuse.
- Intensive treatment should clearly be reserved for offenders who have at least moderate substance abuse problems and at least moderate risk for criminal recidivism. Intensive treatment for low-risk offenders will have only a minor impact on reincarceration rates. However, there is still considerable work to be done to determine the most effective procedures for treatment matching with offenders.
- Failure to identify incarcerated offenders who need postrelease treatment reduces the impact of positive change that occurred during correctional treatment.
- Improved instruments and procedures for substance abuse screening and assessment will assist in matching offenders to appropriate postrelease treatment services.
- Matching has not been consistently demonstrated to be effective, and only limited alternative approaches are available.
- Because reports of offenders' drug problems are incomplete or contain contradictory information, other collateral sources of information need to be obtained (e.g., drug test results, correctional records) that can be combined with self-report information to make referral decisions. For example, in many correctional facilities, drug tests are used to flag the need for treatment—even when an offender denies recent substance abuse. Similarly, criminal records may indicate substance abuse problems, based on a history of drug-related or DUI/DWI arrests, or presentence investigation results.
- While most staff may conduct screenings, staff with appropriate training should provide assessments and related diagnoses and treatment plan recommendations.
- Screening and assessment instruments vary considerably in their ability to detect substance use disorders and to provide information regarding other areas related to substance abuse. A range of substance abuse screening and assessment instruments have been validated for use with offenders, and some are available at relatively little expense.
- The psychometric properties of screening and assessment instruments should be carefully reviewed, and choice of instruments based on demonstrated reliability and validity within substance abuse populations, and optimally, the utility of instruments in criminal justice settings.
- A tiered screening and assessment approach could be developed in settings in which several types of treatment services are available. The initial screening includes a broad filter to detect those who have substance abuse problems, while the more intensive assessment reviews specific treatment needs and risk levels so that the offender can be assigned to an appropriate level of treatment.
- Screening and assessment information should be obtained at each major point of transition within the criminal justice system (e.g., booking to jail, placement on probation). In some cases, relevant information can be obtained from previous stages in the system, for example through transfer of records from probation to institutional settings.

A range of substance abuse screening and assessment instruments have been validated for use with offenders, and some are available at relatively little expense.

- Offenders initially assessed with symptoms of co-occurring disorders should be evaluated over an extended period of time to examine whether these symptoms resolve in the absence of substance abuse. This reassessment should be conducted by staff members who understand patterns of symptom interaction among co-occurring disorders.
- Screening and assessment for a prior history of physical and sexual abuse should be conducted routinely, particularly in settings that include large numbers of female offenders. Staff training is needed to develop effective interviewing approaches related to the prior history of abuse, counseling approaches in dealing with abuse and trauma issues, and in making referral to mental health services.
- Memoranda of understanding and other formal agreements can be developed across different agencies working within the criminal justice system to promote sharing of screening and assessment information. Key information related to treatment progress, outcomes, diagnoses, and ancillary services needs should be communicated across different points in the criminal justice system.

3 Triage and Placement in Treatment Services

In This Chapter...

Treatment Levels and Components

Potential Barriers to Triage and Placement

Creating a Triage and Placement System

Compiling Information To Guide Triage and Placement Decisions

Conclusions and Recommendations

Overview

Identifying offenders in need of substance abuse treatment is only the first step in providing help to these individuals. Because no single treatment has been shown to be effective for all offenders, effective matching to individual needs such as vocational or employment skills, family counseling, and mental health services improves the likelihood that the client will successfully complete treatment. Matching to specific treatment interventions also is cost-effective and improves the quality of services within existing programs. For example, offenders appropriately matched to either a high-structure, behaviorally oriented program or a low-structure counseling program consistently have significantly less severe problems and lower rates of substance abuse than those not appropriately matched to treatment programs. Finally, with only a limited number of available intensive treatment slots (e.g., residential services) in many criminal justice settings, offenders placed in these programs who do not need or desire intensive treatment may be disruptive or drop out of treatment prematurely, preventing others from benefiting from them.

This chapter provides detailed information on how to best use the information obtained through screening and assessment in order to match the offender to appropriate treatment services. It begins by discussing three major treatment categories and outlines barriers to placement. A detailed discussion of triage and placement follows.

Treatment Levels and Components

The consensus panel believes that treatment matching in the criminal justice system is most effective when there is a continuum of services—ranging from low to high intensity. This section provides a brief description of treatment levels that may be available in criminal justice settings. The continuum of treatment levels includes three major treatment categories: pretreatment services, outpatient treatment, and inpatient treatment (including residential care). Several types of program services

Effectiveness of Treatment Levels—Results From the DATOS Study

Results from the federally funded Drug Abuse Treatment Outcome Studies (DATOS) (Hubbard et al. 1997; Simpson et al. 2002) indicate that all major treatment levels (including long-term residential, short-term inpatient, outpatient, and outpatient methadone) are effective in reducing substance abuse and criminal activity. For example, reductions in weekly cocaine use from pretreatment to 1 year posttreatment followup ranged from 46 percent among short-term residential clients to 20 percent among outpatient methadone clients. Reductions in criminal activity from pretreatment to 1 year posttreatment followup ranged from 25 percent among long-term residential clients to 8 percent among outpatient clients.

Key findings and implications from the DATOS studies include the following:

- All substance abuse treatment modalities are effective in reducing substance abuse and criminal activity.
- Residential treatment programs of at least 3 months' duration are particularly cost-effective for use with criminal justice clients.
- Client readiness for and commitment to change and engagement and retention in treatment are important predictors of treatment outcomes. These factors, when routinely assessed by criminal justice programs, may be useful in targeting offenders who need more intensive services (e.g., intensive case management).
- Measures of client engagement and treatment progress are good predictors of dropout from treatment. When routinely assessed, these predictors can help identify clients who require specialized interventions (e.g., peer mentors, motivational enhancement therapies, individual counseling) to sustain their involvement in treatment.
- Involvement in posttreatment peer support activities is helpful in preventing relapse. Clients are more likely to engage in ongoing peer support groups if they begin these activities during treatment.
- Among clients with prior treatment experience, outcomes are more dependent on the quality of relationships with treatment counselors than are outcomes for first-time clients (Franey and Ashton 2002).

often are available within each treatment level. As the text box above indicates, research suggests that all major treatment levels are effective. Nonetheless, the consensus panel believes that clients should be matched not only on the intensity of services they need, but also on the particular components that are responsive to their individual needs.

Pretreatment Services

Pretreatment services, which are not part of primary treatment, include primary prevention, early intervention, and detoxification. Primary prevention and early intervention are not typically used in criminal justice settings.

- *Primary prevention.* These are services for people who have not used substances. Most primary prevention programs are in schools or the community.
- *Early intervention.* This includes psychoeducational programs for those who have used substances and are considered to be at high risk for substance-related problems or have a history of substance abuse. Other interventions include screening and assessment to identify substance abuse problems. Brief interventions also are appropriate for offenders who use substances but who do not meet the diagnosis of having a substance use disorder. For example, ongoing evaluation can help determine if referral to a more intensive level of care is needed. In some instances, early intervention can be used as short-term treatment for individuals with low-severity substance abuse problems.

- *Detoxification.* Medically supervised detoxification services are required for offenders whose alcohol or drug abuse has caused severe and life-threatening symptoms (e.g., acute intoxication, blackouts). Although detoxification typically is conducted prior to the onset of substance abuse treatment, it is important to provide a thorough assessment during detoxification and to provide orientation to the recovery and treatment process. For more information, see chapter 2 of this TIP and the forthcoming TIP *Detoxification and Substance Abuse Treatment* (Center for Substance Abuse Treatment [CSAT] in development *a*).

Outpatient Treatment

Also referred to as ambulatory care, outpatient treatment provides a broad range of services without overnight accommodation and includes nonintensive and intensive outpatient treatment, methadone treatment, and day treatment or partial hospitalization. Some of these services can be provided following inpatient or residential treatment, or as followup care after involvement in a residential program.

- *Nonintensive outpatient treatment.* This is substance abuse treatment that includes professional assessment and treatment involving less than 9 hours per week in regularly scheduled sessions. Nonintensive outpatient treatment often addresses related psychiatric, emotional, and social issues, and offers a forum to explore issues such as the relationship between violence and mental disorders. Nonintensive outpatient treatment also can accommodate clients with job or family responsibilities, as treatment services may be offered on weekends or evenings.
- *Intensive outpatient treatment.* This is substance abuse treatment with professional assessment and treatment from 9 to 20 hours per week in a structured program. These programs can be held on evenings or weekends. (For more information see the forthcoming TIPs *Substance Abuse: Clinical Issues in Intensive Outpatient Treatment* [CSAT in development *d*] and *Substance Abuse: Administrative Issues in Intensive Outpatient Treatment* [CSAT in development *c*].)
- *Methadone treatment.* This is a medically supervised outpatient treatment that provides counseling while maintaining the client on the drug methadone. This regimen is used primarily for heroin or other opioid addiction and provides a legitimate, closely monitored substitute for illicit drugs. The client must be able to document at least a 2-year history of addiction to qualify for a methadone treatment program. It is rarely used with those who are incarcerated. (For more information see TIP 43, *Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs* [CSAT 2005*a*]).
- *Day treatment or partial hospitalization.* This is substance abuse treatment with professional assessment and treatment of more than 20 hours per week in a structured program. This is the most intensive of the outpatient treatment options and can be used for treating clients who demonstrate the greatest degree of dysfunction but who do not require inpatient or residential treatment. Evening and weekend programming often is included.

Inpatient Treatment and Residential Care

Inpatient treatment options include intensive medical, psychiatric, and psychosocial treatment provided on a 24-hour basis. The continuum of residential care includes psychosocial care at the most intensive end and group living with no professional supervision at the least intensive end. It is unlikely that the full range of services will be available in any one community.

- *Intensive residential treatment.* This long-term treatment can be directed by a substance abuse treatment professional or could be medically directed. Intensive residential treatment is appropriate for people

with multiple problems, especially those with co-occurring mental and substance use disorders (COD). Psychosocial rehabilitation is always a goal of treatment. The duration of treatment in this setting varies considerably, from 3 months to as long as 2 years.

- *Therapeutic community (TC).* The traditional TC is a long-term (15 to 24 months) rehabilitative model that is often staffed by recovering professionals, treatment and mental health professionals, and vocational and educational counselors. Therapeutic help from the residential community paves the way for residents to recover from their substance abuse problems and to develop the vocational, educational, and social skills they need to become productive members of society. Most TC residents have been involved with the criminal justice system. The theory and practice of the TC have been detailed in the literature (De Leon 2000), and the effectiveness of these programs has been documented both in prisons and in community-based settings (Melnick et al. 2001). A 2-day training course offered by the Mid-America Addiction Technology Transfer Center in Kansas City, Missouri, is available. This course consists of lectures, small groups, and instructional materials on the TC model and how it works. For more information go to www.mattc.org/index.html.

Accurate screening and assessment are necessary for effective placement.

- *Psychosocial residential care.* This long-term (6 to 24 months) psychosocial care model has elements similar to the therapeutic community model in that it relies heavily on peer pressure as well as formal treatment to shape behavior. It is appropriate for people with substance abuse problems and concomitant disorders that do not require acute medical or psychiatric intervention. People compliant with psychiatric and other prescription medications are appropriate for this level of care. The focus of care is on psychosocial rehabilitation.
- *Medically monitored intensive inpatient treatment.* This level of care involves around-the-clock medical monitoring, assessment, and treatment in an inpatient setting, usually by a nurse or nurse practitioner. It is used for clients who have acute and severe substance use disorders and who may also have a coexisting medical or psychiatric disorder. Such treatment generally involves a short to intermediate length of stay (7 to 45 days) and may include nonmedical or social model programs with variable lengths of stay.
- *Medically managed intensive inpatient treatment.* This level of care involves around-the-clock, medically directed evaluation and treatment in an acute-care inpatient setting, usually by a medical doctor. This level of care is appropriate for the treatment of medical and psychiatric problems that may require biomedical treatment (such as life support) or secure services (such as locked units). Such treatment generally involves a short to intermediate length of stay (7 to 45 days).
- *Short-term nonhospital intensive residential treatment.* This treatment is generally 21 to 45 days in length and is designed to teach the client how to live a substance-free life and to provide motivation for the maintenance of such a lifestyle. Follow-up care on an outpatient basis and continued participation in peer support groups is recommended to maintain the recovery process begun in the residential setting.
- *Halfway house.* Residents are expected to follow house rules and share house responsibilities in a residential setting under staff supervision. Residents generally find their

own way to outside activities (e.g., work, court, counseling, vocational training, and schooling). The house sometimes offers treatment services. Length of stay is limited or unlimited depending on the attainment of specific progress goals.

- *Group home.* This refers to a residential, transitional living situation without any specific treatment plan and minimal staff supervision. It is sometimes known as a three-quarter-way house. Residents may work and receive education, training, or treatment in the community. House residents generally decide on admission of new residents. House responsibilities are shared, and the house is governed and run by its residents. The length of stay is generally unlimited as long as abstinence from substances is maintained; the Oxford House model includes complete resident self-governance and self-sufficiency. The key to success in all such models is that the living situation is substance free, which supports abstinence among residents.

Potential Barriers to Triage and Placement

Inadequate Screening and Assessment

Accurate screening and assessment are necessary for effective placement. However, resources, adequate time to conduct comprehensive assessments, and trained staff are not always available in criminal justice settings. As a result, substance abuse treatment in criminal justice settings often is based on sparse and inadequate information (Knight et al. 2002).

Competing Demands in Institutional Settings

A challenge for substance abuse treatment programs in institutional settings is the competing demands on offenders' time. For example, a prison's need for labor to fulfill its contracts and maintain itself can compete with an offender's needs for treatment. Or, inmates could be assigned to institutional education programs. In addition, there are also competing demands for treatment. Treatment service options often are limited and waiting lists exist for most services in community-based programs. The community-based system of care across the country largely is funded to provide services to a nonoffender population. In some cases, prioritization of community treatment services for offenders has placed a strain on the limited number of available treatment slots.

Information Flow

Issues regarding the transfer of information across different settings in the criminal justice system present a major barrier to effective placement in offender treatment services. For example, this might include a need for a centralized database that can be accessed by various providers as offenders move through the system.

Creating a Triage and Placement System

The consensus panel believes that to ensure appropriate treatment for offenders who abuse substances, the offender's needs and available resources must be balanced. Coordination of treatment matching within the criminal justice system can reduce the long-term costs of incarceration and other criminal justice functions only if adequate personnel and funding are available for case management. Ongoing planning and coordination among criminal justice staff, substance abuse treatment staff, and policymakers and other stakeholders is important to establish an effective treatment matching system.

Based on the experiences of consensus panel members, the optimal approach would be to assemble a team consisting of correctional/supervision and clinical staff to develop a triage and placement system and to assume

responsibility for compiling and processing treatment matching information. Once the triage and placement system has been developed, the team can review cases referred to treatment, transfers, and placement in high intensity or specialized treatment programs (e.g., co-occurring disorders services).

This coordinated approach also can ensure that ongoing troubleshooting occurs to adjust eligibility criteria, to check admission and transfer procedures, and to monitor reentry to the community. Although triage and placement teams do not necessarily meet on a daily basis, they are regularly involved in reviewing offenders' placement status and decisions to place or transfer offenders to different program settings. Scoring criteria for assigning offenders to different levels of treatment often are developed by clinical staff with significant involvement and review by criminal justice staff (e.g., classification officers). Use of scoring criteria and development of a triage and placement database are useful for document standardization and treatment provision across different groups of offenders.

Following are key triage and placement activities that the consensus panel believes can be jointly undertaken by a team of correctional and clinical staff:

- Developing a treatment placement database of treatment resources available in the community or correctional facility
- Defining key characteristics of existing treatment programs and the types of offenders and associated levels of treatment needs with whom the programs are most successful
- Documenting the referral process with appropriate timeframes and communication requirements for each system
- Outlining the information to be shared between agencies and developing procedures for transfer of key information without breaching confidentiality (for more information on confidentiality, go to www.hipaa.samhsa.gov and see CSAT 2004)
- Describing offender treatment and supervision/management responsibilities for each organization to avoid duplication of efforts, interagency conflict, and lapses in monitoring offenders
- Evaluating the effectiveness of treatment matching practices and placement criteria on an ongoing basis
- Determining offenders' eligibility for and access to health, mental health, and social services in the community

Triage and Placement Strategies

Triage and placement strategies for offender treatment programs depend on the range and type of services available, specific eligibility requirements attached to various programs, and the resources available to manage this process. In some criminal justice settings (e.g., jails) only limited types of services are available, such as 12-Step groups or a more intensive treatment program. In these settings, elaborate triage and referral systems are unnecessary, and placement decisions are often based on a brief substance abuse screening and a brief risk screening (e.g., for violence, acute mental health symptoms) to determine eligibility for the program. This often is accomplished by a single staff member and through a combination of self-administered tests, brief interview, and records review.

In settings that feature a range of treatment services, triage and placement are usually lengthier, often involving multiple staff and compilation of multiple sources of information. These settings often use a scoring system or "algorithm" to determine which offenders should receive priority for available treatment slots. The consensus panel recommends that in general, the sophistication of a treatment matching system should reflect the

- Range of different levels of treatment intensity available
- Scope of information needed to determine eligibility for admission to the various levels of treatment
- Consequences for "mismatching" offenders to the different levels of treatment

Under most conditions, triage and placement decisions are guided by the need to reserve program slots for offenders with more severe substance abuse problems and who present at least moderate risk for criminal recidivism (see Figure 3-1, next page). Research indicates that treatment programs targeting offenders with moderate to high risk for recidivism produce the greatest posttreatment reductions in recidivism and are more cost-effective (Andrews et al. 1990; Bonta 1997; Gendreau 1996). However, research does not support placement of moderate- to high-risk offenders in minimally intensive treatment services (e.g., educational groups, 12-Step groups) unless additional, more intensive services are also provided. In summary, offenders with more severe addiction problems and more significant risks for criminal recidivism do not experience positive treatment outcomes unless they are placed in highly structured and intensive treatment programs. Conversely, assigning low-severity offenders to these high-intensity programs often is inefficient and counterproductive for people who use drugs casually, who are then exposed to the corrosive effects of more seasoned offenders with pronounced criminal attitudes, beliefs, and lifestyles.

Compiling Information To Guide Triage and Placement Decisions

Screening and assessment are discussed comprehensively in chapter 2. This section outlines how to use information derived from screening and assessment to make triage and placement decisions.

As described in Figure 3-1, placement and triage strategies in criminal justice settings often use a tiered approach. In the first stage of this process (screening and assessment), attempts are made to identify major mental health problems or psychopathy that would interfere with involvement in substance abuse treatment. If one of these problems is identified, the offender can be directly routed to a specialized treatment or management unit/program. This tiered approach enables criminal justice staff to quickly identify offenders who are not good candidates for substance abuse treatment and prevents unnecessary substance abuse screening and assessment for offenders who would perform poorly in existing substance abuse programs.

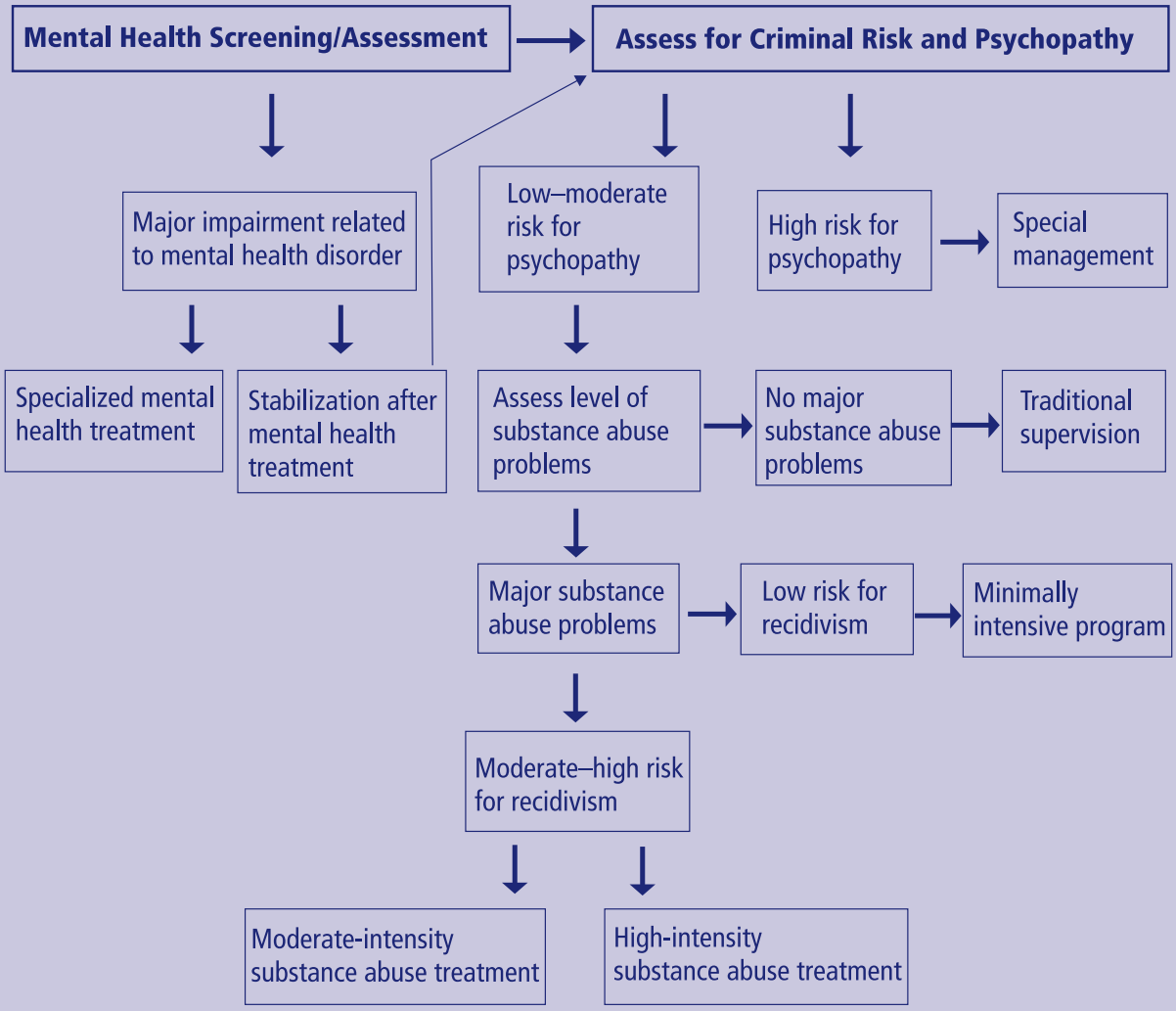
If a range of offender treatment options is available, placement in services usually is determined by the following factors:

- Risk for criminal recidivism

Advice to the Counselor: Triage and Placement

- Measurements of client readiness for change, commitment to change, and engagement in treatment are important predictors of treatment outcomes.
- In settings with limited services available, elaborate triage systems are unnecessary and placement often can be determined with a brief interview of the offender, some self-administered tests, and a records review.
- Accurate screening and assessment are necessary for effective triage and placement in the face of competing demands for resources.

Figure 3-1
Placement and Triage Strategies



Source: Zimmerman 2000.

- Level of offender needs for substance abuse, mental health and other psychosocial or medical services, and employment
- Offender motivation and readiness for treatment
- Other offender characteristics including cognitive and intellectual abilities, abilities to read and write, and related abilities to communicate in individual and group settings and to withstand stress in highly intensive therapeutic communities

Research indicates that treatment programs that place individuals in services according to these areas are likely to enhance outcomes for offenders (Andrews et al. 1990; Gendreau 1996). The following sections discuss each of

these areas in relation to triage and placement services, identify information sources necessary for placement, and list instruments that can be used to compile the information. For more information on the instruments listed, see chapter 2 and appendix C.

Risk for Criminal Recidivism

Assessment of the risk for future criminal and/or violent behavior is of vital importance in the process of assigning offenders to treatment programs within the criminal justice system. Offender characteristics and environmental factors used to estimate the likelihood of future criminal behavior are termed "risk factors." (See chapter 2 for information on identifying risk factors.)

Once criminal risk factors are identified, research indicates that structured and intensive cognitive–behavioral approaches can address offenders' "criminogenic needs" related to their dynamic risk factors (those that are likely to change over time) (Andrews and Bonta 1998; Wanberg and Milkman 1998). Andrews and Bonta (1998) have identified several promising targets for treatment intervention based on dynamic risk factors:

- Developing and improving life management, problemsolving, and self-control skills
- Developing associations or relationships and bonding with prosocial and anticriminal peers and with prosocial and anticriminal role models
- Enhancing closer family feelings and communication
- Improving positive family structures to promote monitoring
- Managing and changing antisocial thoughts, attitudes, and feelings

In general, offenders who are at high risk for criminal recidivism require more structured and intensive treatment interventions such as intensive outpatient treatment, day treatment, residential treatment, or TCs, while low-risk offenders are better suited for low-intensity interventions such as outpatient treatment, drug education, and peer support or 12-Step programs (see Figure 3-1) (Falkin et al. 1999).

Information needed for triage and placement

- Criminal history, including age at first arrest, number and type of prior arrests, history of violence and aggressive behavior, history of incarceration, probation and/or parole revocations
- Age, education, marital status, employment history
- Characteristics of psychopathy, including entitlement, impulsivity, superficial interpersonal relationships, lack of empathy, sensation seeking, poorly controlled anger
- Nature of offender's family and social network (prosocial versus procriminal)
- Other personality disorders, including paranoia

Instruments used to compile this information

Use of some of these instruments is described in chapter 2.

- Psychopathy Checklist—Revised (PCL-R) and the Psychopathy Checklist–Screening Version (PCL-SV)
- Psychopathic Personality Inventory (PPI)
- Level of Services Inventory—Revised (LSI-R)
- Millon Clinical Multiaxial Inventory—III (MCMI-III), Correctional Form
- Personality Assessment Instrument (PAI)
- Novaco Anger Inventory
- Jesness Inventory
- Paulus Deception Scale
- Inventory of Sensation Seeking

Level of Substance Abuse Problems

Offenders with current alcohol or drug dependence and a history of chronic substance use generally require more structured and intensive levels of treatment (Knight et al. 1999*b*; Simpson et al. 1999*a*). There is some evidence that highly structured treatment approaches that use a cognitive–behavioral orientation are more effective for offenders with pronounced substance abuse problems, in comparison to less structured client-centered approaches that use nondirective, supportive counseling strategies (Thornton et al. 1998). Offenders who have less serious substance abuse problems are likely to benefit from a variety of treatment options across a range of modalities and levels of intensity (Knight et al. 1999*b*; Simpson et al. 1999*b*).

Information needed for triage and placement

- Substance dependence symptoms
- Substance abuse-related arrests (e.g., driving under the influence [DUI]/driving while intoxicated [DWI], drug possession and sales)
- History of substance abuse (frequency, quantity, type of substances, route of administration)
- Drug test results or other pre- or postsentence information related to substance abuse
- History of involvement in substance abuse treatment services

Instruments used to compile this information

Use of these instruments is described in chapter 2.

- Addiction Severity Index (ASI)
- Simple Screening Instrument for Substance Abuse (SSI-SA)
- Texas Christian University Drug Screen (TCUDS)
- Alcohol Dependency Scale (ADS)

Level of Mental Health Problems

Offenders with co-occurring mental disorders have participated successfully in many substance abuse treatment programs in criminal justice settings, although they generally have more pronounced difficulties in employment, family relationships, and physical health (Peters et al. 1992) and sometimes have cognitive deficits related to their mental disorders. Although offenders with co-occurring substance use and mental disorders present unique challenges, their ability to participate in treatment programs varies according to their functioning level in several key areas, including the ability to sustain attention and to participate in individual and group interactions, their vulnerability to emotional conflict, and the presence of acute symptoms (e.g., paranoia, delusions). As a result, triage should include a mental health assessment to examine the potential effects of mental health problems on their participation in available treatment programs. Even moderate to high levels of mental disorders can be accommodated in many criminal justice treatment programs, particularly those with mental health and other health services staff available, and that feature specialized treatment services for people with co-occurring disorders (Edens et al. 1997).

Information needed for triage and placement

- Acute mental disorder symptoms that can influence the offender's ability to participate in individual or group treatment settings
- Suicidal or other violent behaviors
- Cognitive and interpersonal or social impairment caused by current mental disorder symptoms, specifically related to atten-

tion and concentration, problemsolving skills, interpersonal skills, and frustration tolerance

- Effects of stress and other environmental influences on mental disorder symptoms and related behavioral problems
- Likelihood of recurrence of mental disorder symptoms and behavioral problems given environmental conditions in available treatment programs
- Accommodations available in existing treatment programs to address mental disorder symptoms and behavioral problems

Instruments used to compile this information

Use of these instruments is described in chapter 2.

- Minnesota Multiphasic Personality Inventory (MMPI)
- Millon Clinical Multiaxial Inventory—III (MCMI-III)
- Symptom Checklist 90-Revised (SCL90-R)
- Brief Symptom Inventory (BSI)

Offender Motivation and Readiness for Change

The offender's motivation and readiness for treatment is another key factor in triage for placement in substance abuse treatment. Motivation and readiness for change are important predictors of treatment compliance, dropout, and outcome, and this information is vital (Ries and Ellingson 1990). Treatment is likely to be ineffective until individuals accept the need for treatment of their substance abuse as well as other related problems.

An offender's motivation to participate in treatment is influenced by justice system sanctions and incentives, including court orders to complete treatment, probation revocation, more intensive mandatory treatment, "good time" credit for involvement in correctional treatment, and incarceration in jail or prison. Offenders also may be motivated by negative consequences outside the justice system, including threats to stable housing, employment, family, and marriage (Ziedonis and Fisher 1994).

However, the consensus panel cautions that assessments of motivation and readiness for change that occur outside clinical settings can misidentify significant numbers of offenders who could benefit from involvement in substance abuse treatment. Many offenders who initially appear unmotivated can quickly become engaged in treatment through peers who are committed to recovery and who are actively involved in treatment. Involvement in group counseling and contact with program participants and staff can stimulate motivation for change in the previously unmotivated offender.

> The offender's motivation and readiness for treatment is a key factor in triage for placement in substance abuse treatment.

Motivation for treatment changes over time, and offenders often cycle through several predictable stages of change during the treatment and recovery process. The stages of change model has been developed to describe recovery from various types of addictive disorders (Prochaska et al. 1992), and includes the following stages:

- Precontemplation (unawareness of substance abuse problems)
- Contemplation (awareness of substance abuse problems)

- Preparation (decision point)
- Action (active behavior change)
- Maintenance (ongoing preventive behaviors)

Offenders who are in the precontemplation stage of change have little awareness of substance abuse (or other) problems and have few intentions of changing their behavior. Awareness of problems increases in later stages, as the individual begins to consider the goal of abstinence. However, due to the chronic relapsing nature of substance use disorders, movement through stages of change is not a linear process, and offenders often return to earlier stages of change before achieving sustained abstinence.

Matching offenders to treatment services that are appropriate to the current stage of change is likely to enhance treatment compliance and outcomes.

Assessments of offenders' motivation for treatment and their current stage of change are useful in matching to different types of treatment and to developing treatment plans. For example, matching offenders to treatment services that are appropriate to the current stage of change is likely to enhance treatment compliance and outcomes. Conversely, for offenders who are in the early stages of change, placement in treatment that is too advanced and that does not address ambivalence regarding behavior change may lead to unsuccessful termination from treatment. For individuals in the later stages of change, placement in services that focus primarily on early recovery issues also may lead to unsuccessful termination from treatment. Several considerations are provided in chapter 5 regarding matching treatment services to the offender's stage of recovery. For more information, see TIP 35, *Enhancing Motivation for Change in Substance Abuse Treatment* (CSAT 1999*b*).

Information needed for triage and placement

- Perceived severity of drug and alcohol problems
- Interest in making changes in drug and alcohol use
- Steps that have been taken by the offender toward abstinence from alcohol or drugs
- Perceived importance of receiving substance abuse treatment

Instruments used to compile this information

- Circumstances, Motivation, Readiness, and Suitability Scale (CMRS) (De Leon and Jainchill 1986; DeLeon et al. 1994)
- Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES)
- University of Rhode Island Change Assessment Scale (URICA) (DiClemente and Hughes 1990)

Examples of Triage and Placement Approaches

The consensus panel thought that the following three examples demonstrated effective use of triage and placement strategies.

Florida Department of Corrections

The Florida Department of Corrections has operationalized a multilevel triage process to refer inmates to substance abuse treatment programs. This process involves the following steps:

- Review by classification staff to examine sentence structure, prior arrests, and correctional history.
- Brief screening for substance abuse problems and dependence symptoms using a modified version of the SSI-SA.
- Personal interview.
- Determination of the need for treatment based on the substance abuse screening, the history of drug or alcohol offenses, prior history in correctional treatment, recommendations by drug courts or other sentencing courts, and staff or self-reported referral for treatment.
- Assignment of a "priority score" for substance abuse treatment, based on the substance abuse screening score, the number of prior substance abuse offenses, number of prior correctional treatment episodes, positive drug test results, and counselor interview results.
- Routine identification of inmates prioritized for substance abuse treatment through "flags" initiated within the computerized database.

Several of the components contributing to the priority score are weighted, including recommendations for treatment from drug courts or other sentencing courts, DUI manslaughter convictions, and unsuccessful termination from community corrections residential treatment programs. The inmate priority score is entered on a computerized database. Inmates with high priority scores are then transferred to facilities with substance abuse treatment programs, where an additional substance abuse screening and interview is conducted. Priority placement in intensive treatment services is provided for inmates with at least 12 to 18 months remaining on their sentence.

Megargee and Case Management Classification Systems

Correctional systems have long used a variety of typologies to match clients to treatment and supervision approaches in institutional and community settings. These typologies usually are based on a combination of criminal history variables and psychosocial characteristics. One example of a multidimensional treatment matching system is the Megargee System, which is based on an extensive analysis of Minnesota Multiphasic Personality Inventory (MMPI) responses given by a large sample of Federal prison inmates. Ten distinctive profile types have been identified, each with varying treatment implications that range from recommended placement in the least restrictive setting to placement in specialized mental health facilities (Vigdal and Stadler 1996).

The Case Management Classification (CMC) system was developed by the Wisconsin Department of Corrections. Based on an offender's responses to a 45-minute semistructured interview, four categories are used to determine treatment assignment within the correctional system:

1. Selective intervention for offenders who have led relatively stable, prosocial lives. The current offense resulted from an isolated stressful event and represents a temporary lapse.
2. Environmental structure for offenders lacking social and vocational skills who are typically led by others into criminal activity.
3. Casework control for offenders with very unstable lives who are actively involved with drugs or alcohol and have a number of prior arrests.
4. Limited setting for offenders with long-term criminal involvement and who are comfortable with their criminal lifestyle and strive for success through criminal activity.

ASAM Patient Placement Criteria

One approach that has been developed to assist in triage and placement decisions for substance abuse treatment services is the revised version of the American Society of Addiction Medicine (ASAM) *Patient Placement Criteria* (PPC-2R) *for the Treatment of Substance-Related Disorders*, Second Edition, Revised (ASAM 2001). These criteria provide guidance for substance abuse counselors and other treatment staff in determining the best "match" between client characteristics and several levels of treatment services. An interview format of the ASAM PPC-2R is under development for use in clinical settings. Within the ASAM approach, treatment matching is facilitated for several different levels of treatment, including the following:

- Level 0.5—Early intervention
- Level 1—Outpatient treatment
- Level 2—Intensive outpatient treatment/partial hospitalization
- Level 3—Residential/inpatient treatment
- Level 4—Medically managed intensive inpatient treatment

Client characteristics are described across six dimensions for each level of treatment. Within each of these dimensions, the client characteristics described are intended to reflect a good "match" between client needs and the treatment setting. Dimensions of client characteristics in the ASAM-PPC-2R system are

1. Alcohol intoxication and/or withdrawal potential
2. Biomedical conditions and complications
3. Emotional, behavioral, or cognitive conditions and complications
4. Readiness to change
5. Relapse, continued use, or continued problem potential
6. Recovery environment

The ASAM approach, or similar dimensional matching strategies, may be useful for substance abuse treatment staff within criminal justice settings. Although the ASAM criteria have not yet been formally adapted for offender populations, the PPC-2R could prove helpful in providing a structured vehicle for determining which offenders would benefit from different levels of treatment intensity, structure, and supervision. One additional dimension that could be useful to incorporate in criminal justice adaptations of the ASAM PPC-2R is the risk for criminal recidivism. Levels of treatment services specified within the ASAM criteria would also need to be tailored to specific types of criminal justice settings (e.g., drug courts, restitution or day treatment centers, in-jail and in-prison settings), with additional client–offender dimensional criteria developed for each of these new settings. Although this adaptation process would require some attention, there is likely to be significant overlap between client–offender dimensional criteria for these new settings (e.g., drug courts), and existing ASAM criteria for various settings (e.g., intensive outpatient treatment, therapeutic communities).

Conclusions and Recommendations

The consensus panel recommends that several key points be considered when developing a triage and placement system for substance abuse treatment in the criminal justice system:

- An effective triage and placement system should be developed to ensure adequate training and availability of staff to conduct assessments.
- In general, offenders who have significant risk for substance abuse and criminal recidivism should be prioritized for initial placement in substance abuse treatment services, rather than in other institutional programs (e.g., educational or vocational/employment services). These offenders should be referred to intensive

treatment programs (e.g., day treatment, intensive outpatient, residential services).

- Mental disorder symptoms and impairment should be carefully considered in determining placement in substance abuse treatment services. The functional ability of inmates should be the central concern in triage and placement decisions, rather than mental disorder diagnoses.
- A centralized substance abuse treatment database should be created to organize results from screening and assessment, to help coordinate the triage and placement process, and to track offender progress in treatment.
- In addition to key information regarding substance abuse problems, risk for criminal recidivism, and mental health problems, triage and placement decisions also should consider the offender's motivation and readiness for treatment, the length of sentence/incarceration, prior history in treatment, violence potential, and other related security and management issues.
- A centralized database that provides timely information on offenders as well as the availability of services should be developed to improve triage and placement.

4 Substance Abuse Treatment Planning

In This Chapter...

Assessing the Severity of Substance Use Disorders

Assessing the Severity of Co-Occurring Disorders

Criminality and Psychopathy

Client Motivation and Readiness for Change

Implementing an Effective Treatment Planning Process

Conclusions and Recommendations

The good treatment plan is a comprehensive set of tools and strategies that address the client's identifiable strengths as well as her or his problems and deficits. It presents an approach for sequencing resources and activities, and identifies benchmarks of progress to guide evaluation.

—Center for Substance Abuse Treatment (CSAT) 1994*d*, p. 21

Overview

While screening and assessment identify the offender's need for substance abuse and other treatment services, and triage and placement services match the offender to the proper treatment, the treatment plan is where the information gathered is used to put treatment into practice. A treatment plan is a map specifying where clients are in recovery from substance use and criminality, where they need to be, and how they can best use available resources (personal, program-based, or criminal justice) to get there. At a minimum, the treatment plan serves as a basis of shared understanding between the client and treatment providers. Clients learn what is expected of them in program commitments and attendance.

There are many approaches to treatment planning, but they possess some basic commonalities; this chapter discusses each in further detail. The severity of substance abuse-related problems must be determined, since this is the basis for appropriate placement in a treatment program. In addition, the presence of co-occurring mental disorders must be assessed because these may limit the type of treatment approach and identify the need for psychiatric care. Also important is assessing factors such as procriminal attitudes and psychopathy that may suggest persistent criminality unrelated to substance abuse. The degree to which the individual is motivated to change behavior and lifestyle is another critical factor that has a bearing on whether motivational enhancement interventions, sanctions, or more self-directed treatments are appropriate. Finally, offender-clients should be involved in developing their treatment plan so that they can be referred to appropriate services in the community.

Assessing the Severity of Substance Use Disorders

Treatment planning within the criminal justice system requires a comprehensive assessment of an offender's substance abuse history and patterns of use, including drug(s) of abuse, chronological patterns of use, specific reasons for use, consequences of use, and family history of drug and alcohol abuse. Often treatment involvement within the criminal justice system is based primarily on a conviction or plea to a drug-related offense. Although the number and type of substance-related charges is sometimes a fairly good indicator of substance abuse and related problems, the offense category alone is not a foolproof indicator of treatment need or of appropriateness of referral to a specific program. The presence of intoxicants in blood or urine at the time of arrest is a better, albeit imperfect, indicator.

Using multiple indicators for assessing the severity of a substance use disorder is important because individuals with few substance-related problems typically do not respond favorably to intensive treatment and fail to identify with the process of recovery. Close association with more severely affected offenders can result in the less-severe offender becoming socialized into a criminal and drug-oriented lifestyle through contagion of attitudes and introduction to a criminal social network. Minimally, an assessment of severity should focus on determining the impact of use on the individual's community adjustment. Usually this also entails taking a drug history that inquires about the frequency, dosage, and types of drugs used. A drug history may also inquire about the times at which, or settings in which, an offender uses.

Assessment of the severity of a substance use disorder may lead to an actual diagnosis of a substance use or dependence disorder. However, most offender treatment programs consider routine use of illicit drugs without a diagnosable disorder to be a legitimate focus for treatment, since any use is illegal and may result in arrest or violations of community supervision guidelines. Also, most settings lack the qualified staff and time required to make formal diagnoses, and clients are sometimes in the setting for too short a time to delay treatment while awaiting formal diagnosis of a substance use disorder. In these settings, clinical impressions are more feasible than are formal diagnoses, and common sense, assisted where possible by standardized assessment instruments, should prevail in deciding whether and how to provide treatment services. Fortunately, several standardized instruments with good psychometric properties are available in the public domain, or at low cost, for the purpose of screening and assessment of substance use severity (see chapter 2).

Assessing the Severity of Co-Occurring Disorders

Another important area to assess in developing a treatment plan is the presence and impact of psychological and emotional problems, particularly those that are not the direct result of substance abuse. Offenders with severe substance use disorders have relatively high rates of affective disorders, anxiety disorders, and personality disorders. These disorders can contribute to the development of substance use problems, or the emotional disorders may develop as a consequence of the physiological effects of long-standing drug use and the stressful or traumatic life events that are often experienced as part of a lifestyle in which drug use plays a central role. Some individuals have mental health problems prior to intake; others develop them during adjudication, incarceration, or community supervision. Commonly encountered disorders include anxiety, depression, and posttraumatic stress disorder (PTSD) (Teplin et al. 1996). Developing programs to assist those with co-occurring mental and substance use disorders requires integrating treatments and modifying commonly

used interventions to take into account possible cognitive disabilities and increased need for support among these individuals. In addition, system-level barriers in funding, staffing, and training must be overcome (Drake et al. 2001). (See also TIP 42, *Substance Abuse Treatment for Persons With Co-Occurring Disorders* [CSAT 2005*c*].)

Although the treatment of co-occurring severe mental disorders and substance use disorders sometimes is provided in specialized, more intensive programs, less severe mental disorders that do not cause major functional impairment can be treated and managed effectively within mainstream programs. Moreover, not addressing these underlying problems can increase the likelihood of relapse. It is important to note, however, that the early stages of recovery often are marked by increases in depression and anxiety, due, in part, to residual effects of substance withdrawal and also to the individual's recognition of consequences related to his substance abuse, including incarceration or other restrictions to his liberty. Likewise, substance abuse may mask an underlying mental disorder that may not become apparent until the offender is no longer using drugs or alcohol. Thus, assessments should be repeated regularly during the treatment process.

Posttraumatic Stress Disorder and Depression

Problematic early life experiences, physical and sexual abuse, witnessing violence among family and friends, and other traumatic life events often emerge as key issues in substance abuse treatment. Whether identified initially or after a period of treatment, it is important that these issues be reflected in the treatment plan, matched with interventions likely to be effective, and tracked with regard to progress. For example, while most clients will find that negative mood will decrease over the first few months of abstinence and treatment, an individual's depression, nightmares, and other trauma-related symptoms might persist after several months. If symptoms do not require transfer to a mental health services program, this individual should be referred to mental health professionals for further assessment and treatment. The referral could result in recommendations for antidepressants and/or antianxiety medications and/or involvement in cognitive–behavioral therapy related to trauma and substance abuse issues. These interventions may be instrumental in preventing substance abuse relapse and allowing the client to continue making progress within her substance abuse treatment program.

Advice to the Counselor: Mental Health Issues

- After a few months of abstinence, most clients will show a decrease in negative mood related to their substance use. However, abstinence may reveal the presence of other, more serious mental disorders (such as posttraumatic stress disorder, depression, schizophrenia, intermittent explosive disorder, or borderline personality disorder) that will require collaboration with a mental health professional. Some individuals will achieve a level of adjustment that will allow them to continue in mainstream substance abuse treatment, but others will require more intensive intervention for their co-occurring disorders.

Serious Mental Disorders

Although they occur less frequently than PTSD and mild anxiety or depression, serious mental disorders (including schizophrenia, delusional disorder, bipolar disorder, and major depression) can adversely affect the ability of treatment programs to manage an offender's behavior. Behavioral disorders that involve self-harm (e.g., cutting or burning oneself, suicidal threats or attempts), and impulsive and uncontrollable aggression are particularly problematic to manage in a treatment setting. These more severe

behaviors require involvement of mental health professionals for diagnostic workup and treatment interventions.

In the case of serious mental disorders and threatening behavioral disorders, an assertive, psychiatrically based treatment approach is needed during the most intensive phases of the disorder. After the more severe symptoms have abated (usually through medication and behavioral management on a specialized unit or in a hospital), collaboration between mental health and substance abuse professionals is needed to determine the best approach to manage and treat the individual. Some individuals will achieve a level of adjustment that will allow mainstreaming within substance abuse programs, with medication monitoring in collaboration with medical staff. Other individuals will require more intensively integrated care and intervention for their co-occurring disorders.

Intermittent Explosive Disorder

Treatment planning for individuals who present with an intermittent threatening behavioral disorder is complex. If these behaviors are fairly frequent, it will be impractical to manage the individual in a mainstream program. If these behaviors occur infrequently, the individual may be manageable in the mainstream setting, but only with additional assessment as to the causal antecedents (immediate situation and circumstances) of the outbursts or self-harm behaviors and an analysis of the incentives and perpetuating factors that fuel the behavior. With this assessment in hand, the treatment plan can be used to alert and guide the individual and staff regarding triggers for the unwanted behaviors and ways to defuse their appearance, or ways to limit the threat they present to the client and others.

The treatment plan in such cases will often involve the client's committing to a behavior contract that requires reporting strong temptations or urges to the staff, specifies self-control strategies, and clarifies the consequences of the behavior, which may include sanctions for misconduct, intensification of treatment, or removal from the mainstream program with referral to a specialized behavioral unit. In many cases psychiatric consultations and medication management can be helpful.

Borderline Personality Disorder

Individuals diagnosed with borderline personality disorder (BPD) sometimes engage in severely disruptive behaviors. Individuals with this disorder typically experience many specific negative emotions (vulnerability, hostility, sadness, anxiety, etc.) or a nonspecific but intense sense of distress or "feeling bad." This is combined with an inability to monitor and control emotions, alternating chaotic or contradictory ways of relating to self and others, and self-harm or dramatically self-destructive behaviors.

Dialectical Behavior Therapy (DBT) (Linehan 1993) has been developed specifically for treatment of BPD. This treatment requires specialized training, and manualized interventions are available to guide group treatment sessions. DBT approaches can be successfully integrated with substance abuse treatment in much the same way that the treatment of severe mental disorders is coordinated with mainstream substance abuse treatment. Clients participating in DBT do so on a voluntary basis, and agree to attend skills training sessions and to work on reducing suicidal or self-injurious behavior and other behaviors that interfere with treatment. Core DBT interventions involve careful examination of clients' problems and emotional difficulties, as well as a recognition that these problems make sense within the context of current life situations. Problemsolving skills are used throughout DBT, as are contingency management, cognitive–behavioral treatment approaches, supervised "exposure" to past trauma events, and use of psychotropic medication.

The DBT approach typically consists of at least 1 year of treatment, comprising weekly individual psychotherapy and group therapy sessions. Individual sessions explore problematic behaviors and chains of events leading up to the behaviors, while therapy sessions focus on interpersonal effectiveness skills, tolerance of distress, emotional regulation, and self-awareness or "mindfulness" skills. The pretreatment phase of DBT is dedicated to assessment, orientation, and developing commitment to the treatment process.

Three subsequent stages of treatment emphasize self-examination and development of skills. Stage 1 of DBT involves examination of suicidal and other problem behaviors that interfere with treatment and the client's quality of life, and development of related skills to address these issues. Stage 2 of DBT addresses problems related to PTSD, and Stage 3 is focused on developing self-esteem and addressing individual treatment goals.

Advice to the Counselor: Borderline Personality Disorder

- Severely disruptive clients may have borderline personality disorder. Dialectical Behavior Therapy has been developed specifically for treatment of this disorder and can be successfully integrated with substance abuse treatment programs.

Criminality and Psychopathy

In developing treatment plans for substance-involved offenders, it is important to assess whether criminal attitudes and behaviors predated drug and alcohol abuse and whether criminogenic personality features will impede involvement in treatment. This assessment is useful in constructing a balance between risk containment and rehabilitative activities prescribed for the offender, and, along with substance use disorder severity and presence of psychopathology, is one of the most important predictors of treatment outcome. Although substance abuse treatment has become increasingly integral to the criminal justice system, it should not be assumed that crimes committed by drug-involved offenders are solely the result of drug-acquiring behavior or are attributable to intoxication and impaired brain functioning. The majority of drug-involved offenders show a dramatically reduced pattern of criminal activity while they are abstinent and involved in treatment, as compared with periods of active substance abuse (De Leon et al. 1982; Deschenes et al. 1991). Nonetheless, some offenders persist in committing a high frequency of property and violent crimes, even in the absence of substance abuse.

Sources of Criminality

Many offenders begin their criminal careers before the onset of substance use, with drugs and alcohol being more symptomatic of a broader pattern of delinquency, acting-out, and social deviance. Three sources of criminal behavior that are closely associated with drug use can be identified: procriminal values, procriminal associates, and psychopathy.

Procriminal values

Procriminal values in adults are most often the result of the combination of early involvement with delinquent peers, the experience of parental neglect or abuse, the absence of prosocial resources and strengths (such as literacy, employability, and social skills), and exposure to an overly permissive or procriminal environment, such as an unsafe school or crime-ridden neighborhood. Examples of procriminal values include intolerance for personal distress and unwillingness to accept responsibility for behaviors that adversely affect others. Procriminal values and attitudes, coupled with a longstanding pattern of antisocial and criminal behaviors, are the key elements of psychopathy.

Procriminal associates

Procriminal associates can develop from life in proximity to high-frequency crime areas, but more often the choice of criminal associates is the logical result of "criminal thinking" and procriminal values. Procriminal associations are also formed during incarceration or involvement in criminal justice programming. Often these are not balanced by prosocial friendships because of the person's inability to overcome the stigma of having a criminal record or attract and maintain relationships with individuals who are socially less "marginal."

Procriminal values and thinking, as well as criminal associates, are rooted in normal cognitive, emotional, and social processes, such as the need for belonging and approval, the need to feel that one has gotten a "fair deal" in life, and the need to feel a sense of self-efficacy and security. Because the origin and perpetuation of these factors are based primarily in normal psychosocial aspects of the person—that is, they are based on thoughts, emotions, and ways of relating that are within normal limits—they are fairly susceptible to being modified using the psychosocial methods common to the major substance abuse treatment modalities. Individuals whose criminality results primarily from these two factors can learn new ways of thinking and valuing, as well as new ways of feeling and how to manage their feelings, especially in the context of developing new prosocial and pro-recovery relationships. Treatment approaches that address criminal thinking are discussed in chapter 5.

Psychopathy

Psychopathy is distinguished from both procriminal values and procriminal associates in that it is most often conceptualized as a personality trait with primarily biological underpinnings. When this trait becomes extreme it can be described as a personality disorder. Personality disorders are distinctive, long-standing, pervasive patterns of behavior, which usually begin early in life. Personality disorders tend to affect almost every aspect of a person, such as thinking, feeling, perceiving, and relating to others, with worsening cycles of self-defeating and maladaptive behavior. Most theorists and researchers view psychopathy as the result of interactions between biological differences—primarily located in the brain (Anderson et al. 1999; Laakso et al. 2001)—and the most early and basic experiences that shape the personality, such as the experience of bonding, attachment, and concern for others (Hare 1996). Psychopathy is expressed in ways of thinking (impulsive, irresponsible, and grandiose) and feeling (without empathy and shallow) that typically result in behaviors that seriously infringe on the rights of others.

In contrast to the BPD, the most notable characteristic of individuals with severe psychopathy (other than persistent criminality and exploitation of others) is the lack of normal attachment to and value for other people. Although they can be glib and charming, people with psychopathy have a shallow and fleeting ability to experience, express, and understand social emotions such as embarrassment, self-consciousness, shame, guilt, pity, and remorse. This affective-interpersonal deficit often is expressed in the form of cold and callous use of other people without regard for their feelings or well-being. This lack of empathy is usually the basis for a lack of remorse for criminal behavior and is supported by the belief that society and the victim are at fault, rather than the perpetrator, or that the damage done by one's crimes is of little consequence (Hare 1998*a*).

The Psychopathy Checklist–Screening Version (PCL–SV) can provide an important screening mechanism for identifying those offenders who may require a more extensive evaluation. The PCL-SV and other instruments for examining psychopathy are discussed in more detail in chapter 2. All other things being equal, individuals who are low in psychopathy can be expected to respond favorably to substance abuse treatment in the

criminal justice system and to significantly reduce their criminal behavior as the result of this treatment. Individuals who are in the moderate range of psychopathy will benefit from treatment but will require more intensive monitoring, an emphasis on consequences and potential sanctions versus personal aspirations and goals, and vigilance for deception and manipulation of treatment and criminal justice supervisors.

Individuals high in psychopathy require the most intensive in-prison and community supervision and monitoring. Intensive treatments that engage the client in deep emotional processing, that require "working through" life experiences to develop insight, or that stress the development of social skills for their own sake should be avoided for this group. Treatments should be limited to practical relapse prevention activities, including relapse to illegal or seriously self-defeating forms of manipulation and exploitation of others, with increased monitoring for drug use. All self-reported aspects of community adjustment must be carefully corroborated by first-hand observation or reported by an independent third party, including, for example, attendance at required programming, status of living conditions, type and hours of work, criminal background of close associates, and use of leisure time.

Offenders with severe psychopathy tend to do poorly in treatments of all types, when compared to those without severe psychopathy. Of great importance is the surprising and paradoxical finding (now replicated) that offenders with severe psychopathy who are given intensive treatment re-offend more frequently and more seriously than offenders with psychopathy who go untreated (Hobson et al. 2000; Reiss et al. 1999, 2000). In other words, treatment may be contraindicated for offenders with severe psychopathy.

Client Motivation and Readiness for Change

The successful implementation of a treatment plan depends, to a great extent, on the client's motivation and readiness for change. Motivation level has been found to be an important predictor of treatment compliance, dropout, and outcome, and is useful in making referrals to treatment services and in determining prognosis (Ries and Ellingson 1990). Motivation is sometimes thought of as an emotional commitment to voluntary engagement in treatment. However, this view is overly simplistic, since motivation can be influenced by many factors including the threat of sanctions or the promise of rewards for treatment engagement (such as reduced jail time, access to needed services, or transfer to a desired correctional facility where the treatment will take place). Motivation and readiness for treatment are expected to change over time, and individuals often cycle through several predictable "stages of change" during the treatment and recovery process. Due to the chronic relapsing nature of substance abuse problems, offenders frequently return to previous stages of change before achieving recovery goals and sustained periods of abstinence. (See chapter 3 for a discussion of the stages.)

A number of attempts have been made to link the readiness to change approach to a substance abuse-specific model that involves

Advice to the Counselor: Psychopathy

- Individuals high in psychopathy require the most intensive in-prison and community supervision and monitoring. Treatment should be limited to practical relapse prevention activities, including relapse to illegal or seriously self-defeating forms of manipulation and exploitation of others, with increased monitoring for drug use.
- All self-reported aspects of community adjustment must be carefully corroborated by first-hand observation or an independent third party.

"phases" of recovery. Each phase of recovery is typified by a characteristic level of motivation, often reflected in engagement with treatment and with specific recovery-related activities. These models have considerable value for both treatment planning and research as ways of describing and communicating about where a client is in regard to readiness (McHugo et al. 1995).

Assessment of treatment readiness and stage of change is useful in treatment planning and in matching the offender to different types of treatment. For example, matching offenders to treatment that is appropriate to their current stage of change is likely to enhance treatment compliance and outcomes. For individuals in the early stages of change, placement in treatment that is too advanced and that does not address ambivalence regarding behavior change may lead to early termination from the program. For offenders who are in later stages of change, placement in services that focus primarily on early recovery issues may also lead to premature termination from treatment. Staff involved in treatment planning should be careful to assess the offender's stage of change and readiness for substance abuse treatment and to consider this information when developing treatment plan goals. Ongoing review of readiness for treatment can be provided through use of self-report instruments, focused discussion with the client, observation of the client within a treatment program, and review of collateral reports from treatment staff, criminal justice staff, and family members. Several techniques for screening and assessment of readiness for change are discussed in chapter 3.

Motivation for change is so often an issue for criminal justice clients that perhaps most treatment plans should contain a section addressing motivation and readiness for change. Surprisingly, individuals who verbalize the greatest desire for treatment may not have more than a vague sense of their own motivation to escape the negative consequences they are currently experiencing, such as incarceration, debt, or ill health. However, staying focused on the positive consequences and rewards of recovery is an essential aspect of the recovery process. From the first point of intake to the final community supervision session, promoting and utilizing motivation should be an upfront aspect of criminal justice management of substance abuse treatment. Motivational interviewing methods, providing feedback to clients on key aspects of assessment findings and progress toward treatment plan goals and intimate involvement of the client in the construction and revision of the treatment plan are important ways of enhancing client engagement in treatment. (For more information, see TIP 35, *Enhancing Motivation for Change in Substance Abuse Treatment* [CSAT 1999*b*].)

Focus on Personal Strengths

The strengths-based approach to treatment planning in juvenile justice and adult criminal justice settings has been received with enthusiasm in many quarters. This contrasts with the traditional deficit-based approach to treatment planning for adults involved in the criminal justice system. Strengths can be recognized and used in treatment planning without neglecting deficits or decreasing the necessary emphasis on accountability and responsibility. Offenders

Advice to the Counselor: Motivation for Change

- Treatment plans should contain a section addressing motivation for change. Clients may have only a vague sense of their own motivation for treatment. However, staying focused on the positive consequences of recovery is an essential aspect of the recovery process.
- From the first point of intake to the final community supervision session, promoting and utilizing motivation should be an upfront aspect of substance abuse treatment.

tend to exaggerate or minimize their strengths. Assisting clients in identifying and getting an accurate estimate of their personal strengths should emphasize, but not be limited to, those that are relevant to recovery.

Strengths assessment often begins by determining what interests or inspires the client or by identifying those things in which the client has a sense of pride. Therapeutic community settings often identify specific roles within the treatment environment that clients can take on as their strengths and work to develop them further. Other modes of intervention perhaps need to create roles or activities for clients that use their strengths or identify opportunities outside of the program itself. Women's programs often emphasize the strengths that enabled survival during periods of abuse or neglect. Identifying and working with strengths in the treatment planning process allows the client to be less defensive about the identified deficits and problem areas in the same plan. It is important, however, that the perception of the strengths as legitimate and of value be shared among the members of the planning team and with the client.

Implementing an Effective Treatment Planning Process

Offender Involvement in the Development of the Treatment Plan

The consensus panel believes that it is essential for clients to be involved in setting case management goals that are in their own best interests. Success of the treatment plan can be greatly aided by the client's involvement in the development of specific objectives and interventions. An example of this process is the Client's Recovery Plan (CRP), in use at the Walden House program in San Francisco (see Figure 4-1, next page). The client documents his perception of his circumstances, needs, and tendencies, and these are incorporated into the program treatment plan. The CRP opens the dialog between the client and the staff on a more equal footing.

Coordination of Treatment Planning and Sharing of Treatment Information

Treatment planning activities in criminal justice settings should include the full range of professionals involved in supervising, monitoring, and providing therapeutic services. In noncustody settings, it is useful to have probation or parole officers involved in this process, in addition to staff from halfway houses, employment/vocational services, and family members. In custody settings, treatment planning could involve case management or transition staff who may be responsible for coordinating prerelease plans and making arrangements for treatment appointments following release from custody. The consensus panel recommends that treatment plans be updated at different transition points in the criminal justice system (e.g., following release from custody, transfer to less intensive supervision status, or departure from a halfway house setting), as the offender's motivation, response to environmental stressors, and level of involvement in treatment may significantly change. Signed releases of confidential information and interagency memorandums of agreement can help to ensure that treatment plans and other key information are transferred to appropriate staff during these transition points.

Relapse prevention plans often are used within community-based treatment programs in the criminal justice system to develop a coordinated approach to supervision, treatment, and judicial supervision that recognizes the importance of substance abuse relapse. Relapse prevention plans often describe high-risk situations for the offender which increase the likelihood of relapse, relapse "triggers" or cues (e.g., interpersonal conflict, negative or

Figure 4-1
Client's Recovery Plan (CRP)

Name _____ *Date* _____ *WH #* _____

Note to client

This form is provided to you, as a Walden House client, in order to obtain **your** input into your treatment plan. Your counselors will be evaluating you and your treatment needs based on the Psycho-Social History and Assessment that you provided them. This form is your opportunity to do your own self-evaluations on the same categories.

Instructions

Please describe your own preferences or ideas of what you feel you need in the following categories (if the category does not apply, please put "N/A").

Drug and Alcohol

_____

_____

Childhood/Family

_____

_____

Relationship/Marital/Sexual

_____

_____

Friendship/Recreation and Leisure/Religious/Spiritual

_____

_____

Parenting/Child Protective Services (CPS)

_____

_____

Criminal Justice

_____

_____

Education

_____

_____

Employment

_____

_____

Housing

_____

_____

Mental Health

_____

_____

Overall, is there anything else you feel you need that is not covered in the above areas that is related to your substance abuse recovery?

_____

_____

In your opinion, how much treatment time do you feel you need? Be specific.

_____

_____

Your signature: _____

Thank you. Your input is appreciated and will be taken into consideration in the development of your treatment plan. You are to bring this completed form with you to your clinical assessment meeting.

positive emotions, drug paraphernalia, old drinking or drug associates), skills to be developed to address problems related to relapse, and specific strategies to deal with relapse urges, "triggers," and high-risk situations. Relapse prevention plans are used in a number of drug courts, and help develop consensus among court, supervision, and treatment staff about an offender's current "risk" level for relapse and in organizing responses to critical incidents and problem behaviors.

Linkages With Community Treatment

For criminal justice clients who will not remain long in a jail setting, linkages to the appropriate community services are an essential part the treatment plan. The shorter the jail detention, the more important these links become, especially if a client needs a range of services, including educational, vocational, legal, medical, and mental health. For these links to work most effectively, the treatment plan must include all relevant information about the client that may be needed by the community providers involved. This will allow all the different parties to agree on their own responsibilities to the client as well as the conditions for reporting back to the case manager as needed for the client's welfare. In some cases an interagency audit, however informal, can be useful to identify gaps in the treatment plan and barriers to the client's progress, as well as the strengths present in the client's situation.

Successful links with community agencies require careful planning and considerable resources to develop. Treatment planning and case management as a whole will be easier for treatment professionals if these relationships already exist and can be called upon quickly. Case managers can cultivate these relationships by being involved whenever possible in activities of the agencies they work with, such as by attending committee or planning meetings, in helping staff members of these organizations to develop offender programs and policies, and by contributing to resource materials and manuals. (See TIP 30,

Continuity of Offender Treatment for Substance Use Disorders From Institution to Community [CSAT 1998*b*].)

Conclusions and Recommendations

The consensus panel recommends that several key points be considered when developing a substance abuse treatment plan for clients in the criminal justice system:

- Sufficient resources are needed for comprehensive assessment and treatment planning, including adequate staffing, clerical support, and access to computers and management information systems.
- When sharing information is not feasible (e.g., routinely providing detailed information to a drug court judge regarding offender disclosures in treatment), consultation, training, and written agreements are needed to define the types of information that will be shared, with whom, and under what circumstances.
- Procedures should be developed to control the flow of relevant information to the various staff involved in an offender's treatment and supervision. These procedures are required to protect the privacy and confidentiality rights of offenders. (For more information on confidentiality, consult www.hipaa.samhsa.gov and see CSAT 2004.)
- The offender should be involved in all major aspects of the treatment planning process.
- Procedures should be adopted for in-prison treatment programs regarding information sharing and flow of treatment records from one institution to another. Such procedures should control access to treatment providers and provide protection against rerelease of information related to self-disclosures of previous unreported criminal behavior or the intent to commit future crimes and psychiatric and medical histories, except when required by law. (For more information on confidentiality, consult www.hipaa.samhsa.gov and see CSAT 2004.)
- Treatment plans should assess the severity of the substance use disorder as well as any COD in order to place the offender in an appropriate treatment setting.
- Treatment plans should address motivation and readiness for change.
- Treatment plans should incorporate a strengths-based approach.
- Offenders possessing some degree of psychopathy may respond less well to traditional substance abuse treatment but benefit from intensive in-prison and community supervision that emphasizes consequences and sanctions for relapses.
- Correctional therapeutic community (TC) programs should consider use of instruments to measure client progress in treatment, as defined by the TC's goals for social and psychological change.

5 Major Treatment Issues and Approaches

In This Chapter...

Clinical Strategies

Program Components and Strategies

Conclusions and Recommendations

Overview

While many similarities exist between substance abuse treatment for those in the criminal justice system and for those in the general population, people in the criminal justice system have added stressors, including but not limited to their precarious legal situation. Criminal justice clients also tend to have characteristics that affect treatment. These include criminal thinking and criminal values along with the more typical resistance and denial issues found in other substance abuse treatment populations.

Many offenders also have a long history of psychosocial problems that have contributed to their substance abuse: interpersonal difficulties with family members, difficulties in sustaining long-term relationships, emotional and psychological problems and disorders, difficulty managing anger and stress, lack of education and vocational skills, and problems finding and maintaining gainful employment (Belenko and Peugh 1998; Peters 1993). These chronic problems often are associated with reduced self-esteem, anxiety, depression, and enhanced expectations about the initial use of substances. Unsuccessful attempts at abstinence also tend to reinforce a negative self-image and increase the likelihood that offenders will use substances when faced with conflict or stress.

This chapter addresses strategies for modifying substance abuse treatment services for criminal justice clients. Some of these strategies are underlying program components, such as incentives for program participation and emphasis on personal accountability; others are more directly related to clinical issues, such as intervening with criminal thinking and teaching basic problemsolving skills.

While the suggestions offered here are applicable to many criminal justice clients, it is important to note that treatment approaches must take into account the unique situation of the offender and his stage in the recovery process. Treatment plans and assessments should be continually revised to reflect changes in the client's situation, such as

recent relapses, continued sobriety, and improvements in mental and psychological functioning. For more on issues affecting specific subpopulations within the criminal justice system, see chapter 6.

Clinical Strategies

Substance abuse counselors working with criminal justice clients are likely to face a host of challenges. Offenders may require help meeting basic life needs, such as finding housing, applying for a job, or cooking a meal. Moreover, counselors generally will have to motivate clients to find new ways to manage their feelings, control impulses, and work toward concrete goals. Confronting manipulation and setting boundaries are constant challenges for many substance abuse counselors who work with criminal justice clients.

This section discusses some of the issues that the counselor is likely to face, along with strategies for meeting those challenges. The second part of this chapter, "Program Components and Strategies" addresses a broader range of strategies.

Addressing Basic Needs

It is difficult to label any particular needs of offenders who abuse substances as more basic than others. Offender needs vary depending on issues such as their legal status, gender, culture, sexual orientation, age, and functional capacities. There are also significant differences in what an individual experiences in different criminal justice settings (i.e., jail, prison, community supervision). Despite these differences, there are commonalities in the treatment needs of offenders. In addition to substance abuse treatment, offenders typically require the following services:

- Detoxification
- Screening and assessment (see chapter 2)
- Treatment for co-occurring mental disorders (see chapters 2, 3, 4, and 6)
- Treatment for physical health issues
- Family-related services such as visitation, childcare, and reunification
- Case management
- Legal assistance
- Vocational skills development and employment

What varies from offender to offender is the emphasis placed on particular needs and the treatment and related services available to meet those needs. The following highlights some of the more salient issues offenders face—detoxification, homelessness, and life skills. For more information on assessing and meeting basic needs, see chapters 2, 3, and 4.

Detoxification

Chapter 2 provides information on how to identify offenders in need of detoxification services. However, even if a counselor does not perform screening and evaluation, he or she should be aware of the signs and symptoms of withdrawal. Sometimes offenders in need of detoxification are not identified at intake because they lied about the extent of their substance use, there was no reason to suspect substance dependency, or withdrawal symptoms were mistaken for mental illness. Offenders who experience withdrawal without medical attention are at risk for serious health consequences, and withdrawal from some drugs (e.g., alcohol, barbiturates) even carries a risk of death.

Symptoms of withdrawal vary according to the substance abused, but signs that may be noted by the counselor include

- Anxiety, restlessness, irritability, panic attacks, insomnia
- Profuse sweating, muscle jerks, constant blinking
- Yawning, sleepiness, exhaustion, lethargy
- Depression, crying fits, disorientation
- Suicidal thoughts or behavior

For some drugs, symptoms of withdrawal can be prolonged. For example, the insomnia and

anxiety common in people with benzodiazepine dependency can continue for months following discontinuation of use (Federal Bureau of Prisons 2000). For offenders undergoing treatment for withdrawal, the counselor should work closely with the medical team to ensure that symptoms are identified and treated.

For more on information on detoxification, see chapter 2 of this TIP and the forthcoming TIP *Detoxification and Substance Abuse Treatment* (Center for Substance Abuse Treatment [CSAT] in development *a*).

Homelessness

The impact of homelessness on offenders varies depending on the particular setting in which they are being treated. Jails frequently work with homeless offenders; in fact, some people enter jail to get food and housing (and may enter substance abuse treatment programs for the same reasons). Homelessness can be a traumatic experience, and for some clients who have had to live on the streets, jail may be the safest environment in which they have lived for some time. Those used to being homeless may need to relearn how to live their lives in a stable environment.

Some offenders may have become homeless because of their incarceration in jail or prison. Even if homelessness was not an issue when the offender was arrested, it is likely that an offender will be homeless upon release. In some instances, people who have served their full sentence (and therefore are not being released on parole) enter the community without aftercare options or any plan for housing.

Counselors should be aware that a great deal of stigma and shame is attached to homelessness, and many clients are reluctant to discuss it without prompting. Panel members have had experiences with clients who were willing to talk about criminal activity, substance use, and past trauma before they were willing to discuss the fact that they were homeless. One way to obtain this information is to ask offenders where they lived in the month prior to incarceration or arrest and if they anticipate being homeless upon their release. A plan should be in place to provide offenders with housing if they are leaving a prison facility. In all cases, effective counselors have working relationships with personnel in housing services to which to refer offenders in need of housing.

Life skills

Many offenders have hidden deficits in basic life skills (e.g., knowing how to balance a checkbook, prepare a meal, accept feedback from an employer). While these deficits are as individual as the offender, the consensus panel feels that treatment programs with criminal justice clients should address a range of instrumental skills (e.g., meal preparation, money management, laundry, resume writing), as well as some basic social skills, particularly those needed in employment and other interpersonal situations. Counselors should observe offenders to identify problem areas.

Among the skills most underdeveloped in offender-clients are basic problemsolving skills. Because of their impulsiveness and difficulty delaying gratification, many offenders are particularly poor at breaking down moderately complex problems into the few basic

Advice to the Counselor: Homelessness

- Offenders should be asked where they lived in the month prior to arrest.
- If offenders anticipate being homeless when they leave the prison, a plan to provide offenders with housing should be in place before their release.
- Addressing deficits in basic life skills as well as housing issues can help prevent recidivism.

steps required to get from problem to solution. Practice is needed to learn clear problem identification, generation of options, thinking through likely outcomes, option selection, trying out options, and reviewing outcomes.

Addressing Criminality

Antonowicz and Ross (1994) address the need to prioritize treatment according to the criminogenic needs of criminal justice clients, particularly the specific issues that brought the client to the criminal justice system in the first place. These are most often substance abuse and criminal thinking and values. This section describes the components of criminality (i.e., criminal thinking, the criminal code, and manipulation), and suggests programmatic and clinical strategies for addressing criminality in substance abuse treatment for offenders.

Criminal thinking

A range of factors are associated with substance use among offenders, including peer substance abuse, impulse control difficulties, trouble managing negative emotions, poor problemsolving and self-management skills, impaired moral reasoning, and cognitive distortions (Wanberg and Milkman 1998). As noted, criminal thinking is especially important to address, as individuals with ingrained criminal lifestyles employ a number of cognitive distortions or "thinking errors" (see Figure 5-1).

Offenders can learn to recognize thinking errors and to understand how those errors can lead to behavior that gets them into trouble (Wanberg and Milkman 1998). Strategies include

- Involvement in specialized therapeutic community (TC) programs
- Cognitive–behavioral group interventions focused on correcting and eliminating criminal thinking errors
- Self-monitoring exercises through keeping a journal and "thought logs"
- Staff and peer confrontation regarding criminal thinking patterns and related behaviors observed within treatment programs (Field 1986; Wanberg and Milkman 1998)

A number of approaches, drawing largely on cognitive–behavioral methods, have also been developed in recent years to address criminal thinking, the most popular among these being *Thinking for a Change*, issued by the National Institute of Corrections (NIC) (Bush et al. 2000), Gordon Graham and Company's *Framework for Recovery* (Graham 1999), and Wanberg and Milkman's *Criminal Conduct and Substance Abuse Treatment* (Wanberg and Milkman 1998). The core components of *Thinking for a Change* are described below. For more information on *Framework for Recovery*, go to www.ggco.com/. Wanberg and Milkman's module is available as a provider's guide and participant's workbook.

Criminal thinking also can be addressed using the same paradigms used in substance abuse relapse prevention. Many of the early warning signs and risk factors for relapse will be the same or very similar to those warning signs and risk factors for the client's criminal thinking. It is important that the focus on

Advice to the Counselor: Criminal Thinking

- Criminal thinking should be viewed as an outcome of maladaptive coping strategies rather than as a permanent fixture of the offender's personality.
- Criminal thinking can be addressed using the same tools as in substance abuse relapse prevention. This includes identifying offenders' primary thinking errors, instructing clients to self-monitor when these errors occur, and providing regular feedback from peers to prevent reversion to criminal behavior.

Figure 5-1
Common Thinking Errors

Power thrust	Putting people down, dominating
Closed channel	Seeing things only one way
Victim stance	Blaming other people
Pride	Feeling superior to other people
Don't care	Feeling unconcerned about how other people are affected
Want it now	Demanding gratification now
Don't need anybody	Refusing to be dependent on others for anything
Rigid thinking	Thinking in black and white terms
They deserve it	Believing that people have it coming
Screwed	Feeling mistreated

Source: Wanberg and Milkman 1998.

addressing criminal thinking not become another way of stigmatizing criminal justice clients. Criminal thinking should be viewed as the outcome of maladaptive coping strategies rather than as a permanent fixture of the offender's personality.

Client manipulativeness

Criminal justice client manipulativeness can be addressed by identifying "criminal thinking errors" or one of the other, similar methods of identifying cognitive distortions (Wanberg and Milkman 1998). For example, a particular client may try to avoid the work of personal change by repetitively demeaning others, including the counselor. Another client may repetitively project an attitude of giving up at every small setback ("zero state"). These maladaptive and manipulative coping strategies readily undermine the treatment process unless they are addressed. Addressing client manipulativeness involves

- Counselor or treatment group identifying the primary thinking errors they observe
- Instructing the client to begin self-monitoring when these occur (journaling)
- Providing regular feedback to the client, usually from peers in a treatment group

Criminal code

Offenders tend to have a shared value system that includes refusal both to cooperate with authority and to confront negative behavior by others. This "criminal code" or "convict code" is another part of criminal thinking that must be addressed in treatment. The criminal code explains why good treatment programs stressing personal accountability, peer support for change, and peer confrontation of negative behavior are so threatening to the offender culture. It also explains why it is often necessary to separate inmates in treatment in correctional institutions from the general inmate population.

Treatment staff need to pay attention to the extent to which their clients are being stigmatized by other offenders as "snitches" or "weak" because they participate in treatment. It is sometimes necessary to remove clients from a negative situation to give treatment a chance. Sometimes, a newer treatment group might be pressured to revert to the criminal code with antisocial values predominating over prosocial values. These situations

Thinking for a Change

NIC's *Thinking for a Change* helps offenders learn to change criminal behaviors using three basic techniques:

- *Cognitive self-change.* Offenders learn how to examine their thinking, feelings, beliefs, and attitudes in order to understand how these factors contribute to criminal behaviors.
- *Social skills development.* Participants explore alternatives to antisocial and criminal behaviors.
- *Problemsolving skills development.* Offenders integrate the skills they learn and use them to work through difficult situations without engaging in criminal behavior.

Thinking for a Change is designed to work in a variety of criminal justice settings, and is ideally implemented in groups of 8 to 12. The curriculum is available online, along with more information (at www.nicic.org/pubs/2001/016672.htm).

require careful confrontation, limit-setting, and clear expectations with consequences by treatment staff.

Addressing Anger and Hostility

Dealing with anger and hostility with criminal justice clients is much like dealing with anger and hostility with other clients. However, due to their higher incidence of antisocial personality disorder, criminal justice clients are more likely to use anger as a manipulative coping strategy and less likely to be able to separate anger from other feelings.

Clients may be angry for a variety of reasons, including

- Genuine feelings of being treated unfairly
- Limited affect recognition; confusing anger with other feelings
- Using anger to maintain adrenaline
- Goal-directed manipulative coping strategies such as deflecting attention from other issues or to keep others off-balance

Often, problems with expressed anger relate to an inability to express other feelings—a problem with affect. Interventions involve teaching criminal justice clients to recognize their affective states and to understand the difference between feelings and action. Many criminal justice clients (especially men) have limited understanding of and insight into what they are feeling at particular points in time. The counselor's goal, then, is to broaden affect (emotions) identification. For a surprising number of offenders, feeling states initially consist of "angry" and "other." Often, what they first think is anger turns out to be frustration, hurt, loneliness, fear, etc.

Offenders who abuse substances also have a tendency to think that if they feel it, they must act on it. Learning the relationships between behavior, thinking, and feeling, and how each affects the other, is helpful to many criminal justice clients. Learning that feelings do not equal thinking or behavior can be a revelation for many offenders. Counselors should point out that feeling it doesn't make it so, nor does it mean the client has to act on the feeling. As the Alcoholics Anonymous saying states, "Your feelings are not facts."

In summary, interventions addressing emotions should encompass

1. Identifying the feeling(s). Maybe other feelings are involved, such as embarrassment or guilt.
2. Understanding clearly where the feeling is coming from. What is the real source of the anger?
3. Identifying the goals the anger is serving (e.g., deflecting attention).

4. Identifying the goals the anger is undermining (e.g., staying out of jail or keeping a job).
5. Working toward taking the longer view (e.g., beginning to use a prosocial thought process to manage the anger).

Several additional strategies can help clients to recognize their feelings. For example, counselors can set boundaries on how anger and hostility can be expressed and set limits as to reasonable duration of expression of anger and hostility. Once the offender calms down, the counselor can refocus on what the client can learn from the situation and how the client can benefit in the future. Counselors can also use peers in a group setting to explore how the client might use anger and hostility for secondary gain. TC groups have "cardinal rules" that include no violence or threat of violence (justification for program removal if violated) that provide a safe environment for exploring anger issues. For more information on anger management, see Reilly and Shopshire (2002).

Addressing Identity Issues

As offenders move through the criminal justice system, important elements in their identity can change. In the pretrial stage, their identity as a member of a racial or cultural group, a family member, or employee may be most prominent. In jails there is generally a more immediate crisis, as one grapples with the shame and stigma of being labeled a criminal and the fear of facing extensive incarceration.

Criminal identity

In prison, some people learn a new identity based on the prison culture in which they are involved; some prisoners learn to think of themselves as criminals. 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 persona of criminal. For offenders who enter community supervision programs on release from prison, embedded criminal identities can pose a number of problems.

Regardless of whether the offender is in jail, prison, or under community supervision, the identity of an offender often is an issue that needs to be confronted in treatment. Those who have adopted a criminal identity need to learn new ways of thinking about themselves; those whose identity is shaken by the incarceration will need help coping with their criminal charges. An overall rehabilitation goal is to help offenders develop more prosocial identities consistent with positive social values.

Cultural identity

Race and cultural background can play an important role in the life of offenders, but the dynamics of race and culture are especially pronounced in jails and prisons. In these settings, Caucasians often are in the minority for the first time in their lives. A number of subcultures are found within jails and prisons. Inmates who belong to minority groups may see correctional staff members (including treatment staff) as adversaries. Gangs represent the most significant of these subcultures, at least among male populations. Gang affiliation can influence with whom an offender is able to socialize. Thus, treatment must take into account this aspect of the offender's identity.

Role as a family member and/or parent

Family relationships are often an important part of an offender's life. Family can represent a connection to the outside world and can be a source of stability for offenders as they move through the criminal justice system. Moreover, the quality of the offender's relationship with his or her family can be an important factor in recovery. Slaght (1999) reported that the only independent variable related significantly to relapse at 3 months

after release to the community was whether the offender was getting along with family members. Those who were getting along very well with family members were the least likely to use drugs. Based on this, Slaght recommends more extensive efforts to involve family members in drug treatment.

Just as positive family relationships can foster abstinence, family connections also can be a source of confusion and worry for clients who see their role as a family member in conflict with their role as an inmate and/or criminal. This can be especially true for parents. According to the Bureau of Justice Statistics, in 1999 the majority of State and Federal prisoners reported having at least one child under the age of 18 (Mumola 2000). For many of these offenders, drug or alcohol abuse was a factor in their incarceration. For example, one in three mothers in State prison committed her crime to get money for drugs, and 65 percent reported drug use in the month prior to the offense. For both mothers and fathers, 25 percent met the diagnostic criteria for alcohol abuse (Mumola 2000). In a survey of female inmates, Acoa and Austin (1996) found that nearly 20 percent of mothers were concerned that one or more children may have been exposed to substances in utero.

Confronting the guilt associated with their drug abuse can be important in treating parents involved in the criminal justice system. These individuals often identify themselves as "bad" parents and experience a great deal of shame over how their involvement in the criminal justice system has impacted their children. While this may be especially true for mothers, fathers also have strong feelings about their role as parents and express concern about their children. Jeffries and colleagues (2001) reviewed several parenting programs for male offenders. Descriptions of these programs are available online at www.vera.org/publication_pdf/fathers.pdf.

Treatment that includes other family members can be of use. In some families, more than one family member is incarcerated; treating the family can address a generational cycle of incarceration. Family treatment also can prepare inmates and their families for release. Since family problems can be a relapse trigger, Slaght (1999) recommends that offenders learn how to identify and cope with family conflicts. Substance abuse treatment programs also can use family involvement as a source of motivation. For example, extended parent–child visits can be used as a reward for good behavior.

It is important to note that family involvement in recovery is not always positive. Inmates, especially those with moderate to longer sentences, often can develop a false sense of "healing" of family problems. This results from a number of factors including reduced and controlled contact with family members and the tendency of families to shelter the inmate from problems on the outside. This false sense that family relations have changed becomes a potential stressor on release, when the inmate discovers that the previously existing problems are still present and often worsened. It is also important to note that sometimes offenders use their families to provide them with drugs and to enable their substance abuse. Family members may also be

Advice to the Counselor: Family Involvement

- Involving the family in an offender's treatment can be a positive source of support. Unfortunately, however, some family members may provide offenders with drugs and be involved in criminal activity. Inmates can develop a false sense of "healing" of family problems from having reduced and controlled contact with family.
- Extended family visitation can be used as a reward for good behavior.
- On release, inmates often find that preexisting family problems are still present and often worse.

involved in criminal activity and be expected to carry on criminal activities such as drug dealing while one member is incarcerated.

Role as a person of status

Prisons and jails are hierarchical societies, and men and women can attain status within a prison or jail community often using a different set of skills and behaviors than they would use in the community. This is especially true in prisons where longer stays make status and belonging more important issues. Therefore it is possible that an offender may face a loss of status either by going to prison (and losing a job and a place in the community) or by being released from prison (where the individual may have been a leader). Providers also should be aware that the offender may have had high status and a large income on the "outside" because of criminal activity (e.g., drug dealing) and may need to deal with a loss of status when incarcerated or resist the temptation of returning to a high-paying but illegal occupation on release. In other instances, an inmate may carry status (e.g., as a gang member) into jail or prison, and may resist treatment in order to maintain that status. Regardless of the setting, the consensus panel believes that treatment activities should include opportunities for participants to "earn" status in the program.

Addressing Denial

Criminal justice clients exhibit denial in ways similar to those of other populations. For some offenders, denial is a product of their criminal thinking. The criminal justice system may help reduce denial—it is harder for an offender to deny that drugs are a problem while sitting in a cell. Treatment staff can remind clients of the reality of their legal problems as a way to break through denial.

While substance abuse treatment providers often are trained to view denial as a negative symptom of the offender's addiction, denial may be a necessary strategy to further the offender's legal goals. In some situations, offenders have incentives to admit to a substance use disorder even if they do not have such a disorder, so that they can avoid prison and enter a treatment program instead. Admitting to substance abuse can have legal consequences for the offender that need to be understood by treatment providers before they ask an offender to self-identify as an "addict" or "alcoholic." It should also be noted that there are offenders who use or sell substances but do not have a substance use disorder.

Denial of criminal activity is a different, but related, issue. People may deny criminal activity even if they have dealt with their substance abuse. Just because an offender is in recovery from substance abuse does not mean he or she has ceased criminal activity. Treatment providers also will find that some offenders do not believe that what they have done is criminal or, at least, do not believe it is immoral. Some (e.g., gang members) perceive their actions as a normal part of daily life in their community and believe that the only problem was that they got caught. They see themselves as victimized by the law, rather than as victimizers. Others admit their substance abuse and even realize that they must cease criminal activity but deny that they have to change their lifestyle (e.g., their associations, the place they live), which can contribute to relapse.

Addressing Resistance

Sending criminal justice clients to treatment under threat of direct consequences with little incentive and loss of freedoms is not effective coercion. However, coercion can be very effective at getting criminal justice clients to treatment and keeping them there (Leukefeld and Tims 1988). This is best done using incentives as well as sanctions and involving some degree of choice by the client, even if leverage is present to encourage the client to make the desired choice.

When dealing one-on-one with the criminal justice client on this issue, the consensus panel suggests the following strategies:

- Avoid personalizing the situation and focus on the client's role in forcing the consequence. For example, avoid phrasing that sends the message "I'm doing this to you." Say things such as "You sort of forced the judge into giving you this consequence for using again."
- Focus the client on the future and what she can learn from the current situation.
- Be aware of cultural differences. Clients have culturally based attitudes toward authority that can affect how they respond to coercion in treatment. For example, confrontational treatment modalities may not be helpful for American Indians (Vacc et al. 1995).
- Approach clients with sensitivity, understanding, and honesty. This includes paying careful attention to body language, eye contact, and tone of voice.

For more information on treating coerced clients, see TIP 35, *Enhancing Motivation for Change in Substance Abuse Treatment* (CSAT 1999*b*); the TIP includes a section titled "Motivational Enhancement and Coerced Clients" that will be of particular use in the treatment of offenders.

Addressing Guilt, Shame, and Stigma

Guilt and shame may also be a major consideration for some criminal justice clients. Offenders new to the criminal justice system, particularly first-time offenders who have recently lost much of their social standing, may struggle with guilt and shame. In some cases these feelings are realistic and may facilitate treatment, but in other cases they may be exaggerated and interfere with substance abuse treatment until they are adequately processed. As noted above, many offenders experience a significant amount of shame over their actions even if they are not willing to show it. Those who do not may either have an antisocial personality disorder (see p. 112 for more information) or come from criminally involved family or social networks where criminal behavior is expected and approved; those clients may still feel shame, but it could be because they "messed up" and got caught.

Shame can be healthy, if it can motivate people to change their lives. Making amends can be a positive way to address guilt and shame and further treatment goals. Talking about feelings of guilt and self-loathing can also help an offender reduce feelings of hostility and anger. Shame and guilt, however, can also fuel denial and can make some individuals more prone to violence in order to cover up their feelings of shame. In general, female offenders face more shame than men or are, at least, more conscious of the shame they feel.

The stigma associated with criminal behavior and substance abuse also can be very powerful but is less useful as motivation for clients. The criminal justice system does much to stigmatize the offenders in the system, and the people involved in that system (whether they be corrections officers or inmates) often reinforce guilt, shame, and stigma.

Advice to the Counselor: Addressing the Coerced Client

- Approach coerced clients with understanding and honesty, paying careful attention to body language, eye contact, and tone of voice.
- When dealing one-on-one with the coerced client, focus on the client's role in forcing the consequence, with statements such as "You sort of forced the judge into giving you this consequence for using again."
- Focus the client on the future and the difference treatment can make.

Sealed Records

A criminal record follows offenders long after they serve their time in prison. Many recovering individuals find that, despite their best efforts, the stigma of their criminal records limits their options. A 2001 CSAT initiative, Rehabilitation and Restitution, contains a component to help recovering offenders get their criminal records sealed. Additionally, participating programs may offer

- Comprehensive assessments
- Individualized service plans
- Case management
- Continuum of substance abuse treatment services
- Support in obtaining a GED or other necessary education
- Job training, placement, and retention programs
- Continuum of supervision, aftercare, and continuing care programs

CSAT's cooperative agreement initiative is aimed at improving the likelihood of successful reintegration. Programs funded through the initiative will compare the success rates of those who receive additional assistance with those who receive whatever help is usually offered to recovering offenders.

Stigma also comes from outside the criminal justice system (e.g., family, mass media, society). While it is important for offenders not to forget their past, it is not necessarily helpful that society does not allow people to move on or accept that they have paid their debts. It is also important for offenders to have appropriate role models who have overcome the stigma of a criminal past and a history of substance abuse in order to achieve something in their recovery.

While there has been some reduction of stigma attached to substance abuse and mental illness in recent years, the stigma associated with arrest, conviction, and incarceration remains very strong. Societal change occurs slowly, but treatment providers can help the situation by not burdening clients with additional stigma because they are involved in the criminal justice system. The consensus panel suggests that if crime is part of addictive behavior, then criminal behavior can be seen as another manifestation of a substance use disorder. Treatment providers need not condone an offender's past criminal activity, but they should be able to accept it as part of the client's past and not a permanent character flaw or insurmountable obstacle to recovery.

Establishing Boundaries

Counselors' methods for establishing a relationship with clients vary according to the setting. It is much more difficult to develop a

Advice to the Counselor: Establishing Boundaries

- No matter how much empathy they feel for offenders, counselors need to remember that they represent the criminal justice system.
- Counselors' self-disclosures can be helpful when balanced by appropriate boundaries.
- Offenders are often deft at conning a counselor into doing small and seemingly meaningless things for them, but this is often a first step in an unhealthy alliance that can be used against the counselor at a later date. A well-trained counselor can confront the offender and turn the attempted manipulation into a step for developing a stronger treatment alliance.

relationship in prisons or jails than in the community because boundaries and rules limit how psychologically close one can get to incarcerated offenders. For example, while eliciting emotional responses is quite useful in psychotherapy, corrections staff generally see this as a problem to be avoided. In these settings there needs to be careful supervision to evaluate how closely counselors and clients are interacting.

Because boundaries between staff and clients have a special significance in criminal justice settings, treatment staff need to be especially vigilant about self-disclosure. The counselor needs to ask him- or herself whether a personal disclosure is going to make a difference for the client and not just for the counselor. For example, using one's personal experience as guiding life lessons can add credibility and be helpful on a more personal level, but recent experiences that may expose too much vulnerability should be avoided. Also, recovering staff in TCs who often share personal experiences have found the practice to be beneficial when balanced with appropriate boundaries. Counselors also should not associate with clients to the detriment of their relationship with corrections and treatment staff; no matter how much empathy they feel toward offenders, counselors need to remember that they represent the criminal justice system. Offenders are often deft at conning a counselor into doing small and seemingly meaningless things for them, but this is often the first step in an unhealthy alliance that can be used against the counselor at a later date. Alternatively, a well-trained counselor can often confront the offender and turn the attempted manipulation into a step in developing a stronger treatment alliance.

Creating a Therapeutic Alliance

While it is not always easy, given the boundary issues that exist in criminal justice settings, the creation of a therapeutic alliance is very important when working with this population. Of course, the ability to create this alliance and its relative importance varies according to staff ability, experience, and training. In jails, it may be less crucial because clients may remain in treatment only a short time. It may, however, be most critical in community supervision settings if clients are engaged in outpatient treatment. In residential programs, such as therapeutic communities, peers play a larger part in the treatment experience, and the client's relationship with his or her peers is often as important as or more important than the relationship with the counselor.

Relationships with criminal justice staff are often quite important in the therapeutic process. This is especially important for offenders under community supervision, as their alliance with their probation or parole officer is critical. In a prison or jail setting, it also helps to include corrections staff as part of the treatment team, but clients should be told if this is going to be the case. When probation officers or corrections staff members are part of the treatment team, roles need to be very clearly defined. Because they may lack experience in treatment, corrections officers can become too involved in the treatment process and become overly distraught over treatment failures. In order to operate within a prison or jail, corrections staff need to maintain a certain degree of distance from offenders as well as keep their respect. The consensus panel recommends that treatment programs that are going to involve corrections staff or probation officers should provide extensive cross-training between corrections and substance abuse treatment staffs. The legal issues surrounding confidentiality, for example, are a suitable subject for cross-training.

Striving for counselor credibility

Counselors working in any treatment setting need to maintain credibility with their clients.

If offenders believe that treatment staff are competent, they will be more influenced by

the treatment and less likely to return to incarceration. Research by Broome and colleagues (1996*a*) showed that high self-esteem and high ratings of counselor competence were associated with a significant reduction in recidivism by probationers ending their treatment. Strauss and Falkin (2000) found similar results with a cohort of female offenders. Their data indicate that clients who successfully completed treatment had more favorable perceptions of staff within the first 2 weeks of treatment than those who did not.

Striving for cultural competence

Cultural competence is an important factor in developing a counselor–client relationship. Programs should have a culturally diverse staff that reflects the diversity of the population they serve; however, that is not always possible. What is possible is that staff be trained to understand cultural issues affecting the populations in the area in which they work. Cultural issues reflect a range of influences and are not just a matter of ethnic or racial identity (e.g., Ohio prisons have a large number of inmates from Appalachia, and staff there need to understand that culture). Special training programs can be developed to help counselors attain cultural competence for the cultures the agency serves. (The forthcoming TIP *Improving Cultural Competence in Substance Abuse Treatment* [CSAT in development *b*] provides indepth information on developing cultural competence and providing culturally competent treatment.)

Advice to the Counselor: Establishing Counselor Credibility

- Avoid making promises that you foresee being unable to keep. If you are unable to keep a promise, be clear as to why you cannot do so and accept the consequences.
- Demonstrate the attitudes and behaviors you are trying to get clients to implement (credible staff are those who do as they say).
- Show a positive attitude toward colleagues, the program, one's family, and so on.
- Work to have the client respect who you are, even if he does not like what you represent.
- Ensure that you maintain the respect of your supervisor and other staff (including corrections officers and probation officers). Credibility with offenders is affected by their observations of the counselors' interactions with other staff, and clients do watch staff closely.
- Clearly articulate roles and boundaries. Inmates often see treatment staff as potential inroads into all areas ranging from personal property issues, to job assignments, to case management concerns. Treatment staff need to clearly define their role and limits or they quickly find their credibility lost because inmates interpret the staff's inability to correct a nontreatment issue as a lack of concern or caring.

Designing Treatment to Reflect the Stages of Change

The concepts behind the stages of change model of recovery (Prochaska et al. 1992) were introduced and summarized in chapter 3. While these are important concepts in recovery generally, they are particularly relevant in the treatment of criminal justice clients because so many of these clients are in the early stages of change. Figure 5-2 (next page) summarizes treatment strategies based on the offender's stage in recovery.

Counselors with criminal justice clients often find they spend much of their time working in the precontemplation and contemplation stages. This can be discouraging to some, but the trade-off is that this is important work

Figure 5-2
Strategies for Working With Offenders Based on Their Stage in Recovery

State	Description	Strategies
Precontemplation	Unaware of substance abuse problems	Instill discomfort in a supportive manner. Increase the client's ability to recognize problems with current behavior and dissonance with future goals.
Contemplation	Awareness of substance abuse problems	Tip the balance. Elicit from the client the reasons to change, and the risks of not changing. Support prosocial thinking from the client.
Preparation	Decision point	Plan the action. Help the client determine the best course of action. These plans are individualized as they vary considerably from client to client.
Action	Active behavior change	Help the client take steps toward change. Begin shifting from external motivators to internal motivators by supporting the client's self-efficacy for change.
Maintenance	Ongoing preventive behaviors	Relapse prevention focusing on coping mechanisms and avoidance of triggers. Monitoring of attitudes and behaviors that can lead to relapse. Assisting the client in making lifestyle changes and encouraging the client to assist others who are in the recovery process.

that reduces both crime and the number of crime victims, in addition to rehabilitating offenders.

Program Components and Strategies

The initial goals of substance abuse treatment are to "get them there" (engagement) and to "keep them there" (retention). This section addresses programmatic strategies to foster both engagement and retention and discusses other program components that promote effective substance abuse treatment for criminal justice clients.

Engagement

Arrest and incarceration can provide an important opportunity to identify substance abuse and other psychosocial problems, to provide stabilization of acute needs (e.g., detoxification from alcohol or opioids, medication for psychotic or depressive symptoms), and to engage offenders in substance abuse treatment services (Peters and Kearns 1992). Jails, prisons, and community diversion or supervision programs often serve as the first point of contact for offenders who have substance abuse problems. Motivation to enter treatment frequently occurs at particularly stressful times such as after being arrested, after one's children have been removed by authorities, or following an overdose or a "bad high." Substance abuse treatment staff need to watch for these opportune times and respond quickly so that the client can be engaged in treatment while the motivation is still strong. Most of these individuals have not had previous contact with substance abuse treatment agencies, and their first involvement in treatment services is frequently while in jail or prison (Mumola 1999).

Program incentives and sanctions to encourage engagement

In the community, the usual sanction for refusing to participate in treatment is loss of freedom—often incarceration. In jails and prisons it usually involves longer incarceration times. At the point of decision of whether or not to participate in treatment, the offender usually faces more sanctions than incentives to participate, and the sanctions may be severe.

A key point in "getting them there" is to be sure that disincentives to program participation are minimized. For example, if offenders lose freedoms or have worse housing (in institutions) as a result of program participation, many will not give treatment a chance.

Enhancing motivation

While legal pressures may be sufficient to get a client into treatment, engagement is necessary if the client is to become motivated to commit to change and maintain recovery (Hubbard et al. 1988). Therefore, treatment programs need to be aware of the common characteristics of clients who leave treatment early and use this knowledge to develop approaches that motivate these clients to stay in treatment.

In a study of offenders on probation, Broome and colleagues (1996*a*) looked at three client background factors that are associated with treatment outcomes to see if they had an effect on establishing therapeutic relationships. Recognition of the existence of a substance abuse problem was associated with a positive therapeutic relationship and engagement in treatment, while the degree of peer deviance in the client's social network and family dysfunction was not. The fact that recognition of substance abuse problems was a positive indicator for successful engagement in treatment lends support to the use of motivational approaches that help the client recognize he or she has a problem with substance abuse.

Effective Use of Coercion at the Program Level

"Coercion" means using incentives and sanctions to encourage program participation. In some jurisdictions, coercion may come in the form of legal mandate to treatment. This rarely affects offenders already sentenced to prison, but it often affects clients under community supervision who may need to be involved in treatment as part of their probation or parole. Clients under community supervision also may elect to enter treatment to avoid harsher alternatives (such as involuntary admission into a mental hospital) or negative repercussions (such as losing custody of one's children). Individuals convicted of driving while under the influence may be required to complete a psychoeducational class to retain their driver's license. The California initiative known as Proposition 36 offers a choice between incarceration and probation with substance abuse treatment to first- or second-time offenders convicted of nonviolent drug possession charges (see chapter 11 for more information). Arizona has enacted a similar law, and other States have them under consideration. Offenders may also receive pressure from other governmental agencies (e.g., child protective services agencies) to enter or continue treatment, as part of community supervision or while in jail or prison. Not all forms of coercion are explicit for clients involved in the criminal justice system; people may receive reduced sentences or avoid incarceration in a higher security facility if they enter treatment.

Retention in Treatment

Roberts and Nishimoto (1996) studied retention in treatment among a group of women who were cocaine dependent, many of whom were under criminal justice supervision. The type of treatment services provided to the women made the largest difference in reten-

Does Coerced Treatment Work?

In a review of 11 coerced treatment studies conducted over 20 years, Anglin and colleagues (1998) found that, while coercion was generally effective, the results were far from unequivocal, with five studies reporting that coerced clients did better, four studies reporting no difference, and two studies reporting that the coerced clients did worse. It is important to note, however, that in the 11 coerced treatment studies reviewed, none directly assessed the motivation of the clients (Farabee et al. 1998). In most cases, involuntary or coerced status of clients was inferred from criminal justice status at intake. Many clients whose treatment was coerced say they would have entered treatment without legal pressure to do so (Marlowe et al. 1996). Only about a third of those who entered coerced treatment for cocaine abuse said that legal coercion was a reason for entering treatment. Rather, psychological, financial, social, familial, and medical pressures exerted more influence in the decision to enter treatment (Marlowe et al. 1996).

While some critics have argued that treatment will be ineffective unless a client is motivated to change his or her substance abuse behavior, treatment itself can alter the client's motivation. In fact, an important indicator of an effective program is its ability to engage and retain clients who initially join under coercive pressures. The major difficulty, then, is often a matter of getting resistant clients to enter treatment, and coercion has been shown to increase the likelihood of an offender's entering treatment (Anglin et al. 1998).

Coercion such as that from the criminal justice system can play an important role in making sure the client enters treatment, but it will be internal motivation that predicts whether the client will stay in treatment and have a positive outcome. Knight and colleagues (2000) showed that external legal pressure and internal motivation are positively and independently related to retention in treatment. The authors recommend targeting those with low internal motivation for an intervention to increase readiness.

Research also suggests that in the absence of leverage imposed by the criminal justice system, offenders have a poor record of retention and graduation from substance abuse treatment programs. Moreover, outcomes for offenders who receive coerced treatment are as good as or better than for other participants in treatment (Hubbard et al. 1988*a*; Miller and Flaherty 2000). Leverage through the criminal justice system also helps retain offenders in treatment over time (Miller and Flaherty 2000), which tends to reduce the rate of criminal recidivism.

tion. The authors concluded that the intensity of the treatment, its structure, and the existence of woman-focused programming engaged the clients. However, greater levels of severity of a substance abuse problem also predicted shorter stays in treatment, and previous substance abuse treatment increased slightly the risk of dropping out.

Other research has shown that early dropout from treatment in criminal justice settings is correlated with having a history of psychiatric treatment, high levels of anxiety and depression, unemployment immediately prior to sentencing, cocaine dependence, lower levels of self-efficacy, and social networks that demonstrate low levels of social conformity (Hiller et al. 1999*b*). These authors found that the strongest predictor of treatment dropout was a high score on a criminality classification system they developed based on the Lifestyle Criminality Screening Form (Walters et al. 1991) that measured aspects of an offender's lifestyle related to criminality (e.g., irresponsibility, self-indulgence, interpersonal intrusiveness, social rule-breaking). Lang and Belenko (2000) found that offenders in a diversionary treatment program for felony drug offenders who completed treatment had higher levels of social conformity and more friends, fewer drug felony convic-

tions, less involvement in psychiatric treatment, less income from drug dealing, less unprotected sex, and fewer injuries from gunshots or stabbings.

While many of the factors that correlate with treatment dropout cannot be altered, the consensus panel suggests that some changes to treatment programs can be developed based on these studies. For one, there seems to be general agreement that a client's friends can have a good deal of influence on whether that person will successfully complete treatment. Developing positive peer networks should therefore be a priority for retaining offenders in treatment.

A history of co-occurring mental illness, as demonstrated through a history of mental health system involvement, can have a significant negative effect on treatment retention. High rates of co-occurring mental illness have been documented in the offender population (estimated to be 7.4 percent in Federal prisons, 16.2 percent in State prisons, and 16.3 percent in jails) (Ditton 1999), suggesting a need for treatment programs tailored for offenders with co-occurring disorders in order to reduce dropout rates.

The consensus panel also recommends that coerced individuals be mainstreamed with noncoerced clients where possible—such as in community settings—and should not be separated into different treatment tracks. Coerced treatment is much less likely to work if only similarly coerced individuals participate in the program. Because research showed that coerced treatment can be effective under some circumstances, some criminal justice systems developed new programs for these clients that did not build on existing programs; clients in these programs do not seem to have fared as well because they lacked community support from clients who were committed to treatment. It is not always clear that treatment models are followed accurately (Farabee et al. 1999). Administrators should avoid creating coercive programs with minimal resources.

There is a risk that treatment could become overly coercive and susceptible to charges of cruel and unusual punishment. It is important that participants in treatment be offered the opportunity to leave the program after a minimum time period (e.g., 90 days). The use of experienced outside contractors and recovering staff can help reduce the mistrust.

Incentives and sanctions to improve retention

Once the offender enters treatment, more options usually become available for creative use of incentives and sanctions to keep the offender in treatment. It is important to continue to push for a preponderance of incentives over sanctions to motivate offenders (Gendreau 1995). Because of the manipulative coping strategies and evidence of criminal thinking that bombard treatment staff daily, it is all too easy to focus on the negative behaviors instead of "catching people in the act of doing good work." But positive reinforcement is relatively more powerful than sanctioning in changing behavior as well as other aspects of personal growth.

The types of incentives to use are limited only by creativity. Beyond reduced supervision, other incentives can be greater access to other services (e.g., employment training or improved housing), higher status within the treatment group or community, or even variations on a token economy can be considered. The point is to continue to refocus on reinforcing desired behavior, look for additional ways to motivate the clients from a positive perspective, and to remember that most people begin and sustain personal change out of external motivation (the internalized motivation comes later).

The key points in effective use of incentives and sanctions are:

- Emphasize incentives over sanctions. Gendreau (1995) has suggested that 4:1 is optimal.

- Sanctions should be applied as rapidly as possible. The longer the time period between the undesired behavior and the consequences, the less effective the consequences.
- Repetitive use of mild sanctions (implemented quickly) is more effective than repetitive threats of sanctions followed by an intensive sanction (e.g., incarceration).
- Be creative with incentives.
- Treatment staff and criminal justice staff should collaboratively apply incentives and sanctions.

Prosocial Activity

Prosocial activity is any positive activity. In other words, criminal justice clients will do better in treatment when kept busy doing any positive activity. Most criminal justice clients tolerate boredom poorly. This is probably partly due to the high incidence of antisocial personality disorders and attention deficit disorders within this population (Jemelka et al. 1994; Wender et al. 2001). Offenders tend to demonstrate high excitement needs coupled with poor delay of gratification (Field 1986). Without positive activity, criminal justice clients tend to use unstructured time for antisocial thinking and behavior. Therefore, regardless of content, the consensus panel believes that treatment programs need to be heavily structured, particularly for clients who are early in the change process.

Staff Modeling Accountability

Criminal justice clients are particularly sensitive to what staff actually do, in contrast to what staff say. Words about personal accountability with this population will have only modest impact unless staff are willing to model the behavior and hold themselves to the same standards. The modeling of this behavior, of insisting on demonstrating one's accountability instead of waiting for others to demand it, can be very powerful in helping criminal justice clients change. This is another point of collaboration between treatment staff and criminal justice staff, as both need to model personal accountability in their behavior.

Peer Support and Feedback

Peers usually have more opportunity than staff to observe each other's behavior. Peers using a group treatment modality have the capacity to give more immediate feedback for positive steps to change and for negative thinking and behavior. Peers can often give feedback in ways that the client can more readily assimilate. Criminal justice clients often quickly and accurately see the relapse signs in others well ahead of the time they are able to see relapse signs in themselves. Using peer support and feedback also serves to prepare incarcerated criminal justice clients for using peer support organizations in the community.

Program Phasing

Many criminal justice clients have little experience with success with prosocial endeavors. Dividing programs into identifiable phases can provide markers of accomplishment and progress and focuses treatment efforts at steps along the way. Typically, residential programs include orientation, treatment, and reentry phases.

Self-Management Skills—Relapse Prevention

Once personal change occurs during treatment, a sustained effort is required to maintain that change, namely relapse prevention and recovery planning. Relapse prevention is "a systematic method of teaching recovering patients to recognize and manage relapse warning signs" (Gorski and Kelley 1996, p. 15). For more on relapse prevention for criminal justice clients, see the Technical Assistance Publication Series Number 19: *Counselor's Manual for Relapse Prevention with Chemically Dependent Criminal Offenders* (Gorski and Kelley 1996).

There are several advantages to using relapse prevention as a general approach throughout criminal justice programs:

- *Relapse prevention is a key issue for community supervision.* Beyond the obvious applicability of self-management training to offenders, this work provides key information to parole and probation officers. If the supervision officer knows that a primary overt relapse sign for a particular offender is isolating in his room, for example, the officer has critical supervision information. Knowing an offender's early warning signs for relapse is probably as important to supervision as employment and living situation.
- *Relapse prevention emphasizes taking responsibility for oneself.* Relapse prevention work makes it difficult for the offender to blame others. Self-management training puts responsibility squarely on the individual. The occurrence of a partial or full relapse is a signal that the individual has more work to do in developing or performing his own relapse prevention and recovery plan. Relapse prevention work, then, can be a primary means of moving from necessary external controls (on the offender) early in treatment to the needed internal controls (from the offender) later in treatment.
- *Relapse prevention work emphasizes the long-term nature of many disorders.* Many major life problems, such as addictions, are life-long problems, requiring continuing work by the individual. The concept of relapse prevention implicitly communicates this point to criminal justice clients.
- *Relapse prevention work is easy to communicate.* Warning signs in the individual's behavior, and specific actions by the individual in response to those signs are easy to communicate between corrections program staff, offenders, supervision officers, and others in the offender's support network. Relapse prevention plans aid communication from institutional programs to community supervision and to community programs.
- *Relapse prevention is applicable across theoretical perspectives.* Practitioners from the theoretical perspectives of behaviorism and disease concepts are currently using relapse prevention and recovery planning techniques with equal facility. Relapse prevention strategies seem to ring true regardless of beliefs about the etiology of addictions or criminality.
- *Relapse prevention is a unifying concept across programs.* Whether the problem is alcohol abuse, drug abuse, mental illness, sex offending, or criminality generally, the same basic process seems to occur in relapses, and the same basic strategies seem to be needed in recovery. Relapse prevention work therefore offers a unifying concept and means of communication across types of programs and service populations.

Spiritual Approaches

Spiritual approaches have been used in combination with substance abuse treatment services and can provide powerful tools for some to achieve sustained abstinence. There are, however, limitations to what can be done in a public institution such as a jail or prison. While a distinction should be made between "spiritual" and "religious" practices (the for-

Advice to the Counselor: Spiritual Approaches

- Spiritual approaches can provide powerful tools for some to achieve sustained abstinence. Counselors can refer clients to the religious leaders of their choice for additional counseling, or to voluntary 12-Step groups that do not explicitly endorse any one religion.
- Rituals and ceremonies can be used to mark positive events.
- Providing a time and a suitable place can promote individual meditation, reflection, or prayer.

mer being concerned with one's own identity and a connection to a greater whole, the latter involving the formal practice of a system of beliefs), such a distinction is not always perceived by criminal justice authorities. Because of issues concerning the separation of church and State, it can be difficult for treatment programs to provide any kind of specific religious activities. However, treatment providers can refer clients to the religious leaders of their choice for additional counseling. Treatment programs can also accommodate voluntary 12-Step groups that do not explicitly endorse any one religion.

To provide inmates in jails and prisons with opportunities for spiritual growth, programs can be creative to avoid promoting religion while still facilitating spiritual practices. Some spiritual practices, such as American Indian sweat lodges, have been instituted on the grounds that they are an important cultural activity. Some prison programs use rituals to mark certain events (which provide a way for people to express themselves without using words). Rituals and ceremonies, even if they are as simple as having a meal together, can be very important for these clients because they do not have positive rituals in their lives. The only ceremonies they may have experienced may revolve around gang activity or substance abuse. Other suggestions for promoting spiritual practices include designating an area for meditation and acknowledgements of achievements. Providing a place for such activities is an important step in promoting them. It can also be helpful to schedule times for meditation or silent reflection.

The offender-client should be encouraged to become involved in the spiritual and religious practices with which he or she is most comfortable. Jails and prisons should enable offenders to receive spiritual guidance from religious figures of all persuasions. Clients should be encouraged to connect with the religious or spiritual tradition with which they associate most closely and to think about how that tradition can help them understand their own lives and what may be missing in them.

Interest in faith-based substance abuse treatment programs has opened avenues for treatment improvement that have been less accessible. Many of the "transformational" aspects in religion are similar to effective treatment components, especially relevant in self-help and therapeutic community approaches. Some examples of the common elements include the concept of transformation, credible role models, behavioral rules, the centrality of positive social values, community membership and participation, rituals and celebrations, and stages of change. In addition, consideration of a faith-based perspective offers additional support for treatment that is not usually considered, such as inviting an offender's church of choice to consult and provide resources for the postrelease planning process.

Conclusions and Recommendations

The consensus panel believes that several points and recommendations in this chapter deserve highlighting, as follows:

- Whenever possible, treatment should be modified as needed to meet the individual client's specific needs. A thorough client assessment covering multiple dimensions will enable treatment providers to determine what modifications to treatment are required.
- Individual needs should be considered in adapting the sequence, focus, and intensity of treatment.
- It is important for offenders to have appropriate peer and staff role models who have overcome the stigma of a criminal past and a history of substance abuse. Provisions should be made whenever possible to allow criminal justice programs to hire staff who are ex-offenders and who are in recovery. Treatment programs have found it useful to maintain a blend of recovering and nonrecovering staff.

- While legal pressures may be sufficient to leverage a client into treatment, specific engagement strategies are necessary if the client is to be motivated to commit to change and to maintain recovery.
- Anxiety, guilt, and remorse related to past substance abuse and criminal behavior can be productive in motivating offenders to change their lives. Making amends to those who have been harmed by past behaviors is one strategy that can be used to positively address these emotions.
- There is a risk that treatment could become overly coercive and susceptible to charges of "cruel and unusual punishment." It is important that participants in treatment be offered the opportunity to leave the program after a minimum period of time (e.g., 90 days).
- Internal motivation for treatment is a better predictor of retention than external motivation. The panel recommends targeting those with low internal motivation for an intervention to increase readiness.
- Motivation to enter treatment frequently occurs at particularly stressful times such as after being arrested, after one's children have been removed by authorities, or following an overdose or a "bad high." Substance abuse treatment and criminal justice staff should watch for these opportune times and respond quickly so that the client can be engaged in treatment while their motivation is still strong.
- While clients in criminal justice settings are often coerced and resistant to treatment, they can become invested in treatment through the use of motivational interviewing and similar techniques.
- Clients who agree to enter treatment may be seen as "traitors" by other offenders, as the prison culture makes it a point to resist anything that is seen as a further attempt to control the lives of inmates. For this reason, it is useful to provide treatment services in residential areas or separate prisons that are isolated from the general inmate population.
- In jurisdictions that involve probation/parole officers or corrections staff in treatment team activities, roles need to be very clearly defined. Criminal justice staff who do not have treatment-related experience or specialized training can become overly involved in the treatment process and overly invested in treatment issues.
- Criminal justice professionals have been effectively involved in facilitating psychoeducational groups and other treatment activities and are often included in treatment teams and treatment and discharge planning. Criminal justice professionals providing group treatment services should receive specialized training in therapeutic techniques and treatment approaches and should consider obtaining substance abuse certification and licensure.
- Many correctional treatment programs in jails and prisons have found it useful to establish co-coordinators from both treatment and correctional/security systems. These arrangements provide a sense of joint "ownership" of treatment programs, enhance program credibility among correctional officers, and provide an effective mechanism for addressing critical incidents and solving problems that affect both treatment and corrections staff.
- To operate within a prison or jail and maintain inmates' respect, corrections and treatment staff need to maintain a certain distance from offenders. Cross-training can assist staff in defining appropriate "boundaries" that should be maintained in relationships with inmates, and to identify related situations that can compromise the effectiveness of security/public safety and treatment operations.
- Treatment providers need not condone an offender's past criminal activity, but they should accept it as part of the client's past, and not a permanent character flaw or insurmountable obstacle to recovery.

6 Adapting Offender Treatment for Specific Populations

In This Chapter...

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Women's Treatment Issues

Men's Treatment Issues

Working With Violent Offenders

Treatment Issues Based on Client's Sexual Orientation

Treatment Issues Based on the Client's Cognitive/Learning, Physical, and Sensory Disabilities

Treatment Issues for Older Adults

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Treatment Issues For People With Co-Occurring Substance Use and Mental Disorders

People With Infectious Diseases

Sex Offenders

Conclusions and Recommendations

Overview

Certain criminal justice system populations may be recognized as having specific needs; the consensus panel recommends that whenever possible, treatment be modified to meet those needs. A thorough client assessment will enable treatment providers to determine what modifications to treatment are required. However, the panel also recognizes that in order to explain different types of treatment modifications and the need for those modifications it is necessary to group clients according to certain socially defined categories that mark their relationship to a dominant identity. This chapter provides a basic overview of treatment needs of offenders belonging to subpopulations including women; men; violent offenders; gay, lesbian, and bisexual offenders; clients with physical and sensory disabilities; older adults; people with co-occurring mental and substance use disorders; people with infectious diseases; and sex offenders.

Treatment Issues Related to Cultural Minorities

There is no denying that the ethnic and cultural composition of offender populations is quite different from that of society as a whole. African Americans are disproportionately represented in jails, prisons, and community supervision programs in comparison with their numbers in the general population. They represented 39.2 percent of the jail population and 44.1 percent of the prison population in 2003, 41 percent of those on parole, and 30 percent of those on probation. According to the 2000 Census, however, those who said they were African American alone or in combination with one or more other races represent only 13 percent of the U.S. population. Hispanics/Latinos, of any race, are also somewhat overrepresented, representing 15.4 percent of the jail population and 19.0 percent of the prison population in 2003, but only 13.3

percent of the U.S. population according to 2002 Census data (Ramirez and de la Cruz 2002). Caucasians are underrepresented at each stage of the criminal justice process, making up only 43.6 percent of the jail population and 35 percent of the prison population in 2003, 40 percent of those on parole, and 56 percent of probationers in 2003, but 77.1 percent of the U.S. population (Glaze and Palla 2004; Harrison and Beck 2004; Harrison and Karberg 2004; U.S. Census Bureau 2001).

McKean (1994) summarizes four somewhat overlapping theoretical perspectives to explain why certain racial or ethnic groups are overrepresented among offenders:

- Social isolation
- Social disintegration
- Resource deprivation
- Violent cultural orientation

These theoretical stances inform substance abuse treatment as well. The social isolation model states that the dominant group will always choose to maintain a social distance between itself and minority groups, and to this end may employ discriminatory laws and policies. Social disintegration models look at how weakened informal and institutional social controls lead to increased crime. The resource deprivation theory emphasizes that economic variables such as unemployment, poverty, and income inequality are associated with crime. The idea of a subculture of violence implies that violent interactions are more accepted among some groups than others, for example in gang culture.

In a study of Alaska Native men, Glass and Bieber (1997) found criminal activity to be related to social disintegration caused by acculturative stress. This stress develops when members of a minority culture are pressured to adapt to a dominant culture. The bicultural individuals in their study had the highest levels of acculturative stress and violent behavior and seemed more prone to identity issues, unstable interpersonal relationships, and unstable emotions. The authors surmise that these individuals are not accepted in either culture and that their efforts to walk in both worlds contribute to their stress.

The forthcoming TIP *Improving Cultural Competence in Substance Abuse Treatment* (Center for Substance Abuse Treatment [CSAT] in development *b*) provides detailed information on adapting treatment to specific cultural populations, and, while it is not oriented toward offenders in criminal justice settings, much of what it has to say will apply here as well. There are not, however, many culturally specific programs operating in the criminal justice system, and there also are limited data concerning the benefits of culturally competent services in these settings. This is certainly an area that requires more research.

Longshore and colleagues (1998) have studied treatment motivation among African-American detainees who used drugs and had never been in substance abuse treatment. Of all the factors they studied, "problem recognition" was most clearly associated with motivation for treatment, and that recognition was strongest among those who more strongly endorsed Afrocentric values such as community, spirituality, collective self-esteem, and conventional family roles. Incorporating these values into treatment may therefore improve treatment outcomes. For example, it could be more beneficial to emphasize the prosocial reasons for stopping substance use than the negative effects of continuing use, to include family counseling in treatment, and to view recovery as benefiting the community, not just the individual. Compared to clients in traditional programs, those in Longshore's culturally congruent treatment were more involved in the experience, were more forthcoming in their self-disclosures, and participated more actively. They also reported more motivation to seek help (Longshore et al. 1998).

The consensus panel recognizes that it is extremely difficult, however, to create a culturally specific program within a prison or

jail given the variety of populations who enter the facility and the need to provide equal levels of treatment for all offenders. Culturally specific programs also require from clients a certain level of commitment to their culture that cannot be assumed for all members of a particular group.

Substance abuse treatment requires two-way communication of vital information including instructions, treatment expectations, personal information, and expressions of emotions. In a criminal justice setting, where the counselor represents the same institutional forces that have convicted and imprisoned the client, the levels of distrust and possibilities for misunderstanding are magnified. While all correctional staff members (including counselors) are seen, to some extent, as representatives of the dominant culture, the possibilities for misunderstanding can increase when client and counselor are from different ethnic or cultural backgrounds. These misunderstandings can jeopardize the client's chances for success in treatment. It is the counselor's job to be aware of and sensitive to the values, biases, and assumptions that his or her culture has created in matters of communication, therapeutic style, and interpersonal contact and how they affect his or her ability to provide culturally competent services to clients. The most common misunderstandings in counseling originate in culture, socioeconomic class, and language (Sue and Sue 1999). (See the forthcoming TIP *Improving Cultural Competence in Substance Abuse Treatment* [CSAT in development *b*].)

Advice to the Counselor: Culture and the Counselor

- The most common misunderstandings in counseling originate in culture, socioeconomic class, and language. It is the counselor's job to be aware of and sensitive to the values, biases, and assumptions of his or her own culture and to provide culturally competent services to clients.

Women's Treatment Issues

In 1998, an estimated 950,000 women were under supervision by correctional agencies, with 85 percent on probation or parole in the community. These women were mothers to about 1.3 million children under age 18. Forty-four percent of them, across settings, reported that they had been physically or sexually assaulted at some time during their lives (Greenfeld and Snell 1999).

The percentage of women in the criminal justice system has increased in the past decade—in jails it has risen from 10.2 to 11.9 percent (Harrison and Karberg 2002). The average annual percentage increase in State and Federal prisons for women between 1995 and 2003 was 5.0 percent, compared to 3.3 percent for men. In 2003 more than 100,000 women were in State and Federal prisons, and women represented 11.1 percent of adults on parole under State and Federal jurisdiction in 1997 (Harrison and Beck 2004; Maguire and Pastore 2001).

About 60 percent of women in State prisons used drugs in the month prior to the offense for which they were convicted, and about half of these women admitted to daily drug use. Drug use at the time the crime was committed was higher for female inmates than for males (40 percent compared to 32 percent), but more male inmates than females were under the influence of alcohol at the time the crime was committed (Greenfeld and Snell 1999). Interviews with incarcerated women in California, Connecticut, and Florida State prisons indicated that more than 80 percent had used substances regularly during their lifetimes while 71 percent reported regular substance use during the month prior to their most recent arrest (Acoca and Austin 1996). A study conducted by the Connecticut Department of Corrections indicated that 45 percent of female prisoners compared to 22 percent

of male prisoners were in need of substance abuse treatment (Acoca 1998).

Many of the issues discussed in this section apply to male offenders as well as to females but are discussed here because the issues create greater problems for women offenders. (For more on women's treatment issues in general, see the forthcoming TIP *Substance Abuse Treatment: Addressing the Specific Needs of Women* [CSAT in development *g*].)

Compared to their male counterparts, female inmates are more likely to have mental disorders (Ditton 1999), to be HIV positive (Maruschak 2004), to have been physically or sexually abused (Harlow 1999), and to have lived with their children in the month prior to their arrest (Mumola 2000). According to Peters and colleagues' (1997) study of women in a Tampa, Florida, jail treatment program, the most common mental disorders that incarcerated women have are serious depression and anxiety disorders. In another study of women in jail awaiting trial, 60 percent were found to have substance abuse or dependence, 22 percent had posttraumatic stress disorder (PTSD), and nearly 14 percent had at least one major depressive episode in the 6 months before entering jail (Teplin et al. 1996). Varese and colleagues (1998) demonstrated that depression among female inmates is greater among women who have deficits in social skills (e.g., are less assertive and/or are more aggressive), have dysfunctional attitudes, and are less able to provide self-reinforcement. These issues must be dealt with in substance abuse treatment programs for incarcerated women because they are intertwined with substance abuse and criminal behavior (Henderson 1998).

Few substance abuse treatment programs have been developed specifically for female offenders, and many of the programs that do exist for women in jails and prisons are based on treatment models developed for male offenders (Peters et al. 1997). However, available research suggests that treatment tailored for female offenders is effective. For example, an outcome study of Forever Free from Drugs and Crime, a California program created specifically for women offenders, found that the longer an offender remained in Forever Free, the more likely she was to stay out of jail. Women participating in Forever Free come from California State prisons, live in a 240-bed housing unit, and receive treatment four hours per day, five days per week. Counseling addresses issues specific to women, such as dependency, physical and sexual abuse, and parenting. Information on Forever Free is available online at www.drugstrategies.org/ks1998/p_crimin.html or through the California Department of Corrections Office of Substance Abuse Programs at (916) 327-3707.

Women in treatment, particularly those in early recovery, need to feel they are in a safe environment, but many do not feel, and some are not, safe in jail or prison (Covington 1998). To try and make the treatment experience feel safer, the harsh confrontational techniques often used in therapeutic communities (TCs) can be modified for women's programs. Instead, a more supportive approach should be used, emphasizing therapeutic sanctions (e.g., participation in treatment activities) rather than punitive consequences (e.g., work assignments) for breaking rules. Nearly all women's programs consider the use of harsh language, expressions of hostility, and physical force by staff members as detrimental to their clients' recovery (Welle et al. 1998). Indeed, such staff actions can recreate abusive interpersonal situations experienced by many of the female offenders while they were in the community. Also, rather than needing help in anger management, women are more likely to benefit from learning techniques to reduce "guilt and self-blame, improve self-esteem and self-awareness, and attempt to create an environment of safety and support" (Peugh and Belenko 1999, p. 31). Women are more likely to complete a treatment program designed specifically for women (Roberts and Nishimoto 1996), and clinical experience suggests that women are more likely to disclose personal trauma, such

as sexual abuse and domestic violence, in single-sex groups.

Based on their research with women referred to a jail-based substance abuse treatment program, Peters and colleagues (1997) recommended that programs for female offenders adapt treatment approaches developed for clients with co-occurring disorders (COD). In part, this is because COD are so common in this population, but also because this is one area where more sensitive and flexible clinical approaches have been developed. They stress the need to be flexible in terms of the sequence, focus, and intensity of treatment and to adapt treatment to individual needs wherever possible. They also note that time needs to be set aside for the assessment and diagnosis of COD and for teaching a range of skills (i.e., parenting, nutrition and health care, accessing social services and housing) that are generally not considered as important in treatment programs for male offenders.

Further information on women's treatment issues in general can be found in the forthcoming TIP *Substance Abuse Treatment: Addressing the Specific Needs of Women* (CSAT in development *g*), and more information about treatment for female offenders can be found in Technical Assistance Publication 23, *Substance Abuse Treatment for Women Offenders: A Guide to Promising Practices* (Kassebaum 1999).

Histories of Physical and Sexual Abuse

Histories of abuse are of particular concern for female offenders and can have a significant impact on treatment. (In the general population, about one third of women and between 3 and 24 percent of men have experienced physical or sexual abuse. Among substance using populations, the figures are higher [Gil-Rivas et al. 1997].)

The panel recommends that screening for a history of abuse be included as part of the intake assessments for women in criminal justice treatment settings; to do this, a psychosocial history should be taken that asks about issues such as childhood abuse and domestic violence. One difficulty with addressing these issues with women who are incarcerated is that immediate ongoing counseling is not always possible, given that counseling staff may not be available every day. The consensus panel feels that programs should have aftercare available for clients with histories of abuse. These issues can take a long time to work through and, depending on the setting in which treatment is provided, sufficient time may not be available within the program. Treatment providers should be aware of the range of aftercare options available for clients who are leaving the facility to enter either the community or another facility.

Indepth treatment for the trauma related to a history of abuse should be provided by professionals specifically trained in this area. However, innovative strategies that help women address issues of abuse at a level with which they are comfortable have been developed. For example, the Empowerment through Literacy Project helps women address issues of sexual abuse in a supportive group atmosphere. Women participate in a reading group that facilitates discussions on a number of important issues (e.g., sexual abuse, substance abuse) at the same time it promotes literacy. Readings pertinent to these women's life experiences are selected, including books such as Maya Angelou's *I Know*

Advice to the Counselor: Treating Female Offenders

- Nearly all women's programs consider the use of harsh language, expressions of hostility, and physical force by staff as detrimental to client recovery as these actions recreate abusive interpersonal situations experienced by many of the female offenders while they were in the community.

Why the Caged Bird Sings, Janet Fitch's *White Oleander*, and Elena Diaz Bjorkquist's *Suffer Smoke.*

Under community supervision, an offender's primary goal needs to be to remain drug free and out of trouble, and treatment programs may not have sufficient time or resources to treat all issues that impact their clients. In such cases, however, programs should be prepared to assist clients in finding a suitable treatment program where they can receive treatment for traumatic effects of abuse. Some providers conduct survivors' groups that are geared toward including treatment for trauma issues within substance abuse treatment for women.

In addition to substances, women can also abuse children or even, occasionally, spouses. However, if a cycle of ongoing violence is going to be interrupted, the nature of a woman's crime should not disqualify her for treatment. For example, a woman who is incarcerated for killing an abusive spouse will likely be considered a violent offender and therefore not qualify for treatment.

Two other TIPs are valuable sources of information about treating women with histories of child abuse (TIP 36, *Substance Abuse Treatment for Persons With Child Abuse and Neglect Issues* [CSAT 2000*d*]) and who have been victims of domestic violence (TIP 25, *Substance Abuse Treatment and Domestic Violence* [CSAT 1997*b*]). The forthcoming TIP *Substance Abuse and Trauma* (CSAT in development *f*) also contains useful information.

Low Self-Esteem

Low self-esteem certainly is not just a women's issue. Many offenders, both male and female, experience low self-esteem. Guilt and shame over past actions are often contributing factors to a poor self-image and low self-esteem, but so is a history of discrimination (whether toward the individual or the culture/ethnic group to which he or she belongs) that can produce poor self-esteem when internalized. Low self-esteem often takes years to produce; it can begin early in life and be increased by physical and sexual abuse, substance abuse, and arrest and incarceration. In order to improve a client's self-esteem, programs need to address this issue continually, affirming at each stage of treatment the client's ability to change and create a positive life.

The strengths-based approach to treatment is widely considered the most effective approach for improving women's self-esteem. The panel also recommends that group work be used with both women and men as a crucial means of building self-esteem. (TIP 41, *Substance Abuse Treatment: Group Therapy* [CSAT 2004], has extensive information on how to conduct a variety of substance abuse treatment groups.) Presenting positive role models to clients also is essential for women (even women who have not gone through the criminal justice system can be role models).

For women, the more time spent in treatment the more likely self-esteem will increase; this increase is most likely if the women are in a residential/inpatient setting. A residential TC helps women build awareness of their strengths and helps them "practice" having higher self-esteem (De Leon and Jainchill 1981). However, if treatment is provided in an outpatient setting, women often return to unhealthy situations (e.g., domestic abuse, a job with low pay and high stress) after their treatment session and their self-esteem will drop again. It takes an extended period of positive reinforcement to raise a client's self-esteem to a level sustainable in the face of oppressive forces. Of course, eventually clients will need to leave a treatment program, but to make that difficult transition as smooth as possible, programs should help the client connect to an appropriate support group.

Parenting and Child Custody

The majority of women imprisoned in jails or prisons are parents and some programs in

and out of prison are adding parenting workshops to their agendas (see text box below). In 1999, more than 1.5 million children had a parent in prison (Mumola 2000; Petersilia 2000), and many more children have had a parent incarcerated during a period of their early lives. At least half of the children of imprisoned mothers have not seen or visited their mothers since incarceration began. Under the Adoption and Safe Families Act of 1997, parents of children in foster care for 15 or more of the past 22 months may have their parental rights terminated by the State. Given that the average prison term for incarcerated women is 15 months (Genty 1998), an increasing number of parents are permanently banned from their children's lives—often a devastating blow for mothers and their children.

Parenting is not just a women's issue, and, in fact, the vast majority (93 percent) of incarcerated parents are male. However, mothers in State and Federal prisons are often (46 percent and 51 percent of the time, respectively) the sole parent living with their children at the time of their incarceration; 31 percent of mothers in prison were the only adult caring for their children before incarceration. Only 28 percent of the children of women in State prisons reside with their other parent and nearly 10 percent live in foster care or an agency. The majority of incarcerated mothers rely on grandparents or other members of their extended family to care for their children while they are incarcerated (Mumola 2000). If a woman is in prison and has no one else to care for her children, her loss of custody could be permanent.

Innovative community reintegration programs for female prisoners may feature eventual reunification with their children as a significant motivator for treatment.

Many incarcerated women feel enormous guilt about being away from their children and worry about maintaining custody of their children (Covington 1998). This guilt may be a motivating force, but it can also overwhelm the client and be a cause for relapse. In some cases, children are used to coerce a parent into treatment; family drug courts, for example, may remove children from a mother's custody if she does not successfully complete treatment. However, the presence of children can be a mother's only link to a stable life, and after losing her children to a Child Protective Services agency or another family member, she sometimes increases her substance abuse.

Research does suggest that it is in the best interest of both mothers and their children to have continued interactions while the woman is incarcerated. Early research by Holt and Miller (1972) found that maintaining family ties and providing parenting training positively affected a parent's success on parole. Stevens and Patton (1998) have found that women in a modified TC that enables them to have their children with them had better treatment outcomes than women who had the same treatment unaccompanied by their children. The panel encourages jail and prison programs to allow for more interaction between incarcerated mothers and their children; the 2–4 hours of supervised visitation per week that many institutions allow is not

A Program for Paroled Women and Their Children

Walden House opened a residential treatment facility for paroled women and their children in El Monte, California, in 1999 as part of the Female Offender Treatment and Employment Programs (FOTEP). The program is based on the TC model but includes parenting skills, education and vocational preparation, job readiness, job placement, and intensive case management. FOTEP fosters an environment where clients learn new ways of meeting their needs without relying on substances. In addition to its emphasis on obtaining employment, the program includes components for children and models parenting behaviors (Smith 2001).

The DWCF Program for Women and Their Children

DWCF opened in early 1999 to serve the needs of 900 female offenders. In addition to providing treatment for substance abuse and mental health problems, DWCF follows recommended treatment principles for incarcerated women by addressing gender-specific treatment issues such as improving the relationships of mothers and their children and increasing contact between them. All mothers in DWCF participate in a 12-week Parenting Skills Seminar as well as a 12-week seminar that focuses on family relationships (the Family Dynamics Seminar). Among other things, these seminars teach mothers about the importance of regular phone contact with their children to discuss things such as homework, report cards, and special school events. Additionally, the facility has placed special emphasis on increasing the frequency of phone contacts and visits between mothers and children. Visits are encouraged and facilitated by the DWCF staff. Special children's visiting areas have been created; these are painted with motifs from children's literature and furnished with colorful children's furniture, games, books, and toys. The environment is attractive and appealing to children and facilitates positive mother–child interactions. The DWCF administration also has established a collaborative relationship with a Quaker volunteer organization, whose members provide weekly transportation for children (and their caretakers) who lack other means of transportation to the facility. Additionally, the facility has developed several apartments within the prison, permitting weekend visits for mothers and their children during the 4 to 6 weeks prior to the mother's release into the community; these visits help to reconnect mothers and their children during the crucial period just prior to discharge or parole. Staff monitor these visits and provide support and assistance for mothers and their children when needed.

sufficient for mothers or their children. One program that is attempting to increase interactions between incarcerated mothers and their children is located at the Denver Women's Correctional Facility (DWCF) and is described in the box above.

Job Skills Training

As Peugh and Belenko (1999) note, female inmates with substance use disorders have poorer employment histories than their male counterparts, and likely have fewer opportunities for employment (especially at jobs that pay more than minimum wage) than do men. Vocational training would reduce the need for women to turn to illegal sources of income to support themselves and their families after release (Peugh and Belenko 1999). Therefore, vocational training should be a priority for female offenders in substance abuse treatment; however, this often is not the case. The vocational options available for female inmates are often extremely limited compared to the options available for male offenders. Male offenders have more opportunities to learn higher-paying job skills (such as carpentry or mechanics) than female offenders, and so women too often return to jobs in the community that pay a low wage, do not enable them to support themselves and their children, and do not raise their self-esteem.

The panel recommends that in prisons and jails, substance abuse treatment programs and TCs introduce vocational programs for women and expand

Advice to the Counselor: Parent Training

- Discussions of parenting and the welfare of one's children often promote strong emotional explorations and counseling opportunities.
- Offenders are sometimes more receptive to treatment and more willing to accept prosocial values when the appeal is made for the sake of their children.

the range of vocational skills taught. Programs for offenders under community supervision can obtain access to community vocational programs that will accept their clients. Because so many incarcerated women with substance use disorders have no real employment history or work skills, clients will benefit from learning prevocational skills, earning GEDs, and meeting other educational goals. Counselors can assess both women's vocational interests and their existing work skills. One innovative program that is targeting women with substance use disorders who are serving a prison sentence was developed by the Project for Homemakers in Arizona Seeking Employment (PHASE). A complete description of the program is available online at www.ag.arizona.edu/impacts/2000/ready3.pdf.

TIP 38, *Integrating Substance Abuse Treatment and Vocational Services* (CSAT 2000*c*), provides information on the importance of vocational services, how to integrate them into substance abuse treatment programs, and, in a chapter titled "Working With the Ex-Offender," specific information on the vocational training needs of offenders.

Men's Treatment Issues

Because men make up the vast majority of offenders and because gender bias often makes people see men's treatment as the norm, it sometimes is difficult to see how certain issues need to be addressed for men in substance abuse treatment programs. Typically, these are issues that have been thought of as women's issues (e.g., sexual abuse, parenting) but also can include issues that are significant for men in the general population, but often forgotten for offenders (e.g., status). Much of the information presented above also applies to men. For more information on men's issues related to substance abuse treatment, see the forthcoming TIP *Substance Abuse Treatment and Men's Issues* (CSAT in development *e*).

Fathering

Male offenders often are very concerned about the welfare of their children, although socially defined gender roles still put more pressure on women to be good parents. Male offenders may not talk as much about their children or the feelings they have for them, but they often keep pictures of them and, if asked about them, express concern. According to Mumola (2000), 40 percent of fathers in State prison had at least weekly contact with their children.

It is particularly difficult for male offenders to admit that they failed as fathers. Being a good father is not, as some might expect, looked down on in prisons as a sign of "weakness," but rather is generally perceived as an important and valuable activity. However, an individual perhaps feels a conflict between his role as a caring parent and the role of a "hardened criminal" that he presents within the prison.

Many male offenders feel inadequate when dealing with their children and have never had any instruction or assistance in how to be a good father. Their own fathers often were poor role models, and some were (and may still be) incarcerated themselves, even in the same prison. This does not mean, however, that they are bad fathers—just that they are not aware of what they should be doing or how well they are doing in that role. According to Landreth and Lobaugh (1998), at the end of a parent training class a group of incarcerated fathers was more accepting of their children, perceived fewer problems with their children, and had less stress about parenting compared with offenders who did not participate. The children benefited as well from the structured play therapy, as their self-concept scores improved significantly.

Parent training can also serve as a bridge to counseling. Few criminal justice clients want their children to wind up in prison. Discussions of parenting and the welfare of one's children often promote strong emotional explorations and counseling opportunities.

Offenders are sometimes more receptive to treatment, and more willing to accept prosocial values, when the appeal is made for the sake of their children.

Developing Relationships

Learning how to relate to people and build relationships (including how to be a friend) takes a lot of work for men. In many cases, this is not a matter of rehabilitation but rather habilitation; some male offenders do not understand how to be a friend, family member, or significant other. They often experience great difficulty even talking about this issue, in spite of the fact that they want to learn these skills. One of the attractions of gang participation is that it gives members a sense of belonging and a certainty about their relationships with one another that they do not have outside the gang. Thus, treatment should encourage men to form relationships based on a shared experience with recovery. Relationship training also is important for job success. Learning how to communicate with peers and supervisors is necessary for maintaining employment and advancement.

Working With Violent Offenders

While substance abuse treatment providers working in any setting may need to discuss violence in a client's past, this issue is especially important when working in the criminal justice system because offenders' violence often has led to their arrest and conviction. Clinicians also must be aware of the possibility that violence could erupt in the treatment program and should pay careful attention to issues that could trigger violence between offenders.

Relationship Between Substance Abuse and Violence

Literature on the subject generally concludes that substance use often is a cause of or a predisposing factor for violence (Friedman 1998). Alcohol is the most frequently used substance that can precipitate violent crime. According to victim reports, perpetrators were clearly under the influence of alcohol in nearly 35 percent of violent crimes; two-thirds of victims who suffered violence caused by a current or former spouse or partner also reported that alcohol was a factor in the incident (Greenfeld 1998). In a 1997 survey, 41.7 percent of State prison inmates and 24.5 percent of Federal inmates convicted of a violent crime reported that they were under the influence of alcohol at the time they committed the crime for which they were convicted; 29 percent of State and 24.5 percent of Federal inmates reported that they were under the influence of drugs at the time (Mumola 1999).

There is some evidence that cocaine, amphetamines, and possibly other substances also have the potential to stimulate violent acts. The relationship of cocaine to violence is better established for those inner-city residents who predominantly use crack cocaine (Friedman 1998). The possible effect of race, ethnicity, or culture on this relationship has not been studied systematically. Although more research is needed, there is at least some reason to believe that the relationship of drug and alcohol use to violence may be affected by cultural factors as well (Valdez et al. 1997). Earlier substance abuse seems to be associated with subsequent violent behavior for both women and men. The effect of alcohol as a precipitant of violent crime is better established for men than women (Friedman 1998).

The relation between substance use and violence is complicated, and there are many individual and group differences in the way substances are used and how they affect people. Some people may in fact use substances in order to be calmer and less prone to violence; others may use them to forget the guilt associated with past acts of violence, which may then precipitate further acts of violence.

Drugs influence levels of violence in other ways. The business of manufacturing and selling drugs can be very violent, and offenders who have been involved in these activities may have committed violent acts in order to survive and succeed. A study demonstrating that legal prohibitions against the use of alcohol or drugs actually increase the level of violence (and homicide in particular) was published by Miron in 1999.

Managing Violence

Within prison culture, violence is an everyday part of life and inmates may resort to violence in order to protect themselves. The prevalence of violence in the system reduces a client's feeling of safety within the treatment setting. Many offenders react with violence because they have never developed the social and coping skills necessary to react to problems in more positive ways. This lack of skills is even more prevalent in offenders with extensive histories of substance abuse. Interpersonal violence is also associated with methamphetamine abuse (Cohen et al. 2003). The prison culture reinforces violent behavior. Individuals who are incarcerated without a history of violence quickly learn its value in jail or prison. Past violence is an issue particularly for offenders who are making the transition from incarceration to the community because past actions may come back to "haunt" them. It can be difficult to find treatment programs in the community that will accept violent offenders.

A number of programs have been developed to help offenders stop violent behaviors. Many of these programs use variations on cognitive–behavioral therapy (CBT) and ask offenders to look at their "criminal thinking" and the ways in which it leads them to commit violent crimes. Several programs have been developed from the model of the Oakland Men's Project, a community-based violence prevention program for men that began in 1979. This project developed a series of workshops that use role-playing exercises to help men understand how society pressures them to commit (and rewards them for) violent actions.

Programs such as the Violence Interruption Process (VIP) of the Illinois TASC (Treatment Alternatives for Special Clients) and the Ohio Department of Alcohol and Drug Addiction Service's (ODADAS) Ohio Violence Prevention Process (OVPP) were developed from the Oakland Men's Project model. Illinois's VIP works on the assumption that violent behavior is learned and has an institutional as well as a personal dimension. When people become aware of how they have learned violent attitudes and behaviors, they can learn new methods of communication and resolving conflicts (People for Peace 1996). ODADAS provides onsite trainings in OVPP to substance abuse treatment programs, corrections programs, school systems, and other groups; trainings touch on a variety of issues including the connection between substance abuse and violence, the role of racism and sexism in violence, and building multicultural alliances (ODADAS 2000). More information on promising violence prevention and psychoeducational programs in a range of locales can be found on the Partnership Against Violence Network (Pavnet) Web site (www.pavnet.org).

> Treatment should encourage men to form relationships based on a shared experience with recovery.

Anger management groups are another useful intervention with this population but the consensus panel recommends that these groups be connected with other interventions and not simply provided as a stand-alone treatment for violent offenders. A variety of curricula are available for running anger management

groups in jail or community settings. Incentives also are very important when dealing with this population. These are clients who have not had much positive reinforcement in their lives and have grown accustomed to reacting to negative reinforcement with anger and resentment. Head trauma and related brain injury can be another cause of violent behavior (Diaz 1995; Robinson and Kelley 2000).

People with substance use disorders may experience a coexisting cognitive or physical disability.

In some cases, medication may be called for in order to manage aggressive behaviors (Lavine 1997). When medical, psychiatric, and substance abuse assessments indicate that a client's aggressiveness is not under control, pharmacological treatment sometimes is considered.

Treatment Issues Based on Client's Sexual Orientation

Sexual orientation and sexual behavior are not necessarily congruent, especially within a prison or jail. Many offenders who engage in homosexual activity while in jail or prison do not self-identify as gay, lesbian, or bisexual. Others, who may recognize that they are gay, lesbian, or bisexual, do not openly proclaim that fact (i.e., are not "out") in an incarcerated setting because they fear reprisals. The institutional culture of men's jails and prisons may recognize only the "passive" or receiving sexual partner as gay, which supports a heterosexual self-identification for some men who engage in homosexual activity.

Incarcerated individuals may engage in sexual activity with members of the same gender for many reasons, not all of which reflect their sexual identity. Self-identified heterosexuals may engage in prostitution for money or have sex in order to gain the protection they need to survive within the jail or prison. For such individuals, sexual identity can become an especially important issue upon release as they try to understand their sexual activity and how it relates to their identity and sexual identification. There may be, in fact, men within the prison system who have had more sex with men than women but who still identify as heterosexual. These individuals may face particular difficulties when they return to sex with female partners and may use substances in order to facilitate heterosexual activity.

Reliable data on the prevalence of homosexual behavior in jails and prisons are limited. In one study of a low-medium-security prison, which claimed to underreport some types of sexual behavior, 55 percent of self-identified heterosexuals reported being involved in sexual activity in prison (Donaldson 1990). Despite disciplinary codes in jails and prisons that prohibit all sexual activity, such behavior still occurs. Within men's prisons there is a social hierarchy based on sexual roles. Although middle-aged and older men are most likely to abstain from sexual activity while incarcerated, others engage in sexual behaviors to assert their masculinity, to establish power over others and over their own lives, and, in the case of stable relationships, to provide companionship. Relationships between inmates imply obligations by each partner: the dominant partner to defend his partner physically against mistreatment by others and the receptive partner to obey the other (Donaldson 1990).

In a study of homosexual behavior in prison, Alarid (2000) surveyed men incarcerated in a county jail who had requested and received protective custody because of their sexual orientation. The gay and bisexual men in the group tended to be older and never married.

Nearly half were African American. Slightly more than half of the men in this study self-identified as bisexual, with one third of those preferring female partners (bisexual/heterosexual). Gay and bisexual men were generally satisfied with their sexual orientation. Almost one fourth of the group (a majority of them gay) exchanged sex for money or favors. The bisexual/heterosexual group felt more pressure to have sex and often used it to gain the protection of another inmate. This is perhaps a result of the fact that the group was small in number and that other inmates sought them as sexual partners. Most of the group believed that their fellow jail inmates treated them disrespectfully. Only a few gay inmates and none of the bisexuals felt that jail personnel tolerated gay behavior or gay or bisexual individuals. More than a third of this group feared being raped in prison and believed that having the protection of a heterosexual was the best way to do prison time (Alarid 2000).

In male institutions, individuals who do self-identify as gay are often victims of rape and/or physical violence. They may need to resort to violence to protect themselves or else become a sexual partner of someone who can protect them. However, these are not typically mutual relationships and the gay partner often needs to assume a submissive role that may not be compatible with the sexual role he prefers; gay inmates often wish to distance themselves from these partners upon release.

Many women also face conflicts between sexual orientation and sexual behavior when incarcerated. However, generally, confusion around sexual orientation is not as difficult for women because sexual encounters in prison involve more of a relationship than they do for men; sexual activity is often a part of a nurturing, family relationship (and women often explicitly take on roles as "husbands and wives"). It is assumed that the prevalence of homosexual activity in women's jails and prisons is similar to that in men's. In contrast to relationships among men, women establish partnerships voluntarily and consensually. These partnerships are generally respected by other inmates (Donaldson 1990).

Female offenders also seem more accepting of openly lesbian women than their male counterparts are of openly gay men. Overall, lesbian women have an easier time dealing openly with sexuality while incarcerated than gay men. They may develop very close relationships with other women while incarcerated and express regret that the relationship may end after one partner leaves the institution. Some lesbian offenders say that they enjoy the sexual freedom that a prison environment allows them, and, after release, may express a desire to return to a relationship they had while incarcerated.

Other issues related to sexual orientation, such as conflicts with the family of origin and societal discrimination, can create additional stress that can lead to increased substance abuse. For more general information on working with this population, see *A Provider's Introduction to Substance Abuse Treatment for Lesbian, Gay, Bisexual, and Transgender Individuals* (CSAT 2001).

Treatment Issues Based on the Client's Cognitive/Learning, Physical, and Sensory Disabilities

People with substance use disorders may experience a coexisting cognitive or physical disability. A study by the New York State Office of Alcoholism and Substance Abuse Services found that more than 22 percent of the clients served by licensed treatment facilities had a co-occurring mental or physical disability (CSAT 1998*d*). Self-reports from inmates in 1997 indicate that 31 percent of State prisoners and 23 percent of Federal prisoners had learning or speech disabilities, hearing or vision problems, or mental or physical conditions. This includes 108,000 individuals with learning disabilities, 135,000

with physical impairments, 65,000 with hearing problems, and 94,000 with vision problems (Maruschak and Beck 2001).

Evidence suggests that people with cognitive disabilities are disproportionately involved in the criminal justice system (Cockram et al. 1998). Nearly one third of inmates in State prisons and one quarter of those in Federal prisons report having a physical or cognitive disability. These data, derived from self-reports, are likely to underrepresent some conditions, including learning disabilities, of which inmates themselves may not be aware. Ten percent of State and 5 percent of Federal prison inmates report a learning disability. Also, data from inmates in State prisons show that they are three times more likely than the general population to have a speech disability and more than twice as likely to have impaired vision. These inmates are, however, slightly less likely to have a hearing impairment, but this can be accounted for by the age and gender differences from the general population (Maruschak and Beck 2001).

People with cognitive disabilities are at a significant disadvantage in their contacts with the criminal justice system. For example, offenders with developmental challenges are disproportionately likely to be arrested and coerced into a confession for a crime they did not commit. They may not understand their Miranda rights and are eager to please, ignorant of the value of remaining silent, susceptible to leading questions, insensitive to nonverbal cues, and desirous of appearing competent (Cockram et al. 1998). They also are easily led into criminal activity by others, and, in their desire to feel like they belong to a group, they may even view arrest and incarceration as successful achievements (Wood and White 1992). Inside jails and prisons, they tend to be victimized by other inmates, and often try to hide the presence of their disability in order to avoid further victimization. According to focus group interviews with family members of people with cognitive disabilities, one way the criminal justice system could better assist people with cognitive disabilities is to provide qualified staff members to work with them in the early stages of the legal process (Cockram et al. 1998).

Jails and prisons can be difficult places for people with physical disabilities (e.g., there may be no wheelchair access and bathrooms may not be fitted with hand rails). Sometimes clients with disabilities can be moved to other facilities that are not necessarily appropriate for them, given their sentence (e.g., they may be moved to a medium security facility even though their sentence warrants maximum security). In June 1998, the U.S. Supreme Court ruled that State prisons must comply with the provisions of the Americans with Disabilities Act. This means that they must make reasonable accommodations to provide access to basic facilities and services for eligible prisoners with disabilities (American Civil Liberties Union 1998).

Certain physical disabilities require medication, and this can pose particular problems for treatment facilities in jails and prisons. Facilities may need to give offenders medications at specific times that could conflict with other scheduled activities. Clients under community supervision require a support system that can help them manage their medication and oversee compliance.

Clients who have conditions such as diabetes that require the administration of medication by means of a syringe may face daily what could be a significant trigger for substance use. In the community, they will have to contend with the theft or use of their syringes by others. These clients will need assistance in looking at these triggers and developing a relapse prevention plan that addresses them. For example, individuals who need to administer medications using a syringe who are no longer in a residential program could have a friend or relative available to be with them when they give themselves their shots (at least for the first few months after release). Programs can provide these individuals with a small safe where they can keep needles and should advise them to keep syringes in more

than one place so that if any are stolen they will still be able to administer their medication. Individuals should always check their syringes to see if others have used them and should keep a supply of bleach available to clean needles if they suspect their needles have been used.

Given the prevalence of disabilities in incarcerated populations, especially among offenders with substance use disorders, the consensus panel suggests that treatment providers be able to screen for co-existing disabilities and make accommodations for offenders who have them. For example, someone with mental retardation may not be able to participate in a traditional TC and may need to be sent to a modified TC or have another suitable treatment option available. Information on treatment for clients with co-existing disabilities can be found in TIP 29, *Substance Use Disorder Treatment for People With Physical and Cognitive Disabilities* (CSAT 1998*d*).

Treatment Issues for Older Adults

Age is a factor associated with positive treatment outcomes. The older one is the more likely one is to stay in treatment, complete treatment, and have positive outcomes following treatment. For some older clients the negative consequences of a criminal lifestyle accumulate over time, while the body becomes less capable of managing substance abuse and related stressors, leading to a desire for change. Engaging these individuals in treatment may be relatively easy. However, older offenders also have unique issues that counselors need to be prepared to address. For one, this population is more prone to health problems. Visual impairments and hearing loss are factors, along with chronic health problems, senile dementia, and dementia related to long-term substance abuse. Other characteristics typical of this population that complicate treatment include

- A slow response to directions
- Rigid habits
- The likelihood of a physical condition presenting as an emotional problem
- Lifelong patterns of criminal behavior that cannot easily be altered
- A lack of assertiveness, suggesting that younger, more verbal inmates are more likely to get treatment (Chaiklin 1998)

Readers are referred to TIP 26, *Substance Abuse Among Older Adults* (CSAT 1998*c*), for more information on substance abuse treatment for this population. See also chapter 9, Issues Specific to Treatment in Prisons, for a description of how older inmates can serve an important function in prison-based substance abuse programs.

Age is a factor associated with positive treatment outcomes.

Treatment Issues for Clients From Rural Areas

In the past, alcohol has been the largest substance abuse problem in rural areas, but that is beginning to change. While certain substances of abuse are more available than others, illicit substances are reaching rural communities. There is now no difference in prevalence of illicit drug use between large and small metropolitan areas and rural areas with the exception of marijuana (National Center on Addiction and Substance Abuse [CASA] 2000). In an evaluation of substance abuse in rural Nebraska, marijuana was found to be the most common drug (as it was in urban areas), but methamphetamine abuse was more common than cocaine abuse; those

who abused substances tended to be younger than those in urban Nebraska and were more likely to be involved in the selling of drugs (Herz 2000). However, these patterns vary by region; for example, in rural northern Louisiana, cocaine abuse predominates and methamphetamine abuse does not seem to be a significant problem (Monroe 1998). Abuse of OxyContin has been more common in several rural areas, such as the eastern Kentucky and western Virginia areas of Appalachia.

Clients from rural communities have distinct cultures that differ from region to region. Treatment staff working with clients from a particular rural population should seek to understand that culture in the same way they would any other. Increasingly, offenders from urban areas are being sent to prisons located in rural regions and staffed by local residents; here again, a cultural clash can develop, and training can help staff understand the cultural background of offenders coming from urban areas.

Services available in rural areas may also be more limited than those in more densely populated regions. A rural jail, for example, is generally unable to develop a substance abuse treatment program because its resources are limited. Community supervision programs in rural areas also have particular difficulties. Few programs will be available, there is little coordination between programs, privacy and confidentiality may be difficult to maintain, and certain types of substance abuse (e.g., excessive alcohol consumption) may be the norm in the area.

Advice to the Counselor: Rural Clients, Rural Counselors

- Clients from rural communities have distinct cultures that differ from region to region. In addition, more and more offenders from urban areas are being sent to prisons in rural regions with local staff.
- Counselors should seek to understand urban–rural differences in culture as they would any other.

Treatment Issues for People With Co-Occurring Substance Use and Mental Disorders

According to a study conducted in 1998, an estimated 283,800 offenders in jails and prison and another 547,800 on probation reported having a mental disorder and/or had stayed overnight in a mental hospital (Ditton 1999). Reported mental disorder varied across setting, with 16.2 percent of inmates in State prison, more than 7 percent of Federal prison inmates, 16 percent of jail inmates, and 16 percent of probationers reporting mental disorders or a stay in a mental hospital. Rates were substantially higher for women than men and for Caucasians than African Americans or Hispanics/Latinos. Individuals with mental disorders were more likely to have been under the influence of substances at the time of their offense and substantially more likely to report a history of substance abuse than others (Ditton 1999). The National GAINS Center, a Substance Abuse and Mental Health Services Administration (SAMHSA) initiative to study mental health and substance abuse services for people in the criminal justice system, estimates that of jail inmates identified with mental illness, 64.3 percent reported alcohol or drug use at the time of the offense. Among the State prison population the figure is 58.7 percent (National GAINS Center 1997).

Even conservative estimates report high rates of mental disorders. Ditton (1999) reports that three previous studies of inmates in jail or State prison with rigorous sampling methods found rates of mental disorders to be between 8 and 16 percent. A study of incarcerated women awaiting trial in a Chicago jail found significantly higher rates of mental disorders based on offender

reports of psychiatric symptoms; 18.5 percent of the women had experienced symptoms of a severe disorder (i.e., schizophrenia/schizophreniform, manic episode, major depressive episode) at some point during their lives, 33.5 percent had experienced PTSD, and 70.2 percent had a substance use disorder (Teplin et al. 1996).

More information on the treatment of clients with COD can be found in TIP 42, *Substance Abuse Treatment for Persons With Co-Occurring Disorders* (CSAT 2005*c*).

Identifying Co-Occurring Disorders

There is a great deal of stigma associated with mental disorders even within the culture of prisons and jails. At the same time, in correctional institutions, substance abuse does not carry the same degree of stigma as it does in the outside community. In some prison settings, procedures such as public medication lines expose the inmate with a mental disorder to public ridicule, adding to the stigma and reinforcing the inmate's reluctance to admit to his or her disorder. Offenders may be willing and able to face talking about their criminal activity or substance abuse but reluctant to discuss their mental disorder. Consequently, actual rates of mental disorders in this population are likely to be higher than self-reported rates.

Because one disorder can mask or imitate the other, accurate diagnosis of COD requires skilled screening and assessment. Assessment should look for both problems at the same time, rather than separating assessments for mental disorders and substance abuse. Regular reassessment is also important. Trained staff should be used to perform such assessments. Most prison programs for inmates with COD do use doctoral-level staff for initial screenings (Edens et al. 1997). For more on screening and assessing for COD, see chapter 2.

Co-Occurring Disorders Treatment Programs

In order to serve the high number of offenders with mental and substance use disorders, a number of diversionary and corrections-based programs have been developed for offenders with COD.

Diversionary programs for offenders with co-occurring disorders

These programs, generally referred to as Mental Health Courts, currently exist in a handful of municipalities across the country (Broner et al. 2002). SAMHSA has funded jail diversion programs at nine sites for offenders with COD. In the Eugene, Oregon, program, for example, mental health and substance abuse treatment is collaborative; sanctions applied are sensitive to mental health problems and the case manager is a mental health specialist who acts as court liaison (National GAINS Center 1999*b*).

Prison- and jail-based programs for offenders with co-occurring disorders

In addition to diversion programs such as mental health courts, there has been a rapid growth in corrections-based co-occurring programs during recent years, from only 2 State systems that had developed these programs in 1993, to 7 systems with programs in 1997, to 18 systems in 2002 (Edens et al. 1997). However, few State systems have systematic procedures for identifying and tracking prison inmates with COD. Moreover, little research has yet been done on the effectiveness of these programs. Preliminary outcome data from one study comparing a modified therapeutic community (MTC) program for prison inmates with COD with treatment as usual and with a mental health group showed the MTC group to have fewer new arrests,

less use of illicit drugs, and better compliance with treatment regimens (Sacks et al. 2001).

Several features distinguish the programs that treat inmates with COD from other criminal justice substance abuse treatment programs:

- *An integrated treatment approach is used whenever possible.* Mental health treatment staff, substance abuse treatment staff, and criminal justice staff are located in the same program unit, and often share in decision-making. In some jurisdictions, both correctional officers and community supervision officers have been successfully involved in treatment team meetings, treatment groups, and other therapeutic activities. A wide range of treatment approaches are implemented, according to the client's stage of treatment. Collaboration and/or consultation may be adequate to serve offenders who have less severe COD.
- *Both disorders are treated as "primary."* Integrated treatment involves simultaneous consideration of both disorders and attention to the interactive nature of these disorders. However, the scope and intensity of treatment activities will vary according to the client's needs and functioning level.
- *Comprehensive treatment services are flexible and individualized.* Treatment should be adapted to address different levels of symptom severity, functioning, and commitment to treatment. Both early intervention and active treatment interventions should be adapted for different diagnostic groups and for offenders with special needs (e.g., those with cognitive impairment, women with trauma and abuse histories).
- *Treatment approaches that are commonly used in substance abuse treatment settings (e.g., TCs, cognitive–behavioral treatments, relapse prevention, peer and alumni support groups) are adapted to better suit the needs of offenders with COD.* Common modifications include smaller caseloads, shorter and simplified meetings, special attention to criminal thinking, education about medication, and minimizing confrontation (Edens et al. 1997; Peters and Hills 1997).
- *Treatment is provided in graduated "phases" or "stages," using a highly structured psychoeducational treatment approach.* Early phases of treatment include a focus on orientation, assessment, development of treatment plans, and engagement and persuasion activities. Didactic approaches are particularly useful in early stages of treatment to help offenders understand the nature of their mental disorders and biological aspects of both disorders. Secondary phases focus more on "active treatment," such as development of coping and life skills, lifestyle change, and cognitive–behavioral interventions. Later phases may include relapse prevention, peer mentor activities, vocational training, reentry planning, and linkage with community support and treatment programs. Case management and relapse prevention activities often are provided throughout the various phases of treatment, with a particular emphasis during prerelease and reentry phases. In jails, where the relatively brief period of incarceration may prevent the use of a long-term phased treatment approach, services may focus on assessment, brief psychoeducational interventions, community "in-reach" services, and linkage to community services.
- *The focus of treatment is long term, with an emphasis placed on continuity of treatment in aftercare and postrelease settings.* Recovery and stabilization for offenders with COD often occurs over a period of several years and includes multiple treatment episodes. COD treatment programs should provide linkage with other community treatment and ancillary service providers, and should develop detailed aftercare, transition, and postrelease plans to ensure continuity of services. These should include provisions to furnish an adequate supply of psychotropic medications for the offender during transition from institutional to community programs. The offender also should be monitored carefully during transition periods, when stress levels are high and

there is increased risk for recurrence of mental health symptoms, substance abuse relapse, and recidivism. Forensic coordinators or other case managers have been used successfully in some jurisdictions to help in community transition.

- *Staff are trained and experienced in treating both mental disorders and substance abuse.* A blend of staff experience is needed, including those trained in working with acute symptoms of mental disorders and those who have worked in specialized substance abuse treatment settings, such as TCs. Cross-training activities are useful to share information from the perspectives of each of the treatment disciplines, and also from the perspective of security/community supervision.

Programs for offenders with co-occurring disorders under community supervision

This group of offenders will have particular difficulties finding aftercare programs to accept them because of the stigma associated with the combined problems of COD and a criminal record. Nor will most traditional community mental health interventions be effective for them, as they typically have complex problems that require specialized treatment (Broner et al. 2002). Community supervision of offenders with COD also requires specialized strategies (Peters and Hills 1997), including

- Recognition of special service needs
- Use of supportive rather than confrontational approaches
- Positive reinforcement for small successes and progress
- Different expectations regarding response to supervision
- Flexible responses to infractions
- Use of concrete directions
- Highly structured activities
- Ongoing monitoring
- Enlistment of support from family members to work with offenders with COD where appropriate
- Close coordination between the community supervision/probation officer and the offender's clinician

Medication Management

Substance abuse treatment providers working with people with COD need to understand and be able to help educate clients about the importance of medication management and compliance. Clients sometimes have trouble distinguishing between "good" and "bad" drugs, particularly at the beginning of treatment. The distinction is made more difficult by the fact that the "good" medications are more expensive and more difficult to obtain than illicit drugs. There still is a myth within the substance abuse treatment field that use of psychotropic medication by individuals with co-occurring mental disorders should be discouraged. Programs in criminal justice settings should update their formulary so that they are using the most up-to-date medications. Offenders entering jails may have particular problems around medications because they may not be able to receive necessary medication while incarcerated or may not be given a supply of medication upon discharge (which they might need until they can get prescriptions filled). It often takes well over a month to be seen by a psychiatrist and to receive a prescription for medication. In addition, certain medications (e.g., antidepressants) take several weeks to build up to effective levels in the bloodstream. Moreover,

Advice to the Counselor: "Good" and "Bad" Drugs

- Clients with COD need help with medication management, especially in distinguishing between substances of abuse and licit medication.
- Counselors must be alert to inmates who skillfully mimic the symptoms of mental disorders in order to receive medications.

individuals often do not have enough money to pay for the medication. The consensus panel suggests that programs working with people who are making a transition from institution to community need to ensure that these clients have an adequate supply of psychotropic medications.

On the other hand some inmates can skillfully manipulate signs and symptoms of mental disorders in order to receive medications with sedative properties. Some of these medications (such as benzodiazepines, prior-generation antidepressants, and antipsychotics) can have serious and severe side effects. These medications can be sold to other inmates or exchanged for favors.

Case Management Services

Case management services are useful in providing access to a broad range of mental health and substance abuse services and are complementary to a range of other treatment approaches used with offenders with COD. Research indicates that case management services can lead to improvement in a client's functional status and fewer hospitalizations during an extended followup period (Mueser et al. 1997). One model is Intensive Case Management (ICM). ICM is provided by multidisciplinary teams that include mental health treatment staff, substance abuse specialists, housing specialists, and community supervision officers. These teams often share caseloads to provide flexibility in coverage. Participation in treatment is provided through crisis and outreach services, use of specialized engagement and motivational strategies, and culturally relevant programming over an extended period of time.

Services provided by case managers are developed to address the stage of COD treatment (Lurigio 2000*b*). This includes an early emphasis on client engagement and commitment to the recovery process, and is followed by persuasion to consider abstinence and to begin active behavior change. Later stages of treatment include the use of cognitive–behavioral interventions, development of a drug-free social support network, understanding of relapse risks, and use of relapse prevention skills. Another frequently employed case management approach for use with COD is the Assertive Community Treatment model (ACT) (Brown 2003; Stein and Test 1980). Key elements of this approach include crisis intervention, supportive therapy, substance abuse counseling, skills training, medication monitoring, housing support, vocational rehabilitation, specialized dual diagnosis groups, family psychoeducational groups, and family outreach activities.

Special Considerations in Treating Antisocial Personality Disorder (ASPD)

Substance abuse often is associated with criminal or antisocial lifestyle and is highly correlated with ASPD (Knop et al. 1998; Robins and Regier 1991). Someone with ASPD does not accept society's values or norms and acts without guilt; he sees other people as objects to meet his needs. According to the *Diagnostic and Statistical Manual of Mental Disorders,* 4th edition (DSM-IV), ASPD "is a pattern of disregard for, and violation of, the rights of others" (American Psychiatric Association [APA] 1994, p. 645). In order to be diagnosed with ASPD, a person needs to demonstrate, after the age of 15, three or more of the associated traits. (See Figure 6-1 for list of traits.) Given these criteria it is easy to see why offenders who abuse substances often are diagnosed with ASPD. In a sample of 325 psychiatric patients who had recently been hospitalized, Mueser and colleagues (2000) found that both a history of incarceration and ASPD were predictive of substance use disorders. In another study that looked at clients in substance abuse treatment, Compton and colleagues (2000) found that 44 percent qualified for ASPD at some time during their life. Research from a male prison TC found 52 percent of clients had ASPD (Wexler and Graham 1993).

Figure 6-1
Traits of ASPD (DSM-IV)

- Deceitfulness, as indicated by repeated lying, use of aliases, or conning others for personal profit or pleasure
- Irritability and aggressiveness, as indicated by repeated physical fights and assaults
- Consistent irresponsibility, as indicated by repeated failure to sustain consistent work behavior or honor financial obligations
- Failure to conform to social norms with respect to lawful behaviors as indicated by repeatedly performing acts that are grounds for arrest
- Impulsivity or failure to plan ahead
- Reckless disregard for safety of self or others
- Lack of remorse, as indicated by being indifferent to or rationalizing having hurt, mistreated, or stolen from another

Source: Hare et al. 1991.

While it is generally believed that ASPD is more common in men than women, available data are mixed. Researchers studying people in psychiatric hospitals (Grilo et al. 1996), in treatment programs for alcoholism (Cornelius et al. 1995), and in homeless populations (North et al. 2004) have found significantly higher rates of ASPD for men than for women. Galen and colleagues (2000), however, found prevalence rates of 16 percent for men and 22 percent for women in a group of 235 clients at outpatient substance abuse treatment centers. Rates are high for offenders of both genders. A study of women entering prison in North Carolina found that rates of ASPD were significantly higher than for women in the general population (Jordan et al. 1996), and Teplin and colleagues (1996) in their study of women in Cook County, Illinois, jails found that 13.7 percent met DSM-III-R criteria for ASPD within the 6 months prior to their incarceration.

The panel cautions that some people who meet the criteria for ASPD do not really have the disorder—their behaviors are the result of other factors, most notably substance abuse. The behavior of these clients is improved greatly after treatment. It is not easy, though, to determine who really does have ASPD and who does not. There also are people who have ASPD but who lie about behaviors that qualify for this diagnosis.

Psychopathy is a term used to describe a more extreme form of ASPD. In addition to the criminal tendencies apparent in ASPD, people with psychopathy also exhibit affective and interpersonal dysfunction (Hare et al. 1991). Moreover, offenders who score high on the PLC-R (the test for psychopathy; see chapter 2 for more information) have higher rates of recidivism and are more prone to violence both in and out of criminal institutions (Hare et al. 1991).

ASPD and psychopathy are difficult to treat and in this regard are addressed somewhat differently from other mental disorders. Approaches used for offenders with ASPD and psychopathy are typically focused on behavior management rather than on counseling or other therapeutic techniques. These approaches involve heightened accountability (i.e., surveillance and monitoring), highly structured programming, and application of carefully crafted sanctions and incentives for targeted behaviors.

People with severe ASPD require intensive, long-term residential treatment for their disorder and for substance abuse; if they interrupt treatment they are likely to return to

previous behaviors. It should be noted, however, that about half of all people with ASPD display fewer antisocial behaviors as they grow older, beginning in their 40s or 50s (APA 1994). More information on the treatment of clients with COD can be found in TIP 42, *Substance Abuse Treatment for Persons With Co-Occurring Disorders* (CSAT 2005*c*).

Special Considerations in Treating Borderline Personality Disorder (BPD)

According to the DSM-IV, borderline personality disorder is characterized by "a pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity beginning by early adulthood and present in a variety of contexts" (APA 1994, p. 654). It can include recurrent suicidal or self-harming behavior, intense anger or inability to control anger, and stress-related, psychotic-like symptoms (see Figure 6-2, below). Women are three times more likely than men to be diagnosed as having BPD (APA 1994).

Treating offenders with BPD requires great care due to their emotional instability, tendency toward violence, and risk for self-destructive or suicidal behavior. Moreover, because of their tendency to idealize counselors, the therapeutic relationship is likely to be intense, and the offender with BPD is likely to have strong reactions to the counselor. The American Psychiatric Association recommends that treatment for people with BPD take into account these special features:

- *Co-occurring disorders.* In addition to substance use disorders, mood disorders, eating disorders (especially bulimia), PTSD, anxiety disorders, dissociative identity disorder, and attention deficit/hyperactivity disorder are especially common in people with BPD.
- *Use of alcohol and illicit substances.* People with BPD rarely are forthcoming about their use of alcohol and illicit substances. Counselors should inquire specifically about substance use from the beginning, and continue to educate clients about the dangers of substance use.

Figure 6-2
Borderline Personality Disorder

People diagnosed with BPD must have five or more of the following behaviors:

- Frantic efforts to avoid real or imagined abandonment
- A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation
- Identity disturbance or markedly and persistently unstable self-image or sense of self
- Impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating)
- Recurrent suicidal behavior or gestures, or self-mutilating behavior
- Affective instability due to marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days)
- Chronic feelings of emptiness
- Inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights)
- Transient, stress-related paranoid ideation or severe dissociative symptoms

Source: APA 2000.

- *Violent behavior and antisocial traits.* Treatment courses will vary according to the degree of violent or antisocial behavior. In mild cases (e.g., shoplifting), cognitive therapy is recommended. For more severe cases, residential treatment (e.g., a TC) may be effective. Episodic violence may benefit from the use of mood-stabilizing medication. For severe antisocial features, hospitalization may be required.
- *Self-destructive behavior.* Addressing self-destructive behavior is a primary part of treating BPD. Behaviors such as self-mutilation, suicide attempts, risky sexual behavior, and reckless driving are immediate threats to the individual and should be given treatment priority. Helping clients to think through the consequences of destructive behavior can be of use.
- *Childhood trauma and PTSD.* While not universal, childhood trauma is very common among people with BPD. Treating offenders with BPD will often entail addressing the trauma and symptoms of PTSD.
- *Dissociative symptoms.* Because there often is comorbidity between BPD and dissociative disorders, counselors must also be aware of the likelihood that the offender with BPD experiences transient dissociative symptoms (e.g., depersonalization, derealization, and loss of reality testing), and/or dissociative identity disorder. Counselors can assist by exploring the extent of the dissociative symptoms, the current issues that may lead to dissociative episodes, and the nature of dissociative symptoms. It may also be helpful to teach clients how to control dissociation and to work through posttraumatic symptoms.
- *Psychosocial stressors.* Stress can heighten the symptoms of BPD, trigger relapse, and undermine recovery. Moreover, because of their intense fear of abandonment, many clients with BPD will be sensitive to any perceived rejection within any relationship, including the client–counselor relationship. Counselors should thus be watchful of reactive behavior that often results when the offender feels in danger of being abandoned. (For more information, go to www.psych.org/psych_pract/treatg/pg/borderline_revisebook_index.cfm.)

A general clinical observation is that the TC is an effective treatment for both ASPD and BPD through the emphasis on interventions that facilitate socialization and maturity.

Special Considerations in Treating Depressive and Bipolar Disorders

Treatment strategies for offenders with co-occurring major depressive disorders have focused on modifying thoughts that lead to depression or that are related to substance abuse. Issues surrounding loss and trauma are typically addressed when an offender is able to tolerate uncomfortable mood states without turning to substance abuse. Activities are designed to promote understanding of how trauma and abuse experiences are expressed through emotions, physical reactions, and behaviors, including substance abuse. In addition to the interventions for depressive disorders, treatment for offenders with bipolar disorders addresses impaired judgment that occurs during manic episodes, and the effects of substance abuse on judgment. Treatment strategies often focus on building an acceptable set of coping responses to manic or hypomanic impulses, as well as medication adherence when warranted.

Special Considerations in Treating Schizophrenia/ Psychotic Disorders

Treatment for offenders with co-occurring psychotic disorders is designed to address disorganized thought patterns and communication style. Specialized approaches used in treatment include use of concrete concepts, avoiding harsh confrontation, and greater use of structured exercises and written materials.

Offenders who have psychotic disorders often abuse substances for many of the same reasons as other individuals. Key treatment components include education in drug refusal skills, identification of strategies to fight boredom, building supportive social networks, and medication adherence.

Special Considerations in Treating Attention Deficit/Hyperactivity and Other Cognitive Disorders

Interventions for offenders with co-occurring attention deficit/hyperactivity disorder (AD/HD) focus on interpersonal difficulties, social skill deficits, and cognitive skill-building to address impulsiveness and aggression. Information should be conveyed visually as well as orally when possible. Short therapeutic sessions provided in environments that have few distractions are preferable. With this population it is particularly important to repeat important themes and to rehearse key skills in various settings. Those with cognitive disorders need concrete, practical information and skills. (See also TIP 29, *Substance Use Disorder Treatment for People With Physical and Cognitive Disabilities* [CSAT 1998*d*].)

Special Considerations in Treating PTSD, Phobias, and Other Anxiety Disorders

Treatment of co-occurring anxiety disorders focuses on interventions to improve social skills and to modify cognitions associated with difficult interpersonal situations, particularly those that augment anxiety. It is particularly important in treating clients with anxiety disorders for the counselor to be calm and reassuring. Clients with PTSD often make slow progress in achieving the trust necessary in a therapeutic alliance. It is important not to encourage discussion of traumatic events, particularly early in treatment. Those whose trauma-related symptoms are severe can benefit from learning techniques to help them focus on staying in the "here-and-now." Recovery from PTSD often requires long-term treatment from specially trained clinicians. Counselors should be prepared to refer these clients to trauma experts. (See also the forthcoming TIP *Substance Abuse and Trauma* [CSAT in development *f*].) Clients with phobias can be especially sensitive to social situations and may need help in participating in mutual self-help groups. Specialized approaches, including use of medications, to reduce anxiety-induced insomnia also may be indicated.

People With Infectious Diseases

HIV, AIDS, and tuberculosis are more prevalent among inmates than in the general population. At the end of 2002, 2 percent of all inmates in State and 1.1 percent of all inmates in Federal prisons were known to be infected with the HIV virus. Rates of HIV infection were higher (3 percent) for female inmates of State prisons than for males (1.9 percent) (Maruschak 2004). In 2002 they were also higher for African-American (1.2 percent) and Hispanic/Latino (2.9 percent) jail inmates than for white jail inmates (.8 percent) (Maruschak 2004). More than a quarter of all inmates known to be HIV-positive in 2002 were held in New York State, amounting to 7.5 percent of that State's total prison population (Maruschak 2004). According to 2002 data, 0.50 percent of inmates in State prison had confirmed cases of AIDS, three and one-half times the rate for the general population (Maruschak 2004).

Evidence suggests that sexually transmitted diseases (STDs), hepatitis B and C, and tuberculosis also affect inmates disproportionately (Hammet 1998; Hammet et al. 1999; Varghese and Fields 1999). Routine screening for STDs and hepatitis is not included in many correctional systems, and, although HIV prevention programs are becoming more common, few correctional systems have

implemented systemwide programs to educate inmates about these diseases or to institute preventive measures. High-risk behaviors for the spread of HIV occur with great frequency in correctional facilities. These include unprotected sexual activity, substance use, and tattooing. The data clearly show that there is transmission of HIV between inmates (Hammett et al. 1999). Curricula for HIV prevention are available in many prisons. However, although female inmates have higher rates of HIV than their male counterparts, few HIV educational programs have been developed for the particular needs of women.

The Federal prison system undertakes random HIV testing of inmates for data collection purposes, and all inmates are tested on release; otherwise inmates are tested only if there is a clinical indication that they may be HIV-positive or if they request testing. States have various procedures for testing the HIV status of inmates. Some States test all inmates who meet the criteria for belonging to a high-risk group, some test everyone entering the facility, and still others test inmates upon discharge from the facility. More information on substance abuse treatment for people with HIV/AIDS can be found in TIP 37, *Substance Abuse Treatment for Persons With HIV/AIDS* (CSAT 2000*e*).

Project ARRIVE

Project ARRIVE, a NIDA-funded AIDS prevention training model, was designed specifically for recently released parolees with histories of intravenous drug use—a population particularly vulnerable to resuming high-risk behaviors (Wexler et al. 1994). ARRIVE's assumption was that reinforcing parolees' general social and personal rehabilitation could reduce the risk of contracting AIDS. The program incorporated the principles and techniques found to be useful for treating those with substance use disorders in other settings.

- *Social learning approach to prevention training.* The training program emphasized learning skills to resist relapse and develop personal and social competencies (Botvin et al. 1984) and included rational decisionmaking, coping with anxiety, assertiveness, and relaxation skills.
- *A strong self-help orientation.* Participants were encouraged to accept responsibility for their behavior; to develop their capacity to change negative features of their daily lives; and to engender a sense of mutuality, trust, and honesty among participants (Gartner and Riessman 1977).
- *Use of principles effective in TC programs* (De Leon 1999, 2000; DeLeon and Ziegenfuss 1986). Some ARRIVE training staff were themselves in recovery and could function as role models. In addition, the program fostered the development of peer support networks. Graduates were encouraged to continue their association with the program through weekly aftercare groups.
- *Job readiness preparation and placement assistance.*

These elements were combined into a structured 8-week, 24-session AIDS prevention program. Each new class met for 2 hours a night, three times per week over an 8-week period. Participants received $10 per session for a total of up to $240 if they attended all 24 sessions. Trainees also were given two subway tokens per session. ARRIVE participants were offered confidential HIV testing and counseling.

During the NIDA study, a total of 394 eligible parolees were recruited, of whom 241 (61 percent) attended the Training Program, including 164 program completers, for a 68 percent graduation rate. (During the second half of the program, 81 percent graduated.) The outcome evaluation, conducted 1 year after study recruitment, compared program graduates with parolees who never attended, controlling for observed group differences at baseline. ARRIVE participation significantly decreased most sexual and some drug-related risk behaviors and improved parolees' community adjustment during the followup period (Wexler et al. 1994).

While HIV/AIDS is widely recognized as a serious and significant problem within prisons, other infectious diseases are not always given the same attention. A vaccine is available for hepatitis B that could control the spread of that disease. However, the prevalence of hepatitis C virus (HCV) is increasing. In California, 41 percent of incoming prisoners were positive for HCV in 1994. Prevalence rates among HIV-positive offenders are higher (Hammett et al. 1999). Because the incubation period is so long (approximately 20 years), many offenders who have the disease will not experience its effects until after they are released. Consequently, not all prison systems recognize hepatitis C as a problem; nor do they expend costly resources on its treatment. Rates of tuberculosis (TB) have declined since 1991 both in the general population and among incarcerated offenders, although they are still higher among inmates. Not all systems routinely screen for TB and report results. There is a risk to correctional employees of contracting TB due to insufficient control measures (Hammett et al. 1999).

Medical Care

Research indicates that medical care for offenders in the criminal justice system is inadequate and underfunded, and the burden is increasing as the inmate population ages. This exacerbates poor health habits and neglect of health care not uncommon among people who come in contact with the criminal justice system. Medical care is extremely important for offenders with substance use disorders, who often have a number of medical problems. While using alcohol and illicit drugs, offenders often ignore their health problems. When they finally enter treatment they could have several problems that have been untreated except for self-medication. If they are in pain they are less able to focus on their substance abuse treatment. As a consequence, substance abuse treatment staff often request that the institution pay greater attention to medical issues and advocate for medical services for their clients.

Substance abuse treatment staff also should stress the importance of good health when working with offenders. Health improvement can be included as a goal for clients and written into their treatment plans.

Prevention and Education

Educational programs about infectious diseases are a useful addition to a treatment program but cannot stand alone without counseling and treatment for those diseases. Simply informing a group of offenders about the dangers of infectious disease without helping them deal with the possibility of infection can actually cause additional problems, such as fights caused by fears of infection. Prevention and testing efforts often work more smoothly if integrated into a substance abuse treatment program, as counseling staff can work with an individual and help him or her deal with concerns and fears. Programs can use peers who are HIV-positive to provide education to other offenders; in addition to providing other offenders with information from a credible source, peer education helps the person who is HIV-positive feel that his or her life has some sense of purpose.

Advice to the Counselor: Infectious Diseases

- Education about infectious diseases such as HIV/AIDS and hepatitis C is a useful addition to a treatment program. However, this education must take care not to cause additional problems such as fights over fear of infection.
- Counseling by peers who are HIV-positive provides information from a credible source.
- Health improvement can be included as a goal for clients and can be written into their treatment plans.

Sex Offenders

Self reports of those incarcerated for rape or sexual assault reveal that 23 percent admitted they were under the influence of alcohol alone when they committed their crime, another 15 percent acknowledged using both alcohol and drugs, and an additional 5 percent reported they had been using drugs alone (CASA 1999). That even these self-report numbers considerably underestimate the pervasiveness of substance abuse among sex offenders is suggested by the fact that 42 percent of those arrested for sex offenses tested positive for drugs at the time of arrest (CASA 1999). Similar evidence for alcohol use is not available but can be presumed to be considerably higher. Among incarcerated sex offenders, two of every three have a history of alcohol or drug use, abuse, or addiction (Peugh and Belenko 2001).

While the high prevalence of substance abuse among sexual offenders is clear, solid information about the relationship between substance abuse and sexual offending is not readily available. While many convicted sex offenders will admit to problems with alcohol or illicit drugs, it is unusual for someone identified with alcohol or drug problems to freely disclose illegal sexual behavior. The negative consequences of such an admission would usually be too great. Consequently, what is known about the co-occurrences of substance use disorders and the commission of sex offenses comes mainly from the personal history and self reports of identified sex offenders within the criminal justice system and their victims.

Sex offenders apprehended and labeled through the criminal justice system are thought to represent a small portion of those who actually commit sexual offenses (Center for Sex Offender Management 2001*a*). Only those individuals actually convicted of sexual offenses are likely to be identified as a sex offender subgroup with COD requiring specialized attention. And for this population, the focus of treatment is likely to be the sexually deviant behavior. Alcohol and drug issues are usually seen as one part of a broad array of problems contributing to the sex offense and specific attention to substance abuse issues may comprise only one of many treatment modules designed to address these underlying problems (Barbaree et al. 1998). Many sex offenders with substance abuse issues are excluded from many substance abuse treatment programs. Analysis of Bureau of Justice Statistics data reveals that 34 percent of sex offenders receive drug treatment in prison, as opposed to 42 percent of other violent offenders (Peugh and Belenko 2001). Often if they are to get any treatment for their substance abuse problems, it must be in or in conjunction with a sex offender treatment program. Otherwise, to participate in substance abuse treatment, they must conceal their sex offender identities and histories—not a promising foundation for fostering the self-disclosure treatment requires.

The subpopulation of sex offenders among offenders who require interventions for substance abuse issues raises many questions and complications, especially since they also may be concurrently mentally ill, culturally diverse, developmentally disabled, or otherwise high need (Raymond et al. 1999). Sex offenders often stir strong emotions and reactions (Jenkins 1998). The criminal justice system, other offenders, and the community at large typically think of sex offenders, particularly those whose victims are children, as a different class of criminal. Within jails and prisons, if identified, they are at great risk of being victimized by other inmates (and sometimes correctional staff) because of the nature of their crimes. Some States provide sex-offender–specific treatment services for a portion of these inmates, pre- and post-release, and many counties require treatment as one of the conditions of probation (Burton and Smith-Darden 2001). When released from incarceration, sex offenders are required to register with local authorities, often receive more stringent supervision than other offenders, can be subject to community

notification procedures, frequently encounter serious problems finding appropriate housing, and may have their identities and pictures made available on the Internet (Center for Sex Offender Management 2000*a*).

Some Relevant Facts About Sex Offenders

The image of the typical sex offender conjured by lurid newspaper headlines bears only some resemblance to the actual picture. The blanket term "sex offenders" includes a population so heterogeneous that only a few generalizations are not inaccurate and misleading (Center for Sex Offender Management 2000*b*). Although once there were thought to be discrete offender types—rapists, child molesters, incest offenders, exhibitionists—an increasing body of evidence derived from polygraph examinations of convicted offenders demonstrates that there is considerable "crossover" between behaviors once thought to define these subgroups. Thus nearly 9 of 10 offenders originally thought to have only adult victims were found, under polygraph examination, also to have victims under 18. Similarly, 36 percent of those convicted of an incest offense disclosed that they also had victimized adults (English et al. 2000). One important distinction, however, is that sexual offenses committed while intoxicated (e.g., date rape) are unusual occurrences and do not represent habitual behavior. These problems are more about impulse control amplified by alcohol and other substance use and often can be treated in substance abuse programs.

It now is generally accepted that no single causative factor can adequately explain the commission of sexual offenses. Only multifactorial explanations that take into account the presence, to various degrees, of deviant sexual arousal, lack of victim empathy, inadequate social skills, personal trauma history, criminal association, thinking errors, and other elements now appear to provide adequate models for understanding these crimes. The use of alcohol and drugs is seen as contributing to disinhibition but is never thought to be a stand-alone explanation for sexual offending (Laws et al. 2000).

Sex-Offender–Specific Treatment

The emergence, over the past 20 years, of an increasingly solid body of research-based information about sexual offending has led to correspondingly sophisticated treatment models and outcome studies (Marshall et al. 1998). Treatment focus areas are based on an emerging set of "dynamic" (i.e., modifiable) risk variables. One widely used instrument for assessing such factors is the Sex Offender Needs Assessment Rating (SONAR) (Hanson and Harris 2001). Risk factors identified in the SONAR include intimacy deficits, negative social influences, antisocial attitudes, inadequate sexual self-regulation, and general self-regulation. Addressing such factors in non–sex-offender-specific treatment might have some impact on reducing the risk of sexual recidivism. A growing body of solid research provides evidence that, overall, treatment now reduces the reoffense rate between 10 and 17 percent (Center for Sex Offender Management 2001*b*).

Relapse Prevention: The Common Thread

With some modifications, relapse prevention concepts and formulations borrowed from the substance abuse treatment field have been found to fit sex offender programming needs quite well (Laws 1989; Laws et al. 2000). At present, relapse prevention—or the more broadly designated cognitive–behavioral therapy—has grown to be the dominant model used by most sex offender treatment programs, whether institutional or community-based, so that currently over 80 percent of programs in North America identify "cognitive–behavioral/relapse prevention" as their primary treatment model (Burton and Smith-

SHARPER FUTURE

Awareness of the presence of significant numbers of sex offenders among inmates participating in California's in-prison substance abuse treatment programs—as high as 30 percent—led to the development of a specialized aftercare program specifically tailored to address both substance abuse and sex offense issues concurrently. For many reasons, in-prison programs do not address sex offense issues. SHARPER FUTURE (Social Habilitation and Relapse Prevention – Expert Resources), a private-sector forensic mental health agency, has been operating a program under contract in central Los Angeles since 1999 to meet the needs of parolees who have completed one of the in-prison substance abuse programs but who are screened out of other aftercare programs because of their sex offense histories. (SHARPER FUTURE also has a component to treat offenders with mental disorders.)

SHARPER FUTURE is staffed by licensed clinicians with expertise in treating both areas concurrently. The existence of many parallels between treatment strategies for substance abuse and for sex offense issues offers a foundation for such an integrated approach. Concepts from relapse prevention apply equally well to both areas of concern.

Because of restrictions in California codes prohibiting registered sex offenders from sharing a common residence, SHARPER FUTURE is exclusively outpatient. As an outpatient program, SHARPER FUTURE cannot fully continue but does support the therapeutic community philosophy that is the foundation of the prison-based system. Although the program is considered "aftercare" for substance abuse issues, which have been directly addressed previously in the institutional setting, the sex offense issues are addressed directly for the first time only in this outpatient phase. During the 14-month intensive treatment phase of SHARPER FUTURE, participants, all on parole, attend three 2-hour groups per week. A weekly aftercare group can subsequently continue until the end of the parole period or beyond.

Because personal issues related to substance abuse already have been addressed in prison and because the level of shame related to sex offense behavior generally is much more intense, greater resistance in dealing with the sexual behavior is common. Frequently analogies with substance abuse cycles, behavior chains, thinking errors, low capacity for delayed gratification, and similar themes offer a more acceptable entrance to the sex offense work. Creating a group treatment culture supportive of the work needed to address deviant sexual patterns is essential to treatment success.

Standards of the Association for the Treatment of Sexual Abusers (ATSA—see www.ATSA.com) require substantial training and experience for staff involved in treating sex offenders and finding such qualified staff, especially individuals who also have expertise in substance abuse treatment, has been a challenge, as has working collaboratively within such a large and complex system as the California Department of Corrections. Future goals include replicating this pilot program in other geographical areas and, ultimately, developing structures to allow the sex offense issues to be addressed from the beginning of treatment in specialized separate tracks of the in-prison substance abuse treatment system. (For more information go to www.thesharpprogram.com/.)

Darden 2001). Sharing such a common lineage has the benefit of permitting easy movement in the treatment setting between relapse prevention as applied to substance abuse and relapse prevention as applied to sex offending.

Areas of Divergence

Important differences prevent a simplistic merger of sex offender treatment and substance abuse treatment models. Sex offender treatment usually is provided by specially trained—sometimes specifically credentialed—mental health professionals, and interventions can include medical and behavioral efforts to modify deviant sexual arousal patterns (ATSA 2001). Stakes are higher because any "relapse" involves another traumatized victim and can lead to a long, even lifetime, prison sentence. Since the primary goal is community safety, sex offender treatment usually involves close collaboration with the criminal justice system, represented by probation and parole officers. Great caution is exercised with regard to encouraging mutual support efforts between sex offenders and, consequently, self-help support systems are ordinarily unavailable. Treatment themes seldom are discussed freely with support persons outside of the program since the stigma and other social consequences of being a sex offender are considerably higher than for those in substance abuse recovery.

Conclusions and Recommendations

The consensus panel believes the following points and recommendations merit emphasis:

- The panel recommends that screening and assessment for a history of physical/sexual abuse be included as part of intake assessments for men and women in criminal justice treatment settings. Referral information should be provided to inmates who report prior abuse and who are interested in receiving services related to this abuse.
- Use of "strengths-based" approaches to substance abuse treatment is highly recommended, particularly for female offenders. These interventions are considered effective in improving self-esteem.
- Substance abuse treatment programs in jails and prisons (including TCs) should include vocational programs for men and women. Offenders under community supervision also should have access to community vocational programs.
- Treatment programs in women's institutions are encouraged to use the segregation of genders within the criminal justice system to the advantage of their clients by developing treatment programs that specifically address women's needs.
- The panel encourages jail and prison programs to allow for more interaction between incarcerated mothers and their children; the 2–4 hours of supervised visitation per week that many institutions allow is not sufficient for mothers or their children.
- Given the high rates of co-occurring mental disorders in the offender population, more treatment programs need to be developed for offenders with COD.
- Given the prevalence of cognitive and physical disabilities in incarcerated populations, especially among offenders with substance use disorders, treatment providers need to be able to screen for and to provide accommodations for offenders who have these coexisting disabilities.
- Because mental health and substance use disorders can mask or imitate each other, accurate diagnosis of these disorders requires skilled screening and assessment. Assessment should look for evidence of both disorders, rather than providing separate assessments for the disorders. Regular reassessment for COD also is important, and should be conducted at major transition points in the criminal justice system by staff with specialized training in this area.
- Substance abuse treatment programs for offenders should include staff who reflect

the cultural diversity of the population they are treating. Efforts need to be made to adopt treatment to specific cultural populations (e.g., ethnicity, race, age, sexual orientation, rural cultures, socioeconomic class, and language). Counselors need to be aware of different cultural sets of values, biases, and assumptions related to communication, therapeutic style, and interpersonal contact and should be trained in techniques for adapting treatment approaches to reflect these differences, in order to more effectively engage and maintain clients in program services.

- The therapeutic community has been successfully modified to treat specific populations, including female offenders and offenders with COD.

7 Treatment Issues in Pretrial and Diversion Settings

In This Chapter...

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Overview

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.

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 consensus panel posited the following observations 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

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).

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).

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).

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 decisionmakers and possible decision outcomes.

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

- 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.

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. The consensus panel suggests that, 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.

Advice to the Counselor: Diversion to Treatment Decision Points

- 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

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 proba-

ble 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. The consensus panel recommends 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. The consensus panel recommends that, ideally, judges should mandate as a condition of release that offenders receive treatment within 24 hours.

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.

Trial and Postverdict Periods

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

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. (For more information on confidentiality, go to www.hipaa.samhsa.gov and see CSAT 2004.)

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 on the prosecutor's approach to 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. (See TIP 23, *Treatment Drug Courts: Integrating Substance Abuse Treatment With Legal Case Processing* [Center for Substance Abuse Treatment {CSAT} 1996].) 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 post-plea or presentence arrangements, and post-conviction 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 7-1 (p. 134) 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 7-1 also demonstrates the need for evaluation and reevaluation. During the treatment and recovery process, the

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).

- Drug courts integrate alcohol and drug treatment services with justice system case processing.
- Using a nonadversarial approach, prosecution and defense counsel promote public safety while protecting participants' due process rights.
- Eligible participants are identified early and promptly placed in the drug court program.
- Drug courts provide access to a continuum of alcohol, drug, and related treatment and rehabilitation services.
- Abstinence is monitored by frequent alcohol and illicit drug testing.
- A coordinated strategy governs drug court responses to participants' compliance.
- Ongoing judicial interaction with each drug court participant is essential.
- Monitoring and evaluating achievement of program goals is necessary to gauge effectiveness.
- Continuing interdisciplinary education promotes effective drug court planning, implementation, and operations.
- Forging partnerships among drug courts, public agencies, and community-based organizations generates local support and enhances drug court program effectiveness.

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.

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.

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

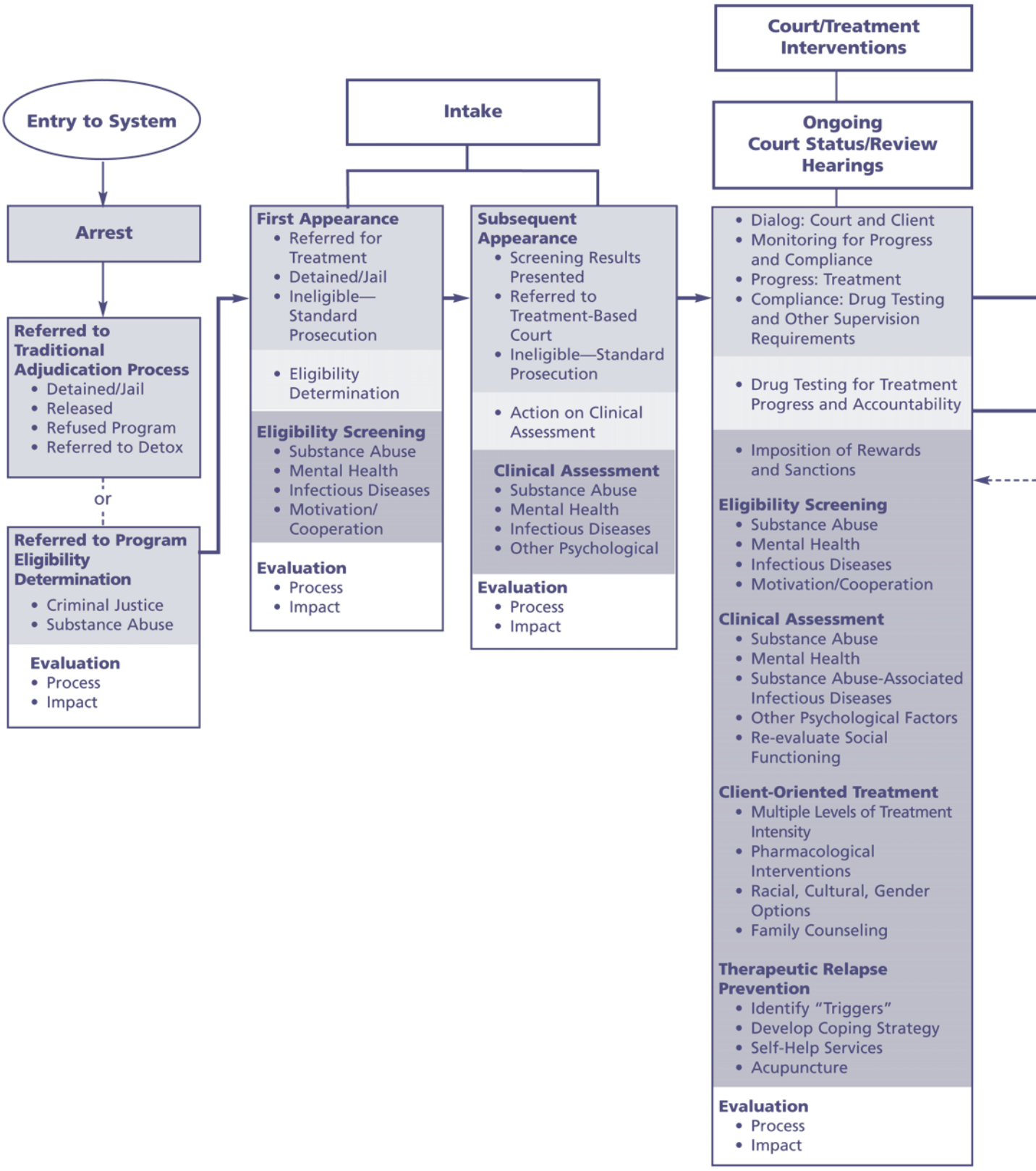
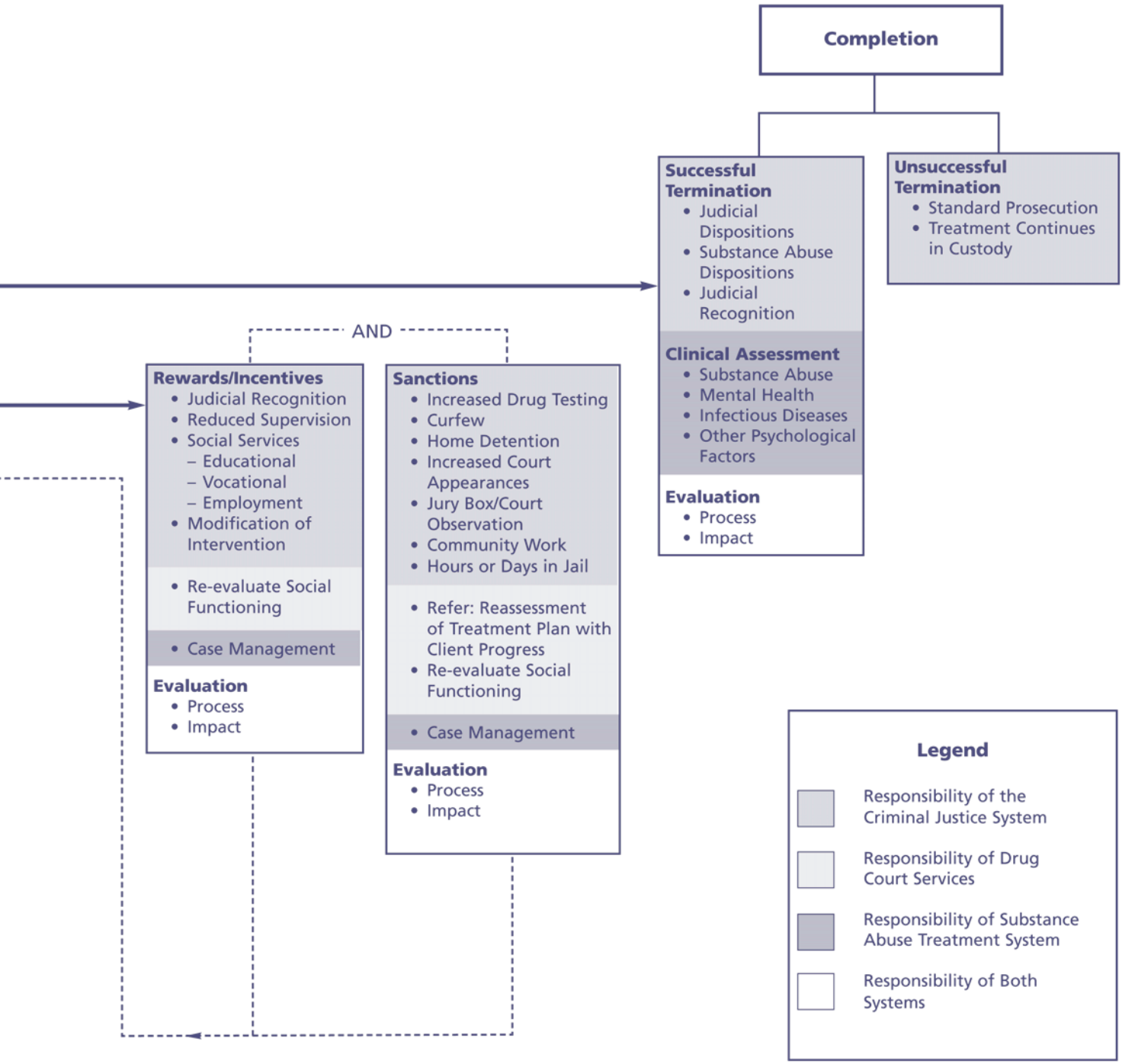

Entry to System
Arrest
Referred to Traditional Adjudication Process
• Detained/Jail
• Released
• Refused Program
• Referred to Detox
or
Referred to Program Eligibility Determination
• Criminal Justice
• Substance Abuse
Evaluation
• Process
• Impact
Intake
First Appearance
• Referred for Treatment
• Detained/Jail
• Ineligible—Standard Prosecution
• Eligibility Determination
Eligibility Screening
• Substance Abuse
• Mental Health
• Infectious Diseases
• Motivation/Cooperation
Evaluation
• Process
• Impact
Subsequent Appearance
• Screening Results Presented
• Referred to Treatment-Based Court
• Ineligible—Standard Prosecution
• Action on Clinical Assessment
Clinical Assessment
• Substance Abuse
• Mental Health
• Infectious Diseases
• Other Psychological
Evaluation
• Process
• Impact
Court/Treatment Interventions
Ongoing Court Status/Review Hearings
• Dialog: Court and Client
• Monitoring for Progress and Compliance
• Progress: Treatment
• Compliance: Drug Testing and Other Supervision Requirements
• Drug Testing for Treatment Progress and Accountability
• Imposition of Rewards and Sanctions
Eligibility Screening
• Substance Abuse
• Mental Health
• Infectious Diseases
• Motivation/Cooperation
Clinical Assessment
• Substance Abuse
• Mental Health
• Substance Abuse-Associated Infectious Diseases
• Other Psychological Factors
• Re-evaluate Social Functioning
Client-Oriented Treatment
• Multiple Levels of Treatment Intensity
• Pharmacological Interventions
• Racial, Cultural, Gender Options
• Family Counseling
Therapeutic Relapse Prevention
• Identify "Triggers"
• Develop Coping Strategy
• Self-Help Services
• Acupuncture
Evaluation
• Process
• Impact

Figure 7-1
Substance Abuse Treatment Planning Chart for Treatment-Based Drug Courts



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 re-arrested 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 decision-maker, 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.

Recent evaluations of drug court programs throughout the United States indicate that they are achieving their goals.

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).

For some offenders, especially during the pretrial stage, a brief intervention can determine if treatment is necessary.

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. The panel also addressed the many barriers to achieving this goal, including a lack of funding, a negative "soft on crime" perception held by the public, delayed adjudication, and minimal incentives for offenders to enter treatment (e.g., reduced or suspended jail time) (National Drug Court Institute 1999).

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 recommended by the consensus panel 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.

TIP 34, *Brief Interventions and Brief Therapies for Substance Abuse*, describes

other brief interventions in more detail (CSAT 1999*a*).

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. TIP 19, *Detoxification From Alcohol and Other Drugs* (CSAT 1995*a*), describes clinical detoxification protocols for a variety of substances (see also the forthcoming revision of TIP 19, *Detoxification and Substance Abuse Treatment* [CSAT in development *a*]).

Day reporting centers

Day reporting centers are used to monitor the behavior of arrestees in the pretrial setting and of probationers and parolees under com-

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).

munity supervision. They provide closer supervision than twice-a-week drug testing, but are less restrictive than residential treatment.

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, the consensus panel believes that 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. (See chapter 2, Screening and Assessment, for examples of appropriate screening instruments.) 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, the panel suggests that treatment counselors 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 profes-

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.

sional alcohol breathalizers can also be helpful in determining the need for further screening and treatment.

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.

The consensus panel recommends that counselors 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?

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*).

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

- *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.

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 consensus panel believes 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.

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.

- Include stakeholders from a variety of domains in the planning process.

Effective Pretrial and Diversion Programs

The consensus panel recommends that 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. The Addiction Technology Transfer Centers (ATTCs), funded by CSAT, also offer an extensive array of training and resource materials for use by criminal justice and treatment professionals. For more information, contact the ATTC National Office at (816) 482-1200, or their Web site at www.nattc.org.

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. (See the forthcoming TIP *Improving Cultural Competence in Substance Abuse Treatment* [CSAT in development *b*].)

The consensus panel suggests that 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, set-

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 offenders' denial.
- Use brief interventions, where appropriate.
- Identify treatment and ancillary resources in the community.

ting, 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. (For information on confidentiality, go to www.hipaa.samhsa.gov and see CSAT 2004.) 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.

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 the consensus panel's 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.

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

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).

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.

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).

Resources

Examples of Diversion Programs

These programs, in the view of the consensus panel, exemplify effective diversion programs. While some are still in operation in 2005, others are not.

Brooklyn Drug Treatment Alternative to Prison (DTAP) Program

The Brooklyn Drug Treatment Alternative to Prison program was established by Kings County District Attorney Charles J. Hynes in 1990 to divert nonviolent felony offenders with one or more prior felony convictions and a documented history of drug abuse into treatment. Although DTAP started as a deferred prosecution model, in 1998 the DTAP shifted to a deferred sentencing model (Kings County District Attorney's Office 2001).

DTAP's target population includes nonviolent felons who, under New York State's Second-Felony Offender Law, face a mandatory prison sentence. Defendants accepted into DTAP have their sentences deferred while undergoing 15–24 months of rigorous, intensive drug treatment. Those who successfully

complete treatment are returned to court to have their charges dismissed. The program is a therapeutic community with a rigid structure, rules, timetables, and goals. As of March 2005, 2,094 individuals have begun the program, 831 have completed it, and 374 are currently enrolled (Kings County District Attorney's Office 2001).

A 5-year study of the program indicates that 53 percent of these participants have completed it (National Center on Addiction and Substance Abuse [CASA] 2003). Their rearrest rates and reconviction rates are significantly lower than a matched sample of offenders who received regular processing in the criminal justice system. After 2 years, DTAP graduates were 87 percent less likely to return to prison. In addition, preliminary results show that graduates had decreased their drug use compared with offenders who dropped out of the program or did not participate. Those participating in DTAP stayed in treatment longer than those in the general treatment population (17.8 months, compared to 3 months). Retention rates were highly associated with high levels of perceived legal pressure to remain in treatment. The average cost for a person in DTAP compared favorably with costs of incarceration: $32,975 versus $64,338 (CASA 2003).

Memphis Prebooking Jail Diversion Program

Memphis police officers have been specially trained to handle mental health and substance abuse crises while on patrol. They receive training in psychiatric diagnosis, substance abuse issues, de-escalation techniques, community mental health and substance abuse resources, and legal issues. The officers have a working relationship with the University of Tennessee's Medical Center and help community agencies implement treatment plans for those diverted to treatment.

Montgomery County (Pennsylvania) Pre- and Post-Booking and Coterminous Jail Diversion

The county's Emergency Services works closely with County Administration and a local Task Force to maximize multidisciplinary involvement in the diversion program. Its success is credited to police training, a 24-hour crisis response team, inpatient treatment, case managers, and an outreach team. Prebooking uses psychiatric treatment in lieu of arrest while postbooking involves regular screenings for incarcerated individuals with mental health and substance abuse problems. By taking an offender directly to psychiatric treatment while concurrently filing charges, police engage coterminous jail diversion, which diverts the individual from criminal incarceration. The program was funded through a CSAT grant to the University of Pennsylvania.

Addiction Prevention and Recovery Administration and the Salvation Army

These two organizations have formed a partnership to expand the current community-based residential treatment program, Salvation Army Beacon for Adult Males in the Justice System, through a grant awarded by the U.S. Department of Health and Human Services. The program, which was funded through a CSAT grant to the District of Columbia's Department of Health Addiction Prevention and Recovery, addresses the needs of men in pretrial or presentence status who abuse substances and who have been charged with a nonviolent drug-related crime. The program currently serves 95 men annually, but the grant will increase the number by 30 and incorporate Treatment Readiness and an aftercare component.

Assistance for drug treatment courts

The National Association of Drug Court Professionals (NADCP) is the main member organization that provides advocacy and support for the development of drug treatment courts throughout the country. The group has an extensive training and technical assistance program with experience in planning and implementing drug courts and establishing community linkages with law enforcement. A network of 27 mentor drug courts uses practitioners to act as resources at meetings and conferences and onsite visits. (For more information, see the NADCP Web site at www.nadcp.org/index.html.)

Other pretrial diversion models

- Phoenix, Arizona's and Eugene, Oregon's Substance Abuse and Mental Health Services Administration (SAMHSA) Diversion Projects (for co-occurring disorders)
- Jacksonville, Florida, Drug Court (pays for aftercare)
- Pensacola, Florida, Drug Court (serves as "mentor" court for other drug treatment courts)
- San Bernardino, California, Drug Court (higher level of supervision and services provided for the most serious offenders)
- Reno, Nevada, Family Drug Court (one of the earliest family/dependency drug courts)
- South Carolina's statewide diversion program
- Various sites participating in the SAMHSA Jail Diversion project

Program Resources

The following resources include instructional as well as financial assistance.

Substance Abuse and Mental Health Services Administration

To help States break the pattern of incarceration without treatment and reduce the high rate of recidivism, SAMHSA provides grants for diversion and reentry programs for adolescents, teens, and adults with substance use and mental disorders. These grant programs focus on treatment as well as housing, vocational and employment services, and long-term supports. For more information go to www.samhsa.gov.

SAMHSA provides grants for diversion and reentry programs for adolescents, teens, and adults with substance use and mental disorders.

Bureau of Justice Assistance (BJA)

The BJA in the U.S. Department of Justice is authorized by Congress under the Edward Byrne Memorial State and Local Law Enforcement Assistance Program to make grants to States in order to improve the functioning of the local criminal justice system. The program places emphasis on violent crimes and serious offenders, and the enforcement of State and local laws that establish offenses similar to those in the Federal Controlled Substances Act. The Drug Court Grant Program in the BJA administers financial and technical assistance and training to State, local, and tribal governments and jurisdictions to develop and implement drug treatment courts. (Additional information is available at www.ojp.usdoj.gov/BJA.)

Training outlets

- National Association of Pretrial Services Agencies (www.napsa.org/)
- National TASC Conference (for case managers, assessment staff, clinicians) (www.nationaltasc.org/)
- National Drug Court Institute (provides targeted training for all of disciplines involved in drug courts; judges, prosecutors, defense attorneys, probation officers, treatment professionals) (www.ndci.org/aboutndci.htm)
- National Association of Drug Court Professionals Annual Training Conference (www.nadcp.org/home.html)
- The National GAINS Center (www.gainscenter.samhsa.gov/html/default.asp)

Conclusions and Recommendations

The consensus panel highlights the conclusions and recommendations as follows:

- 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.

8 Treatment Issues Specific to Jails

In This Chapter...

Definitions

Trends

Treatment Services in Jails

Description of the Population

Key Issues Related to Treatment

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

Coordination of Jail Treatment Services

Examples of Jail Treatment Programs

Research Related to Jail Treatment

Recommendations for Treatment Providers

Overview

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. For more information on diversion, see chapter 7.

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

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

1. Who are, or who would be under normal circumstances, incarcerated in a State institution
2. 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.

- 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.

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 (James 2004).

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 followup 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) (James 2004). 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 (James 2004).

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) (James 2004).

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 alco-

hol (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) (James 2004).

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 (James 2004). 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).

The percentage of those who participate in substance abuse treatment programs in jails varies widely.

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).

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.

> Jails can serve a pivotal role in engaging family members, peers, and community organizations in supporting the recovery efforts of inmates.

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. It has been the experience of consensus panel members that 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 the consensus panel believes can impact the availability and/or effectiveness of treatment. See chapter 5 for more general issues affecting 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.

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

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

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.

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.

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 of the stressors identified in chapter 5 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). See chapter 7 for a more detailed discussion of interpersonal issues facing recent arrestees.

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. For more information about the confidentiality laws and regulations and their implications for substance abuse treatment in jails, see CSAT 2004 and go to www.hipaa.samhsa.gov.

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. (For more information on confidentiality, go to www.hipaa.samhsa.gov and see CSAT 2004.)

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 (SAMHSA 1996). 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. In this section the panel 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. Issues of screening and assessment, regardless of the setting, are discussed in chapter 2.

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 8-1 (p. 168) 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.

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.

Support and continued professional development can reduce therapist burnout and increase treatment efficacy.

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.

Figure 8-1
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 medications: education and compliance			Criminal thinking

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. (For more information about motivational interviewing, see TIP 35, *Enhancing Motivation for Change in Substance Abuse Treatment* [CSAT 1999*b*].) 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 (TCU) include a board game called Downward Spiral, which helps clients examine the conse-

quences 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.

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

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

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) (see also TIP 30, *Continuity of Offender Treatment for Substance Use Disorders From Institution to Community* [CSAT 1998*b*]).

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.

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

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

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

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.

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 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.

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 problemsolving 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.

Problemsolving

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 problemsolving can help inmates articulate methods of problemsolving 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.

Strengths building identifies and uses the assets that clients bring to the treatment program to improve their chances for successful recovery.

Social skills training

Social skills training can be provided independently or as part of modules related to problemsolving 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 9, Issues Specific to Treatment in Prisons.

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 contra-

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

band, 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 followup mental health and substance abuse services in the community. Treatment of individuals with co-occurring substance use disorders and mental illness is discussed in greater detail in chapter 5.

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. For more information on criminal thinking, see chapter 5.

Coordination of Jail Treatment Services

The consensus panel believes that 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 is based on the experiences of consensus panel members and 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 8-2 highlights the specific goals of correctional and treatment systems within jail settings and the shared goals of these systems.

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

Figure 8-2
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 abuse
Rehabilitation	Punishment	Reducing violence
Long-term good of individual and family	Safety of community	Changing behaviors

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.

To more efficiently focus limited resources, the consensus panel suggests that 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.

Prioritizing substance abuse treatment for traditional versus special needs populations

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. The consensus panel recommends that jails 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 8-3 (p. 178) compares the advantages and disadvantages of prioritizing substance abuse treatment services for traditional and special needs populations.

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

Figure 8-3
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

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.

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 followup 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 8-4 (p. 180) describes some of the advantages and disadvantages of medication use, for inmates enrolled in jail substance abuse treatment programs.

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 p. 181).

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 com-

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.

Figure 8-4
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

munication 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

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).

disorders (Broner et al. 2002; 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 infrac-

tions. 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.

Jail programs can serve as a therapeutic sanction to remove an individual from salient relapse cues.

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). For more information on drug courts and diversion programs, see chapter 7.

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 followup 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

The consensus panel believes that 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.

9 Treatment Issues Specific to Prisons

In This Chapter...

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Key Issues Affecting Treatment in Prison Settings

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

In-Prison Therapeutic Communities

Specific Populations in Prisons

Systems Issues

Recommendations and Further Research

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 www.nicic.org/pubs/2001/016672.htm), 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. 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, 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.

10 Treatment for Offenders Under Community Supervision

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Overview

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.

The offenders discussed in this chapter also are discussed elsewhere in the TIP. Probationers, for example, are often sentenced through the drug courts described in chapter 7, Treatment Issues in Pretrial and Diversion Settings. Indeed, much of the material in chapter 7 is applicable to the probation population. Many probationers also have spent time in jail, as discussed in chapter 8, Treatment Issues Specific to Jails. Chapter 9, Treatment Issues Specific to Prisons, describes the prison culture that parolees left upon release. In order to acquire an understanding of the full range of issues that affect the treatment of offenders under community supervision, the reader is advised to consult these other relevant chapters.

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 10-1 indicates, parolees and probationers differ considerably.

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

Chapter 3, Triage and Placement in Treatment Services, provides detailed information on selecting an appropriate treatment level. This section builds on the material in chapter 3 to provide information specific to offenders under community supervision. Placement 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; clini-

Figure 10-1
Comparison of Probationers and Parolees

	Probationers	Parolees
Number (as of December 31, 2003)	4,073,987	774,588
Gender (as of December 31, 2003)	77 percent male 23 percent female	87 percent male 13 percent female
Race/Ethnicity (as of December 31, 2003)		
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 in 1998	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.

cal 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. (See chapter 9 for a discussion of prison-based TCs.)

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 problemsolving, goal setting, and improving cooperation and communication skills. Residential treatment should be followed by continued care in an outpatient setting.

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. For more details on this level of care, see chapters 3 and 5 of this TIP, as well as the forthcoming revised TIPs, *Substance Abuse: Clinical Issues in Intensive Outpatient Treatment for Alcohol and Other Drug Abuse* (Center for Substance Abuse Treatment [CSAT] in development *d*) and *Substance Abuse: Administrative Issues in Intensive Outpatient Treatment* (CSAT in development *c*).

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,

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

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).

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.

Treatment Components

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

- Screening and assessments—medical, psychiatric, and substance abuse (see also chapter 2, Screening and Assessment)
- Detoxification (see also the forthcoming TIP *Detoxification and Substance Abuse Treatment* [CSAT in development *a*])
- Medical assessment—pregnancy tests and treatment for HIV and AIDS, other sexually transmitted diseases, and tuberculosis (see also chapter 2, Screening and Assessment)
- Full-range medical treatment
- Treatment planning—medical, psychiatric, and substance abuse (see chapter 4, Substance Abuse Treatment Planning)
- Counseling—group, individual, family, couples (see chapter 5, Major Treatment Issues and Approaches)
- 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

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).

- 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 the panel's 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 followup 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. For additional information about vocational issues and offenders, see chapter 8 in TIP 38, *Integrating Substance Abuse Treatment and Vocational Services* (CSAT 2000*c*).

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

Attention to residential resources for clients should be a critical factor in case planning by corrections supervisors.

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. For more on MOUs see chapter 11, Key Issues Related to Program Development. For more on case management see TIP 27, *Comprehensive Case Management for Substance Abuse Treatment* (CSAT 1998*a*).

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 decisionmakers 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

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, the panel recommends that training in developing client self-esteem 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.

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.

Financial Concerns

Many offenders have multiple financial responsibilities—child support, family obliga-

tions, 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.

Establishing an offender's motivation to change is an essential first step in substance abuse treatment.

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). For more on motivational interviewing, see the section on brief treatment in chapter 8 and TIP 35 *Enhancing Motivation for Change in Substance Abuse Treatment* (CSAT 1999*b*).

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, the consensus panel suggests that 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.

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. For more detailed information, see chapter 5, Major Treatment Issues and Approaches.

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 2000c). 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 on the next page.

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.gainscenter.samhsa.gov/.

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

- 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.

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 followup. 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).

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. The consensus panel believes that 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 followup and hospice care. Case managers can assist in coordinating care for such infectious diseases as HIV, hepatitis C, tuberculosis, and sexually transmitted diseases. For more on infectious diseases in criminal justice clients, see chapters 2 and 6.

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 commu-

nity 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.

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. TIP 30, *Continuity of Offender Treatment for Substance Use Disorders From Institution to Community* (CSAT 1998*b*), discusses this topic in depth.

Aftercare and Continuing Care

Several studies have supported the long-term efficacy of postprison 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 postprison 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.

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 7 is also applicable to probationers, since many probationers have been sentenced through drug courts.

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 postprison 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.

Strategies for Improving System Collaboration

Initiatives such as cross-training, coordinated and comprehensive planning, and followup interdisciplinary meetings can help justice and treatment system partners to develop a shared, client-centered mission and a coordinated response. Figure 10-2 (next page) 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.

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.

Figure 10-2
Paradigm of Collaboration

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

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. For more detailed information on confidentiality and privacy, see chapter 7. (Additional information on confidentiality can be found at www.hipaa.samhsa.gov; also consult CSAT 2004.)

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. The consensus panel feels strongly that 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. For more on training on screening and assessment, see chapter 2. For general information on treating offenders, see chapter 5.

Sample Programs

Treatment Accountability for Safer Communities

For a description of TASC, see chapter 7.

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 followup indicate that the group in aftercare shows the most powerful effects of the earlier treatment (Martin et al. 1999). For additional information, see chapter 9.

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

Based on their knowledge and experience, consensus panel members offer the following conclusions and recommendations regarding treatment for probationers and parolees:

- 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.

11 Key Issues Related To Program Development

In This Chapter...

Reconciling Public Safety and Public Health Interests

Interdependence of Criminal Justice and Treatment Systems

Program-Level Coordination

Research and Evaluation

Cost Issues

Key Goals of SAMHSA

Conclusions

Overview

An important thread running throughout this TIP is the interdependence of criminal justice and substance abuse treatment systems, which influences what program activities are undertaken and how they are implemented. The members of the TIP consensus panel feel strongly that effective collaboration between the criminal justice and substance abuse treatment systems can result in better treatment for offenders and, ultimately, a reduction in crime. When available and effectively implemented, substance abuse treatment programs can reduce recidivism, reduce substance use, and help offenders to change their lives. The guiding notion in this chapter is to provide thoughtful consideration of key issues that frame effective programming and coordination.

This chapter is primarily aimed at program administrators, although counselors will benefit from reading it as well. The chapter presents information on issues such as reconciling the goals of the criminal justice and substance abuse treatment systems; the interdependence of the two systems and how to collaborate effectively; program-level coordination, including barriers to coordination and solutions, and integrating criminal justice and substance abuse treatment; research and evaluation issues; cost issues; and conclusions.

Reconciling Public Safety and Public Health Interests

Any discussion concerning the effectiveness of substance abuse treatment for clients under criminal justice supervision needs to address the historic differences between the criminal justice and public health systems. These differences influence the nature and quality of services provided at both the program and policy levels. A basic difference is the primary focuses of the two fields. The responsibility of the criminal justice system is to protect the public safety, with a focus on activi-

ties designed to isolate, and supervise individuals who threaten the lives and well-being of others (Office of the Federal Register 2004). The substance abuse treatment system's focus is on restoring individuals to productive lives and minimizing the consequences of alcohol and drug dependence on people with substance use disorders, their families, and communities.

Because of these differences in focus, the two systems sometimes operate at cross-purposes. The perceived need to "get tough" on crime and the rehabilitation of the offender have fueled the continued debate. Offenders are sometimes viewed as less deserving competitors for scarce substance abuse treatment services compared to nonoffending citizens. For some, punishment is the primary goal; treatment—if available at all—is secondary.

The missions of public health departments and correctional agencies are complementary.

At the same time, security and public safety issues may not be a primary consideration for substance abuse treatment professionals. Counselors may forget that offenders are there because they have committed crimes, sometimes violent ones, and that not all offenders will become law-abiding citizens, even if they are not under the influence of drugs or alcohol. Moreover, some treatment programs may not address the additional needs of criminal justice clients, such as issues underlying criminal activity (e.g., criminal belief systems and criminal peer groups).

Despite these differences, the missions of public health departments and correctional agencies are complementary. An important common ground—a goal that is critically important to both systems—is the reduction of crime. The remainder of this chapter addresses ways to build on that common ground to create systems that habilitate offenders, prevent crime, and protect the public.

"Good treatment is good public safety."

—Claire McKaskill, former county prosecutor in Missouri

Interdependence of Criminal Justice and Treatment Systems

The criminal justice and substance abuse treatment systems can work together to improve the results of both systems. The Criminal Justice Treatment Planning Chart prepared by the Center for Substance Abuse Treatment (CSAT) might serve as a frame of reference (CSAT 1994*b*). In the chart (Figure 11-1, pp. 238–239), specific connections between the criminal justice and substance abuse treatment systems are targeted.

It is vitally important that these two systems, and the people who work within them, agree that treatment must be tailored to the particular criminal justice setting and to the client's stage in the recovery process. Steps to promote integration between the criminal justice and the substance abuse treatment systems are discussed below.

Effective Collaboration Between Criminal Justice and Treatment Systems

Several conditions must exist for effective relationships between different groups or systems (Argyris 1970), such as the treatment and criminal justice systems. These conditions include

- Investment in the system's effectiveness
- Confidence in their own system
- Belief in the interdependent nature of the systems

- Willingness to accept or develop common goals to link the systems
- Willingness to work collaboratively with other systems on joint projects

The consensus panel recommends the following basic principles, which are used to promote change in different organizations and systems but can be applied to the criminal justice and substance abuse treatment systems:

- Development of leadership and goals
- Endorsement from system leaders
- Establishment of common goals and objectives
- Identification of stakeholders

The following section describes how these recommended principles can be used to strengthen coordination between criminal justice and substance abuse treatment systems.

Development of leadership and goals

Small groups of individuals who have endorsement of leadership within the criminal justice and substance abuse treatment systems can help develop an agenda for action. Preliminary goals that link the two systems can then be established. It is important that preliminary goals identified are specific and attainable. Building on small successes at the beginning of the process is important.

Endorsement from system leaders

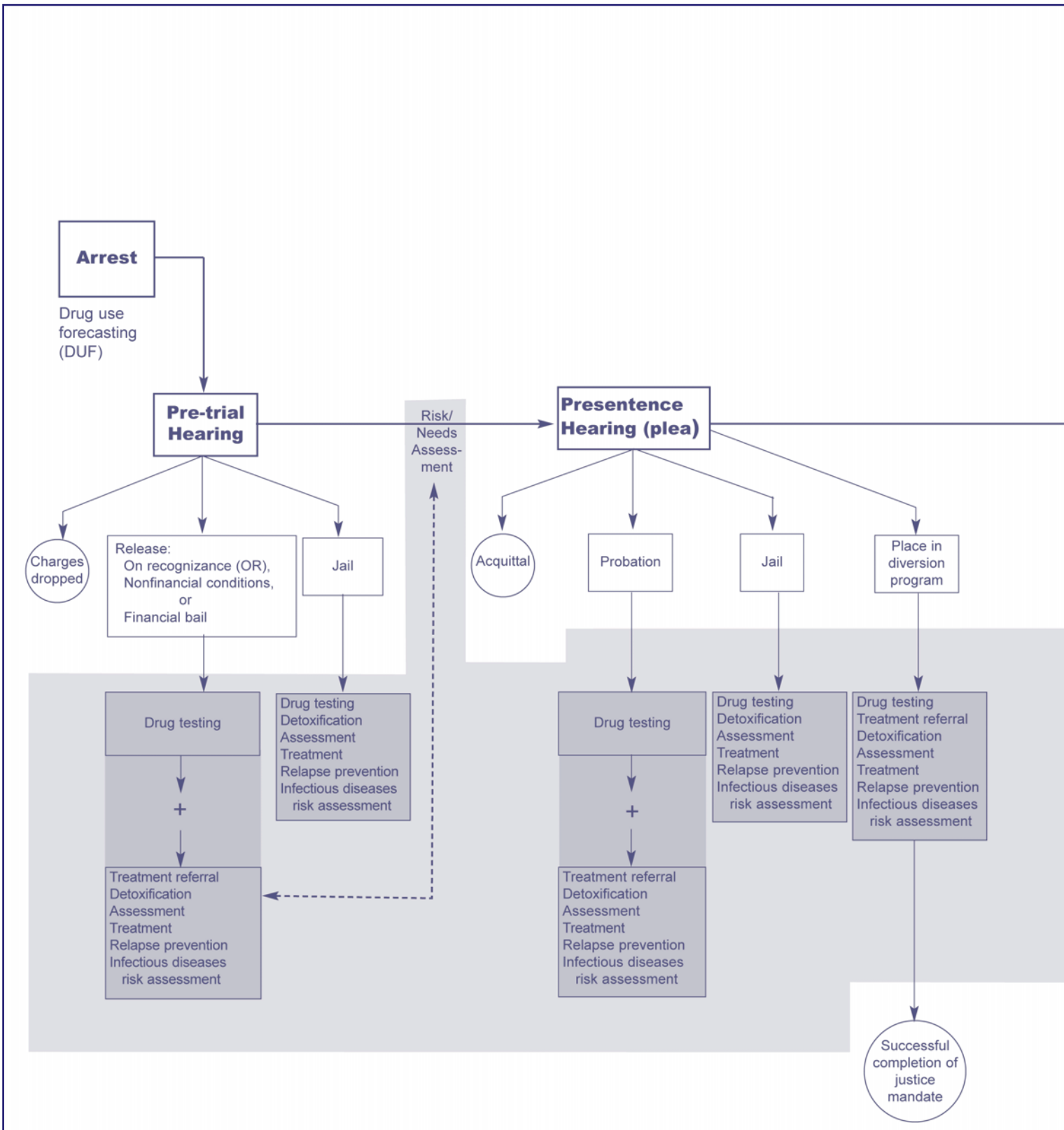
Formal endorsement should be obtained for collaborative projects from both systems' leaders. Endorsement may be implicit if leaders are part of the group or may be obtained from a more formalized process if they are not. This endorsement can take the form of an executive order from the governor, mayor, or commissioner; a legislative declaration for the group's work; or simply a memorandum of understanding from those who hold power in the criminal justice and substance abuse treatment systems. Whoever commissions the collaborative project activities must be kept informed about progress and goals at every stage, preferably in an informal, uncomplicated way. A systems audit may be an effective way to measure the starting point and level of collaboration. This may be conducted internally by project staff or by external evaluators.

Establishment of common goals and objectives

For systems collaboration to be effective, a unifying goal must be identified and pursued. The planning group should set a unifying goal that encompasses the needs of both the substance abuse treatment and criminal justice systems. For example, a goal to reallocate money from current treatment programs in order to treat other groups of offenders may be divisive rather than unifying. However, a goal of finding new funding for offender treatment that focuses on the most dangerous offenders is an example of a superordinate or unifying goal. The process of articulating goals will help to clarify and resolve differences among group members and to expedite project development. As soon as the goals have been determined, objectives should be described. A series of concrete objectives should be accompanied by an action plan to achieve the goals. The objectives should then be assigned to individual group members for followup.

Identification of stakeholders

Everyone has a vested interest in preventing and addressing crime related to substance abuse. As the example of Portland's Regional Drug Initiative (see text box on page 240) demonstrates, when systems and individuals work together the results can be impressive.


Arrest
Drug use forecasting (DUF)
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Risk/ Needs Assess-ment
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Charges dropped
Release: On recognizance (OR), Nonfinancial conditions, or Financial bail
Jail
Acquittal
Probation
Jail
Place in diversion program
Drug testing
Drug testing Detoxification Assessment Treatment Relapse prevention Infectious diseases risk assessment
+
Treatment referral Detoxification Assessment Treatment Relapse prevention Infectious diseases risk assessment
Drug testing
Drug testing Detoxification Assessment Treatment Relapse prevention Infectious diseases risk assessment
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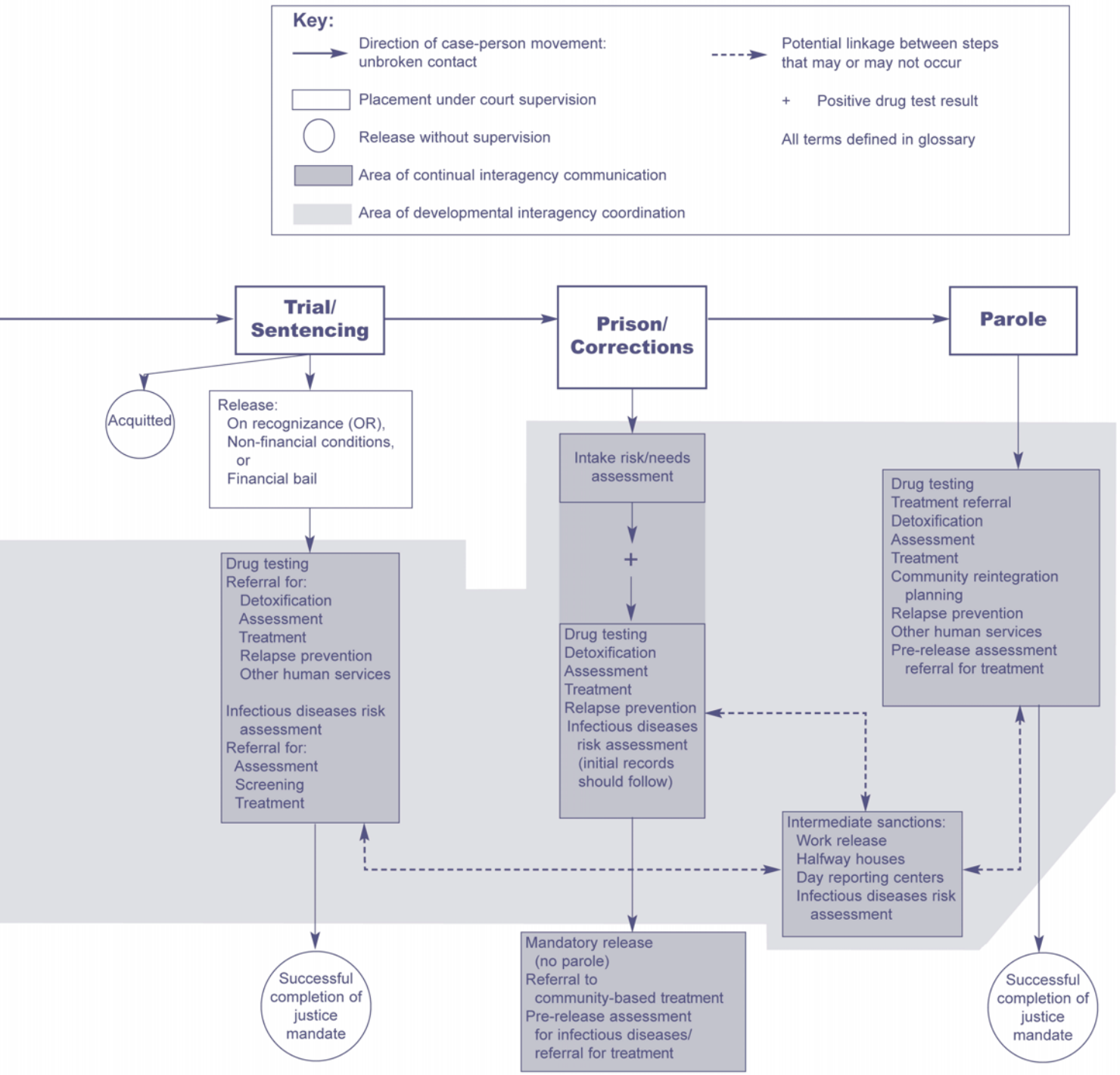
Treatment referral Detoxification Assessment Treatment Relapse prevention Infectious diseases risk assessment
Drug testing Detoxification Assessment Treatment Relapse prevention Infectious diseases risk assessment
Drug testing Treatment referral Detoxification Assessment Treatment Relapse prevention Infectious diseases risk assessment
Successful completion of justice mandate

Figure 11-1
CSAT Criminal Justice Treatment Planning Chart



Regional Drug Initiative, Portland, Oregon

In 1987, citizens and leaders in Portland, Oregon, and surrounding communities united to form a coalition, the Regional Drug Initiative (RDI). Although the RDI was dissolved in June 2002, it continues to serve as a national model for community coalitions. Join Together hosts an archival Web site (www.regionaldruginitiative.org) that contains basic documents describing RDI, its approach, and how to replicate its work.

RDI's purpose was to substantially reduce alcohol and drug abuse in Portland and Multnomah County. It worked to coordinate networking efforts of the criminal justice system, treatment and prevention agencies, healthcare and education systems, community organizations and advocates, youth, the faith community, businesses, and the media. RDI aimed to increase the number of drug-free workplaces, strengthen youth and adult leadership to reduce alcohol and drug use among youth, and educate community leaders and the public on actions and policies needed to reduce substance abuse.

The *Drug Impact Index* was an annual compilation of indicators that highlighted the severity of the drug problem in Oregon and Multnomah County. The last volume of the *Index* (2001) showed that approximately one fifth of those needing substance abuse treatment in Oregon received it in any one year.

The *Index* also showed that that when stakeholders cooperate, treatment can work. For example, every dollar invested in public substance abuse treatment returned over $5 in direct costs to taxpayers. Other significant findings from the report included:

- In the Multnomah County, Oregon STOP (Sanction Treatment Opportunity Progress) program, which provided court-monitored outpatient treatment, graduates averaged 0.4 re-arrests 2 years following completion of the program, versus 1.5 re-arrests for people who were eligible to participate in the program but did not.
- Due to court-mandated treatment, for every dollar spent, $2.50 was saved in direct State and local government costs. Total savings including theft and costs to victims amounted to $10 per dollar spent.
- Positive drug tests in the workplace had increased since 1997, after they had decreased by almost half from 1993 to 1997.
- The percentage of adult arrestees testing positive for drugs was 67 percent in 2000. The percentage testing positive for drugs was similar across a wide variety of offenses.
- Alcohol-involved traffic deaths declined 28 percent statewide and 43 percent in Multnomah County between 1998 and 1999. Alcohol-related deaths are at their lowest level in over 20 years.
- Drug-related deaths dropped in 2000, both statewide (by 15 percent) and countywide (by 35 percent). Eighty percent of drug-related deaths in Multnomah County were heroin related.

Source: Regional Drug Initiative 2001.

The following groups can be targeted to garner support for initiatives designed to provide substance abuse treatment for offenders.

The public. As taxpayers, voters, and residents, the public can influence what happens at every point along the criminal justice treatment continuum. As such, they are primary stakeholders who should be kept informed of relevant issues. For example, officials might consider releasing an annual community progress report, similar to a corporate annual report that includes facts such as the number of people who have successfully completed a treatment program. When members of the public participate in planning, an ongoing educative process is initiated. Public involvement also can address fears associated with

proximity to offenders who use drugs and help the public recognize the benefits of treatment programs (e.g., jobs in the community, reduced crime, etc.).

Victims. Those victimized by a crime include the crime victim and family members—especially children and significant others. Several States have passed constitutional amendments that protect the rights of victims and that usually provide an opportunity for the victim to take part in the criminal justice process. Additionally, community-based victims' rights groups have been established in many communities, and some prosecutors' offices employ victim advocates.

Victims have a variety of interests, depending on the circumstances of their cases. Most victims want to see a combination of punishment, restitution, and protection, while others may be interested in having the offender's substance abuse problem addressed. There are a number of "indirect" victims of drug-related crime who are not readily identified by law enforcement or the courts, such as individuals who live near "crack" houses and whose main goal is to close them down. As stakeholders, these victims should have the opportunity to represent their own interests.

Recovering criminal justice clients. Offenders in recovery are the "consumers" of treatment services. Although their criminal behavior creates public safety problems, often they are also the victims of abuse and other crimes. It is important to include criminal justice clients who are in recovery as stakeholders, since they are well informed about issues related to coordination between the justice and treatment systems. It is also important to reference the statements, writings, achievements, and testimonials of recovering criminal justice clients.

Media. The media play a major role in shaping public attitudes toward the criminal justice system, especially attitudes about how to handle substance-involved offenders. Avenues of communication between the media and the criminal justice and substance abuse treatment systems must be kept open. Continual efforts should be made to communicate to the media a full picture of the multifaceted issues surrounding crime, substance use disorders, and substance abuse treatment. When media representatives are involved in planning, they may begin to see the positive side of joint efforts of the criminal justice and substance abuse treatment systems.

Legislators. Legislators should be consulted and provided up-to-date information about offenders who use substances and are involved with the criminal justice system. It is important that they also become aware of "success" stories, so that the influence of failed cases does not dominate their policy decisions. The political stance of being "tough on crime" and "waging war on drugs" has resulted in legislation requiring mandatory sentences for drug offenses, which must be tempered with information regarding positive treatment outcomes, the availability of effective alternatives to incarceration, and the consequences of punitive approaches for drug offenders. Tough crime bills (e.g., "three strikes" laws) have resulted in high criminal justice expenses that often shift limited funds from social services and education to construction and operation of correctional facilities—actions that tend to exacerbate the crime problem and reduce the availability of needed services for citizens. In some cases, this type of punitive sentencing reform has been developed in reaction to a particularly heinous crime, with inadequate consideration provided to the public policy consequences.

Community organizations. Community groups include local boards, recreational programs, church groups, neighborhood watches, and other community associations that address, either directly or indirectly, the issues of substance abuse and criminal behavior. These groups can play a role in prevention, treatment, and referral. Advocacy groups such as Mothers Against Drunk Driving and other special interest groups also can work effectively at the community level to address prevention issues. Their agendas often are con-

sistent with those of other community groups that can be helped to understand the importance of reaching offenders with effective treatment.

Businesses. Local businesses and business groups, such as Kiwanis, Rotary, and downtown business associations, have a strong interest in preventing crime, since they may be targets, and often take an active role in their communities. Employers also are interested in preventing substance abuse by their employees. Businesses are a vital component of the larger community and should be involved in planning for substance abuse treatment in the criminal justice system. Business leaders can provide invaluable assistance in planning training programs and providing opportunities for job placements. Vocational training is a critical component of the transition and reintegration process for offenders with substance use disorders reentering communities (see also chapter 8 in TIP 38, *Integrating Substance Abuse Treatment and Vocational Services* [CSAT 2000*c*]).

The consensus panel believes that leaders from the criminal justice and substance abuse treatment systems can do the hard work of planning substance abuse treatment for offenders in all parts of the criminal justice system continuum. Policy, procedures, relationships, and shared responsibilities should be developed to operationalize effective substance abuse treatment within the criminal justice system.

Program-Level Coordination

Federal, State, and local policies have a tremendous effect on the quality and availability of substance abuse treatment for offenders, as do policies and procedures within individual programs. The following sections address the barriers to effective program coordination and integrating substance abuse treatment into criminal justice at the program level.

Barriers to Program Coordination

Farabee and colleagues (1999) identified six major barriers that prevent effective implementation of substance abuse treatment in the criminal justice system. These barriers and their suggested solutions are summarized in Figure 11-2.

Program Components

Effective programs include case management along with procedures to coordinate the flow of information and to serve the best interests of the offender.

Case management

Case management is the process of linking the offender with appropriate resources; tracking the offender's participation and progress in the referred programs; reporting this information to the appropriate supervising authority and, when requested, to the court; and monitoring the conditions imposed by the court. Effective case management often requires supplementary funding and reallocation of resources.

Case management activities optimally begin at the pretrial period, continue throughout the treatment process, and provide a means to coordinate the requirements of the justice system with treatment goals and other immediate concerns. Case management activities focus on coordination of services during transitions between different stages of the justice system. When clearly defined, accountability guidelines established across the two systems ensure that information regarding criminal activity, infractions, and other critical incidents are reported in a timely and effective manner.

Figure 11-2
Barriers to Effective Treatment

Problem Area	Description of Problem	Solution(s)
Assessment	Assessment uses broad definitions of drug abuse and applies criteria unrelated to addiction. As a result, inmates are not always matched with the appropriate level of services, and some inmates who do not have substance abuse problems are placed in treatment.	Expand treatment options by establishing larger numbers of carefully targeted programs at more institutions.
Staff training	Many newer prisons have been constructed in rural areas where local communities have a smaller pool of treatment professionals and fewer people in recovery as potential staff members.	Offer better wages; recruit and train offenders who are serving life sentences; and orient and train treatment staff and correctional staff together.
Staff redeployment	Effective correctional officers and treatment counselors often move "up and out."	Change rotation policies; certify and reward officers who wish to work in jail- or prison-based treatment programs.
Overreliance on institutional sanctions	In successful treatment programs, noncompliant participants face peer pressure and eventually develop internal controls. Often, however, institutional sanctions are imposed before peers can have a positive impact.	Treatment and correctional staffs cooperate to determine conditions for imposing both therapeutic and institutional sanctions.
Aftercare	Many participants drop out of treatment as soon as they can; many providers in the community hesitate to work with ex-prisoners, especially those sentenced for violent or sexual offenses.	Establish treatment programs in the community that cater to or willingly accept parolees, probationers, and others under community supervision.
Coercion	Often inmates do not volunteer for treatment because peers attach stigma to it, programs demand more rules and structure, and participants often lose seniority and job opportunities in the facility.	Focus on rewarding good behavior. Remove disincentives and add such inducements as early release, better living quarters, and better job opportunities.

Source: Farabee et al. 1999.

Procedures to coordinate the flow of information

Information management is the key to identifying treatment needs and can provide treatment and related services more effectively. Basic information gathered about the defendant should follow the offender through subsequent stages of the criminal justice system and substance abuse treatment system. Agencies from both systems should decide what information is necessary and useful and should develop methods for sharing that information. However, the defendant's civil liberties and rights of confidentiality must be considered whenever information is shared.

Procedures to improve information flow include the following:

- Establish methods for timely collection and reporting of information.
- Implement regular quality control procedures to maximize completeness, accuracy, and consistency of data.
- Establish consistent definitions of the data elements between the different participating agencies.
- Ensure that information flows in both directions: from treatment providers to criminal justice staff, and from criminal justice staff to treatment providers.
- Increase sensitivity to the confidentiality requirements and political concerns of criminal justice agencies and treatment providers.
- Create a designated central repository for appropriate client information.

Integrating Public Safety and Treatment at the Program Level

Good substance abuse treatment programs contribute heavily to enhancing safety and security, as program participants usually present the fewest safety and security-related problems (Belenko 2001). Treatment and security can be thought of as two sides of the same coin, rather than as opposites. For

Information Sharing: Maricopa County Data Link Project

An innovative approach to sharing information between the jail and community services is reflected in the Maricopa County (Arizona) Data Link Project (National GAINS Center 1999*c*). Computer experts developed an electronic data link between the Maricopa County Jail and the public mental health system to identify clients who have previously received mental health services. This link identifies mental health clients regardless of their charges, time of jail booking, or mental health status at the time of booking.

All jail admissions are electronically routed to the management information system (MIS) operated by the public mental health system, with the MIS automatically matching clients based on demographic and other identifying information. Clients identified as matches with the mental health system are immediately "flagged" for the jail diversion program—an initiative funded by the Substance Abuse and Mental Health Services Administration (SAMHSA) to provide triage, case management, and treatment services for nonviolent inmates who have co-occurring substance use and mental disorders. The jail diversion team then evaluates potential candidates for its program, based on public safety risk factors, current mental status, availability of community mental health and treatment resources for those with co-occurring disorders, and prior history in treatment services. Clients accepted into the jail diversion program may be released from jail under pretrial or deferred prosecution arrangements to participate in treatment as a condition of community supervision. The Data Link Project has enabled the jail to increase the number of inmates identified for diversion and treatment involvement by approximately 100 percent within the first year of operation.

example, substance abuse treatment significantly enhances offenders' accountability through additional monitoring and communication with the courts, community supervision, and other criminal justice staff. Accountability also is provided by drug testing and by behavioral and skills-oriented interventions that are provided by treatment.

The consensus panel believes that the following conceptual model is helpful in understanding how the justice system is strengthened by substance abuse treatment involvement.

Supportive environment with accountability

A key issue for criminal justice programs is how treatment and justice system staff can work together to maintain a positive atmosphere that supports offenders' recovery efforts while confronting and managing offender "games" and manipulative coping strategies. Programs that focus exclusively on either supportive or confrontational approaches generally are not effective within the criminal justice system. Criminal justice treatment programs run smoothly and successfully only when staff employ both supportive and accountability procedures. "Confrontation" as used here does not mean a hard and aggressive verbal interchange, but rather assertively pointing out misbehavior and discrepancies between goals and behavior.

Some programs are successful in implementing only half of this formula. Supportiveness without accountability leads to the appearance that staff are trying to be "friends" with clients, leaving staff vulnerable to offender manipulation. The staff relationship with the client is better represented as that of a teacher and student, with staff modeling adaptive skills, behaviors, and attitudes. Conversely, accountability procedures that are developed in a nonsupportive environment often lead to an atmosphere characterized by hostility and punitiveness. Criminal justice system programs with this type of atmosphere are not typically successful in engaging offenders in treatment recovery.

Justice system programs flourish when all staff contribute to both the supportive environment and accountability of the clients. Keys to success include staff appreciation of the need to set limits supportively and to establish clear personal boundaries with clients. A final point for all staff who are integrating the work of criminal justice staff and treatment staff is that good treatment is good public safety. Treatment staff should demonstrate to justice system staff how their program might enhance safety and security. Substance abuse treatment programs can quickly demonstrate their worth by effectively managing clients' difficult behavior, supporting the work of criminal justice staff, and holding themselves and criminal justice staff accountable for following through with their respective commitments to the program.

Personnel needs

Training and professional and workforce development issues are of paramount concern in implementation of treatment programs with the criminal justice system. Because the criminal justice system affects the environment in which treatment occurs and provides the structure to which the client must respond, substance abuse treatment counselors need to become familiar with the criminal justice system, its unique terminology, and methods of balancing client treatment needs with safety issues. Treatment professionals working with criminal justice clients should be knowledgeable about criminogenic risk factors, the most effective strategies and approaches for use with offender populations, and the need for professional boundaries.

By the same token, criminal justice staff should understand the goals of substance abuse treatment, the effects of frequently abused drugs, and the types of treatment that are available. Treatment knowledge is particularly important for criminal justice staff,

since treatment is increasingly affecting all aspects of diversion, community supervision, court monitoring, and incarceration. Cross-training activities can encourage employees to work together. Training is also needed to address the wide variety of "special needs" populations under criminal justice supervision and the impact of managed care systems and tiered placement criteria (e.g., American Society of Addiction Medicine criteria) on publicly funded treatment systems.

Given that the rapid growth of treatment programs within the criminal justice system has not been matched by equal growth in organizational and staff resources, the system has been strained. Staff turnover, burnout, and other occupational hazards can be addressed through efforts to increase professionalism, such as developing

- A clear hierarchy of staff positions with increasing responsibilities at each level
- Clear requirements for advancement in the hierarchy
- Incentives for additional training, made readily available
- Incentives for working on units that are considered more difficult or are higher security
- Merit pay

Training resources

CSAT launched a network of Addiction Technology Transfer Centers (ATTCs) in 1993 to increase the knowledge and skills of substance abuse treatment professionals; to facilitate access to state-of-the-art research and education; heighten the awareness, knowledge, and skills of all professionals who may be in a position to help people with substance use disorders; and to foster alliances among stakeholders. Information on and links to ATTC's 14 Regional Centers and National Office can be accessed online at www.nattc.org.

The ATTCs have extensive resources of value to professionals working with offenders who abuse substances, a few of which are highlighted below:

Working with Criminal Justice Clients. Designed to familiarize substance abuse treatment counselors to work with criminal justice clients, the curriculum includes material on intersystem teamwork and relapse issues. (For further information or to order the material online go to www.neattc.org.)

Training for Professionals Working with MICA (Mentally Ill Chemical Abusing) *Offenders.* This 1-day course module serves as cross-training for staff in law enforcement, mental health, and substance abuse settings. (For further information or to order the material online go to www.neattc.org.)

Orientation to Therapeutic Community. Developed to introduce administrators and ancillary staff to the history, theory, and current research on the therapeutic community model, this training provides a fundamental framework for therapeutic communities. This training curriculum is not intended for frontline workers. (For further information or to order the materials online go to www.mattc.org.)

Therapeutic Community Experiential Training. Intended for frontline staff of start-up therapeutic communities, this 5-day intensive experiential training provides participants with the knowledge, expertise, and attitudes that have been used effectively by professionals in the field. (For further information or to order the material online go to www.mattc.org).

Criminal Justice/Substance Abuse Cross Training: Working Together for Change. This program is designed to help administrators and professionals integrate criminal justice and substance abuse services systems to coordinate treatment and recovery services and overcome barriers to collaboration. (For further information or to order the material online go to www.mattc.org.)

Research and Evaluation

Research and evaluation is a critical dimension of substance abuse treatment programs in the criminal justice system. Evaluations are needed for program monitoring and for decisionmaking by program staff, prison administrators, and policymakers. Evaluations provide accountability, identify strengths and weaknesses, and provide a basis for program revision. In addition, evaluation reports are useful learning tools for others who are interested in developing effective programs. Many treatment programs in the criminal justice system have operated without evaluations for many years, only to find out later that key outcome data are needed to justify program continuation.

Conducting an adequate evaluation requires one to clearly formulate the treatment model and reasonable program goals and specific objectives related to client needs. General goals must be translated into measurable outcomes. The evaluator generally works closely with program administrators to translate their evaluation guidelines into operational components. For example, general goals of helping program participants become drug and crime free can be operationalized into intermediate goals of changing behavior (e.g., reductions in rule infractions and fewer positive drug test results) while in a program.

There are three basic types of evaluations:

1. Implementation
2. Process
3. Outcome

While implementation and process evaluations can begin when the program is initiated, outcome evaluation should not begin until the program has been fully implemented. Outcome evaluations are generally more costly than other types of evaluation and are warranted for programs of longer duration that are aimed at modifying lifestyles (such as therapeutic communities), rather than drug education interventions that are less intensive and less likely to produce long-term effects.

Implementation Evaluation

While programs often look promising in the proposal stage, many fail to materialize as planned in the security-oriented correctional environment. Other programs are rigidly implemented as planned and without adjustments for the realities of prison, often rendering them less effective. Implementation evaluations are aimed at identifying problems and accomplishments during the early phases of program development for feedback to clinical and administrative staff. Such evaluations involve informal and formal interviews with correctional administrators, officers, and inmates to ascertain their degree of satisfaction with the program and their perceptions of problems.

Research and evaluation is a critical dimension of substance abuse treatment programs in the criminal justice system.

In order to initiate an evaluation, in addition to having a clear, detailed proposal that describes the planned program, evaluators will need to know

- The model or theory the program is based on
- Criteria for participation
- Program components
- Planned treatment duration
- Staff qualifications
- Plans for staff orientation and training
- The schedule for implementation

These elements provide the basis for assessment. Periodic implementation feedback

reports to program and institutional administrators can be very useful in identifying problems and planning corrective measures.

Process Evaluation

Traditionally, process evaluation refers to assessment of the effects of the program on clients while they are in the program, making it possible to assess the institution's intermediary goals. Process evaluation involves analyzing records related to

- Type and amount of services provided
- Attendance and participation in group meetings
- Number of clients who are screened, admitted, reviewed, and discharged
- Percentage of clients who favorably complete treatment each month
- Percentage of clients who have infractions or rule violations
- Number of clients who test positive for substances (this can be compared to urinalysis results for the general prison population)

Effective programs produce positive client changes. These changes initially occur during participation in the program and ideally continue upon release into the community. The areas of potential client change that should be assessed include

- Cognitive understanding (e.g., mastery of program curriculum)
- Emotional functioning (e.g., anxiety and depression)
- Attitudes/values (e.g., honesty, responsibility, and concern for others)
- Education and vocational training progress (e.g., achievement tests)
- Behavior (e.g., rule infractions and urinalyses results)

Within corrections it is also important to evaluate program impact on the host institution. Well-run treatment programs often generate an array of positive developments affecting the morale and functioning of adjacent cellblocks and entire prisons. Areas to examine include

- *Inmate behavior.* Review the number of rule infractions, the cost of hearings, court litigation expenses, and inmate cooperation in general prison operations.
- *Staff functioning.* Assess stress levels, which may become manifest in the number of sick days taken and the rate of staff turnover. Generally, the better the program, the lower the stress, and the better the attendance, the involvement, and the commitment of staff.
- *Physical plant.* Examine the physical properties of the program. Assess general vandalism apparent in terms of damage to furniture or windows, as well as the presence of graffiti. Assess structural damage, for example, to walls and plumbing.

Institutional impact can be evaluated by comparing the status of the environment before and after program implementation (pre/post comparison), as well as by comparing the current status of similar cellblocks that do not have treatment programs. Careful cost assessment of institutional impact can help provide convincing information regarding program cost benefits to administrators, funding sources, and policymakers.

Outcome Evaluation

Outcome evaluations are more ambitious and expensive than implementation or process evaluations. Outcome evaluations involve quantitative research aimed at assessing the impact of the program on long-term treatment outcomes. Such evaluations are usually carefully designed studies that compare outcomes for a treatment group with outcomes for other less intensive treatments or a no-treatment control group (i.e., a sample of inmates who meet the program admission criteria but who do not receive treatment), complex statistical analyses, and sophisticated report preparation.

Followup data (e.g., drug relapse, recidivism, employment status) are the heart of outcome evaluation. Followup data can be collected from criminal justice and substance abuse treatment agency records or from face-to-face interviews with individuals who participated in prison programs. Studies that use agency records are less expensive than locating former inmates and conducting followup interviews. Outcome evaluations can include cost-effectiveness and cost-benefit information that is important to policymakers.

Because outcome research usually involves a relatively large investment of time and money, as well as the cooperation of a variety of people and agencies, it must be carefully planned. A research design may be very simple and easy to implement or it may be more complex. In the case of more complex studies it is usually advisable to enlist the assistance of an experienced researcher. The kinds of outcome information that might be collected are summarized in Figure 11-3 (next page).

There is a hierarchy of evaluation approaches ranging from simple outcome monitoring to nonrandom or quasi-experimental designs to experimental research studies that use random assignment. The selection of a research design depends on available funding and available comparison groups.

Any claims to a program's effectiveness rest on comparisons that demonstrate it is superior to nontreatment groups or to groups that have received another type of treatment. The power of a research design is related to how defensible study results are against potential criticisms. Although simple outcome monitoring studies are relatively economical to conduct, they lack the comparison groups needed to show the specific effects of a program. While specific program outcomes can be compared with national and State norms or with published outcomes of another program, such comparisons are limited because of the many uncontrolled potential differences between the program group being monitored and the comparison groups.

The defining characteristic of a pure research design is random assignment of inmates to treatment and control groups. Random assignment may be done by using a lottery type procedure that ensures that there are no systematic pretreatment differences between the groups (such as motivation or background characteristics). The concern is that any important preprogram difference in program and control groups may bias the results and compromise any claims for program effectiveness. Random assignment is difficult to implement in prisons because of ethical and legal implications of denying inmates treatment. If a program has a substantial waiting list it may be feasible to implement a lottery procedure as a fair method to control program admission, thus creating a random assignment situation.

Nonrandom assignment is an attempt to approximate the power of the pure experimental design. A popular quasi-experimental design uses a comparison group that is matched to the program group on as many pretreatment factors as possible. Often, statistical methods are employed to control pretreatment group differences that might influence outcomes.

Locating criminal justice clients for outcome studies is a very difficult and expensive undertaking. Collection of extensive locator information at program intake will assist interviewers in the locating task. Examples of useful locator information include social security number, driver's license number, mother's maiden name, aliases, names and locations of family members and friends, and locations of favorite hangouts.

Large samples are needed in outcome studies to demonstrate significant results and to study the effects of multiple variables. For example, an analysis of the role of ethnicity (African American, Caucasian, and

Figure 11-3 Outcome Information	
Drugs	• Urinalysis results • Drug-related parole infractions • Drug-related arrests
Crime	• Parole rule infractions • Time until parole rule infraction • New misdemeanor arrests of any type • New felony arrests for non–drug-related crimes • New felony arrests for drug-related crimes • New felony arrests for violent crimes • Time until arrest • Re-incarceration
Social adjustment	• Employment and education • Family (e.g., support, child rearing, marital, etc.) • Substance abuse treatment • Community involvement (e.g., community service)
HIV risk behaviors	• Intravenous drug injection • Sexual behavior • HIV test results
Cost information	• Cost estimates of substance use • Cost estimates of crimes • Cost estimates of social services to family (e.g., welfare) • Criminal justice processing and detention costs
Tracking information	• Tracking locator information (e.g., social security and license numbers, addresses of family and friends, etc.)

Hispanic/Latino) reduces group size by a third. When reporting results it is generally best to use less complex statistics such as percentages and averages so that they are clear and understandable to nonstatisticians. Often, showing results in figures and charts is helpful. It is advisable to keep reports concise and clear for policymakers who may have little time or patience to study complex material. Finally, the credibility of outcome studies is often enhanced when conducted by outside researchers who have fewer vested interests in the outcomes.

The consensus panel provided several recommendations for improving evaluation efforts within criminal justice programs:

- Management information systems should be coordinated for use by substance abuse treatment and justice system professionals. This can lead to greater sharing of information and ensure that information is available for evaluation purposes.
- Quality assurance and quality improvement measures should be applied across all criminal justice program settings.

- Monitoring and evaluation should be part of all major treatment initiatives established within the criminal justice system.

Cost Issues

Another critical area in program development is that of program costs, including cost savings and cost-benefit/cost-offset information. Program administrators are routinely required to provide evidence that monies are spent effectively. The literature indicates that treatment has cost benefits in certain settings. Positive cost-offset results (savings down the road) have been demonstrated from treatment through specific approaches, such as drug courts (Belenko 2001). Similar results have been shown for treatment in prison settings (McCollister and French 2001).

Cost analyses (see Figure 11-4 below for definition) are important in determining how to allocate funds within a program and for understanding the relationship between costs and outcomes. Examining costs for the program as a whole (or for parts of it) is a basic form of cost analysis. Cost analyses can be provided as a monthly or quarterly report and costs generally vary over time. Costs provided at several levels include:

- Total cost of the program for the average treatment
- Cost of each part of the program each day
- Total monthly or annual cost per offender

The major types of cost analyses include "cost," "cost-effectiveness," and "cost benefit," and are described below in Figure 11-4.

Some treatment program evaluations measure direct monetary outcomes, such as a reduction in the use of health services. Other treatment program evaluations can measure indirect costs, such as reduction in crime-related costs, reduced recidivism, and the costs of incarcerating offenders.

Other ways to report the relationship between costs and benefits include

- The *net benefit* of a program can be shown by subtracting the costs of a program from its benefits.
- The *ratio* of benefits to costs is found by dividing total program benefits by total program costs.
- The *time to return on investment* is the time it takes for program benefits to equal program costs.
- The *present value* of benefits takes into account the decreasing value of benefits attained in the distant future.
- Because neither net benefits nor cost-benefit ratios indicate the size of the cost (*initial investment*) required for treatment to yield the observed benefits, it is important to report this as well.

Figure 11-4
Definition of Terms

Name	Definition
Cost analysis	A thorough description of the type and amount of all resources used to produce substance abuse treatment services.
Cost-effectiveness analysis	The relationship between program costs and program effectiveness, that is, patient outcome.
Cost benefit analysis	The measurement of both costs and outcomes in monetary terms.

Source: Yates 1999.

How Politics and Policy Can Affect Treatment: California's Proposition 36

In November 2000, by a 60 percent majority, California passed Proposition 36 (the Substance Abuse and Crime Prevention Act [SACPA], see chapter 7 for more information). Its passage has been interpreted, in part, as an expression of public dissatisfaction with the increasing share of State budgets allocated to expansion of correctional facilities at the expense of other public services, such as education.

Under the SACPA initiative, offenders who are convicted of nonviolent drug-related offenses are eligible for diversion to community treatment programs. Diversionary program eligibility is also provided for an estimated 9,500 parole violators annually. Offenders may apply to have their charges dismissed after successful completion of probation and treatment. Proponents of this law suggest that treatment saves money and enhances public safety and public health by reducing crime and substance abuse. Opponents countered that the proposition offers a quick fix that lacks safeguards, compromises public safety, and invites ineffective treatment. The law became effective July 1, 2001. In its second year (July 2002 to June 2003), about 50,000 offenders were referred for substance abuse treatment. Of those, about 71 percent (35,947) went on to enter treatment (Longshore et al. 2004).

Key Goals of SAMHSA

SAMHSA is committed to serving justice-involved populations and shares that responsibility with other agencies. In 2004 SAMHSA began a 2-year action plan to create a strategy to facilitate development and management of mental health and substance abuse prevention, early intervention, clinical treatment, and recovery support policies, programs, strategies, and practices for adults and juveniles in contact with or involved with the justice system. Following are some of the key activities that are underway:

- Develop and implement a Recovery Management Framework that will foster resiliency and manage recovery among adults and juveniles involved in the criminal justice system.
- Examine the gaps within SAMHSA's criminal and juvenile justice activities and identify key efforts that could be implemented.
- Provide training and technical assistance on best practices and evidence-based programs for persons in the criminal justice system.
- Support mechanisms that promote science-based policies, programs, and models to ensure that services are provided at all points in the criminal justice system.
- Support knowledge synthesis and information dissemination efforts to help change attitudes of and reduce stigma among service providers who work with clients in the justice system.
- Engage in targeted collaborations at local, State, and Federal levels to promote effective, integrated systems approaches.
- Inform communities, policymakers, and other stakeholders of the importance of substance abuse and mental health services for people in the criminal justice system.

For more information about SAMHSA's efforts regarding substance abuse and mental health services for adults and juveniles in the criminal justice system go to www.samhsa.gov.

Conclusions

The consensus panel draws conclusions and makes recommendations as follows:

- A goal that is critically important to both the substance abuse treatment and correctional systems is the reduction of crime.

- It is vitally important that these two systems recognize that treatment must be tailored to the particular criminal justice setting and to the client's stage in the recovery process.
- The following basic principles can be used to promote change in the criminal justice and treatment systems: developing leadership, obtaining endorsement from systems leaders, establishing common goals and objectives, identifying stakeholders, and encouraging collaboration among stakeholders.
- Good treatment programs contribute to enhancing safety and security, as program participants usually present the fewest safety and security-related problems.
- Substance abuse treatment professionals should be trained in criminal justice issues, and criminal justice personnel should be trained in substance abuse issues. Cross-training activities can encourage employees' willingness to work with each other more and can help personnel manage the wide variety of "special needs" populations under criminal justice supervision as well as the impact of managed care systems and tiered placement criteria.
- Research and evaluation are a critical dimension of substance abuse treatment programs in the criminal justice system. Evaluations provide feedback related to key issues and also can identify major problems related to program implementation.
- Program costs are another critical area. Cost analyses can help a program determine how to allocate funds and understand the relationship between costs and outcomes.

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Appendix B: Glossary

Acquittal

Judicial deliverance from a criminal charge on a verdict or finding of not guilty.

ADAM

Arrestee Drug Abuse Monitoring Program; a program sponsored by the National Institute of Justice that periodically administers drug tests and short research interviews to samples of new arrestees in selected cities.

Addiction

Drug craving accompanied by physical dependence that motivates continuing use, resulting in a tolerance to the drug's effects and a syndrome of identifiable symptoms.

Addiction Severity Index (ASI)

A standardized assessment tool used to conduct a comprehensive drug evaluation and to match offenders' drug problems with treatment approaches. (See also **Offender Profile Index**.)

Adjudication (for adults)

The process of resolving a criminal case through the determination of guilt or innocence and determining a sentence if the person is convicted of the crime.

Adult offender

In most States people 18 or older are considered adult offenders and processed through the adult criminal justice system, but in three States people 16 or older are processed as adults and in some other States it is 17 or older.

Aftercare

Treatment that occurs after completion of inpatient or residential treatment.

Alcoholics Anonymous

The best known of self-help support groups, which serves as an important adjunct to treatment.

Ancillary treatment services

These include education about substance abuse, self-help groups (Alcoholics Anonymous, Narcotics Anonymous), and skills training.

Arrest

The physical taking of a person into custody on the grounds that there is probable cause to believe he or she has committed a criminal offense. An arrest may follow an investigation by law enforcement and is authorized by a warrant issued by a court.

Assessment

Evaluation or appraisal of a candidate's suitability for substance abuse treatment and placement in a specific treatment modality/setting. This evaluation includes information on current and past use/abuse of drugs; justice system involvement; medical, familial, social, educational, military, employment, and treatment histories; and risk for infectious diseases (e.g., sexually transmitted diseases, tuberculosis, HIV/AIDS, and hepatitis). (See also **Screening**.)

Bail

Security (usually financial) provided as a guarantee that an arrested person will appear for trial; release from imprisonment based on that security. (See also **Financial bail and Nonfinancial conditions**.)

Behavior contracts

An agreement between counselor and client about the sanctions and incentives that are to be applied when specified when the client performs specified behaviors.

Bond hearing

Proceeding before a judge to determine what (if any) conditions to set for a detainee's release pending trial.

Booking facility

A secure lockup usually operated by the local police or sheriff's department. New arrestees are taken to and held in booking facilities for paper processing, fingerprinting, criminal records, and warrant checks, pending the initial appearance before a judge.

Boot camp

Typically, a sentence to a boot camp (also called shock incarceration) is for a relatively short time (3–6 months). These camps are characterized by intense regimentation, physical conditioning, manual labor, drill and ceremony, and military-style obedience.

Boundary-spanner

An individual with knowledge of both substance abuse treatment and criminal justice systems who can facilitate the interaction of the two for the purpose of obtaining substance abuse treatment for offenders under criminal justice supervision.

Center for Substance Abuse Treatment

CSAT is a Federal agency within the Substance Abuse and Mental Health Services Administration (SAMHSA). SAMHSA is part of the Public Health Service, under the Cabinet-level Department of Health and Human Services.

Changing the Conversation

CSAT's National Treatment Plan Initiative, published November 2000, which is a consensus document on how to improve substance abuse treatment and how those changes can be accomplished.

Classification

The process by which a jail, prison, probation office, parole, or other criminal justice agency assesses the security risk of an individual offender and the individual's need for social services.

Clinical formulation

The process of integrating information obtained through assessment into larger patterns or processes.

Clinicians

(See **Counselors and clinicians**.)

Coercion

The use of incentives and sanctions to encourage participation in substance abuse treatment.

Cognitive–behavioral therapy

Treatment that focuses on learning and practicing coping skills, some of which are cognitive in nature.

Community corrections

A model of corrections that has a primary goal of reintegrating the offender into the community. Typically will consist of judicial dispositions that involve alternatives to incarceration, such as diversion program, house arrest, electronic monitoring, probation, and parole.

Community notification laws

Laws that allow law enforcement to inform the public of the whereabouts (in some jurisdictions the specific home address) of offenders. The laws generally apply to sex offenders and typically include the "risk" level of the offender. Community notification laws are in effect in 50 States and the District of Columbia.

Community reintegration planning

Preparation and strategy for each prisoner's release from custody. The plan prepares for the prisoner's return to the community in a law-abiding role after release.

Community supervision or Community-supervised activities

These are outside the formal criminal justice system. Such activities include, for example, drug testing, programs to promote sobriety and prevent relapses, and day reporting centers.

Community treatment

This is a program outside the formal criminal justice setting. It may be run by public or private organizations (nonprofit or profit-making). Treatment may take place in a residential group (e.g., a halfway house) or a nonresidential activity (e.g., required attendance at Alcoholics Anonymous meetings). Treatment methods may vary. Both community treatment and community supervision are usually mandated by a court. An active partnership between these two should be built into planning activities for both.

Conditional release

Release from custody under specified conditions.

Confidentiality

The right of privacy for a client's/offender's personal information, except in certain law-enforcement situations.

Continual interagency communication

The ongoing cooperative effort among treatment/criminal justice/public health personnel needed to successfully treat and supervise offenders involved with drugs. Communication among these systems facilitates a united approach.

Co-occurring disorders

TIP 42, *Substance Abuse Treatment for People With Co-Occurring Disorders*, uses the term to specify the co-occurrence of a mental disorder and a substance use disorder. Other uses of the term include substance abuse accompanied by one or more physical or psychological conditions. Sometimes referred to as dual disorders.

Corrections system

Includes jails and detention centers, prisons, and community supervised settings.

Counselors and clinicians

Treatment professionals serving clients who abuse substances and are involved in the criminal justice system.

Court-mandated treatment

A court order to participate in treatment as part of a sentence or in lieu of some aspect of the judicial process.

Cultural competence

A set of academic and interpersonal skills that helps individuals increase their understanding and appreciation of cultural differences and similarities within, among, and between groups. It requires a willingness and ability to draw on community-based values, traditions, and customs and to work with knowledgeable people from the community in developing focused interventions, communication, and support. (See TIP 12, appendix C, for more on this topic, such as the "Continuum of Competence.")

Curfew

In the criminal justice context, a rule or condition applied to individuals on probation or parole, requiring them to be in their residence and remain there by a specific time. An individual sentenced to house arrest will have a curfew.

Day reporting center

An intermediate sanction, this is a place where offenders on probation or parole must report to receive supervision for a certain number of hours each day. These centers may include educational services, vocational or skills training, and other service delivery. Offenders may also report by phone from a job or treatment site during the day.

Denial breaking

An intervention strategy designed to confront thought processes that prevent the individual from acknowledging problems related to his or her use of alcohol or illicit substances.

Detention

Holding a defendant in jail or other facility pending trial or determination of guilt.

Detention center

For adults, a holding facility such as a jail.

Determinate sentence

A sentence in which the length of incarceration is fixed by the court.

Deterrence

Being deterred from criminal activity because of fear of involvement in the criminal justice system or other punishment.

Detoxification

A structured medical or social milieu in which an individual is monitored for withdrawal from the acute physical and psychological effects of addiction.

Developmental interagency coordination

Collaboration among personnel from criminal justice, treatment, and public health to form expert justice/treatment/public health systems. For example, developmental interagency coordination is essential in the assessment of the drug-involved offender and in the development of referral procedures and reporting policies, as well as in understanding each system's definition of success and failure.

Disposition

The final resolution of a criminal case (e.g., in a case in which an individual is found not guilty, the disposition is an acquittal and release).

Diversion

The process whereby a defendant's prosecution is deferred or dropped if certain conditions are met. Diversion also is the judicial option to refer prison-bound cases to a review board, which in turn may recommend that the original sentence be modified or suspended and that the offender be placed in a residential or nonresidential program.

Drug courts/Drug treatment courts

Specialized courts commonly designed to handle only felony drug cases, usually involving adult nonviolent offenders. Drug courts can involve intensive monitoring, drug testing, outpatient treatment, and

support services. They often operate with probation supervision and services.

Drug testing

Technical examination of urine samples to determine the presence or absence of specified drugs or their metabolized traces.

Drug use forecasting

Arrestee urinalysis data based on studies conducted under the Drug Use Forecasting (DUF) System of the National Institute of Justice.

DSM-IV

Diagnostic and Statistical Manual, 4th edition, published by the American Psychiatric Association, a standard manual used to categorize psychological or psychiatric conditions.

Due Process (of Law)

Legal proceedings established to protect individual rights and liberties.

DUI, DWI

Driving under the influence or driving while intoxicated.

Duty to warn

A treatment professional's duty to report a patient's threat to harm another or to commit a crime (does not apply to knowledge of a client's past offenses).

Electronic monitoring

A sanction in which an electronic device is worn by an offender that can alert corrections officials to the unauthorized absence from the house of a person under curfew/house arrest. (See also **House arrest**.)

Financial bail

An amount of money, set by a judge, that is used to ensure the defendant's appearance at court. (See also **Bail and Nonfinancial conditions**.)

Habilitation

Training in social problemsolving skills for people with mental illness requiring the client to: (1) define the problem; (2) generate alternative solutions; (3) choose the best solution, (4) make a plan, and execute it; and (5) evaluate the outcome.

Halfway house

A transitional facility where a client is involved in school, work, training, etc. The client lives onsite while either stabilizing or reentering society drug free. The client usually receives individual counseling, as well as group/family/marital therapy. He or she may leave the site only for work, school, or treatment. This facility can be in the community or attached to a jail or similar institution. (See also **Work release**.)

House arrest

The restriction of offenders to their homes for various periods of time. (See also **Electronic monitoring**.)

Incarceration

Holding a person in a detention center, jail, or prison (State or Federal) because of suspected or actual involvement in criminal activity.

Indeterminate sentence

A prison sentence in which the amount of time to be served is indeterminate and is usually determined by a Parole Board after a minimum period of incarceration. Judges generally impose a minimum and maximum incarceration term in indeterminate sentences.

Infectious diseases risk assessment

Evaluation of a person's risk for sexually transmitted diseases, tuberculosis, HIV/AIDS, and other infectious diseases including information regarding current and past history, screening, and treatment of such diseases. Testing and referral for treatment are recommended for those with

substance use disorders who are assessed as at high risk for such diseases. Those with substance use disorders who are assessed as at low risk should be reassessed intermittently. Thus, collaboration between criminal justice personnel, treatment personnel, and public health personnel must be developed in order to ensure interagency coordination in the assessment and treatment of the drug-involved offender at various stages throughout the criminal justice continuum and in the development of referral procedures and reporting policies, as well as in understanding each system's definitions of success and failure.

Intermediate sanctions

Community-based programs providing increased surveillance, tighter controls on movement, more intense treatment for a wider assortment of maladies or deficiencies, increased offender accountability, and greater emphasis on payments to victims and/or corrections authorities. Intermediate sanctions are less punitive than incarceration but more punitive than simple probation. (See also **Sanctions**.)

Interpersonal issues

Those between the client and counselor in the therapeutic relationship. Includes boundaries, training, the need for peer role models and cultural sensitivity, respect for confidentiality and privacy, and the counselor's duty to report certain client crimes.

Intrapersonal issues

Those stemming from an individual's psychological makeup and/or physical conditions (including co-occurring disorders), as well as one's social skills, educational status, and personal support system.

Jail

A place for holding a person in lawful custody, usually while he or she is awaiting trial. In some jurisdictions, jails are used punitively for offenders serving short-term sentences or those involving work release or weekends in incarceration. Jails range in size from small rural ones with a dozen or so cells to urban settings with thousands of cells. Jails usually are operated by cities or counties.

Linkages

The provider establishes working relationships with various agencies and facilities in order to refer clients with multiple life problems to accessible, appropriate vocational training, medical, assisted living, and legal assistance services.

Management Information System (MIS)

A computer system that assists in organizing information for the purposes of planning and maintaining a business or other organization.

Mandatory release

Required release of an inmate from incarceration upon the expiration of a certain period, as stipulated by a determinate sentencing law or by parole guidelines.

Memorandum of understanding (MOU)

A written but noncontractual agreement between two or more agencies or other parties to take a certain course of action.

Methadone treatment

Medically supervised outpatient treatment that provides counseling while maintaining a client on the drug methadone (used mainly for heroin or other opioid addiction).

Monitoring for compliance

Surveillance of an offender to ensure that the conditions imposed on an individual are being adhered to.

Narcotics Anonymous

A self-help and support group similar to Alcoholics Anonymous.

National Treatment Plan Initiative

Developed by CSAT, this initiative is a blueprint for improving substance abuse treatment.

Negative predictive value

The proportion of offenders identified by a screening or assessment instrument as not

having substance abuse problems, compared to the total number not having substance abuse problems.

Nonfinancial conditions

Release requirements set by a judge that do not include monetary payment (e.g., required participation in supporting services, such as substance abuse treatment). (See also **Bail and Financial bail**.)

Nonresidential treatment of incarcerated people

In this form of treatment, prisoners receive treatment either through day care programs, regularly scheduled therapeutic groups, or other nonresidential programs.

"No Wrong Door"

This key component of CSAT's National Treatment Initiative indicates that no matter where they enter the health or social service system, people should be able to get treatment for substance abuse, either directly or through appropriate referral.

Offender Profile Index

A standardized assessment tool used to conduct a comprehensive drug evaluation and to match offenders' drug problems with treatment approaches. (See also **Addiction Severity Index**.)

On recognizance

Release on one's own responsibility (e.g., with an obligation to appear in court, but the release is not secured by financial bail).

Overall accuracy

The extent to which a screening or assessment instrument classifies respondents correctly.

Parole

The conditional release of an inmate from prison under supervision after part of a sentence has been served. The inmate is subject to specific terms and conditions which are monitored by an officer/agent.

Peer staff

Individuals in recovery from substance abuse disorders who have been trained for work in the treatment or criminal justice areas.

Personal bond

Release from court on one's own promise to appear in court, without financial conditions. Similar to release **on recognizance**.

Pharmacotherapies

Treatment of disease with drugs. In substance abuse treatment, these include methadone, naltrexone, and buprenorphine.

Placement

Assigning substance abuse treatment program participants with appropriate community substance abuse treatment facilities when such individuals leave the correctional facility at the end of a sentence or on parole.

Plea bargain

An agreement by a defendant to plead guilty to a criminal charge with the expectation of receiving some consideration from the prosecution for doing so. Typically the consideration is a reduction of the charge. The defendant's goal is a penalty lighter than the one warranted by the charged offense.

Positive predictive value

The proportion of offenders identified by a screening or assessment instrument as having substance abuse problems, compared to the total number having substance abuse problems.

Preliminary hearing

A court hearing in which initial information about the case is presented. This hearing usually is used to determine if there is sufficient evidence of guilt to continue the case, resolve evidentiary issues, or make initial case decisions.

Prerelease assessment

This information on an individual's situation/condition, as provided by treatment professionals, should be available to the judge, prosecutor, and other participants at the time of a presentence hearing or trial/sentencing. If an individual is paroled, the information should be conveyed to the parole officer for followup and evaluation. Recommendations for referral for treatment can be made at this time.

Presentence hearing

An event at which the prosecutor, defense attorney, and judge meet before a trial to establish parameters for that trial. A plea bargain is often negotiated at this point.

Presentence investigation

An investigation into the background and character of a defendant that assists the court in determining the most appropriate sentence in a case. Typically occurs after the person has been convicted, but prior to sentencing.

Pretrial hearing

Appearance in court before a magistrate, at which time bond is set or a determination is made to retain a person in jail or release him or her.

Pretrial stage

Activities in the criminal justice process that occur between arrest and trial.

Prison

A secured institution (Federal or State) in which convicted felons are confined after sentencing for crimes. Prisons are classified as minimum-, medium-, or maximum-security facilities, based on the need for internal institutional fortification. Inmates are similarly classified, according to severity of offense and/or other behavior and are usually assigned to prisons having a corresponding level of security.

Probation

A sentence in which the offender is allowed to remain in the community in lieu of incarceration. The individual is supervised and is ordered to comply with specific terms and conditions.

Problem-solving courts

These specialized court settings include drug courts, family courts, jail courts, and mental health courts.

Process evaluation

Determination of whether individuals actually received the treatment as it was intended to be delivered; examines implementation and operation of a program in comparison with the stated intent.

Protocol

Consists of guidelines and procedures for dealing with a particular issue or activity.

Psychopharmacology

The science dealing with the effect of medications in treating psychiatric conditions.

Recidivism

The commission of crime after an offender has been sentenced and/or released.

Re-entry formulation

The process of providing counseling and community-based supports to ex-offenders who abused substances and who are returning to society.

Relapse prevention

Strategy to train people with substance use disorders to cope more effectively and to overcome the stressors/triggers in their environments that may lead them back into drug use and dependency.

Reparation

(See **Restoration**.)

Residential treatment

Inpatient treatment, in which the client spends 24 hours a day in the treatment environment.

Restoration

Sometimes referred to as reparation, its aim is to restore the community to its state before a crime was committed. It does this in part by preventing the offender from reoffending through rehabilitation, incapacitation, or deterrence.

Restitution

Payment by an offender of the costs of a victim's losses or injuries and/or damages to the victim. Payment can be made to a general victim compensation fund or to the community as a whole (with the payment going to the municipal or State treasury).

Risk/needs assessment

A comprehensive report that includes a client's social, criminal, and other history. The report usually includes a recommendation for sentencing if the client is found guilty.

Sanctions

Legally binding orders of a court or paroling authority that deprive or restrict offender liberty or property. An **intermediate sanction** (see p. 296) is more rigorous than traditional probation but less so than total incarceration.

Screening

Gathering and sorting of information used to determine if an individual has a problem with substance abuse and, if so, whether a detailed clinical assessment is appropriate. (See also **Assessment**.)

Security classification (in criminal justice)

The process of assigning an inmate to a category based on the perceived likelihood of an offender's attempt at escape, propensity for violence, or management concerns.

Sensitivity

The extent to which a screening or assessment instrument accurately identifies those with substance use disorders (true positives).

Sentencing

The disposition of a case where penalties are imposed.

Skills training

This includes job and vocational skills, life skills (budgeting, leisure, etc.), literacy and GED classes, anger management, general coping skills, communication skills, parenting classes, building families and relationships, and social skills.

Sobering station

A 24-hour facility where individuals can be housed and monitored while under the influence of mood-altering substances.

Sobriety maintenance

The last step in recovery when the client has achieved stable sobriety and efforts are directed toward maintaining that stability.

Special-needs probation programs or caseloads

In these approaches to intermediate sanctions, officers with special training carry a restricted caseload. Typically, these approaches are used with offenders who have committed certain categories of domestic violence, sex offenses, and DUI, and with offenders who are mentally ill, developmentally disabled, or abuse substances. This situation can mean more intensive or intrusive supervision than in routine caseloads; enhanced social and psychological services; and/or specific training or group activities, such as anger management classes.

Specific populations

These include a wide range of people facing a wide range of issues—for example, racial/ethnic/sexual minorities and women, people with disabilities, older people, and those who are underserved or underrepresented in treatment. This term can also include violent offenders, sexual offenders, victims or perpetrators of domestic abuse, psychopaths, and offenders with life sentences.

Specificity

The extent to which a screening or assessment instrument accurately identifies those without substance use disorders (true negatives).

Split sentence

A sentence involving a short period of incarceration followed by probation or some other form of community supervision.

Stakeholders

Those who have a key interest/investment in an issue or activity—includes clients, treatment and criminal justice personnel, and policymakers.

Test-retest reliability

This quality of a screening or assessment instrument, expressed as a coefficient, is "obtained by administering the same test a second time to the same group after a time interval and correlating the two sets of scores" (American Educational Research Association 1999, p. 183).

Therapeutic community

Traditionally, this is a long-term (up to 24 months) rehabilitative model that relies mainly on peer staff and on work as education and therapy. Other staff include treatment and mental health professionals and vocational and educational counselors. The aim here is a global change in a person's lifestyle, focused on developing vocational, educational, and social skills. Most residents have been involved with the criminal justice system.

Treatment

Refers to the broad range of primary and supportive services—including identification, brief intervention, assessment, diagnosis, counseling, medical services, psychological services, and followup—provided for people with alcohol and illicit drug problems. The overall goal of treatment is to eliminate the use of alcohol and illicit drugs as a contributing factor to physical, psychological, and social dysfunction and to arrest, retard, or reverse progress of associated problems.

Treatment matching

Pairing clients with treatments and services that reflect their particular traits and needs in order to enhance the potential for better outcomes.

Treatment planning

The process of planning a client's total course of treatment, based on the findings of assessment procedures.

Treatment progress assessment

A process that determines the value of the chosen course of treatment, its suitability for the client, and how it should be extended or adjusted if necessary.

Triage

A process for sorting injured people into groups based on their need for medical treatment—in short, immediate attention and first-stage treatment for people with substance abuse disorders and others.

Trial

A court hearing at which a prosecutor presents a case against a 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. The judge or jury decides the verdict.

Unbroken contact

Early, thorough, and substantial substance abuse treatment delivered in an unbroken manner throughout the entire criminal case-handling process, from arrest through the completion of the sentence. The components of the system must transfer not only the offender but also the cumulative record of what the system has learned and what it has done.

Urinalysis

The testing of a urine sample for the presence of drugs.

Waiver

A court action in which the defendant agrees to forgo certain legal rights, such as the right to a grand jury hearing or the right to a speedy trial. The term is also used to indicate the transfer of a juvenile offender to the adult criminal justice system when he or she has been accused of committing certain serious crimes.

Work release

An alternative to total incarceration, whereby inmates are permitted to work for pay in the free community but must return to a secure facility during their nonworking hours. (See also **Halfway House**.)

Appendix C: Screening and Assessment Instruments

Addiction Severity Index (ASI)

Purpose: The ASI is most useful as a general intake screening tool. It effectively assesses a client's status in several areas, and the composite score measures how a client's need for treatment changes over time.

Clinical utility: The ASI has been used extensively for treatment planning and outcome evaluation. Outcome evaluation packages for individual programs or for treatment systems are available.

Groups with whom this instrument has been used: Designed for adults of both sexes who are not intoxicated (drugs or alcohol) when interviewed. Also available in Spanish.

Norms: The ASI has been used with males and females with drug and alcohol disorders in both inpatient and outpatient settings.

Format: Structured interview.

Administration time: 50 minutes to 1 hour.

Scoring time: 5 minutes for severity rating.

Computer scoring? Yes.

Administrator training and qualifications: A self-training packet is available as well as onsite training by experienced trainers.

Fee for use: No cost; minimal charges for photocopying and mailing may apply.

Available from:
A. Thomas McLellan, Ph.D.
Building 7
PVAMC
University Avenue
Philadelphia, PA 19104
Ph: (800) 238-2433

The Alcohol Use Disorders Identification Test (AUDIT)

Purpose: The purpose of the AUDIT is to identify persons whose alcohol consumption has become hazardous or harmful to their health.

Clinical utility: The AUDIT screening procedure is linked to a decision process that includes brief intervention with heavy drinkers or referral to specialized treatment for patients who show evidence of more serious alcohol involvement.

Groups with whom this instrument has been used: Adults, particularly primary care, emergency room, surgery, and psychiatric patients; DWI offenders, criminals in court, jail, and prison; enlisted men in the armed forces; workers in employee assistance programs and industrial settings.

Norms: Yes, heavy drinkers and people with alcohol use disorders.

Format: A 10-item screening questionnaire with 3 questions on the amount and frequency of drinking, 3 questions on alcohol dependence, and 4 questions on problems caused by alcohol.

Administration time: 2 minutes.

Scoring time: 1 minute.

Computer scoring? No.

Administrator training and qualifications: The AUDIT is administered by a health professional or paraprofessional. Training is required for administration. A detailed user's manual and a videotape training module explain proper administration, procedures, scoring, interpretation, and clinical management.

Fee for use: No.

Available from: Can be downloaded from Project Cork Web site: www.projectcork.org

Beck Depression Inventory–II (BDI–II)

Purpose: Used to screen for the presence and rate the severity of depression symptoms.

Clinical utility: Like its predecessor, the BDI–II consists of 21 items to assess the intensity of depression. The BDI-II can also be used as a screening device to determine the need for a referral for further evaluation. Each item is a list of four statements arranged in increasing severity about a particular symptom of depression. These new items bring the BDI–II into alignment with *Diagnostic and Statistical Manual for Mental Disorders, 4th edition* (DSM-IV) criteria.

Items on the new scale replace items that dealt with symptoms of weight loss, changes in body image, and somatic preoccupation. Another item on the BDI that tapped work difficulty was revised to examine loss of energy. Also, sleep loss and appetite loss items were revised to assess both increases and decreases in sleep and appetite. The BDI-II shows improved clinical sensitivity and higher reliability than the BDI.

Groups with whom this instrument has been used: All clients aged 13 through 80 who can read and understand the instructions and clients who cannot read (requires reading the statements to them).

Norms: The BDI has been used with people with substance use disorders, psychiatric patients, medical inpatients, and many other populations.

Format: Paper-and-pencil self-administered test.

Administration time: 5 minutes, either self-administered or administered verbally by a trained administrator.

Scoring time: N/A.

Computer scoring? No. Any staff member can perform the simple scoring.

Administrator training and qualifications: Doctoral-level training or master's-level training with supervision by a doctoral-level clinician are required to interpret test results.

Fee for use: $66 for manual and package of 25 record forms.

Available from: The Psychological Corporation
19500 Bulderve
San Antonio, TX 78259
Ph: (800) 872-1726
www.psychcorp.com

CAGE Questionnaire

Purpose: The purpose of the CAGE Questionnaire is to detect alcoholism.

Clinical utility: The CAGE Questionnaire is a very useful bedside, clinical desk instrument and has become the favorite of many family practice and general internists—also very popular in nursing.

Groups with whom this instrument has been used: Adults, adolescents (over 16 years).

Norms: Yes.

Format: Very brief, relatively nonconfrontational questionnaire for detection of alcoholism, usually beginning "have you ever" but which can be phrased to refer to past month or current behavior.

Administration time: Less than 1 minute.

Scoring time: Instantaneous.

Computer scoring? No.

Administrator training and qualifications: No training required for administration; it is easy to learn, easy to remember, and easy to replicate.

Fee for use: No.

Available from: May be downloaded from the Project Cork Web site
www.projectcork.org

Circumstances, Motivation, and Readiness Scales (CMR Scales)

Purpose: The instrument is designed to predict retention in treatment and is applicable to both residential and outpatient treatment modalities.

Clinical utility: The instrument consists of four derived scales measuring external pressure to enter treatment, external pressure to leave treatment, motivation to change, and readiness for treatment. Items were developed from focus groups of recovering staff and clients and retain much of the original language. Clients entering substance abuse treatment perceive the items as relevant to their experience.

Groups with whom this instrument has been used: Adults.

Norms: Norms are available from a large secondary analysis of more than 10,000 clients in referral agencies, methadone maintenance, drug-free outpatient and residential treatment. Norms are also available for specific populations, such as clients with COD, prison-based programs, and women's programs.

Format: 18 items at approximately a third-grade reading level. Responses to the items consist of a 5-point Likert scale on which the individual rates each item on a scale from Strongly Disagree to Strongly Agree. Versions are also available in Spanish and Norwegian.

Administration time: 5 to 10 minutes.

Scoring time: Can be easily scored by reversing negatively worded items and summing the item values.

Computer scoring? No.

Administrator training and qualifications: Self-administered; no training required for administration.

Fee for use: N/A.

Available from:

George De Leon, Ph.D., or
Gerald Melnick, Ph.D.
National Development and Research Institutes, Inc.
71 West 23rd Street
8th Floor
New York, NY 10010
Ph: (212) 845-4400
Fax: (917) 438-0894
E-mail:
gerry.melnick@ndri.org
www.ndri.org

The Drug Abuse Screening Test (DAST)

Purpose: The purpose of the DAST is (1) to provide a brief, simple, practical, but valid method for identifying individuals who are abusing psychoactive drugs; and (2) to yield a quantitative index score of the degree of problems related to drug use and misuse.

Clinical utility: Screening and case finding; level of treatment and treatment/goal planning.

Groups with whom this instrument has been used: Individuals with at least a sixth grade reading level.

Norms: Yes. A normative sample consisting of 501 patients, representative of those applying for treatment in Toronto, Canada.

Format: A 20-item instrument that may be given in either a self-report or in a structured interview format; a "yes" or "no" response is requested from each of 20 questions.

Administration time: 5 minutes.

Scoring time: N/A.

Computer scoring? No. The DAST is planned to yield only one total or summary score ranging from 0 to 20, which is computed by summing all items that are endorsed in the direction of increased drug problems.

Administrator training and qualifications: For a qualified drug counselor, only a careful reading and adherence to the instructions in the "DAST Guidelines for Administration and Scoring," which is provided, is required. No other training is required.

Fee for use: The DAST form and scoring key are available either without cost or at nominal cost.

Available from:

Centre for Addiction and Mental Health Marketing and Sales Services
33 Russell Street
Toronto, Ontario, Canada
M5S 2S1
Ph: (800) 661-1111
(Continental North America)
International and Toronto area: (416) 595-6059

Michigan Alcoholism Screening Test (MAST)

Purpose: Used to screen for alcoholism with a variety of populations.

Clinical utility: A 25-item questionnaire designed to provide a rapid and effective screen for lifetime alcohol-related problems and alcoholism.

Groups with whom this instrument has been used: Adults.

Norms: N/A.

Format: Consists of 25 questions.

Administration time: 10 minutes.

Scoring time: 5 minutes.

Computer scoring? No.

Administrator training and qualifications: No training required.

Fee for use: Fee for a copy, no fee for use.

Available from: Melvin L. Selzer, M.D.
6967 Paseo Laredo
La Jolla, CA 92037-6425

Structured Clinical Interview for DSM-IV Disorders (SCID)

Purpose: Obtains Axis I and II diagnoses using the DSM-IV diagnostic criteria for enabling the interviewer to either rule out or to establish a diagnosis of "drug abuse" or "drug dependence" and/or "alcohol abuse" or "alcohol dependence."

Clinical utility: A psychiatric interview.

Groups with whom this instrument has been used: Psychiatric, medical, or community-based normal adults.

Norms: No.

Format: A psychiatric interview form in which diagnosis can be made by the examiner asking a series of approximately 10 questions of a client.

Administration time: Administration of Axis I and Axis II batteries may require more than 2 hours each for patients with multiple diagnoses. The Psychoactive Substance Use Disorders module may be administered by itself in 30 to 60 minutes.

Scoring time: Approximately 10 minutes.

Computer scoring? No.

Administrator training and qualifications: Designed for use by a trained clinical evaluator at the master's or doctoral level, although in research settings it has been used by bachelor's-level technicians with extensive training.

Fee for use: Yes.

Available from: American Psychiatric Publishing, Inc.
1400 K Street, N.W.
Washington, DC 20005
www.appi.org/

University of Rhode Island Change Assessment (URICA)

Purpose: The URICA operationally defines four theoretical stages of change—precontemplation, contemplation, action, and maintenance—relevant to change of a "problem" determined by the subjects, each assessed by eight items. For an alcohol problem population, a 28-item version with 7 items per subscale is available.

Clinical utility: Assessment of stages of change/readiness construct can be used as a predictor of treatment and outcome variables.

Groups with whom this instrument has been used: Both inpatient and outpatient adults.

Norms: Yes, for outpatient alcoholism treatment population.

Format: The URICA is a 32-item inventory designed to assess an individual's stage of change, located along a continuum of change, in people who abuse alcohol or drugs.

Administration time: 5 to 10 minutes to complete.

Scoring time: 4 to 5 minutes.

Computer scoring? Yes, computer-scannable forms.

Administrator training and qualifications: N/A

Fee for use: No; instrument is in the public domain. Available from author.

Available from: Carlo C. DiClemente
University of Maryland
Psychology Department
1000 Hilltop Circle
Baltimore, MD 21250
Ph: (410) 455-2415

Appendix D: Resource Panel

Linell P. Broecker, M.S.W.
Senior Prevention Programs Manager
Demand Reduction Section
Drug Enforcement Administration
Washington, DC

Patrick Coleman
Deputy Director
Bureau of Justice Assistance
Washington, DC

Cathi Coridan, M.A.
Senior Director for Substance Abuse Programs and Policy
National Mental Health Association
Alexandria, Virginia

Gloria Danzinger
Staff Director
Standing Committee on Substance Abuse
American Bar Association
Washington, DC

Peter J. Delany, D.S.W.
Deputy Director
Division of Epidemiology, Services and Prevention Research
National Institute on Drug Abuse
Bethesda, Maryland

Jennifer Kay Edwards, M.A.
Assistant to the Deputy Director
Corrections Program Office
U.S. Department of Justice
Washington, DC

Jerry P. Flanzer, D.S.W., LCSW, CAC
Chief
Services Research Branch
National Institute on Drug Abuse
Bethesda, Maryland

Irene Gainer
Executive Director
Treatment Accountability for Safer Communities
Arlington, Virginia

R.J. Gregrich, M.S.
Chief
Treatment Branch
Office of Demand Reduction
Office of National Drug Control Policy
Washington, DC

Stephen J. Ingley
Executive Director
American Jail Association
Hagerstown, Maryland

Jane E. Kennedy, M.P.A., CDP
Executive Director
Treatment Alternatives to Street Crime
Seattle, Washington

Bruce R. Lorenz, B.S., CADC, NCAC II
Director
Thresholds, Inc.
Georgetown, Delaware

Cranston Mitchell
Correctional Program Specialist
Community Corrections Division
National Institute of Corrections
Washington, DC

Stacia Murphy
President
National Council on Alcoholism and Drug Dependence
New York, New York

Madeline Ortiz
Corrections Program Specialist
Prisons Division
National Institute of Corrections
Washington, DC

Marjorie A. Rock, Dr.P.H.
Associate Professor
Ehrenkranz School of Social Work
New York University
New York, New York

Erik J. Roskes, M.D.
Director
Forensic Treatment and Correctional Services
School of Medicine
Springfield Hospital Center
Sykesville, Maryland

Susan E. Salasin
Director
Mental Health and Criminal Justice Program
Center for Mental Health Services
Rockville, Maryland

Mary K. Shilton
Executive Director
National Treatment Accountability for Safer Communities
Washington, DC

Audrey Wright Spolarich
Health Policy Analysts, Inc.
Washington, DC

Patrick H. Tarr, Ph.D.
Senior Policy Advisor
Office of Policy Development
U.S. Department of Justice
Washington, DC

Jennifer Taussig, M.P.H.
Health Scientist
Centers for Disease Control and Prevention
Atlanta, Georgia

Vicky Verdeyen
Psychology Administrator
Bureau of Prisons
Department of Justice
Washington, DC

Beth A. Weinman, M.A.
National Drug Abuse Treatment Coordinator
Federal Bureau of Prisons
Department of Justice
Washington, DC

Steve Wing
Senior Advisor for Drug Policy
Office of Policy and Program Coordination
Substance Abuse and Mental Health Services Administration
Rockville, Maryland

Appendix E: Cultural Competency and Diversity Network Participants

Elmore T. Briggs, CCDC, NCAC II
Program Manager
Adolescent Recovery Center
Vanguard Services Unlimited
Arlington, Virginia
African American Workgroup

Deion Cash
Executive Director
Community Treatment & Correction Center, Inc.
Canton, Ohio
African American Workgroup

E. Bernard Anderson, Jr., M.S., M.A., NCAC, ICADC, CCS
Regional Administrator
Correctional Treatment
Florida Addictions and Correctional Treatment Services, Inc.
Tallahassee, Florida
LGBT Workgroup

Richard T. Suchinsky, M.D.
Associate Director for Addictive Disorders and Psychiatric Rehabilitation
Mental Health and Behavioral Sciences Services
Department of Veterans Affairs
Washington, DC
Disabilities Workgroup

Appendix F: Special Consultants

Gary Field, Ph.D.
Administrator
Counseling and Treatment Services Correctional Programs
Oregon Department of Corrections
Salem, Oregon

Thomas J. Tobin, Ph.D.
Chief Executive Officer/Co-Founder
The SHARP Program
Orinda, California

Appendix G: Field Reviewers

Robert B. Auckerman, M.S.W.
Program Services Consultant
Littleton, Colorado

Joanne Barnett, M.Ed., LPC, LADC, CCS, CDP, MAC, CCJS
Addiction Services Coordinator
Community Partners in Action
Hartford, Connecticut

Sonya Brown
State TASC Director
Division of Mental Health
Developmental Disabilities and Substance Abuse Services, DHHS
Raleigh, North Carolina

Barry S. Brown, Ph.D.
Adjunct Professor
University of North Carolina at Wilmington
Carolina Beach, North Carolina

Eddie Canterbury, LCSW, BCSAC
Social Worker Specialist—LCSW
Rapides Adult Drug Treatment Court
Alexandria, Louisiana

Redonna Chandler, Ph.D.
Health Scientist Administrator
Services Research Branch
National Institute on Drug Abuse
Bethesda, Maryland

Laura Choate
Manager
Office of Drug Court Programs
California Department of Alcohol and Drug Programs
Sacramento, California

Richard Craig, Ph.D.
Director of Research
Patuxent Institution
Jessup, Maryland

George De Leon, Ph.D.
Director
Center for Therapeutic Community Research
National Development and Research Institutes, Inc.
New York, New York

David Farabee
Research Psychologist
UCLA Integrated Substance Abuse Programs
Los Angeles, California

Kathleen J. Farkas, Ph.D., LISW
Mandel School of Applied Social Sciences
Case Western Reserve University
Cleveland, Ohio

Jerry P. Flanzer, D.S.W., LCSW, CAC
Chief
Services Research Branch
National Institute on Drug Abuse
Bethesda, Maryland

Richard S. Gebelein
Judge
Superior Court of Delaware
Wilmington, Delaware

Bobby G. Greer, Ph.D., LPC, CCRC
Memphis, Tennessee

Hendree E. Jones, Ph.D.
Assistant Professor
CAP Research Director
Department of Psychiatry and Behavioral Sciences
Johns Hopkins University Center
Baltimore, Maryland

Margaret Williams Kherlopian
Coordinator of Criminal Justice Programs
South Carolina Department of Alcohol and Other Drug Abuse Services
Columbia, South Carolina

Kevin Knight, Ph.D.
Research Scientist
Texas Christian University
Fort Worth, Texas

Jeffrey N. Kushner, M.A., M.H.R.A.
Drug Court Administrator
Municipal Court of Saint Louis
Saint Louis, Missouri

Gerald Melnick, Ph.D.
Senior Principal Investigator
National Development and Research Institutes, Inc.
New York, New York

Ethan Nebelkopf, Ph.D., MFCC
Clinic Director
Family and Child Guidance Center
Native American Health Center
Oakland, California

Michael L. Prendergast, Ph.D.
Director
Criminal Justice Research Group
UCLA Integrated Substance Abuse Programs
Los Angeles, California

JoAnn Y. Sacks, Ph.D.
Principal Investigator
National Development and Research Institutes
New York, New York

Robert Philip Schwartz, M.D.
Medical Director
Friends Research Institute
Baltimore, Maryland

Elizabeth Simoni, J.P.
Executive Director
Maine Pretrial Services, Inc.
Portland, Maine

Elizabeth Stanley-Salazar
Vice President
Director of Public Policy
Phoenix Houses of California
Lake View Terrace, California

Richard E. Steinberg, M.S.
President/Chief Executive Officer
WestCare Foundation, Inc.
Las Vegas, Nevada

Pamela D. Stokes, M.S.M.
Program Analyst
National Association of State Alcohol and Drug Abuse Directors, Inc.
Washington, DC

Richard T. Suchinsky, M.D.
Associate Director for Addictive Disorders and Psychiatric Rehabilitation
Mental Health and Behavioral Sciences Services
Department of Veterans Affairs
Washington, DC

Anne Swern
Counsel to the District Attorney of Kings County
Kings County District Attorney, Charles J. Hynes
Brooklyn, New York

Faye S. Taxman, Ph.D.
Director
Bureau of Governmental Research
University of Maryland
College Park, Maryland

Angel Velez, CASAC
Addiction Program Specialist-II
New York State Office of Alcohol and Substance Abuse Services
New York, New York

Pogos H. Voskanian, M.D.
Huntingdon Valley, Pennsylvania

Robert Walker, M.S.W., LCSW
Assistant Professor
Center on Drug and Alcohol Research
University of Kentucky
Lexington, Kentucky

Suzanne L. Wenzel, Ph.D.
Behavioral Scientist
RAND
Santa Monica, California

Karen M. Wheeler
Program and Policy Development Specialist
Office of Mental Health and Addiction Services
Salem, Oregon

Dorian L. Wingard, B.A., CCDC
Education Coordinator
Chair Education Committee
Education Resource Center
Steven's House Residential Treatment Center for Adolescents
A House of Hope, Inc. Program
Columbus, Ohio

Edie Wooldridge, B.A., CADC II
Program Manager
InterChange Treatment Program
Multnomah County Department of Community Justice
Hillsboro, Oregon

Buck Zeller
RCE Director, TASC
Region IV
Blue Ridge Center
Asheville, North Carolina

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Because the entire volume is about substance abuse treatment for adults in the criminal justice system, the use of these terms as entry points has been minimized in this index. Commonly known acronyms are listed as main headings. Page references for information contained in figures appear in *italics*.

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CSAT TIPs and Publications Based on TIPs

What Is a TIP?

Treatment Improvement Protocols (TIPs) are the products of a systematic and innovative process that brings together clinicians, researchers, program managers, policymakers, and other Federal and non-Federal experts to reach consensus on state-of-the-art treatment practices. TIPs are developed under CSAT's Knowledge Application Program to improve the treatment capabilities of the Nation's alcohol and drug abuse treatment service system.

What Is a Quick Guide?

A Quick Guide clearly and concisely presents the primary information from a TIP in a pocket-sized booklet. Each Quick Guide is divided into sections to help readers quickly locate relevant material. Some contain glossaries of terms or lists of resources. Page numbers from the original TIP are referenced so providers can refer back to the source document for more information.

What Are KAP Keys?

Also based on TIPs, KAP Keys are handy, durable tools. Keys may include assessment or screening instruments, checklists, and summaries of treatment phases. Printed on coated paper, each KAP Keys set is fastened together with a key ring and can be kept within a treatment provider's reach and consulted frequently. The Keys allow you—the busy clinician or program administrator—to locate information easily and to use this information to enhance treatment services.

TIP 1 **State Methadone Treatment Guidelines**—Replaced by TIP 43

TIP 2* **Pregnant, Substance-Using Women**— *BKD107*
Quick Guide for Clinicians *QGCT02*
KAP Keys for Clinicians *KAPT02*

TIP 3 **Screening and Assessment of Alcohol- and Other Drug-Abusing Adolescents**—Replaced by TIP 31

TIP 4 **Guidelines for the Treatment of Alcohol- and Other Drug-Abusing Adolescents**—Replaced by TIP 32

TIP 5 **Improving Treatment for Drug-Exposed Infants**—*BKD110*

TIP 6 **Screening for Infectious Diseases Among Substance Abusers**—*BKD131*
Quick Guide for Clinicians *QGCT06*
KAP Keys for Clinicians *KAPT06*

TIP 7 **Screening and Assessment for Alcohol and Other Drug Abuse Among Adults in the Criminal Justice System**—Replaced by TIP 44

TIP 8* **Intensive Outpatient Treatment for Alcohol and Other Drug Abuse**—*BKD139*

TIP 9 **Assessment and Treatment of Patients With Coexisting Mental Illness and Alcohol and Other Drug Abuse**—Replaced by TIP 42

TIP 10 **Assessment and Treatment of Cocaine-Abusing Methadone-Maintained Patients**—Replaced by TIP 43

TIP 11 **Simple Screening Instruments for Outreach for Alcohol and Other Drug Abuse and Infectious Diseases**— *BKD143*
Quick Guide for Clinicians *QGCT11*
KAP Keys for Clinicians *KAPT11*

TIP 12 **Combining Substance Abuse Treatment With Intermediate Sanctions for Adults in the Criminal Justice System**—Replaced by TIP 44

TIP 13 **Role and Current Status of Patient Placement Criteria in the Treatment of Substance Use Disorders**—*BKD161*
Quick Guide for Clinicians *QGCT13*
Quick Guide for Administrators *QGAT13*
KAP Keys for Clinicians *KAPT13*

TIP 14 **Developing State Outcomes Monitoring Systems for Alcohol and Other Drug Abuse Treatment**—*BKD162*

TIP 15 **Treatment for HIV-Infected Alcohol and Other Drug Abusers**—Replaced by TIP 37

TIP 16 **Alcohol and Other Drug Screening of Hospitalized Trauma Patients**—*BKD164*
Quick Guide for Clinicians *QGCT16*
KAP Keys for Clinicians *KAPT16*

TIP 17 **Planning for Alcohol and Other Drug Abuse Treatment for Adults in the Criminal Justice System**—Replaced by TIP 44

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TIP 26 **Substance Abuse Among Older Adults—** *BKD250*

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See companion products for TIP 32.

TIP 32 **Treatment of Adolescents With Substance Use Disorders—***BKD307*

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TIP 33 **Treatment for Stimulant Use Disorders—***BKD289*

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TIP 36 **Substance Abuse Treatment for Persons With Child Abuse and Neglect Issues—***BKD343*

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Helping Yourself Heal: A Recovering Woman's Guide to Coping With Childhood Abuse Issues—*PHD981*

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Substance Abuse Treatment
For Adults in the Criminal Justice System

This TIP, *Substance Abuse Treatment for Adults in the Criminal Justice System*, revises and supersedes TIP 7, *Screening and Assessment for Alcohol and Other Drug Abuse Among Adults in the Criminal Justice System*, TIP 12, *Combining Substance Abuse Treatment With Intermediate Sanctions for Adults in the Criminal Justice System*, and TIP 17, *Planning for Alcohol and Other Drug Abuse Treatment for Adults in the Criminal Justice System*. The revised TIP provides the current clinical evidence-based guidelines, tools, and resources necessary to help substance abuse counselors treat clients involved with the criminal justice system.

Collateral Products
Based on TIP 44

Quick Guide for Clinicians
KAP Keys for Clinicians

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