



Drug Treatment in the Criminal Justice System: The Current State of Knowledge

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This report is one of an Urban Institute four-part series on drug treatment in the criminal justice system:

Drug Treatment in the Criminal Justice System: The Current State of Knowledge

by Daniel P. Mears, Laura Winterfield, John Hunsaker, Gretchen E. Moore, and Ruth M. White

Voices from the Field: Practitioners Identify Key Issues in Corrections-Based Drug Treatment

by Gretchen E. Moore and Daniel P. Mears

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Executive Summary

Only 61 percent of state correctional facilities provide substance abuse treatment. Notwithstanding a significant infusion of federal funds to support residential substance abuse treatment in prisons, the percentage of state prisoners participating in such programs has declined from 25 percent in 1991 to 10 percent in 1997. The policy shortfall is clear: Prisoners are not getting the drug treatment programs that would reduce their drug abuse and criminal behavior.

It is clear that we need to understand what happens as correctional agencies bring drug treatment into their systems. There are, perhaps, conflicting expectations, systems constraints, and philosophies. There are yet-to-be-specified roles that federal agencies might play to assist the integration of treatment into corrections.

The goal of this collaboration between the Urban Institute and the National Institute on Drug Abuse was to help inform the development of a research agenda that can address the unique circumstances of the criminal justice environment and the challenges posed by the integration of treatment services and a public health orientation into this environment.

To help achieve this goal, this report presents results from a review of the literature for six different dimensions bearing on drug treatment in the criminal justice correctional system. These dimensions are:

- prevalence of drug abuse needs,
- screening and assessment,
- treatment programs and approaches,
- treatment effectiveness,
- linkages to post-release supervision, and
- barriers to implementing drug treatment.

The literature reviews necessarily were broad in scope. The aim was to highlight research findings, issues, and gaps most relevant to developing research-based strategies for promoting and developing effective correctional drug treatment approaches.

Incarceration Trends

- Incarceration trends among states and in the federal prison system increased dramatically throughout the past two decades, with a growth of 240 percent in the incarceration rate between 1980 and 1999 to almost 500 per 100,000 residents.
- The state and federal prison system nearly quadrupled over a 20-year time span, from 320,000 in 1980 to 1.3 million in 1999, with 1,179,214 inmates in state prisons and 131,496 inmates in federal prisons.
- Incarceration of drug offenders was by far the leading cause of increased correctional populations, accounting for 33 percent of the overall prison growth between 1980 and 1999.
- In 1980, the drug incarceration rate was 15 per 100,000 adults, but by 1996, the rate had increased to 148, representing approximately a 900 percent increase in a 17-year period.
- The increased drug incarceration rate was largely attributable to increases in drug arrests and to increased incarceration of those arrested for drug offenses. Approximately one-third of the growth in drug incarceration was due to increased arrests, and the remaining two-thirds to increases in the conversion of drug arrests into prison sentences.
- Growth in the incarceration of drug offenders does not necessarily indicate increased demand for drug treatment, but highlights the increasing role of drugs in corrections and the broader context in which drug treatment endeavors are situated.

Expenditure Trends

- Federal, state, and local expenditures on corrections grew by more than 400 percent from 1982 to 1997, from approximately \$10 billion to \$45 billion. Expenditures steadily increased for much of the 1980s, before rising more rapidly during the 1990s.
- Incarceration trends were driven primarily by increased drug incarceration rates, thus the increase in correctional expenditures represents a significant investment in the incarceration of drug offenders.
- Consistent and accurate estimates of expenditures on treatment, especially for drug treatment, are not readily available. However, estimates compiled by the Center on Addiction and Substance Abuse indicate that in 1996 less than 5 percent of state prison budgets went toward drug treatment, and that less than 1 percent (\$25 million) of the federal prison budget was targeted for drug treatment, including drug abuse education, residential counseling services, and community transitional services.
- Aggregate prevalence estimates mask considerable variation among states. For example, some states report spending less than 1 percent of their correctional budget on treatment, while others report spending up to 22 percent. Many states are not able to separate inmate programming costs from general operations expenditures.
- On a national level, over \$3 billion in funds went to drug treatment in 2000, compared with \$2 billion to drug prevention and \$9 billion to the criminal justice system.
- If international drug control efforts, interdiction, research, and intelligence are included, over \$18 billion was spent on drug control efforts in 2000.

Prevalence of Drug Use

Arrests

- The Arrestee Drug Abuse Monitoring (ADAM) Program indicates that at least 50 percent of adult male arrestees test positive for at least one of the NIDA-5 drugs (cocaine, marijuana, methamphetamine, opiates, PCP), with higher prevalence rates for certain sites (e.g., 77 percent in San Antonio).

Jails

- Among jail inmates in 1996, 74 percent reported past drug involvement, as defined by regular use of drugs, receipt of drug treatment, intravenous use of drugs, and being sentenced for past drug offenses.
- Among convicted jail inmates in 1996 using drugs in the month prior to arrest, 37 percent used marijuana or hashish, 24 percent used cocaine or crack cocaine, 10 percent used stimulants, 9 percent used heroin or opiates, 6 percent used depressants, 5 percent used hallucinogens, and 1 percent used inhalants. Thirty-six percent reported using drugs at the time of their offense.
- Among jail inmates tested for drugs in 1998, 10 percent tested positive for use of one or more drugs.
- Half of all jail inmates in the United States in 1998 were in jails that test for drug use.

State and Federal Prisons

- Few reliable estimates of the prevalence of drug use, drug abuse, and drug dependency/addiction in jails and state and federal prisons exist. In one study, state officials estimated that 70 to 85 percent of their inmates needed drug treatment, and the Federal Bureau of Prisons has estimated that in 1996, 31 percent of their inmates needed treatment.
- In 1997, 83 percent of state and federal inmates reported ever using any drugs—77 percent for marijuana/hashish, 49 percent for cocaine/crack, 29 percent for hallucinogens, 28 percent for stimulants, 25 percent for heroin/opiates, 24 percent for depressants, and 14 percent for inhalants.

- In 1997, 57 percent of state and federal inmates reported using drugs in the past month—39 percent for marijuana/hashish, 25 percent for cocaine/crack, 9 percent for heroin/opiates, 9 percent for stimulants, 5 percent for depressants, 4 percent for hallucinogens, and 1 percent for inhalants.
- In 1997, 33 percent of state and federal inmates reported using drugs at the time of their offense.

Drug Abuse and Drug Dependency Disorders

- Few studies systematically provide a rigorous assessment of the prevalence in correctional facilities of drug abuse and drug dependency/addiction disorders, as defined by the American Psychological Association's Diagnostic Statistical Manual, fourth edition (DSM-IV).
- A Bureau of Prisons study conducted in 1991 indicated that 20.9 percent of inmates met the criteria for drug abuse disorder and 30.8 percent for drug dependency disorder, for a combined prevalence of 51.7 percent having either type of disorder.
- The importance of distinguishing between self-reported drug use and clinically defined substance use disorders—such as drug abuse disorder and drug dependency disorder—lies in the fact that self-reported accounts of prior drug use likely overestimate the need for drug treatment. However, there increasingly is evidence that not all individuals are equally likely to become addicted after initial use of a drug. Such dispositions or risks may be reflected in self-reported use statistics, especially those focusing on drug use in the month prior to arrest or at the time of the offense. However, at present, it remains unknown whether or to what extent this is true and, more generally, whether and to what extent self-report statistics overestimate the prevalence of drug addiction.

Drug Treatment in Corrections

- There are few precise estimates of drug treatment in correctional settings. In one study conducted in 1996 by the Center on Addiction and Substance Abuse, state officials estimated that while 70 to 85 percent of their inmates needed drug treatment, only 13 percent received any. By contrast, the Federal Bureau of Prisons estimated that while 31 percent of their inmates needed treatment, only 10 percent actually received any.
- According to a national survey of state and federal prison inmates by the Bureau of Justice Statistics, 24 percent of state and federal inmates participated in some type of alcohol treatment or program in 1997. In that same year, 9.7 percent (101,200) of state prison inmates received drug treatment after admission, down from 24.5 percent (169,700) in 1991. Among federal prison inmates in 1997, 9.2 percent (8,100) received drug treatment, a decline from 15.7 percent (8,300) in 1991.
- Of inmates receiving drug treatment in state or federal prisons, approximately half were placed in residential facilities and the other half received counseling, with a small fraction receiving any type of maintenance drug therapy.
- Using recent prison survey data from the Bureau of Justice Statistics, a conservative estimate is that 150,000 inmates in 1997 needed drug treatment but did not receive it. A more realistic and less conservative estimate is that 420,000 inmates needed some form of drug treatment but did not receive it. A more liberal estimate, based on the questionable assumption that 75 percent of the state prison population requires drug treatment in any given year, is that 680,000 inmates needed but did not receive drug treatment in 1997.
- Whether the more conservative or liberal estimates of the treatment need/service gap are relied upon, there is a clear indication that many prison inmates who need treatment are not receiving it. This gap persists and has been increasing despite a considerable infusion of federal dollars into substance abuse treatment. Yet even with such infusions, in absolute numbers, state prisons have decreased drug treatment for inmates, with those receiving drug treatment declining from 169,700 inmates in 1991 to 101,200 inmates in 1997. The decline is significant because it stands in contrast to data indicating that state and federal correctional facilities operating as alcohol/drug treatment institutions rose from 92 in 1990 to 192 in 1995, and that 97 percent of correctional facilities offer drug and alcohol counseling.

Public Support for Drug Treatment

- Public concern about drug abuse peaked during the late 1980s and then subsequently and dramatically returned to considerably lower levels. In 1989, 38 percent of the American public viewed drug abuse as the single most important problem facing the country. A decade later, only 5 percent of the public expressed this view.

Key Research Questions

- Among newly sentenced offenders, how widespread is the need for drug treatment of various kinds? That is, what is the prevalence not only of drug use, but of drug abuse and drug dependency/addiction, for specific types of drugs (heroin, cocaine/crack, alcohol, etc.)?
- What precisely is the gap between treatment need and services in jails and prisons?
- Which types of drug treatment services are most prevalent and why?
- How does the extent of drug abuse/addiction among prisoners compare with other problems, such as lack of education or vocational training, or mental or physical illness?
- What factors determine which offender services are funded?

Screening and Assessment in the Criminal Justice System

- Screening and assessment are separate processes to evaluate an offender's risks, treatment needs, and, if appropriate, a treatment plan. The screening process is a short initial determination of whether a potential problem, such as drug abuse, exists and merits further investigation. The assessment process follows screening and is an in-depth process, often taking several hours and involving professionals trained in assessing specific issues. The goals for screening include:
 - Determine the presence of substance abuse, mental health disorder, and medical conditions.
 - Define major areas of strengths and deficits.
 - Screen out persons with no identifiable problems.
 - Identify individuals with a history of violent offenses/behavior.
 - Identify environmental factors (e.g., residential stability, relationship issues) or other problems (e.g., mental disorders, cognitive deficits) that may undermine success in treatment.
 - Identify minimum level of security or supervision needed to promote public safety.
 - Identify motivation for participation.
 - Identify perceived benefits as well as disadvantages of participation in the program.
- The goals for assessment include:
 - Examine the scope and nature of substance abuse problems.
 - Identify specific psychosocial problems to be addressed in treatment, including mental health disorders.
 - Understand the impact substance abuse has had on the individual, including its influence on criminal involvement.
 - Determine the client's level of maturation and readiness for treatment.
 - Identify specific physical problems to be addressed in treatment planning.
 - Identify the full range of service needs, pursuant to treatment planning.
 - Match participants to particular services.
- Screening and assessment should happen at the earliest point in the criminal justice system because it can help guide the decisionmaking process, including deciding whether a diversionary program, such as a drug court or probation with intermediate treatment sanctions, is appropriate.
- A variety of techniques is needed for a successful screening and assessment process, including actuarial instruments; archival material, such as criminal justice records, previous treatment records, and drug test results; and observation.
- Screening and assessment is not a static process; rather, it involves a continuous process of assessment, interventions, evaluations, and feedback loops throughout the criminal justice system.
- A continuous process of assessment can greatly enhance the overall efficiency and efficacy of criminal justice operations and ensure that treatment efficacy is enhanced. There are several components to this continuous process.
 - Treatment needs assessments should be in place to determine what type of programmatic intervention is appropriate, including long-term or short-term residential treatment, intensive or moderate outpatient treatment, chemical detoxification, etc. In this capacity, needs assessment acts as a type of sorting mechanism.
 - Readiness for treatment assessments should be implemented to understand better the extent to which clients are motivated for treatment and whether they are likely to benefit from the services offered to them.
 - Comprehensive treatment planning assessments should occur once a client reaches a program to determine how intensive the treatment should be and the areas on which it should focus.
 - Treatment progress assessments should be undertaken periodically to determine whether clients are responding to treatment and whether changes in the intervention should be considered.
 - Treatment outcome assessments are critical to determine the extent of behavioral change, success, and failure.

Screening and Assessment Instruments and Treatment Effectiveness

- There currently are three generations of assessments. First-generation assessments refer to “gut feelings” or clinical judgments; they generally fare poorly at predicting offender risk. Second-generation assessments represent an improvement because they are tested standardized instruments; however, they predominately capture historic and unchangeable information. Third-generation assessments include dynamic, or changeable, factors and measure offender need in a standardized way. Many departments still use first-generation assessments.
 - Instruments are most effective when the information garnered from them is used for client matching and treatment planning. For example, research has shown that clients appropriately matched to treatment are more motivated than those placed in any available program; they stay longer, experience fewer negative discharges, and perform better on a range of outcomes. Information gathered in the risk, needs, and psychological assessments can be used for this type of matching.
 - An ideal approach to treatment includes an assessment of risk predictors, criminogenic needs, and a psychological assessment with a focus on responsivity, exercising discretion and judgment when appropriate.
 - There are population subgroups—especially women, offenders with co-occurring disorders, and offenders with infectious diseases such as HIV/AIDS—who have special assessment issues and treatment implications. It is important to identify these groups and assess their specific needs and how they can best be addressed.
 - Assessment instruments should be standardized and tested, as well as reliable and valid. Unreliable and invalid instruments result in misidentification of both those who need treatment and those who do not.
 - Few studies have compared the effectiveness of screening instruments. One study indicates that the most effective instruments in screening for substance abuse are:
 - Combined Alcohol Dependence Scale (ADS) and Addiction Severity Index (ASI) instruments
 - Texas Christian University Drug Dependence (TCUDD) Screen
 - Simple Screening Instrument (SSI)
- Several instrument combinations work best when screening for co-occurring disorders:
- either the Brief Symptom Inventory (BSI) or the Referral Decision Scale (RDS) to address mental health symptoms
- AND**
- either the TCCUD Screen, SSI, or the combination of the ADS/ASI-Drug Use section to address substance abuse symptoms.
- Several instrument combinations work best when assessing for co-occurring disorders:
- either the Minnesota Multiphasic Personality Inventory-2 (MMPI-2), the Millon Clinical Multiaxial Inventory-III (MCMI-III), or the Personality Assessment Inventory (PAI) to examine mental health disorders
- AND**
- the Addiction Severity Index (ASI) to examine areas related to substance abuse.
- Offender information should be linked and shared throughout the criminal justice and substance abuse treatment systems to increase efficiency, aid in analysis and management tasks, and create then carry out effective treatment plans. However, confidentiality laws must be recognized. In addition, agencies must adhere to laws regulating inter-agency communication, and offenders must sign consent forms at each stage of the criminal justice system.

Assessment Practices

- A 1997 Survey of Correctional Facilities (SAMHSA 2000) found that 63.6 percent of jails, 67.1 percent of state prisons, and 86.8 percent of federal prisons provide assessment for treatment need.
- State assessment procedures can vary from state to state and within states. There is little coordinated or standardized information about state-specific assessment tools and procedures. The Federal Bureau of Prisons has a standardized intake and assessment process, using the American Psychological Association's Diagnostic Statistical Manual-IV (1994).

Barriers to Effective Screening and Assessment

Administrative and System Issue Impede Assessment

- Multiple and redundant assessments are conducted at various stages of processing.
- Time constraints prevent conducting screening and assessments.
- Information is collected that is not used.
- Staff are not trained adequately on the administration and use of screening and assessment instruments.
- Criminal justice personnel may lack familiarity with mental health and/or substance abuse disorders.
- There may be limited time and resources for codifying existing information, transferring it to various parts of the criminal justice system, or easily accessing existing information.

Inappropriate Use of Assessment Instruments

- Staff may not complete and use screening and assessment instruments appropriately.
- There may be a lack of consistency in questions and/or documentation to allow reliable analysis of program level needs or outcomes.
- Use of nonvalidated instruments.
- Use of instruments for populations for which they were not designed.
- Use of instruments that do not address criminogenic needs.
- Records may be incomplete, misleading, or mislabeled.
- Traditional subjective "intuitive assessments," or "first-generation assessments," still are used widely, despite demonstration of their ineffectiveness.

Minimal Assessment of Co-Occurring Disorders

- The primary barrier to treating co-occurring disorders is the minimal attempts to screen and assess for these disorders.
- Mental health and substance use disorders have a waxing and waning course and may appear in different forms at different points in time. This variability leads to different, and often conflicting, diagnoses at different stages of processing.
- There is considerable symptom interaction between co-occurring disorders, leading to difficulties in interpreting whether symptoms are related to mental illness or substance abuse.
- Individuals in the criminal justice system may anticipate negative consequences related to disclosure of mental health or substance abuse symptoms.

Limited Guidance from Research about the “Best” Instruments

- Few studies comparatively examine the effectiveness of different types of screening and assessment instruments.
- We lack systematic research on which criminogenic needs most influence future offending.
- Research has not identified the combination of risk, needs, personality types, and responsivity needed for programming to be most effective, and how assessments can be devised that can be used feasibly to assist with decisionmaking.

Key Research Questions

- How are specific screening and assessment instruments selected for use in correctional settings?
- How, if at all, are the results from screening and assessment used?
- Are the results from screening and assessment helpful in assisting with decisionmaking and, more specifically, with placing offenders into appropriate types and levels of drug treatment?
- What are the major problems in conducting and using screening and assessment of prisoners?

Defining Treatment

- The term “treatment” is widely used throughout jails and state and federal prisons, yet a concise, agreed upon definition of “treatment” is rare. Alcohol/other drug abuse treatment can refer to a wide range of services to help offenders change their behavior and lifestyle and/or medically assist the recovery process to reduce alcohol or drug abuse addiction. Different services are needed based on the type of alcohol or drug abuse, client attitude and mental state, prior drug and treatment history, etc. Some researchers distinguish between “treatment” services, typically intensive services such as residential treatment or counseling, and “non-treatment” services, typically self-help or education groups.

Treatment in the Criminal Justice System

- Treatment in the criminal justice system can occur at a variety of “impact points” (pretrial, jail, pre-sentencing, probation, prison, parole). The key to effective processing for offenders who need drug treatment is to provide assessments and comprehensive treatment; develop, adhere to, and monitor “treatment plans”; and implement an effective case management plan for post-release supervision and treatment.
- The provision of drug treatment is compatible with the goals of controlling and managing inmates and protecting the public.
- A core set of principles should guide the delivery of alcohol or drug abuse treatment in correctional settings.
 - Treatment should not represent a substitute for punishment or sanctions.
 - Treatment should be universally available as needed for persons with drug treatment needs.
 - Alcohol or drug abuse treatment services should be tailored to the needs of the specific offender, based on a thorough assessment at jail or prison intake.
 - Offender supervision should continue once an individual enters treatment.
 - Offenders should remain accountable to the sentencing judge or probation/parole authorities.
- Offenders entering state or federal prisons are confined to a sentence of at least one year in most states, providing a unique opportunity for providing alcohol and drug abuse treatment services. The range of alcohol and drug abuse programs and approaches should consist of one or more of the following:
 - Comprehensive pregnancy management for alcohol or drug abusers to enable a woman to carry her baby to term while incarcerated. Foster care services may be needed and medical services should be available for both mother and child.
 - Medical treatment for prisoners with chronic and communicable diseases, including TB and HIV/AIDS, should be available in prison.
 - Pharmacotherapy for disorders such as bipolar disorder and major depression should be incorporated into these services.
 - Alcohol or drug abuse treatment should extend across institutional boundaries when offenders are transferred to different correctional facilities, and to the community after release.
 - Special arrangements should be made for alcohol or drug abuse treatment and health care services for offenders in protective custody and administrative segregation.
 - Pre-release group programs and transitional community programming should be offered to all offenders, in particular to those who have been incarcerated for long periods of time.
 - Education about HIV/AIDS and its risk factors should be a critical component of prison programs.
 - Relapse prevention for alcohol or drug abusers should be part of transitional programming.

Drug Treatment Modalities and Services

- The primary treatment modalities and services in correctional settings include:
 - no specialized services,
 - specialized services for problems other than drug abuse,
 - drug education and/or drug abuse counseling,
 - dedicated residential units, and
 - client-initiated or client-maintained services.
- Research shows that highly intensive residential programs are the most effective in reducing drug and criminal behavior in the long term, yet most prison facilities do not offer this type of treatment, or offer it to only a small percentage of the population. Residential treatment is considerably less likely to be found in jails. Correctional departments blame budgetary constraints (71 percent) and space limitations (51 percent) as two of the major reasons that state and federal systems do not provide more drug treatment.
- The most prevalent types of program models in prisons, according to various surveys, are self-help programs such as Alcoholics Anonymous and Narcotics Anonymous, and education/awareness programs. These types of programs can address large groups at once, require relatively little ongoing investment, and can be staffed by inmates or volunteers.
- The range of treatment approaches and settings in correctional facilities varies tremendously, ranging from low-intensity services, such as education and self-help groups, to high-intensity services, such as those offered in a therapeutic community (TC) setting. These treatment services are not mutually exclusive; indeed, a variety of services matched to an individual's specific needs is likely to be more effective than provision of just one service. The range of treatment programs and services in correctional settings includes:
 - Detoxification
 - Self-help groups
 - Drug testing
 - Education
 - Individual counseling
 - Group counseling
 - Outpatient drug treatment services

- Milieu therapy
- Family therapy
- In-patient short-term therapy
- Residential programs
- Pharmacological maintenance
- Transitional services

Cost of Drug Treatment

- A report by the Center on Addiction and Substance Abuse (1998) indicates that it costs \$3,500, over and above incarceration costs, to provide residential drug treatment to inmates. The cost would be \$6,500 if education, job training, and health care were included. These costs would be substantially offset by increased productivity of offenders who not only do not return to prison but obtain employment. Other research supports the notion that drug treatment is cost-effective, as compared to incarceration without treatment.

Drug Treatment Prevalence in Correctional Institutions

- Several recent survey sources illustrate the state of knowledge of treatment programs in prisons and jails, with each source providing a different perspective on treatment in incarcerated settings.
 - The 1997 Uniform Facility Data Set (SAMHSA 2000).
 - The Corrections Yearbook 1999: Adult Corrections and the Corrections Yearbook 1999: Jails (Camp and Camp 1999a, b).
 - The 2001 American Correctional Association Survey of the Adult Division of the Department of Corrections (American Correctional Association 2001).
 - The 1996 Center for Substance Abuse Treatment, Treatment Survey of Prison Facilities (Center on Addiction and Substance Abuse 1998).
 - The 1997 Survey of Inmates in State and Federal Correctional Facilities (Bureau of Justice Statistics 1999a).
- A study by the Substance Abuse and Mental Health Services Administration (SAMHSA) found that only 40 percent of correctional facilities (including federal, state, jails, and juvenile facilities) nationwide provided on-site substance abuse treatment, ranging from a low of 16 percent in Mississippi to a high of 71 percent in Delaware. Treatment was defined as detoxification, group or individual counseling, rehabilitation, and methadone or other pharmaceutical treatment.
- According to the *Corrections Yearbook 1999*, the percent of inmates in a treatment program, as a percentage of all inmates, ranges from a low of 0.8 percent in Louisiana to a high of 68 percent in Alaska. On average, 16 percent of all inmates have experienced treatment, defined as separate unit treatment, addiction groups, or counseling.
- According to the Bureau of Justice Statistics, since 1991 there has been a decrease in participation in professional substance abuse treatment programs in state and federal prisons, but an increase in enrollment in other drug abuse programs, such as self-help or peer groups and drug education class.
- Jails—According to SAMHSA, a total of 34 percent of jails provide “treatment.” A majority of jails provide individual (77 percent) or group counseling (64 percent), with 28 percent of jails offering detoxification to inmates. Less than half of the jails used drug testing (42 percent) to monitor offenders. Approximately 36 percent of jails do not provide assessments for drug treatment need.
- State prisons—According to SAMHSA, a total of 61 percent of state prisons provide “treatment.” Most state prisons that provided treatment offered individual (90 percent) or group (93 percent) counseling. Family counseling was available in 26 percent of state prisons. Approximately 33 percent of state prisons do not assess for drug treatment need. The vast majority (93 percent) of state institutions provide self-help, 88 percent use drug testing, 83 percent provide education and awareness programs, and only 8 percent of institutions have detoxification capabilities.
- Federal prisons—According to SAMHSA, 93.8 percent of federal prisons provide “treatment.” Almost all federal prisons provide group counseling (99.2 percent) and individual counseling (99.2 percent), but only 11.6 percent of federal prisons offer family counseling. A majority of federal prisons also offer what the study refers to as “non-treatment” services. Close to all (86.8 percent) federal prisons assess for treatment need. Approximately 85 percent of federal prisons provide self-help groups, 88 percent use drug testing, 90 percent provide drug education programs, and 23 percent have detoxification capabilities.

Treatment Programming Issues

- The treatment plan is as important as provision of treatment. Without a plan, treatment can be disjointed, piecemeal, and, ultimately, ineffective. Treatment plans ideally should be:
 - biopsychosocial in nature
 - multidisciplinary in delivery
 - comprehensive in scope
 - driven by ongoing assessments
 - closely monitored.
- Maintaining a drug-free setting is critical for ensuring effective drug treatment, deterring inmates in general, and monitoring treatment. Although there is anecdotal evidence about the high prevalence of drugs and alcohol in correctional facilities, drug tests suggest otherwise. On average, over 95 percent of samples from 41 agencies tested negative (i.e., drug free).
- Bridging the gap between research and practice requires addressing critical barriers. Research in Residence, a pilot program in New York State, matched researchers with community clinics to assist the clinic implement research-based treatment improvements, yet numerous challenges precluded many improvements from occurring. These challenges may pose more significant barriers to correctional institutions.

Key Research Questions

- What exactly is the treatment need/services gap?
- Why do correctional facilities choose particular treatment programs? Among the many possible treatment approaches, why take one particular approach? Who makes this decision? Are treatment programming decisions driven primarily by unique, one-time opportunities, legislation, correctional philosophy, or other factors?
- How many facilities evaluate their programs, including screening and assessing potential clients and matching that information to new and improved programs?
- What are the primary challenges to providing drug treatment?
- What are the challenges involved in linking substance abuse treatment to other aspects of correctional operations?
- Are there certain types of treatment that are easier to implement in a prison setting?
- Do correctional administrators stay current with the effectiveness of different treatment models and adjust their programs as information changes?

Drug Treatment Effectiveness

- Treatment in and out of correctional facilities works across treatment modalities and offenders, and can include a wide range of positive outcomes:
 - decrease relapse and increase times between treatments
 - improve pro-social behavior
 - decrease criminal recidivism
 - decrease high-risk behaviors
 - improve prospects for employment
 - improve family and other social relations
- Although little conclusive research has been done to compare directly treatment effectiveness across treatment modalities, a combination of pharmacological treatment and psychosocial/behavioral therapy typically are effective for most types of drug abuse.
- The most successful treatments include but are not limited to cognitive-behavioral, social learning, incentive-based, and pharmacological approaches. Promising approaches include therapeutic communities and certain types of individualized treatment programming. Unsuccessful programs include boot camps, intensive probation and parole programs, guided group interaction and positive peer culture programs, and shock incarceration.

The Foundations of Effective Treatment

- Target dynamic/criminogenic needs.
- Provide multimodal treatment.
- Incorporate treatment responsivity.
- Address risk differentiation.
- Provide skills-oriented and cognitive-behavioral treatment.
- Provide integrated and comprehensive treatment.
- Provide continuity of care.
- Draw on external sources to promote completion of treatment.
- Apply appropriate dosages/levels of intervention.
- Provide effective program design, implementation, and monitoring.
- Involve researchers in program design, implementation, and evaluation.

The Future of Effective Drug Treatment?

- Researchers are beginning to conduct research that can better identify what treatments, either in isolation or in combination, work best (i.e., are most effective in reducing drug use, criminal behavior, and other negative outcomes, and in increasing positive outcomes, such as education, employment, etc.).
- Comprehensive models of treatment that include multiple interventions and involve continuous assessment and treatment may prove ultimately to be the most effective treatment strategy.
- Although considerable advances in drug treatment have been achieved, few of these advances have been systematically incorporated into correctional practice. Thus, the critical challenge for researchers and practitioners lies in identifying ways in which research and practice can be effectively linked.

Compulsory Drug Treatment

- Research shows that treatment need not be voluntary to be effective.
- Early criminal justice system intervention can force clients to remain in treatment, resulting in long-term benefits for offenders and more substantial changes in behavior during treatment.

Cost-Effectiveness

- Different sources agree that drug treatment is cost-effective, with the initial and extra investment in treatment considerably offset by reduced criminal behavior and criminal justice system involvement and by increased employment opportunities. Some estimates indicate that every \$1 invested in addiction treatment programs yields between \$4 and \$7 in reduced drug-related crime, criminal justice costs, and theft. Additional benefits accrue in the form of savings and positive outcomes for families, potential victims, and society.

Methodological Issues

- Research on drug treatment effectiveness suffers from a wide range of methodological challenges and flaws, including:
 - selection bias
 - measuring drug use vs. drug abuse vs. drug dependency/addiction
 - measuring drug treatment need severity/level
 - measuring recidivism
 - poor data quality generally, including record-keeping and data management issues.

Key Research Questions

- How does use of illicit drugs intensify or perpetuate criminal activity? How does a reduction in the use of illicit drugs reduce criminal activity?
- What types of treatment approaches work in a jail setting vs. a prison setting?
- What are the primary obstacles to effective treatment in correctional settings?
- What are the unique challenges and programmatic issues involved in treating drug use, drug abuse, and drug dependency/addiction?
- What treatment approaches work best for high-severity drug abusers vs. low-severity drug abusers?
- How should recidivism be measured?
- What factors are most instrumental for preventing relapse?
- What factors are most instrumental for not only preventing relapse but also criminal recidivism?
- What is the relative cost benefit/cost-effectiveness of different treatment approaches?

Reentry of Offenders into the Community

- Although reentry programs vary in the types of services provided and the types of offenders targeted, the main goal of these programs is to reduce recidivism among ex-offenders and help them adjust to life in the community.
- Post-incarceration services range from providing educational and vocational services to programs specifically geared toward drug treatment. The most common post-incarceration services generally include one or more of the following:
 - Vocational training and job placement services
 - Life skills programs
 - Family therapy
 - Housing assistance
 - Drug treatment
 - Intensive community supervision
- Some programs offer comprehensive post-release services, including drug treatment, employment and housing assistance, family strengthening services, and physical/mental health services.

Measuring Program Effectiveness

- Research indicates that post-release services may decrease recidivism and prevent relapse:
 - Overall, clients who receive aftercare services fare significantly better along many dimensions, including recidivism, compared with those who do not receive aftercare.
 - Vocational training and job placement programs appear to have a positive effect on employment for ex-offenders. However, there is evidence that these types of programs are not successful in decreasing recidivism.
 - The increased surveillance and control of Intensive Supervised Probation/Parole (ISP) does not appear to result in reduced recidivism. However, combining drug treatment with ISP may have more positive results.

To What Extent Have Linkages Been Developed?

- The call for post-release structure, supervision, and treatment of offenders is pervasive in the treatment literature. Nevertheless, many researchers note that post-release supervision is inadequate and that few offenders receive post-release drug treatment or reentry services.
- A major obstacle to developing linkages with post-incarceration supervision and community services is the lack of coordination among correctional institutions, mental health providers, and other aftercare service providers in the community.
- Case managers can play a critical role in assisting with post-release treatment by
 - assessing an offender's needs and ability to remain substance and crime free
 - planning for treatment services and other criminal justice obligations
 - maintaining contact with other criminal justice officials
 - brokering treatment and other services for the offender
 - monitoring and reporting progress to other transition team members
 - providing client support and helping offender with all aspects of treatment and reentry
 - monitoring urinalysis, breath analysis, or other objective tests of substance use
 - protecting the confidentiality of clients and treatment records.

Methodological Issues

- The methodological issues involved in evaluating post-incarceration service programs parallel those for evaluating treatment effectiveness, including:
 - selection bias,
 - measuring drug use vs. drug abuse vs. drug dependency/addiction,
 - measuring drug treatment need severity/level,
 - measuring recidivism, and
 - poor data quality generally, including record-keeping and data management issues.
- Selection bias represents a particular challenge when assessing post-release services because many programs rely on the motivation of the offender rather than institutional coercion. Among offenders released from prison, the disappearance/dropout rate from parole and/or treatment can be considerable, resulting in a highly motivated treatment group and, in turn, biasing treatment vs. control group comparisons.
- An additional critical problem is that few studies examine relapse rates for offenders participating in aftercare programs.
- Many studies do not distinguish between aftercare effects versus effects that may result from duration of supervision or from in-prison treatment, offender-level characteristics, or effects due to family or community characteristics.

Key Research Questions

- Are the linkages between prisons and communities adequate? If not, why?
- How are treatment priorities set for individual offenders as they reenter society?
- What are the major obstacles to providing drug treatment aftercare?
- How effective are reentry and post-release supervision and aftercare programs in reducing recidivism, preventing relapse, and promoting positive outcomes?
- Among existing reentry and post-release programs, which are the most effective?
- What types of reentry and post-release programs work best for which types of offenders, especially for level of drug problem (use/abuse/addiction) and risk of re-offending (prior criminal history)?
- What types of policies will promote and allow for coordination and cooperation among the criminal justice system practitioners, mental health providers, and community service providers?
- How can reentry of violent offenders with drug treatment needs best be managed?
- What are the rates of aftercare attendance among parolees? How does aftercare attendance affect long-term treatment goals?
- What is the overall quality of service provided by aftercare treatment centers?
- Does case management make a positive difference? What elements of case management are most important?
- How does an increase in the prison population, as well as subsequent releases, affect the capacity to implement quality aftercare services?
- How, or to what extent, do factors such as race, sex, family structure, neighborhood conditions, and other contextual factors influence the effectiveness of post-release drug treatment services? How, or to what extent, can they assist with these services?

Political Barriers

Declining Public Concern about Drug Abuse

- Public concern about drug abuse has declined. In 1989, 38 percent of the American public viewed drug abuse as the single most important problem facing the country. A decade later, only 5 percent of the public expressed this view.
- Public opinion polls show that the public consistently supports rehabilitation and treatment, even as they support “get tough” sanctioning of serious and violent offenders.

No Federal Requirements for Coordinated Case Management or Aftercare

- Despite infusions of federal funds to states to provide correctional drug treatment, case management and aftercare are not required.

Lack of Intra- and Inter-Governmental Coordination of Efforts

- Criminal justice actors often duplicate efforts already performed by others within the criminal justice system or others in local and state health and welfare agencies.
- States without treatment resources may contribute to criminal activity and treatment demands in other states.

Prioritization of Bed Space Management over Drug Treatment

- The lack of commitment from correctional executives and state policymakers poses one of the biggest challenges to providing effective and sustained drug treatment in correctional settings.

Opposition and Skepticism about the Effectiveness of Drug Treatment

- In general, support for correctional drug treatment faces considerable political opposition. The opposition in part is due to public and political beliefs that drug addiction is not a public health problem but rather is a moral failing of individuals. No one agency has responsibility for promoting drug treatment policies, and political support for treatment frequently is lacking.
- Despite research demonstrating the effectiveness of drug treatment, many legislators and correctional executives believe otherwise and see little reason to support programs that in their view receive little public support.

Resource Barriers

Lack of Funding for and Prioritization of Treatment

- Despite considerable infusions of federal dollars into state drug abuse programs, lack of funding for treatment constitutes a key barrier to treatment. More than 70 percent of state and federal prison administrators cite inadequate funding as the greatest challenge to providing treatment.
- The lack of funding is directly linked to another barrier to correctional treatment—the lack of prioritization of treatment among correctional executives.
- Although these factors affect the amount of drug treatment in prisons, they also substantially affect the quality of treatment.

Uncertainty and Certainty about How Best to Utilize Scarce Resources

- Despite significant advances in research, information is needed about which programs, including drug treatment, result in the greatest benefits, are the most cost-effective, and can be feasibly implemented in a correctional setting.
- Certain programs that have been shown to be ineffective, or whose effectiveness has not been determined, nonetheless receive considerable ongoing political support.

A Need for Integrated Community-Based Services

- Most communities do not have the services necessary for diverting offenders from prison or for continuing ex-offender treatment. When services are available, they frequently are not coordinated or easily accessible to offenders. In many instances, potential providers have little incentive to work with offenders. In others, correctional, health, welfare, and other agencies are unwilling or unable to cooperate with one another to provide continuity of treatment.

Assessment Barriers

Administrative and System Issues

- Multiple and redundant assessments are conducted at various stages of processing.
- Time constraints prevent conducting screening and assessments.
- Information is collected that can not be easily used.
- Staff are not trained adequately on the administration and use of screening and assessment instruments.
- Criminal justice personnel may lack familiarity with mental health or substance abuse disorders.
- There may be limited time and resources for codifying existing information, transferring it to various parts of the criminal justice system, or easily accessing existing information.

Inappropriate Use of Assessment Instruments

- Staff may not complete and use screening and assessment instruments appropriately.
- There may be a lack of consistency in questions or documentation to allow reliable analysis of program-level needs or outcomes.
- Non-validated instruments may be used.
- Instruments may be used for populations for which they were not designed.
- Instruments may not address criminogenic needs.
- Records may be incomplete, misleading, or mislabeled.
- Traditional, subjective “intuitive assessments,” or “first-generation assessments,” still are widely used, despite demonstration of their ineffectiveness.

Minimal Assessment of Co-Occurring Disorders

- The primary barrier to treating co-occurring disorders is the minimal attempt systemwide to screen and assess for these disorders.
- Mental health and substance use disorders have a waxing and waning course and may appear in different forms at different points in time. This variability leads to different, and often conflicting, diagnoses at different stages of processing.
- There is considerable symptom interaction between co-occurring disorders, leading to difficulties in interpreting whether symptoms are related to mental illness or substance abuse.
- Individuals in the criminal justice system may anticipate negative consequences related to disclosure of mental health or substance abuse symptoms.

Limited Guidance from Research about the “Best” Instruments

- Few studies comprehensively and comparatively examine the effectiveness of different types of screening and assessment instruments.
- There is little systematic research identifying which criminogenic needs most influence future offending.
- Research has not shown the combination of risk, needs, personality types, and responsivity needed for programming to be most effective, and how assessments can be devised that can be feasibly used to assist with decisionmaking.

Administrative and Organizational Barriers

Legislative or Policy Restrictions on Treatment Access

- Legislative or policy requirements frequently limit treatment to inmates who have a lifetime history of substance use or have been convicted of drug sales or drug trafficking, irrespective of their current use pattern. Programs also may be required to exclude violent and/or sex offenders and those involved with prison gangs. The exclusions assume, incorrectly, that all drug-involved offenders have substance abuse problems, that only those offenders with lifetime histories of use need treatment, or that offenders who engage in drug trafficking require treatment.
- Correctional facilities may have policies that limit treatment access by restricting the movement of inmates to facilities with treatment services, even though treatment would be appropriate.

Difficulties in Implementation and Delivery

- Treatment programs often encounter opposition because they run counter to the established punishment/control culture in correctional settings.
- The involvement of experienced treatment providers is crucial at all stages of implementation, including design and monitoring of both the program and its budget. Without this involvement, programs frequently suffer from a wide range of challenges, including failure to obtain appropriate supplies, placement of inappropriate clients, and an inability to anticipate and address fluctuations in available resources.
- The best designed programs are ineffective if inappropriately delivered, yet many evaluations indicate that program delivery is frequently and significantly compromised.

Challenges in Institutionalizing Effective Treatment

- Treatment programs too often rely on specific individuals to motivate and sustain them. As a result, when those individuals leave, programming frequently suffers. Sustained and effective treatment requires institutionalizing key aspects of treatment programming, including commitment to treatment, documentation of program policies and procedures, and commitment to hiring trained counselors.

Overcrowding and Security Issues Compromise Treatment

- Security issues in correctional facilities represent a persistent problem for drug abuse programs. If inmates with different risk classifications are placed in the same program, lower-risk offenders are put at risk and treatment is compromised. However, because of limited general population bed space, treatment programs frequently become a primary source for relieving overcrowding.
- Sometimes treatment is not offered to inmates in high-security facilities due to costs associated with providing treatment in these settings, even though treatment could be beneficial.

Limited Treatment Access within Corrections Due to Location

- The frequent placement of correctional facilities in remote areas or a limited set of institutions can undermine treatment, making it difficult to attract qualified treatment counselors.
- Treatment programs generally are located in a small number of facilities within state correctional systems. As a result, many inmates are not sent to treatment because of the distance involved. Those placed in treatment frequently are too far away for family members to participate in treatment.

Challenges in Training and Retaining Treatment Staff

- Effective treatment requires well-trained staff and a certain level of consistency in staffing, yet many programs suffer from both problems.
- Effective treatment is facilitated by mutual understanding among treatment and correctional staff, but few correctional staff are cross-trained in both correctional and treatment orientations.

Conflicting Treatment and Correctional Cultures

- Many correctional officers do not understand, appreciate, or support treatment, while many treatment providers view correctional philosophies as fundamentally inappropriate, unnecessary, and ineffective. Ultimately, the conflicting correctional and treatment cultures typically work against treatment programming and efficacy. Few institutions directly address this conflict.

Privately Run Prisons May Not Prioritize Treatment

- Although there are no definitive studies of treatment provision or effectiveness in privately vs. government-run correctional facilities, evidence suggests that privately run facilities do not prioritize treatment, possibly due to a conflict of interest (e.g., a desire to fill bed spaces).

Key System Gaps Contribute to Lack of Treatment

- Pre-sentencing investigations can highlight the needs of offenders and assist with diversion. Frequently, however, pre-sentencing reports do not focus on or emphasize drug treatment needs.
- One of the major barriers to drug treatment in correctional settings is the fact that need exceeds demand by a ratio of 5 to 1 in state and federal prisons. Diversion to non-incarcerative treatment programs can alleviate this problem, but it often is not supported or is not available.
- Three-fourths or more of offenders with histories of heroin and cocaine abuse relapse within three months of release from prison and engage in criminal activity. The absence of effective drug treatment in prisons, coupled with limited or no aftercare treatment, can contribute both to prison growth and to the demand for correctional drug treatment.

Programmatic Barriers

Limited or Low-Quality Case Management

- For most treatment programs to be effective, there must be successful coordination of services and transitions from one stage of processing to another. For this reason, case management is an essential part of the treatment process. However, case management frequently is not provided or suffers from several problems. In addition, case management plans rarely are fully developed and often do not include relapse prevention strategies.

Lack of Monitoring or Drug Testing

- Research shows that frequent monitoring and drug testing can significantly reduce relapse and recidivism rates, yet many drug-abusing offenders released from correctional facilities are not monitored closely or tested.

Availability of Drugs in Correctional Settings

- Correctional drug treatment can be significantly undermined by the availability of licit and illicit drugs. Inattention to security issues and control of drug trade can compromise treatment goals and reduce treatment effectiveness.

Inappropriate Treatment or Delivery of Treatment

- Treatment should be based on empirical evidence on what works and for whom, but frequently correctional facilities rely on programs that are ineffective or have not been evaluated. These programs also frequently are not implemented or delivered as they were designed.

Client Resistance to Treatment and the Balancing of Rewards and Sanctions

- Although voluntary participation in treatment is not always necessary for treatment to be effective, it nonetheless can contribute to it and, over the long term, may be necessary to reduce relapse. However, many correctional treatment programs fail to incorporate a system of rewards and incentives, such as linking release to treatment completion.
- Rewards and sanctions constitute effective strategies for engaging inmates in the treatment process. However, arriving at an effective balance of the two can present considerable challenges. As a result, correctional and treatment facilities frequently rely on one or the other or, more generally, emphasize sanctions rather than rewards.

Insufficient Levels of Treatment and Reentry Preparation

- Program completion is one of the major predictors of successful treatment. Inmates must be in treatment long enough—generally 12 to 18 months—to end the physical addiction and to allow the full course of treatment to take effect. Yet many inmates do not complete treatment because of behaviors while in treatment or termination of their sentence. In addition, inmates who complete treatment frequently are transitioned directly into society without any type of reentry programming or development of plans for maintaining continuity of care.

Lack of Treatment Responsivity

- Few correctional treatment programs provide individualized treatment, yet no single treatment is appropriate for all individuals. Treatment programs generally must meet the needs of individual inmates and accommodate their particular personality, circumstances, and learning style, what sometimes is referred to as “treatment responsivity.” Responsivity includes addressing issues such as co-occurring disorders, racial/ethnic and gender differences in both needs and the effectiveness of specific treatment modalities, and cultural competency and differences.

A Comprehensive Correctional Drug Treatment Strategy

- There is no one solution to enhancing drug treatment in correctional settings. Rather, for any sustained strategy of correctional drug treatment, a comprehensive and systematic approach holds the most promise.
- A suggested comprehensive strategy should include generating state-level support and commitment, providing appropriate screening and assessment, appropriate treatment, preparation for release, and aftercare. In each instance, there are concrete steps that can be taken to enhance the provision, delivery, and, ultimately, the effectiveness of correctional drug treatment.

Key Research Questions

- Of the many barriers to correctional drug treatment, which are the most pervasive, the most important in affecting the provision or effectiveness of treatment, and the most amenable to change?
- What are the major barriers to providing effective drug treatment in prisons? What issues have to be addressed to increase effective drug treatment in prisons?
- How prevalent are key barriers to effective drug treatment in correctional systems?
- Which barriers are the most important in affecting the provision or effectiveness of treatment? Which of these are the most amenable to change?
- Do correctional officials perceive that there is a need for more effective drug treatment in correctional settings?
- Are research findings used in the development of policies and programs, and if not, why not?
- What types of policies encourage collaborative efforts to provide drug treatment?
- To what extent are offenders with substance abuse and dependency needs identified?
- To what degree do correctional institutions cross-train correctional and treatment staff? How effective is cross-training in facilitating effective drug treatment?

CHAPTER 1.

Prison Growth, Drug Abuse, and Treatment in the Criminal Justice System

Drug use and abuse are widespread among offenders processed through the criminal justice system, including not only those who are arrested but those in jails and state and federal prisons. This fact, coupled with research showing that treatment can be effective in reducing both drug use and criminal behavior, suggests that substance abuse treatment throughout the criminal justice system, and especially in corrections, should be a priority. A corrections environment potentially offers a unique opportunity to provide treatment because the target population is readily available and generally can be in treatment for at least one to two years. Yet drug treatment has not kept pace with the growth in prison populations. This chapter reviews the major facts about the prevalence of drug use, abuse, and dependency/addiction, as well as treatment in state and federal incarceration facilities. To establish the context for understanding the demand and need for drug treatment, the chapter focuses first on incarceration trends and changes in funding for incarceration and treatment. The chapter then turns to a review of what is known about the prevalence of drug use, abuse, and dependency/addiction, as well as the availability of treatment programming and resources. Finally, a brief discussion of public views toward drug abuse is provided.

INTRODUCTION

Drug use and abuse are widespread among offenders processed through the criminal justice system. This fact, coupled with research showing that treatment can be effective in reducing both drug use and offending, suggests that substance abuse treatment throughout the criminal justice system, and especially in corrections, should be a priority. Yet drug treatment has not kept pace with the growth in prison populations.

This chapter reviews the major facts about the prevalence of drug abuse and treatment in state and federal incarceration facilities. To establish the context for understanding the demand and need for drug treatment, the chapter focuses first on incarceration trends and changes in funding for incarceration and treatment. It then turns to a review of what is known about the prevalence of drug use and addiction, as well as the availability of treatment programming and resources. Finally, a brief discussion of public views toward drug abuse is provided.

INCARCERATION TRENDS

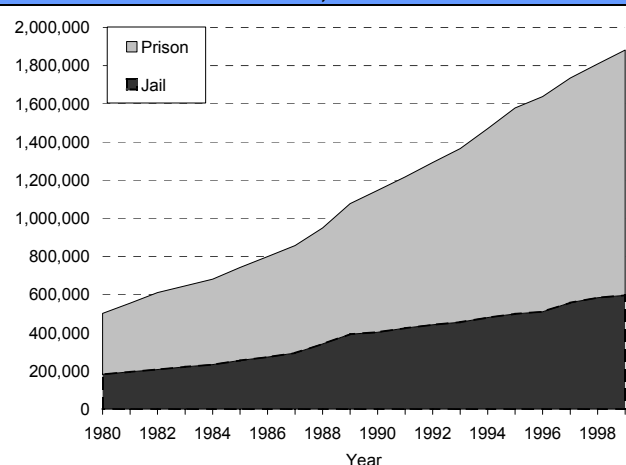
Increases in State and Federal Prison Incarceration

Incarceration trends among states and in the federal prison system increased dramatically throughout the 1990s (Blumstein and Beck 1999; Caplow and Simon 1999). Figure 1-1 charts this growth. After remaining stable throughout most of the 1970s, the number of incarcerated offenders began rising in the 1980s and then rapidly escalated in the 1990s. The result was an annual increase of 5.6 percent in the number of inmates in jail and prison (Beck and Karberg 2001, 1).

Incarceration rates increased as well during the past two decades. Up until the end of the 1970s, the rate per 100,000 residents hovered around 100 (Caplow and Simon 1999, 64). However, as figure 1-2 shows, between 1980 and 1999, the incarceration rate grew by almost 240 percent to a rate of almost 500 per 100,000 residents.

These changes have resulted in a near quadrupling of the prison population over a 20-year time period, rising from approximately 320,000 in 1980 to 1.3 million in 1999 (see figure 1-1). During this same period, the jail population more than tripled, rising from 182,000 in 1980 to 596,000 in 1999 (figure 1-1). Recent estimates—for mid-year 2000—show federal prisons holding 131,496 inmates and state prisons holding 1,179,214 inmates (Beck and Karberg 2001, 1).

Figure 1-1. Number of Adult Offenders Incarcerated in State and Federal Facilities, 1980 – 1999

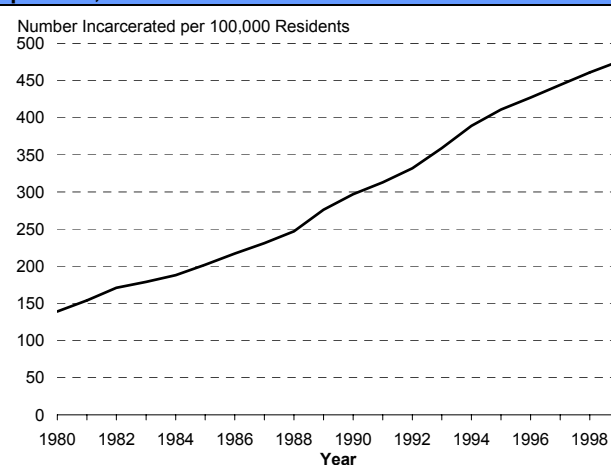


Source: Mumola (2000); Beck (2000).

Prison - Confinement in a state or federal correctional facility to serve a sentence of more than one year, although in some jurisdictions the length of sentence which results in prison confinement is longer.

Jail - Confinement in a local jail while pending trial, awaiting sentencing, serving a sentence that is usually less than one year, or awaiting transfer to other facilities after conviction.

Figure 1-2. Incarcerated Population per 100,000 Residents



Source: Bureau of Justice Statistics (1999b); Beck (2000).

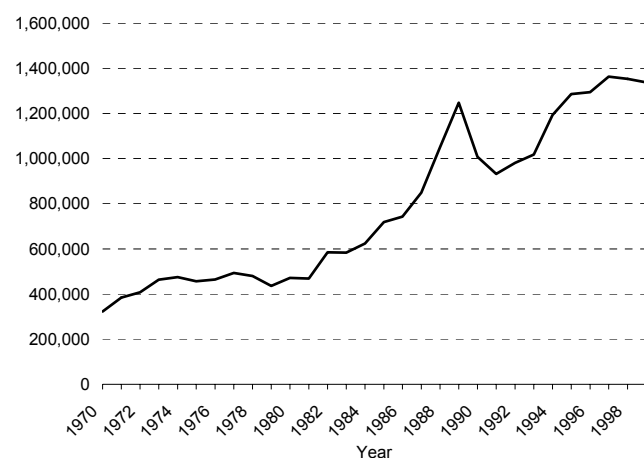
Note: Number of sentenced inmates incarcerated under state and federal jurisdiction per 100,000 residents, 1980-1999.

Increases in State and Federal Prison Incarceration Drug-Related Offenses

Although there are many factors that drove the recent incarceration trends (Caplow and Simon 1999), incarceration of drug offenders was by far the leading cause of increased correctional populations. Analysis of six serious offenses—murder, robbery, assault, burglary, drug offending, and sexual assault—shows that between 1980 and 1996, 45 percent of the overall growth in the incarceration rate for these offenses was driven by incarceration of drug offenders (Blumstein and Beck 1999, 21). If all other crimes were considered, drug incarceration would account for 33 percent of the overall prison growth between 1980 and 1999 (Blumstein and Beck 1999, 22). The reason for this influence can be seen in the changes in the drug incarceration rate: In 1980, the drug incarceration rate was 15 per 100,000 adults, but by 1996, the rate had increased to 148, representing approximately a 900 percent increase in a 17-year period (Blumstein and Beck 1999, 21).

One of the primary drivers of the drug incarceration rate was the combination of increased arrests for drug violations and tougher sentencing for drug crimes. Figure 1-3 charts the increase in arrests for drug violations. During the 1970s the number of arrests remained relatively stable, ranging between 400,000 and 500,000 arrests annually. Adult drug arrests then increased dramatically throughout the 1980s, dipped down from 1989 to 1991, then continued the earlier decade's increase.

Figure 1-3. Adult Drug Abuse Violations, 1970 – 1999



Source: Federal Bureau of Investigation (1999).

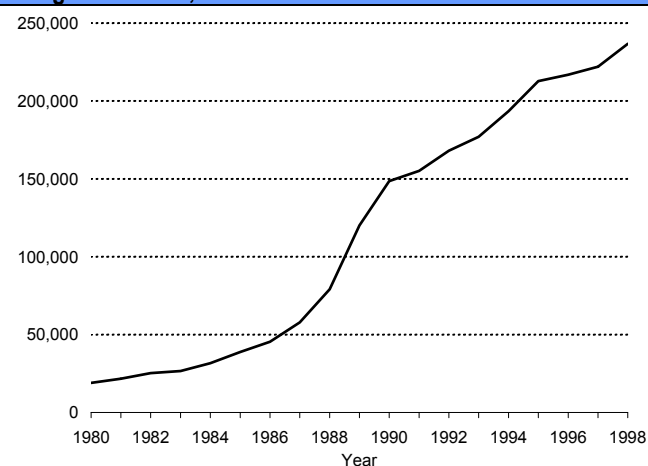
Note: Drug abuse violations are defined as state or local offenses relating to the unlawful possession, sale, use, growing, manufacturing, and making of narcotic drugs including opium or cocaine and their derivatives, marijuana, synthetic narcotics, and dangerous nonnarcotic drugs such as barbiturates.

The increased drug arrest rates alone would be insufficient to fuel the dramatic increases in drug incarceration rates without conversion of those arrests into prison sentences. As figure 1-4 shows, however, incarceration of drug offenders grew markedly over a 20-year time span, rising sharply from 1988 onward. Indeed, during the same time that drug arrests grew, so, too, did the conversion of drug arrests into prison sentences. Blumstein and Beck (1999, 55) report that the conversion rate of 1992 was 5 times that of 1980. Although this rate declined somewhat during the 1990s, the conversion rate of 1996 was still 3.6 times that of 1980.

In short, increased arrest rates, coupled with increased rates of converting drug arrests into prison sentences, accounted for almost all of the growth in drug incarceration. Drug arrests accounted for approximately one-third of the growth, and conversion of arrests into prison sentences for two-thirds of the growth (Blumstein and Beck 1999, 55).

Growth in the incarceration of drug offenders need not mean that there is a greater need for drug treatment in prisons. However, drug abuse is highly prevalent among drug offenders, as it is among property and violent offenders (Harrison 2000, 2). In addition, the trend toward incarcerating increasing numbers of drug offenders highlights the potentially increasing role of drugs in corrections. It also suggests the broader context in which drug treatment endeavors are situated. Estimates of the extent of drug treatment need will be reviewed in subsequent sections.

Figure 1-4. Number of Persons in State Corrections for Drug Violations, 1980 – 1998



Sources: Mumola (2000); Beck (2000).

Note: Drug offenses include possession, manufacturing, trafficking, and other drug offenses.

EXPENDITURE TRENDS

Given the increases in incarceration in the U.S., it is not surprising that expenditures have increased dramatically and in parallel fashion. This section briefly reviews expenditure trends, emphasizing the allocation of resources to drug treatment. The next section focuses directly on the extent of drug treatment need in correctional settings.

Expenditures on Corrections

According to the U.S. Bureau of Justice Statistics (2001), federal, state, and local expenditures on corrections grew by more than 400 percent from 1982 to 1997, from approximately \$10 billion to \$45 billion. As figure 1-5 shows, expenditures steadily increased for much of the 1980s, before rising more rapidly during the 1990s. Given that incarceration trends were driven primarily by the drug incarceration rate (Blumstein and Beck 1999), the increase in correctional expenditures represents a significant investment in the incarceration of drug offenders.

Expenditures on drug treatment in aggregate have been described by the General Accounting Office. Between 1990 and 1998, “total federal drug control spending rose by 64 percent, from about \$9.8 billion in 1990 to about \$16 billion in 1998” (GAO 1998, 5). The treatment budget increased by 78 percent during this same time period, with approximately \$3.2 billion allocated for drug treatment. Of the treatment funds (20 percent of the \$3.2 billion), more than half (54 percent) was allocated to the U.S. Department of Health and Human Services (HHS) to support block grants, treatment, and research (GAO 1998, 6). One-third (34 percent) was allocated to the Department of Veterans Affairs for treating veterans and providing inpatient and outpatient care. The remaining funds went to the Health Care Financing Administration, the Department of Education, the Department of Justice, the federal Judiciary, and the Office of National Drug Control Policy (GAO 1998, 7). Of the HHS’s \$1.7 billion in 1998, close to \$1 billion went to the Substance Abuse and Mental Health Services Administration (SAMHSA). Most of these monies are used to support block grants to states. One-sixth of HHS’s funding went to the National Institutes of Health (NIH) for conducting research on drug and alcohol abuse. The National Institute on Drug Abuse (NIDA), housed within NIH, is required by Congress to allocate 15 percent of its funding to study “the impact of organization, financing, and

management of health services on issues such as access and quality of services” (GAO 1998, 8).

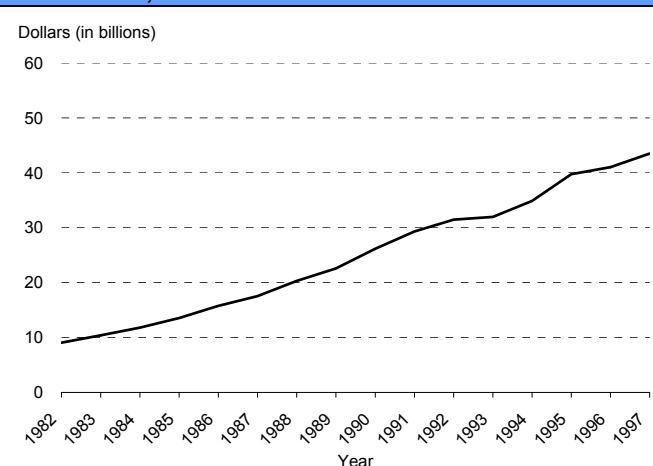
Expenditures on Drug Treatment as Proportion of Total Expenditures

Consistent and accurate estimates of expenditures on treatment, especially for drug treatment, are not readily available. Existing counts frequently rely on definitions of treatment that are not consistently adhered to across states, rendering valid comparisons difficult. Nonetheless, estimates compiled by the Center on Addiction and Substance Abuse (CASA 1998, 11) indicate that in 1996 less than 5 percent of state prison budgets went toward drug treatment, and that less than 1 percent (\$25 million) of the federal prison budget was targeted for drug treatment, including drug abuse education, residential counseling services, and community transitional services.

Such estimates mask considerable variation, however. For example, some states report spending less than 1 percent of the correctional budget on treatment, while others report spending up to 22 percent of their budget on treatment (CASA 1998, 162). In addition, many states are not able to disentangle inmate programming costs from general operations expenditures (CASA 1998, 2001).

On a national level, according to the Office of National Drug Control Policy (2001), more than \$3 billion in funds went to drug treatment in 2000, compared with \$2 billion to drug prevention and \$9 billion to the criminal justice system in the same year. Including

Figure 1-5. Federal, State and Local Expenditures on Corrections, 1982 – 1997



Source: Bureau of Justice Statistics (2001).

international drug control efforts, along with interdiction, research, and intelligence, more than \$18 billion was spent on drug control efforts in 2000.

PREVALENCE OF DRUG USE

Few reliable estimates of the prevalence of drug use, drug abuse, and drug dependency/addiction in jails and state and federal prisons exist. In a study by CASA (1998, 10), state officials estimated that 70 to 85 percent of their inmates needed drug treatment. Similarly, the Federal Bureau of Prisons estimated that in 1996, 31 percent of their inmates needed treatment (CASA 1998, 10).

Prevalence estimates to date have generally relied on self-reports by offenders, who may not wish to reveal the extent of their involvement with illicit substances. Even if they accurately report drug use (in the past year, past 30 days, at arrest, while in prison, etc.), drug use is not the same as drug abuse or addiction. Thus, although drug screens, such as urinalysis, are accurate in detecting recent drug use, they cannot determine the extent to which an individual suffers from a drug abuse disorder or drug dependency (addiction) disorder, as determined by the American Psychological Association's Diagnostic Statistical Manual, fourth edition (DSM-IV). (In this report, "dependency" and "addiction" are interchangeable.)

Other sources of prevalence estimates draw on more sophisticated assessment strategies, yet few have been conducted on a systemwide basis, rendering generalizations to entire criminal justice systems suspect. In a similar vein, it bears emphasizing that much of the drug treatment effectiveness literature relies on a highly heterogeneous definition of the problem condition—that is, drug use / abuse / dependency—as assessed through an equally heterogeneous range of clinical instruments.

Below, some of the primary sources of prevalence estimates of drug use, abuse, and addiction are reviewed. It should be emphasized that regardless of the exact definition of drug use/abuse/addiction, or of the manner in which these are assessed, most sources indicate that the vast majority of offenders are in need of drug treatment. This assessment, coupled with the considerable increase in U.S. prison populations during the past decade, suggests a considerable growth in the demand for drug treatment. As noted above, the supply of any kind of treatment, much less drug treatment, has not kept pace with this demand.

Arrest

The most accurate information on the prevalence of drug use at arrest comes from the Arrestee Drug Abuse Monitoring (ADAM) Program, a project of the U.S. Department of Justice, which includes conducting urinalysis tests on adult arrestees in 35 cities across the U.S. ADAM data provide information on recent drug use among arrestees; they do not provide information on the prevalence of drug abuse or dependency. Although ADAM provides highly accurate information for the cities in which it is conducted, it is of limited utility for assessing the extent of drug abuse or dependency / addiction in corrections. Nonetheless, it provides a foundation for estimating the starting point of the criminal justice "funnel," which ultimately leads to corrections for the most serious offenders. Specifically, all sites combined report at least 50 percent of adult male arrestees tested positive for at least one of the NIDA-5 drugs (cocaine, marijuana, methamphetamine, opiates, PCP), with the prevalence as high as 77 percent in San Antonio (ADAM 1999).

Jail

Jail data on drug use, abuse, and dependency suffer many of the problems noted earlier—most notably, inconsistent definitions of drug problems, reliance on self-reports, or no assessment of the prevalence of drug problems. Drawing on data from the *Survey of Inmates in Local Jails, 1996*, and the *1998 Annual Survey of Jails*, the U.S. Bureau of Justice Statistics (Wilson 2000) reports the following facts about drug use and testing in U.S. jails.

- Among all jail inmates in 1996, 74 percent reported past drug involvement, as defined by regular use of drugs, receipt of drug treatment, intravenous use of drugs, and being sentenced for past drug offenses (Wilson 2000, 3).
- Among convicted inmates in 1996, 66 percent reported active drug involvement prior to admission, 55 percent reported drug use in the month prior to their offense, and 36 percent reported drug use at the time of their offense. (Active drug involvement was defined as using drugs in the month prior to the offense, using drugs at the time of the offense, commission of an offense to obtain money for purchase of drugs, having received drug treatment since placement in jail, or having a current drug charge [Wilson 2000, 3].)

- Among convicted inmates in 1996 using drugs in the month prior to arrest, 37 percent used marijuana or hashish, 24 percent used cocaine or crack cocaine, 10 percent used stimulants, 9 percent used heroin or opiates, 6 percent used depressants, 5 percent used hallucinogens, and 1 percent used inhalants (Wilson 2000, 1).
- Among convicted inmates in 1996, 36 percent reported using drugs at the time of their offense (Wilson 2000, 3).
- Among jail inmates tested for drugs in 1998, 10 percent tested positive for use of one or more drugs (Wilson 2000, 1).
- Half of all jail inmates in the U.S. in 1998 were in jails that test for drug use (Wilson 2000, 4).

State and Federal Prisons

Some estimates indicate that over half of offenders in state and federal prisons have a diagnosed substance abuse or dependency disorder (Peters et al. 1998; Robins and Regier 1991). According to the U.S. Bureau of Justice Statistics' *Correctional Populations in the United States, 1997* (Mumola 2000), which is based on surveys of state and federal inmates, drug use is as prevalent among prisoners as among jail inmates (see table 1-1).

- In 1997, 83 percent of state and federal inmates reported ever using any drugs—77 percent for marijuana/hashish, 49 percent for cocaine/crack, 29 percent for hallucinogens, 28 percent for stimu-

lants, 25 percent for heroin/opiates, 24 percent for depressants, and 14 percent for inhalants (Mumola 2000, 61).

- In 1997, 57 percent of state and federal inmates reported using drugs in the past month—39 percent for marijuana/hashish, 25 percent for cocaine/crack, 9 percent for heroin/opiates, 9 percent for stimulants, 5 percent for depressants, 4 percent for hallucinogens, and 1 percent for inhalants (Mumola 2000, 61).
- In 1997, 33 percent of state and federal inmates reported using drugs at the time of their offense (Mumola 2000, 61).

Drug Abuse and Drug Dependency Disorders

Few studies systematically provide a rigorous assessment of the prevalence of drug abuse and drug dependency/addiction disorders, as defined by the DSM-IV. Indeed, although surveys have been conducted on self-reported prior drug use, and although many site-specific investigations have been conducted, there appear to be few if any systematic assessments of the prevalence of abuse and dependency/addiction disorders among jail or state or federal prison populations.

However, for a three-month period, in the summer of 1991, all offenders (N = 1,165) who entered the federal Bureau of Prisons completed the Inventory of Substance Abuse Patterns (ISAP). Using the American Psychological Association's Diagnostic and Statistical Manual, Third Edition, Revised (DSM-III-R) as a guide, 20.9 percent of inmates met the criteria for psy-

Table 1-1. Drug Use in Month Prior to Arrest Among Inmates in Jails vs. State and Federal Prisons

	Jails	State and Federal Prisons
	% Used Drugs in Month Before Arrest	% Used Drugs in Month Before Arrest
Any drug	55%	57%
Marijuana/hashish	37	39
Cocaine/crack	24	25
Heroin/opiates	9	9
Depressants	6	5
Stimulants	10	9
Hallucinogens	5	4
Inhalants	1	1
Sources: Mumola (2000, 61); Wilson (2000, 1).		
Notes: Jail estimates are for 1998; state and federal estimates are for 1997.		

choactive substance abuse (now termed “drug abuse disorder”) and 30.8 percent for psychoactive substance dependency (now termed “drug dependency disorder”), for a combined prevalence of 51.7 percent having either type of disorder (Murray 1991, 35). The criteria for a diagnosis of drug abuse disorder, as well as for drug dependency disorder, are outlined in table 1-2, using the more recent DSM-IV definitions.

The importance of distinguishing between self-reported drug use versus clinically defined substance use disorders—such as drug abuse disorder and drug dependency disorder—lies in the fact that self-reported accounts of prior drug use likely overestimate the need for drug treatment. However, there is increasingly is evidence that not all individuals are equally likely to become addicted after initial use of a drug (see, e.g., Leshner 1998). Some individuals and groups may have a relatively high genetic disposition toward or general risk of addiction, while others may have relatively low risks. Such dispositions or risks may be reflected in self-reported use statistics, especially those focusing on drug use in the month prior to arrest or at the time of the offense. However, at present, it remains unknown whether or to what extent this is true, and, more generally, whether and to what extent self-report statistics overestimate the prevalence of drug addiction.

DRUG TREATMENT IN CORRECTIONS

Currently, there are few precise estimates of drug treatment in correctional settings. Some sources identify numbers of inmates receiving treatment, but these rarely are specific on the type of drug treatment. In a review by the Center on Addiction and Substance Abuse, state officials estimated that 70 to 85 percent of their inmates needed drug treatment, but that only 13 percent received any. Similarly, the Federal Bureau of Prisons estimated that in 1996, 31 percent of their inmates needed treatment, compared with 10 percent actually receiving it (CASA 1998, 10).

According to the Bureau of Justice Statistics, which drew on a 1997 national survey of state and federal prison inmates, 24 percent of state and federal inmates participated in some type of alcohol treatment or program in 1997 (Mumola 2000, 66). In 1997, 9.7 percent (101,200) of state prison inmates received drug treatment after admission, down from 24.5 percent (169,700) in 1991 (Mumola 2000, 64). In this same year, 9.2 percent (8,100) of federal prison inmates received drug treatment, which represented a decline from 15.7 percent (8,300) in 1991 (Mumola 2000, 64).

Of inmates receiving drug treatment in state or federal prisons, approximately half were placed in residential facilities and the other half received counseling, with a small fraction receiving any type of maintenance drug therapy (Mumola 2000, 64). Close to 20 percent of state and federal inmates participate in self-help group/peer counseling or education programs (Mumola 2000, 64).

Table 1-2. Drug Abuse Disorder vs. Drug Dependency Disorder

Drug Abuse Disorder	Drug Dependency Disorder
A. Pattern of substance use leading to clinically significant impairment or distress, manifested by one (or more) of the following, occurring within a 12-month period: • Unable to fulfill obligations at work, school, or home. • Use alcohol in physically hazardous situations. • Legal problems related to alcohol. • Continue to use despite these recurrent interpersonal and social problems. — and — B. Have not met criteria for substance dependence.	A. Pattern of substance use leading to clinically significant impairment or distress, manifested by three (or more) of the following within a 12-month period: • Alcohol tolerance. • Alcohol withdrawal. • Consume larger amounts than intended. • Persistently and unsuccessfully tried to cut down. • Spend much time in activities revolving around obtaining, using, and recovering from alcohol. • Give up or reduce social, occupational, or recreational opportunities because of use. • Continue despite knowledge of persistent or recurrent physical and psychological problems.
Source: American Psychological Association. 1994. <i>Diagnostic and Statistical Manual—IV</i>. Washington, D.C.: American Psychological Association.	

Assuming that the need for drug treatment in state prisons remained proportionally constant between 1991 and 1997, and that in 1991 all inmates who needed treatment were receiving it (24.5 percent), then approximately 150,000 state inmates who needed drug treatment in state prisons in 1997 were not receiving any (based on subtracting 9.7 percent of the 1997 state prisoner population, which is approximately 100,000, from 24.5 percent of the 1997 population, which is approximately 250,000).

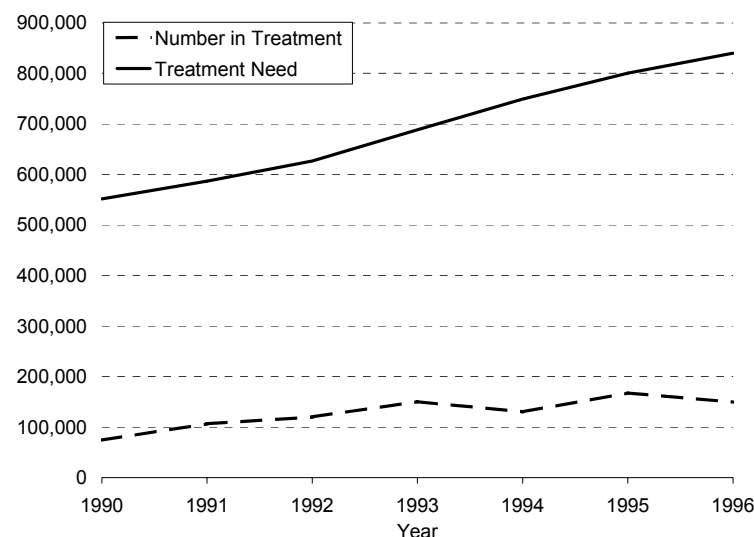
This figure (150,000) likely underestimates the drug treatment gap in state prisons significantly, since not all inmates who needed drug treatment in 1991 received it. For example, if one used a 50 percent prevalence estimate as the basis for ascertaining drug treatment need (see table 1-1), then in 1997 approximately 421,000 state inmates who needed drug treatment went without it (522,000 minus 101,200, or 9.7 percent).

A considerably more liberal estimate comes from the Center on Addiction and Substance Abuse (1998), which assumes that 75 percent of state and 31 percent of federal inmate populations are in need of drug treatment. Applying the 75 percent assumption to the 1997 state prisoner population would indicate that approximately 680,000 inmates needed drug treatment but did not receive it. Drawing on the same assumption of a 75 percent need for treatment, figure 1-6 shows the increasing gap in treatment need vs. treatment services resulting from the dramatic increases in prison population growth during the 1990s.

Whether the more conservative or liberal estimates of the treatment need/service gap are relied upon, there is a clear indication that many prison inmates who need treatment are not receiving it. This gap persists and has been increasing, despite a considerable infusion of federal dollars into substance abuse treatment programs. For example, funding for treatment has been provided through the Residential Substance Abuse Treatment (RSAT) State Prisoners Formula Grant Program through the National Institute of Justice, as well as other programs, such as the Violent Offender Incarceration and Truth-in-Sentencing (VOI/TIS) Incentive Formula Grant Program and the Substance Abuse Prevention and Treatment Block Grant Program (CPO 1998). Yet even with such infusions, in absolute numbers, state prisons have decreased drug treatment for inmates, with those receiving drug treatment declining from 169,700 inmates in 1991 to 101,200 inmates in 1997 (Mumola 2000). This decline is significant in part given the dramatic growth in state prison populations,

which in turn were driven by increased drug incarceration rates. The decline also is significant because it stands in contrast to data indicating that state and federal correctional facilities operating as alcohol/drug treatment institutions rose from 92 in 1990 to 192 in 1995, and that 97 percent of correctional facilities offer drug and alcohol counseling (Bureau of Justice Statistics 1997).

Figure 1-6. Treatment Need in State and Federal Correctional Settings vs. Number of Inmates in Treatment Programs, 1990 - 1996



Source: Center on Addiction and Substance Abuse (1998).

Note: "The number of inmates needing drug treatment is calculated to be 75 percent of the total number of state inmates and 31 percent of the total number of federal inmates for each year based on estimates by the General Accounting Office, Center for Addiction and Substance Abuse, and the Federal Bureau of Prisons. The number of inmates in treatment is estimated from data reported in *The Corrections Yearbook*" (1990-1996) (CASA 1998, 114). The 75 percent estimate likely overestimates the extent of serious substance abuse problems (e.g., drug dependency disorder, as defined by the DSM-IV), but nonetheless echoes many self-report findings concerning the extent of drug use and abuse.

PUBLIC SUPPORT FOR DRUG TREATMENT

Although the relationship between drug treatment in correctional facilities and public support for drug treatment is not necessarily direct, examination of changes in public opinion can help provide a broader context in which to situate correctional drug treatment services. As table 1-3 shows, public concern about drug abuse peaked during the late 1980s and subsequently and dramatically returned to considerably lower levels. Specifically, in 1989, 39 percent of the American public viewed drug abuse as the single most important problem facing the country. A decade later, only 5 percent of the public expressed this view. Thus, one might speculate that one reason correctional drug treatment has not kept pace with increased demand is not simply that there has been an exponential growth in the need for drug treatment, but that there is increasingly little public concern about drug abuse.

KEY RESEARCH QUESTIONS

In reviewing the literature on the prevalence of drug use, abuse, and dependency/addiction in correctional settings, and the availability of drug treatment, it is evident that a number of critical research questions have yet to be addressed. Key research questions that future research should address include the following:

- Among newly sentenced offenders, how widespread is the need for drug treatment of various kinds? That is, what is the prevalence not only of drug use, but of drug abuse and drug dependency/addiction for specific types of drugs (heroin, cocaine/crack, alcohol, etc.)?
- What precisely is the gap between treatment need and services in jails and prisons?
- Which types of drug treatment services are most prevalent and why?
- How does the extent of drug abuse/addiction among prisoners compare with other problems, such as lack of education or vocational training, or mental or physical illness?
- What factors determine which offender services are funded?

Table 1-3. Public Concern about Drug Abuse, 1988–1999	
Percent Reporting Drug Abuse as the Single Most Serious Problem Facing the United States	
1988	11%
1989	39
1990	18
1991	11
1992	8
1993	6
1994	9
1995	6
1996	10
1997	17
1998	9
1999	5
Sources: Pastore and Maguire (1999).	

CHAPTER 2.

Screening and Assessment for Drug Treatment in the Criminal Justice System

Research has shown that not every program works for every person in every setting. Effective screening and assessment is the first step toward providing effective treatment care for incarcerated offenders. For this reason, the screening and assessment process has been called “the first line of defense” in the offender identification process. Because of the high demand and scarce resources for treatment, and because effective treatment can reduce both drug use/abuse and criminal behavior, it is important to identify and target those people with the greatest need for treatment as well as those who will benefit most from treatment. This chapter reviews the screening and assessment process as well as key issues bearing on the effectiveness of this process. Specific topics include defining screening and assessment, including identifying the uses of screening and assessment; reviewing commonly used instruments; describing the screening and assessment procedures used in correctional facilities; and discussing barriers to screening and assessment.

INTRODUCTION

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This chapter reviews the screening and assessment process as well as key issues bearing on the effectiveness of this process. Specific topics include defining screening and assessment, including identifying the uses of screening and assessment; reviewing commonly used instruments; describing the screening and assessment procedures used in correctional facilities; and discussing barriers to screening and assessment.

DEFINING SCREENING AND ASSESSMENT

Screening refers to the initial determination of a substance abuse, mental health, medical, or other problem. It is a short process, typically completed in 5 to 30 minutes and not requiring staff with expertise or extensive experience in the area. Oftentimes, screening is handled through a self-report, sometimes guided by a counselor, as opposed to an interview or interactive session. For drug treatment, the screening process not only identifies people with drug and alcohol problems, but also screens out those who are unsuitable for treatment.

After an initial screening, those who may need treatment are assessed and matched to treatment programs. Assessment is an in-depth process, often taking several hours and involving substance abuse professionals (Peters and Peyton 1998). During this stage, the needs of the client are explored, including coverage in the following areas: mental health history and status, family and social relationships, medical/health care history and status, and criminal justice history and status.

Effective screening and assessment involves the use of instruments, but these cannot be used alone to assess the client. Screening and assessment instruments must be supplemented by other information garnered from individual interviews and archival material such as criminal justice records, previous treatment records, drug test results, and observations. Physical signs such as dilated or constricted pupils, abnormal eye movements, and elevated or lowered vital signs can indicate alcohol or drug use. These signs can be discovered during a systematic and standardized observational evaluation at both the screening and assessment stages.

SCREENING AND ASSESSMENT IN THE CRIMINAL JUSTICE SYSTEM

Goals

Several guides break out the functions of screening and assessment (e.g., Inciardi 1993; Peters and Bartoi 1997; Peters and Peyton 1998). The more prominent functions are listed in table 2-1.

For assessment involving substance abuse issues, a different set of functions or goals can be identified. These are listed in table 2-2.

Table 2-1. Selected Goals of Screening

- Determine presence of substance abuse, mental health disorder, and medical conditions.
- Define major areas of strengths and deficits.
- Screen out persons with no identifiable problems.
- Identify individuals with a history of violent offenses/ behavior.
- Identify environmental factors (e.g., residential stability, relationship issues) or other problems (e.g., mental disorders, cognitive deficits) that may undermine success in treatment.
- Identify minimum level of security or supervision needed to promote public safety.
- Identify motivation for participation.
- Identify perceived benefits as well as disadvantages of participation in the program.

Sources: Inciardi (1993); Peters and Bartoi (1997); Peters and Peyton (1998).

Table 2-2. Selected Goals of Assessment for Offenders with Potential Substance Abuse Problems

- Examine the scope and nature of substance abuse problems.
- Identify specific psychosocial problems to be addressed in treatment, including mental health disorders.
- Understand the impact substance abuse has had on the individual, including its influence on criminal involvement.
- Determine the client’s level of maturation and readiness for treatment.
- Identify specific physical problems to be addressed in treatment planning.
- Identify the full range of service needs, pursuant to treatment planning.
- Match participants to particular services.

Sources: Inciardi (1993); Peters and Bartoi (1997); Peters and Peyton (1998).

In addition to screening and assessment, Peters and Bartoi (1997) identify a process called diagnosis, which occurs after screening and before assessment. The goals of diagnosis include identifying the presence of symptoms of mental health and substance abuse and developing a hypothesized psychosocial assessment. Diagnosis helps to determine where to focus treatment (e.g., mental disorder, substance abuse, or both), and allows professional judgments to complement actuarial-based assessments.

Timing

Assessment should occur at the earliest possible stage in the criminal justice system and should be a continuous process. An early assessment can help to guide the person through the system, via pretrial diversion and alternatives to incarceration, including drug courts. Assessment should be a comprehensive and continuous process because treatment itself is a process that is supposed to lead to change. Ideally, assessment precedes, occurs during, and follows interventions. Reassessments are valuable for several reasons (Bonta 1996). First, they protect the public by alerting the criminal justice system to changes in an offender's situation, which may be a sign to change supervision levels and/or intervene. Second, reassessments are an opportunity for the criminal justice system to evaluate its practices and programs and monitor program effectiveness via change in offender attitude, values, behaviors, etc. Figure 2-1 outlines the ideal type of assessment process.

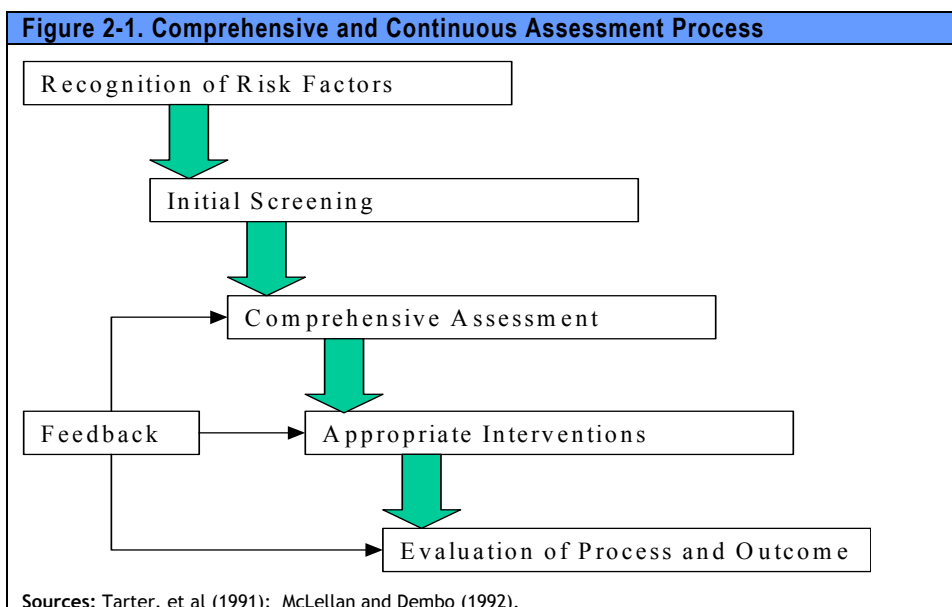
Peters and Bartoi (1997) recommend screening for both mental health and substance abuse problems at the earliest possible point in processing, but not before an offender has reached sobriety (usually through detoxification). Universal screening for *both* mental health and substance abuse should be conducted given the high rates of substance abuse and co-occurring disorders among criminal justice-involved offenders (Peters and Bartoi 1997).

Inciardi (1993) outlines the placement, purpose, and importance of continuous assessment, of varying types, throughout criminal justice processing:

- **Treatment needs assessments** should be in place to determine what type of programmatic intervention is appropriate—long-term or short-term residential treatment, intensive or moderate outpatient treatment, chemical detoxification, etc. In this capacity, needs assessment acts as a “broad sorting mechanism.”
- **Readiness for treatment assessments** should be implemented to understand better the extent to which clients are motivated for treatment, and whether they are likely to benefit from the services offered to them.
- **Comprehensive treatment planning assessments** should occur once a client reaches a given program to determine how intensive the treatment should be and on which areas it should focus.
- **Treatment progress assessments** should be undertaken periodically to determine whether clients are responding to treatment and whether to change an intervention.

• **Treatment outcome assessments** are also critical to determine the extent of behavioral change, success, and failure.

Treatment screening and assessment can happen at a variety of “impact” points in the system and ideally can help to shape the best system options for the offender. [Discussions of system impact points can be found in reports by the National Institute of Corrections (Carter



1991) and Vigdal (1995). In addition, the Center for Substance Abuse Treatment has produced a Criminal Justice System Planning Chart for display, available through the National Clearinghouse for Alcohol and Drug Information at 1-800-729-6686 or 301-468-2600.] For the purposes of this report, we have adapted information from several lists. The system “impact” points and opportunities for intervention and data collection are shown in table 2-3, and the importance of screening and assessment at several of these “impact” points is described below.

Pretrial

During the pretrial phase, the largest numbers of potential substance abusers are in the criminal justice system. This can be the best time for intervention and screening because of the ability to gather information about the largest group of people who have had some kind of contact with the law. Critical information about the person should be collected at this phase, including criminal record, alcohol or drug abuse assessment and treatment information, and general history. This information should follow the offender throughout processing. At this stage, information can be used to guide system options, including arraignment, plea bargaining, and the choice of an alternative to prison.

To alleviate prison crowding, a well-planned and monitored pretrial release program can be an effective alternative to prison. Any such program should be based on a careful assessment of the defendant, appro-

priate treatment and sanctions, and continuous monitoring and evaluation.

Diversion from Incarceration

Drug Courts. Drug courts have made a major impact in the criminal justice system over the past decade. Currently, there are over 400 drug courts throughout the country aimed at diverting addicted offenders to a different “system,” one of drug treatment, monitoring, and criminal sanctions.

Screening and assessment for drug courts provides a structured way for the courts to understand the risks and needs of the participant. A screening and assessment system marks the beginning of the drug court process and helps to integrate diverse information to form a comprehensive picture of each individual participant. It provides the foundation for supporting other drug court functions, including treatment planning, placement in treatment, and identification of the need for other services. It also provides the offender with an orientation to the program, and thus should be structured for the participants to learn about the program and for the program to learn about the participants. At this stage, screening and assessment can be used to assess motivation, commitment to treatment, and “readiness” for treatment.

Boot Camps. Boot camps are one alternative for typically young, nonviolent offenders, although the programs are not exclusively for young offenders. Boot camps involve intensive supervision and treatment

Table 2-3. Impact Points and Their Assessment Implications

Impact Point	Assessment Implications
Pretrial	Screening and assessment can be used with the largest number of potential substance abusers in the system. They can be used to raise awareness of potential problems and to identify the need for resources.
Pre-sentencing	Screening and assessment can be used to divert offenders into treatment programs.
Drug Courts	A primary diversionary program is a drug court, which provides an alternative, nontraditional form of sanctioning for addicted offenders. Drug courts, which rely on appropriate identification of substance users/abusers, focus on drug treatment and monitoring as well as timely criminal sanctions.
Sentencing	Sentencing provides an opportunity to link treatment with sanctioning.
Probation	Assessment can provide better case management through identification and treatment of needs.
Intermediate Sanctions	As with probation, intermediate sanctions can center around treatment plans even as they include a focus on punishment.
Jail/Prison	Screening and assessment assists with monitoring offenders, planning treatment, and providing other special needs while in an incarcerated setting.
Post-incarceration	Data about parolees is important for case management, maintaining treatment progress, and transitioning back into the community.

Source: Vigdal (1995).

programs; they are structured and disciplined programs requiring physical training, work, and treatment. By January 1996, a majority of states (37) offered boot camps as an alternative to incarceration and, at the federal level, the Bureau of Prisons operated two boot camps. Potential participants in boot camps are screened for substance abuse, criminal history, and psychological capacity for the program. Careful matching is critical because the programs focus on techniques such as confrontation, discipline, and behavior modification. Reviews of boot camps have been consistently unfavorable; indeed, according to one review, boot camps are one of the “unmitigated failures” of the new treatment models (Gendreau and Goggin 1997, 273).

TASC. Another popular program is Treatment Alternatives to Street Crime (TASC). This program provides a mix of supervision, treatment, and sanctions and rewards, involving close collaboration with community treatment programs. The TASC program provides screening, assessment, treatment planning, monitoring, urinalysis, and court liaison functions. The program refers a client to a community-based treatment program, monitors the client’s progress and compliance, and reports results back to the referring criminal justice agency. TASC programs can help alleviate prison crowding through diversion to treatment, when it is deemed—through careful screening and assessment—to be the most appropriate course of action for the defendant. A 1996 effectiveness study of TASC found that outcomes for all study sites (7) were moderately favorable and confined to a high-risk offender subsample (Anglin et al. 1996).

Probation, Jail, Prison, and Post-Incarceration/Parole

Probation. The majority of adjudicated offenders are placed on probation, which is community-based supervision that includes a mix of counseling, surveillance, and support services. According to Vigdal (1995), the role of probation has changed dramatically over the past 30 years, from community correction programs for nonviolent offenders to community correction programs addressing a complex set of needs and risk management for offenders requiring a broad array of specialized services. Today, effective probation programming faces significant challenges due to diminishing resources, funding, and personnel.

Continuous screening and assessment is particularly important for offenders on probation. On one hand, probation officers must monitor increasing numbers of probationers and help address their needs. On

the other hand, probation officers must give priority to supervision and compliance with court-ordered sanctions. Maryland’s Break the Cycle program, for example, offers frequent testing and sanctions for probationers in addition to enhanced supervision. Other community-based initiatives include Intensive Supervised Probation or Parole (ISPs) (Petersilia 1995). However, the treatment emphasis is not as prominent in ISPs, and study results of ISPs have shown them to be largely ineffective.

Jail. According to a recent Substance Abuse and Mental Health Services Administration (SAMHSA) report (2000), assessment occurs in 63.6 percent of jails in this country. Due to the typically shorter terms of incarceration, many jails offer detoxification and short-term counseling and self-help groups. Jails can also use drug testing as a way to monitor offenders, identify drug problems, and control drug use. According to a Bureau of Justice Statistics report (Wilson 2000), 7 out of every 10 jails in 1998 reported having a drug testing policy, either urinalysis or another test to determine drug use. Sanctions for positive tests were primarily deterrent-based—that is, loss of good time (52.2 percent of jurisdictions), taking privileges away (69.9 percent of jurisdictions)—as opposed to mandatory treatment or other assistance (8 percent of jurisdictions).

Prison. According to the same SAMHSA (2000) report, assessment occurs in 67.1 percent of state prisons and 86.8 percent of federal prisons. Prison provides a unique atmosphere for drug treatment. The offender will most likely be in the prison for a considerable amount of time (typically more than one year in most states), the atmosphere is hypothetically devoid of drugs and alcohol (although this is a concern in many state and federal prisons), and the inmate is away from a criminogenic environment. Comprehensive risk and needs assessment should take place upon entry into the facility and upon release (and, if treatment is provided, throughout treatment). Intake assessment is a standardized process for all federal prisons, but the process varies considerably from state to state.

Post-Incarceration/Parole. The period after incarceration is an extremely crucial and potentially stressful time in an offender’s recovery. It is important not only to prepare the person for the transition (relapse prevention), but also to continue the case management and assessment process.

History and Types of Assessments

First-, Second-, and Third-Generation Assessments

Both historically and conceptually, there are first-, second-, and third-generation assessments (Bonta 1996). First-generation assessment refers to clinical judgments, or “gut feelings” (Andrews and Bonta 1995). A clinician arrives at a diagnosis based on an information-gathering session that includes a flexible interview, perhaps a psychological test, and a review of files, if available. Several meta-analyses have come to the conclusion that these types of clinical assessments are not accurate and are poor at predicting offender risk (Andrews and Bonta 1998).

A better alternative is the second-generation approach, and the best alternative, to date, is the third-generation approach. Both of these approaches use the actuarial method, using statistical, empirical, and validated assessment batteries. Second-generation approaches are atheoretical and static; that is, they have no theoretical base and primarily capture historical, or unchangeable, items (Andrews and Bonta 1998; Cullen and Gendreau 2000).

Third-generation risk assessments differ from second-generation assessments because of the inclusion of dynamic risk factors and an emphasis on standardization. A 1996 meta-analysis of predictors of recidivism (Gendreau, Little, and Goggin 1996) found that most of the predictors were dynamic in nature; that is, the predictors were changeable attributes of the person. The focus on change is important because it is central to effective treatment; an offender’s criminal history cannot be changed, but his or her beliefs, attitudes, and behaviors can.

Risk, Needs, and Psychological Assessments

There are several types of assessment approaches: risk, need, and psychological assessment (see table 2-4). Risk assessment provides a security function, al-

though it also provides treatment implications; needs assessment provides a treatment/matching function; and psychological assessment provides a treatment/matching function. There is no one instrument that can perform all of these functions and capture all necessary information to make an informed decision about treatment.

Risk assessments (or “offender classifications”) happen at various points in the correctional system, most commonly at pretrial release and prison intake. Risk assessment instruments attempt to quantify risk and to reveal psychological “types” (i.e., individuals who are predisposed to behavioral problems and crime) (van Voorhis et al. 1997; Andrews and Bonta 1998). Risk assessments thus provide a tool for protecting society and maintaining safety in prison. How likely is it that the offender will escape, commit a new offense, or cause harm to someone while in care or out of care? How likely is it that a given personality “type” will be a disciplinary problem? Risk assessment answers these questions and helps to guide placement of the offender into probation, incarceration, or alternatives to prison. It also helps to assess placement and level of guardianship while in a particular correctional setting.

In addition to these uses, risk assessment should be considered for assisting with appropriate treatment placement. Andrews and Bonta (1998) and others have shown that treatment is optimal when matched appropriately to risk level. For example, there are greater reductions in recidivism for high-risk offenders who are placed in intensive services than for high-risk offenders placed in minimal treatment services. By contrast, low-risk offenders matched with low-intensity programs experience greater reductions in recidivism compared with low-risk offenders in high-intensity programs.

Needs assessment focuses primarily on internal classification, needs in general, and needs for treatment. The “needs principle” (van Voorhis et al. 1997) assumes

Table 2-4. Principles of Assessment and Their Treatment Implications

Assessment Focus	Definition	Treatment Implications
Risk	Risk assessments are offender classifications	Characteristics of people and their circumstances that are predictive of future criminal conduct.
Need	Needs assessments address criminogenic and noncriminogenic needs	Treatment services best target those characteristics of higher-risk individuals and their circumstances that, when changed, actually link with variation in criminal conduct.
Psychological	Assessing psychological traits to classify for treatment	The most effective styles and modes of treatment service are those matched with the needs, circumstances, and learning styles of individuals (“responsivity”).

Source: Bonta (1996).

that institutional settings have a moral obligation to meet certain needs of the inmates, particularly substance abuse counseling, job development, education, family/relationship counseling, and medical assistance.

According to Andrews and Bonta (1998), however, it remains unclear which needs are associated with subsequent criminal behavior. To this end, Andrews and Bonta (1998, 243) distinguish between criminogenic and noncriminogenic needs:

Criminogenic needs are a subset of an offender's risk level. They are dynamic attributes of the offender that, when changed, are associated with changes in the probability of recidivism. Noncriminogenic needs are also dynamic and changeable, but these changes are not necessarily associated with the probability of recidivism.

The four most common criminogenic needs are antisocial associates, antisocial values or attitudes, history of antisocial behavior, and skill deficiencies, such as poor problem-solving skills, self-management or self-efficacy problems, impulsivity, poor self-control, and irresponsibility (Gendreau, Little, and Goggin 1996). Unfortunately, commonly used needs assessment instruments do not help to identify all of the important criminogenic needs. Even when better needs instruments are available, correctional personnel frequently use them for purposes other than treatment; for example, they may be used to help correctional personnel allocate resources and maintain client records (van Voorhis et al. 1997).

Psychological assessment focuses on placement and treatment matching based on personality and/or behavioral criteria. Psychological evaluations can reinforce risk classifications and add more information for the treatment-matching process, including information about treatment responsivity (Bonta 1996).

Several different psychological instruments typically are used in correctional settings, each resulting in a different personality type classification. For example, in one test, classification includes categories such as "asocial aggressive," "immature dependent," "neurotic anxious," "manipulator," and "situational" (Behavioral Classification System for Adult Offenders, also known as the Adult Internal Management System [Quay 1983]). In another test, profile types are described with nondescript names (Easy, Baker, Able, Charlie, etc.) to aid in determining behavior characteristics without bias. One of the most common is the Megargee MMPI-based Typology (Megargee and Bohn 1979), which is adapted from the Minnesota Multiphasic Personality Inventory (MMPI).

As noted, psychological assessments address the responsivity principle (van Voorhis et al. 1997), that is, they address factors such as intelligence, anxiety, and cognitive maturity, which affect how a person will respond to different treatment approaches. The "responsivity principle" refers to linking these factors to a treatment plan. Bonta (1996) has described the importance of focusing on the responsivity principle:

Matching on risk and targeting the appropriate criminogenic needs are fundamental to effective rehabilitation, but attention to responsivity factors can serve as a catalyst for treatment. For example, an agency may deal with high-risk offenders who have the same criminogenic needs (substance abuse), but within that group there are individuals differing along such dimensions as anxiety, intelligence, self-esteem, and so on. These factors affect how well the client responds to the style and modes of therapy and necessitate a matching of client characteristics with treatment. It is quite possible that withdrawn and shy clients may respond best when treatment is given on an individual basis, whereas extroverted, self-confident clients may respond well to group therapy format (23).

In addition to risk, targeting criminogenic needs, and responsivity, Andrews and Bonta (1998) emphasize the importance of professional discretion. While the principles of risk, need, and responsivity can provide a fairly objective "picture" of the person, there will always be cases that do not "fit the mold." Andrews and Bonta (1998) suggest that professional judgment should play a role in the assessment. However, this kind of discretion should be undertaken systematically and scientifically. If new patterns begin to arise from this type of assessment, then perhaps new principles of assessment should be created. The principle of professional discretion is, according to Andrews and Bonta (1998), unlike the "indefensible" first-generation approaches, which drew on subjective clinical and/or intuitive assessments and many of which are still used today. Nonetheless, professional discretion constitutes but one part of a comprehensive assessment, albeit one that provides a safeguard against instrument error and allows for the exercise of informed judgment.

An ideal approach to treatment would include an assessment of risk predictors, criminogenic needs, and a psychological assessment, with a focus on responsivity and the exercise of discretion and judgment where appropriate. In an ideal setting, a treatment provider would collect and use risk, needs, and responsivity information to create a personalized treatment plan.

Ongoing assessment then would be provided to identify changes in dynamic/criminogenic factors and potential changes in relevant outcomes, such as drug use/abuse and recidivism.

Assessment and Effective Treatment

Comprehensive assessments are efficient and effective because they are able to isolate human risk, need, and psychological aspects that can be affected by treatment, but assessment only works when the information garnered is used for proper client matching, including attention to the specific needs of certain populations, such as women and offenders with co-occurring disorders or infectious diseases. Specific issues that research shows need to be addressed for treatment to be effective are outlined in table 2-5 and discussed below.

Client Matching: Who Needs What Type of Treatment?

Effective treatment is premised on identifying those who have treatment needs and addressing their level of risk (Carter 1991). For example, research by McLellan et al. (1983) found that clients appropriately matched to treatment were more motivated than clients placed in any available program. They stayed longer, experienced fewer negative discharges, and, consequently, showed greater improvement. It is particularly important to match the characteristics of the offenders, therapists, and programs. Gendreau (1996, 123) describes the matching process as involving several dimensions, including “matching the treatment approach with the learning style and personality of the offender. . . , matching the characteristics of the offender with those of the therapist. . . , and matching the skills of the therapist with the type of program.” Information learned through risk, need, and psychological assessments can be used to match clients to treatment.

Table 2-5. Issues for Client Matching and Treatment

- Client has drug and/or alcohol addiction/alcohol dependency.
- Client is ready for treatment, has sufficient time to complete treatment, and will likely complete treatment.
- Client has ability to understand the program/the principles behind the program.
- Assess and treat dynamic factors of the person/address criminogenic needs.

Treat Those Who Will Complete Treatment

Research in the treatment field shows that program “completers” fare better than “non-completers” on outcomes such as drug relapse and recidivism (Wexler et al. 1992). Therefore, it is most efficient to focus resources on those who may complete treatment. However, relatively little research has focused on the value of assessments for predicting treatment retention in corrections-based programs (Gendreau, Goggin, and Paparozzi 1996). Although there is considerable research about the value of assessment-based classification and treatment placement, there is less evidence about the correlation of these assessments with time in or completion of treatment.

Treat Those Who Are “Ready for Treatment”

Contrary to conventional wisdom, research shows that coerced treatment can be effective, sometimes even more than voluntary treatment (Leukefeld and Tims 1988). In fact, the traits of addiction often include denial and an inability to recognize a problem; without recognition there can be no “readiness.” Thus, those who lack recognition in many ways are prime candidates for intervention (Inciardi 1993). Indeed, biomedical research shows that treatment can be effective even if an offender is not voluntarily participating (NIDA 1999).

However, some research shows that clients who are “ready” for treatment show greater improvement. Peters and Bartoi (1997) list several studies demonstrating the importance of readiness for treatment and its effect on program completion and outcomes. These studies indicate that motivation level is an important predictor of treatment compliance, dropout, and outcome, and is useful in making referrals to treatment services and in determining prognosis. They also show that treatment is likely to be ineffective until individuals accept the need for treatment of mental health and substance abuse problems. In recognition of the importance of treatment readiness, Gorski (1991) has created a Developmental Model of Recovery that breaks down the mental state of readiness into several phases and corresponding tasks for each stage; “readiness” is conceptualized as a series of stages rather than a single state.

Treat Dynamic Factors

Recent meta-analyses reveal that targeting dynamic, or changeable, factors can lead to the largest reductions in relapse and recidivism (Andrews 1995; Gendreau, Little, and Goggin 1996; Andrews and

Bonta 1998; Cullen and Gendreau 2000). Assessment instruments thus ideally must be capable of identifying these factors, but they also should include risk and psychological assessment (Bonta 1996), since these can be used to match offenders with appropriate treatment and levels of supervision.

Offender Subgroups: Assessment Issues and Treatment Implications

Female Inmates

Although the prevalence of women in prison with substance abuse problems is much less than in the male inmate population, these problems nonetheless require treatment. However, treatment may need to be tailored to meet the particular needs of female inmates. For example, according to Smith (1993), incarcerated women typically are low-income, single heads of households with dependent children, unemployed, from families with histories of incarceration, victims of physical and sexual abuse prior to age 18, with multiple medical problems, such as pregnancy (approximately one-fourth of female inmates entering prison are pregnant), HIV/AIDS, sexually transmitted diseases, and tuberculosis. Such factors can affect participation in and the effectiveness of treatment, especially if left unaddressed.

The majority of assessment instruments have been created for a male population and focus on factors centering around traditional male roles. However, some instruments, such as the Addiction Severity Index, have been modified to address women's needs and to be sensitive to women's relationships and living arrangements. For example, assessment instruments used with women may need to measure parenting skills and responsibility for child care since removal from their role as mother or caretaker may produce feelings of depression and/or guilt, which in turn may affect treatment delivery.

Other concerns include the recognition of alcohol problems, traditional criminal profiles, and psychological and medical differences between men and women (Inciardi 1993). Women may not have faced their abuse problem because they may be less likely to be in the workforce or around people that may pressure them into realizing their problem and seeking treatment. An assessment process can be an unexpected "reality check" that raises awareness about a substance abuse problem. Female alcoholics also have higher rates of depression than either women in the general public or male substance abuse offenders. Finally, there is re-

search that suggests that females process alcohol and drugs differently than males (Inciardi 1993).

Co-Occurring Disorders: Mental Health and Substance Abuse

Rates of mental health problems and substance abuse problems are much higher among inmates than the general population (Lurigio and Schwartz 2000; Peters and Bartoi 1997). The most common mental disorders among inmates are psychosis, depression, and bipolar disorder. Dennis (1998) reported on the lack of diagnosing co-occurring mental disorders, citing information from the State of Illinois, where only about 6.3 percent of co-occurring mental health problems were reported. By contrast, the literature suggests that over half of people with substance use disorders have co-occurring mental disorders (Kessler et al. 1994) and that over 65 percent of those presenting for treatment have co-occurring mental disorders (Dennis 1998). Other studies (Chulies et al. 1990; Cote and Hodgins 1990; Mirin et al. 1988) show that:

- 75 percent of addicted offenders have histories of depression
- 25 percent of addicted offenders have histories of major depression, bipolar disorder, or atypical bipolar disorder
- 9 percent of addicted offenders are schizophrenic.

The recognition of co-occurring disorders is especially important because of the unique challenges in treatment that offenders with co-occurring disorders present. It can be difficult to determine these multiple problems, not only because of human error and lack of staff expertise and training, but also because the sheer complexity of the problems can make diagnosis difficult even for trained professionals. Peters and Bartoi (1997) describe several prominent challenges:

- Use of alcohol and drugs can create mental health symptoms.
- Alcohol and drug use may precipitate or bring about the emergence of some mental health disorders. Mental health disorders can also precipitate substance use disorders.
- Mental health symptoms may be exacerbated, or worsened, by alcohol or drug use.
- Mental health symptoms or disorders are sometimes mimicked by alcohol and drug use.

- Alcohol and drug use may mask or hide mental health symptoms or disorders that are actually present. Mental health symptoms are often not identified until after a long period of time.

Another challenge when dealing with co-occurring disorders, in addition to proper diagnosis, is what to do with the person once he or she has been identified. Criminal offenders who are also alcohol or drug abusers and have mental disorders need specialized, coordinated treatment. Yet it is common for substance abuse treatment programs not to admit offenders with mental disorders and, conversely, for mental health programs not to admit offenders with substance abuse problems (Vigdal 1995). Programs for people with comorbid disorders have been called “inadequate,” with little to no research to date on the percentage of offenders receiving both substance abuse and mental health treatment (Lurigio and Schwartz 2000).

Infectious Diseases

Because of the isolated, often overcrowded settings, prisons can contribute to the spread of infectious diseases, such as HIV/AIDS and tuberculosis (TB), to inmates and ultimately to society. A recent Center on Addiction and Substance Abuse report (CASA 1998) found that HIV infection rates are up to six times higher among inmates compared with the general population. Injection drug users are the highest risk groups in prison. Forty percent of inmates who used drugs in the past month before their arrest had used a needle to inject drugs; by contrast, homosexual contacts only account for 2.2 percent of cases of HIV/AIDS among inmates. Rates of HIV/AIDS are slightly higher among female than male inmates.

Given the risks associated with these types of infectious diseases, all assessments should include questions about primary risk factors for HIV/AIDS, especially given the link between frequent drug use and HIV/AIDS. Notably, however, HIV testing is not mandatory in all systems. Confidentiality regulations and some state laws protect this information. In 1997, all states offered HIV testing, although with different testing criteria. Only 18 states test all entering inmates, most systems (44 out of 52) test based on symptoms or inmate request, and 15 states test high-risk offenders (Maruschak 1999).

Prisons historically constitute high-risk settings for the spread of TB. They frequently are crowded, and the buildings typically are older, with poor ventilation and circulation. However, incidents of TB in prisons have

not been disproportionate to the general population for a period of time. In 1992, the number of incidents of TB peaked, due to a resurgence of a new multi-drug resistant strain of TB, MDR-TB. Incarceration provides an opportunity for early detection and treatment of TB. However, a 1992 Centers for Disease Control and Prevention and National Institute of Justice study found that one-third of state and federal systems and one-half of jails did not test for TB (routine skin tests) or include TB in their assessments (Vigdal 1995). When proper screening occurs, it is relatively easy to provide a course of preventive medicine and control the disease in an isolated setting such as a jail or prison.

SCREENING AND ASSESSMENT INSTRUMENTS

Screening and assessments are conducted using a wide range of instruments, yet to date, little agreement exists about which are best, leading one review to state that development of proper and useful instruments constitutes a critical need (Shearer and Carter 1999).

There are several issues relevant to evaluating and using assessment instruments. They should, for example, be standardized and tested for reliability and validity; that is, they should consistently identify the same condition (e.g., drug dependency), and that condition should be the focus of the assessment (i.e., drug dependency as opposed to simple drug use). In addition, assessment instruments should be adjusted to address variation in gender and race. They must address at least basic demographics and criminal and drug history, and they should address dynamic factors because these factors can be addressed in treatment and can affect change in criminal conduct.

Carter and associates (1991) outline several ways in which assessment instruments can be misused, including allowing the instrument to structure a mechanical approach to what is often a complex problem; conducting supervision and service needs assessments with an instrument that has not been validated; using an instrument that was designed for a different purpose or for populations other than that for which it was designed; and perhaps most important, allowing the instrument to make, rather than guide, decisions.

This chapter does not provide a review of every available screening and assessment instrument because there are literally hundreds in use. [For detailed descriptions of instruments, original citations and references to the creators of the instruments, and/or actual

instruments, see Boland, Henderson, and Baker (1998); Dennis (1998); Inciardi (1994); and the following CASA web site for a listing of instruments: <http://casaa-0031.unm.edu/inst%5Cinst.html>].] However, table 2-6 provides an annotated listing of some of the more common instruments in the treatment and correctional literature and in use in jails and correctional facilities across the country.

Screening Instruments

The screening process should be designed to err on the side of “false-positives” or inclusiveness. Some argue that it is better to include more people at the screening stage and move them forward to the assessment phase, only to be excluded at that phase, than to be excluded at the screening phase because of an inaccurate screen. However, if resources are limited, an institution may place more emphasis on limiting assessments only to those cases in which an initial screen strongly suggests the presence of a substance abuse problem.

In addition to standard self-report screening questions, the initial screen can include biological testing, such as urinalysis, breathalyzers, or blood tests, as an objective way to identify substance use. Other useful techniques, especially when an individual may still be under the influence or in withdrawal (for some drugs), include observing for drug use and using drug recognition techniques.

A survey of drug courts found that the most commonly used instruments for screening were the ASI (Addiction Severity Index), the SASSI (Substance Abuse Subtle Screening Inventory), the MAST (Michigan Alcoholism Screening Test), and the OPI (Offender Profile Index). Inciardi (1993) reported that the CAGE, MAST, and OPI are among the most commonly used for screening in the criminal justice system. (CAGE is short for four questions: Have you ever thought you should Cut down on your drinking? Have you ever felt Annoyed by others’ criticism of your drinking? Have you ever felt Guilty about your drinking? Do you have a morning Eye-opener?)

Few studies have undergone a comparative analysis of the effectiveness of screening instruments. Peters and Hunt (2000) wrote a policy brief outlining a study by Peters et al. (2000) of this kind and the implications of the findings. The study consisted of administering eight screening instruments to a sample of 400 prison inmates in Texas in 1996. The chosen screening instruments were:

- Addiction Severity Index (ASI)—Alcohol Use section
- Addiction Severity Index (ASI)—Drug Use section
- Drug Abuse Screening Test (DAST-20)
- Michigan Alcoholism Screening Test (MAST-short version)
- Substance Abuse Subtle Screening Inventory (SASSI-2)
- Simple Screening Instrument (SSI)
- Texas Christian University Drug Screen (TCUDS)

These instruments were chosen based on several criteria: general acceptance by the research and treatment community; frequency of use; availability (i.e., in the public domain); and applicability to correctional settings (Peters and Hunt 2000). The Structured Clinical Interview for DSM-IV (SCID-IV) was used as “diagnostic criterion measure”; results from the screening instruments were measured against this standard for detection of both substance abuse and substance dependence disorders.

- Alcohol Dependence Scale (ADS)

Table 2-6a. Common Instruments Used for Clinical and Research Purposes

Instrument	Area (X=used, x=used somewhat)							Skill Level	Comments
	Screening	Diagnostic	Placement	Reporting	Tx Plan	Severity	Outcome		
Addiction Severity Index (ASI) (McLellan et al. 1985[[1983, per refs?]])	x		x	x	X	X	X	M	Oldest and most widely used, in the public domain, technical support, moderate but well-known psychometrics. It does not cover most modern diagnostic criteria and is not fully standardized.
Drug Abuse Treatment for AIDS-RISK Reduction (DARTAR) (Simpson 1992)				x	X	X	X	L	A descendent of DARP, this form has been used for almost a decade in a series of clinical research projects at Texas Christian University and has appeared in several public-domain evaluation handbooks produced by NIDA and others.
Form 90 (Miller 1991)					x	x	X	M	This was one of the main instruments used in Project MATCH and was used to generate many of the clinical reports for its interventions.
Global Appraisal of Individual Needs (GAIN) (Dennis 1998)	x	X	X	X	X	X	X	L	The GAIN was designed to serve as a standardized biopsychosocial assessment with integrated components for screening, diagnosis, placement, treatment, planning, outcome monitoring, and research. Variations of this instrument have been used for standardized intake and research projects funded by NIDA, NIAAA, CSAT, and several states. Selected items can be used as a 20-30 minute screening version. Preliminary psychometric and normative data now are available, but no commercial support is available.
Individual Assessment Profile (IAP) (Flynn et al. 1995)			X		X	x	X	L	This instrument blended questions from the ASI with other research measures from the Drug Abuse Treatment Outcome Study (DATOS) and was used for centralized intake as part of the DC Initiative and several other studies.
Recovery Attitude and Treatment Evaluation (RAATE) (Mee-Lee et al. 1992)	X	x	X			X		L	This was one of the first tools developed for screening and patient placement and has scales that can help inform diagnostic or placement criteria (which it predates) and its usefulness for outcome monitoring is limited because its questions are not time-bound and do not cover service utilization.
Treatment Services Review (TSR and Teen-TSR) (Kaminer et al. 1997; McLellan and Dembo 1992)					X		X	L	A complementary measure to the ASI, the TSR is designed to track the subsequent behavior and services received each week. It is in the public domain.

Source: Dennis (1998).

Notes: This is an abbreviated table and does not include juvenile/adolescent instruments or several instruments not mentioned in correctional literature. For complete list and citations, see Dennis (1998, 28-34).

For skill levels, L = low; preprinted questions and responses that can be self- or clerically administered. M = medium; clinical schedule of issues to cover that may require training on critical concepts and limited probing. H = high; requires detailed clinical judgment/ratings and extensive quality assurance in order to achieve reliability.

Table 2-6b. Common Instruments Used for Clinical and Research Purposes: Single Domain Instruments

Instrument	Area (X=used, x=used somewhat)							Skill Level	Comments
	Screening	Diagnostic	Placement	Reporting	Tx Plan	Severity	Outcome		
Alcohol Use Disorders Identification Test (AUDIT) (Babor, de la Fuente, et al. 1992).	X	x				X		L	Developed by the World Health Organization, this is designed as a screener to identify problem drinkers, including those who might not yet meet diagnostic criteria but are of interest for public health interventions.
Beck Depression and Anxiety Inventories (Beck 1990, 1996)	X	x				X	X	M	These are among the most widely used measures of depression and anxiety and are commercially supported.
Behavioral and Symptom Identification Scale (BASIS 32) (Medical Outcome Study 1997)	X		x			X	X	L	This short battery, which is geared toward mental health populations, measures psychosis, daily living/role functioning skills, relation to self/others, impulsive addictive behavior, and depression.
CAGE (Mayfield et al. 1974)	X							H	Although very popular with clinicians and public aid programs, this four-question public domain screener is often unreliable unless it is accompanied by extensive training and quality assurance.
Clinical Institute Withdrawal Assessment (CIWA). (Sullivan et al. 1989)	X	X	X			X		H	Clinical rating scale combining physiological symptoms, observations, and self-reported symptoms. Unfortunately, it is focused only on alcohol and may not generalize to other drugs.
Drinker Inventory of Consequences (DrInC) (Miller, Tonigan, and Longabaugh 1995)	X	x			X			L	Although limited to drinking, this scale is particularly useful for identifying the specific problems caused by drinking that can be addressed in treatment.
Drug Abuse Screening Test (DAST) (Skinner 1982)	X					X	X	L	A short screener parallel to the Michigan Alcohol Screening Test (MAST) that is often used to screen for substance abuse and/or to measure change. Unfortunately, it does not map directly on to DSM-IV.
Family Environment Scale (FES) (Moos 1974)					x	X	X	L	This and several subsequent shorter versions are among the most common measure of family functioning and are particularly important to evaluating family therapy or family services.
Hamilton Depression Scale (HAM-D) (Hamilton 1967)	X	x				X	X	M	The HAM-D is one of the original dimensional measures of depression.
Michigan Alcohol Screening Test	X					X		L	The original 25-item public domain versions and several subsequent shorter versions have been used widely for over 20 years, but have only limited correlation with both the frequency of use and measures of dependence.
Minnesota Multiphasic Personality Inventory (MMPI and MMPI-2) (Butcher et al. 1989; Hathaway and McKinley 1951)	x	x			X	X		L	A battery of personality measures, including the MacAndrews scale related to substance use and measure related to impulsiveness, stress, and several co-occurring problems.
Readiness to Change Questionnaire (RTCQ) (Heather et al. 1991)	X		X		X			L	The RTCQ is a scale for measuring treatment readiness based on stages of change theory. This version is copyrighted, but can be used at no cost.

Table 2-6b. Common Instruments Used for Clinical and Research Purposes: Single Domain Instruments (continued)

Instrument	Area (X=used, x=used somewhat)							Skill Level	Comments
	Screening	Diagnostic	Placement	Reporting	Tx Plan	Severity	Outcome		
Substance Abuse Subtle Screening Inventory (SASSI) (Miller 1985)	X	x						L	This is a screener that has been used primarily in schools, criminal justice facilities, and obstetricians' offices. It has a scale that facilitates diagnosis for substance use and is commercially supported.
Symptom Checklist-90 (SCL-90, SCL 90-R) (Derogotis et al. 1974)	X	x	x			X	X	L	One of the oldest psychiatric dimensional measures, the SCL-90 and its commercial cousins (SCL 90-R, Brief Symptom Inventory) are among the most widely used and commercially supported instruments. Although the scales can inform diagnosis, they do not match current criteria (which they predate).
Structured Clinical Interview for DSM-III-R (SCID) (Spitzer et al. 1992)		x						M	Primarily a diagnostic and epidemiological interview. Some manuals, software, training, and other support are available.

Source: Dennis (1998).

Notes: This is an abbreviated table and does not include juvenile/adolescent instruments or several instruments not mentioned in correctional literature. For complete list and citations, see Dennis (1998, 28-34).

For skill levels, L = low; preprinted questions and responses that can be self- or clerically administered. M = medium; clinical schedule of issues to cover that may require training on critical concepts and limited probing. H = high; requires detailed clinical judgment/ratings and extensive quality assurance in order to achieve reliability.

Peters et al. (2000) found that the most effective instruments in screening for substance abuse were the Alcohol Dependence Scale (ADS) and the Addiction Severity Index (ASI) instruments, the Texas Christian University Drug Screen (TCUDS), and the Simple Screening Instrument (SSI) (see table 2-7).

Peters et al. (2000) found that these instruments outperformed the other popular instruments in the screening process on detection of disorders, though all instruments were found to have been reliable. They concluded that there can be considerable variation in screening instruments and their efficacy and that two of the three “most effective” instruments are available free of charge (possible significant savings for systems that are purchasing instruments). Peters et al. also noted that the following factors can help determine the type of instrument that an institution should choose:

- If the primary goal of screening is to reduce inappropriate referrals to treatment (“false positives”), then TCUDS or the ADS/ADI-Drug are best.
- If the goal of screening is to identify the largest number of offenders with substance “dependence” disorders, with less concern for inappropriate referrals to treatment, then the SSI is the most desirable instrument.
- The ADS, TCUDS, and SSI may be self-administered, while the ASI-Drug Use screen was developed for use in an interview setting.

Table 2-7. Effective Screening Instruments

Effective Instruments

- Combination of both the Alcohol Dependence Scale (ADS) and the Addiction Severity Index (ASI).
- Texas Christian University Drug Screen (TCUDS).
- Simple Screening Instrument (SSI).

Recommendations

- If primary goal is to reduce inappropriate referrals to treatment, then use TCUDS or the ADS/ADI.
- If primary goal is to identify the largest number of offenders with substance dependence disorders, use the SSI.
- The ADS, TCUDS, and SSI may be self-administered, while the ASI-Drug Use screen was developed for use in an interview setting.

Source: Peters et al. (2000).

- For mental health screening, the Beck Depression Inventory (BDI) the Brief Symptom Inventory (BSI), the Referral Decision Scale (RDS), and the Symptom Checklist 90-Revised (SCL-90-R) are among the most common and have been validated for use in detecting mental health symptoms (Peters and Peyton 1998).

Several screening instruments have been created for special populations by modifying current instruments. In particular, traditional men’s instruments have been modified for women. For example, the TWEAK was created by modifying the CAGE screener; however, the TWEAK screener was developed specifically for pregnant women. It is one of the few alcohol screening tests that has been developed and validated among women. TWEAK is a five-item scale developed originally to screen for risk drinking during pregnancy. [TWEAK is an acronym for the questions: T = Tolerance: “How many drinks can you hold?” W = Worried: “Have close friends or relatives worried or complained about your drinking in the past year?” E = Eye-openers: “Do you sometimes take a drink in the morning when you first get up?” A = Amnesia (blackouts): “Has a friend or family member ever told you about things you said or did while you were drinking that you could not remember?” K(C) = Cut down: “Do you sometimes feel the need to cut down on your drinking?” (See <http://www.niaaa.nih.gov/publications/tweak.htm>.)]

Assessment Instruments

There is considerable overlap among screening and assessment instruments (see table 2-6). In some cases, the same instrument or part of the same instrument can be used for screening and as part of the assessment. A sampling of popular assessment instruments are outlined here, grouped categorically.

Comprehensive Risk and Needs Assessment

The Wisconsin Uniform Substance Abuse Screening Battery is one of the most comprehensive batteries of tests to match offenders with appropriate interventions. It includes a combination of identification, classification, treatment assessment, personality profiles, and measurements of specific offenders’ needs. Its strengths include a recognition of heterogeneous populations, extensive and varied information collection, a computerized alcohol instrument with instant scoring, and the ability to match needs to types of programs.

The Level of Supervision Inventory-Revised (LSI-R) is a risk assessment instrument found to be highly predictive of recidivism among a variety of correctional clients (Andrews and Bonta 1998). The instrument focuses on many dynamic features, or features that can be targeted in treatment. It is one of the few instruments available that has been intentionally designed to measure criminogenic needs (Bonta 1996), and Andrews and Bonta (1998) have described this instrument as the measure with the best predictive validity.

Probation and Parole

The Wisconsin Risk Assessment System is the prototype for probation and parole systems (van Voorhis et al. 1997). It has the capability to quickly assess the probability of failure and level of supervision. This classification system has been called the most widely used offender classification system in the United States (Baird, Prestine, and Klockziem 1989), and it is both reliable and quick to complete.

Readiness for Treatment

“Readiness for treatment” is an important concept in the screening process. Traditionally, offenders have reported low readiness for treatment (Shearer and Carter 1999). Offenders with low readiness for treatment may need pretreatment interventions to prepare them for treatment. Several popular scales include Circumstances, Motivation, Readiness, and Suitability Scale (CMRS); Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES); and the University of Rhode Island Change Assessment Scale (URICA) (Peters and Peyton 1998). The CTRS scale (Correctional Treatment Resistance Scale) is another scale that currently is being researched.

Dynamic Factors

Research highlighting the importance of offender attitude factors (Gendreau, Little, and Goggin 1996) has led to the creation of several new instruments to assess these factors. The LSI-R has one scale (in its risk section) that addressed some of these factors. The Criminal Sentiments Scale-Modified (CSS-M) and the Pride in Delinquency Scale (PID) are two newer scales, which have relatively high reliability and validity, are simple to administer, score and interpret, and can be used in assessment and program evaluation contexts. The Lifestyle Criminality Screening Form (LCSF) is a classification scale to determine risk of recidivism, using four behavioral dimensions of criminality: irre-

sponsibility, self-indulgence, interpersonal intrusiveness, and social rule breaking.

Risk Assessment

The Client Management Classification (CMC) is used to determine the proper supervision level and service needs of adult probation, parole, and institution populations. The instrument has separate sections for the parole and probation population and the institution population. This instrument is widely used by the probation and parole system. The CMC interrater reliability is 90 percent and evaluations from users have been positive (Carter 1991). The disadvantage of the CMC is that it is an offender classification system only and does not focus on substance abuse. However, combined with a drug-use inventory, this instrument can provide a comprehensive picture of the offender and his/her needs.

Drug and Alcohol Abuse

In the assessment process for drug treatment in general, the ASI (Addiction Severity Index) is the most widely used substance abuse instrument. The ASI assesses an offender’s discomfort level in seven problem areas associated with drug use. Although it is very popular, there are drawbacks to the ASI. It does not recommend an intervention strategy, has not been widely used or validated in correctional settings, and may not be sensitive to certain populations, including women and non-opiate-using populations (Carter 1991). A comprehensive report on assessment instruments (Dennis 1998) outlined common instruments and measures that have been used for both clinical and research purposes. According to this report, the ASI was described as one of the oldest and most widely used, in a variety of areas from screening to outcome, although, as noted, the instrument is weak in the areas of modern diagnostic criteria and standardization.

The Drug Offender Profiles (DOPERS) instrument examines the relationship between an offender’s drug use and criminal behavior to match him or her with appropriate levels of treatment and supervision. This instrument differentiates between the user-driven criminal and the criminal-driven user, similar to the Bureau of Prison classifications. The former is in the correctional system because of a problem with drugs, the latter is in the system because of his or her criminality, with drugs being an aspect of that criminality. According to the National Institute of Corrections (Carter 1991), a disadvantage of this instrument is the complexity of scoring.

SADD (Short Alcohol Dependence Data) is a shortened version of the original Alcohol Dependence Data (ADD) instrument. This 15-item scale has a narrow focus (alcohol) and has become more popular than the original ADD. It has been used on both male and female offenders, as well as youth males.

ADS is another widely used instrument of alcohol dependence; it was adapted from the larger Alcohol Use Inventory (AUI). The current instrument has only 25 items—a classification system that corresponds with the DSM—excellent internal consistency, and good reliability.

In addition, many of the screening instruments for drug and alcohol use and abuse discussed in the screening section can also be used in the assessment phase. For example, pieces of the ASI can be used to screen offenders, while the complete ASI can be used in the assessment phase (the complete ASI consists of 161 questions). The original 25-item MAST (Michigan Alcohol Screening Test) has been adapted and shortened to the 10-item Brief MAST and the 13-item Short MAST to use in the screening process.

Addressing Infectious Diseases

The Drug Offender Profile Index (OPI) is one of the only instruments designed to address HIV risk among offenders. The instrument is appropriate for pretrial and post-institutional populations, although validity and reliability evaluations are in progress. The instrument has been accepted by judges and probation officers in several jurisdictions and is undergoing field testing in several urban areas. It identifies drug use patterns and recommends a course of treatment; however, it does not provide detailed individual treatment planning implications.

The AIA Jail/Prison Supplement instrument was adapted from the full AIA (AIDS Initial Assessment), developed by the National Institute on Drug Abuse. The Jail/Prison Supplement collects HIV risk assessment data on those incarcerated any time since the beginning of the AIDS epidemic (circa 1978). This instrument provides supplemental information when used in conjunction with other supervision and/or risk assessment instruments.

Psychological Assessments

The Symptom Checklist (SCL-90) is designed to measure nine psychopathology disorders, including depression, anxiety, somatization, obsessive-compulsive, paranoid-ideation. It is a self-report, 90-item instrument. This instrument has both high levels

of internal consistency and test-retest reliability (Inciardi 1994).

The Minnesota Multiphasic Personality Inventory (MMPI and MMPI-2) includes a wide range of personality measures as well as scales for identifying substance use. It also identifies stress levels and certain traits such as impulsiveness (Dennis 1998).

Combination Approaches to Screening and Assessment

Peters and Bartoi (1997) present several instrument combinations that may be useful for **screening** in the criminal justice system, with a focus on detecting co-occurring disorders:

- Either the Brief Symptom Inventory (BSI) or the Referral Decision Scale (RDS) to address mental health symptoms

AND

- Either the Texas Christian University Drug Dependence, Simple Screening Instrument (SSI), or the combination of the Alcohol Dependence Scale (ADS) and the Addiction Severity Index (ASI), Drug Use section to address substance abuse symptoms.

Peters and Bartoi (1997) recommend the following combination of instruments for **assessment**:

- Either the Minnesota Multiphasic Personality Inventory-2 (MMPI-2), the Millon Clinical Multiaxial Inventory-III (MCMI-III), or the Personality Assessment Inventory (PAI) to examine mental health disorders

AND

- The Addiction Severity Index (ASI) to examine areas related to substance abuse.

Most researchers recommend a self-report instrument for screening and, in some cases, assessing the client. However, there are disadvantages to the self-report method, including misrepresentation by the offender to avoid a “structured environment,” falsely reporting mental health problems to receive “perks” such as medications, and the nature of several mental health disorders such as psychoses, paranoia, and schizophrenia, which may lead the offender to report false statements and answers. Therefore, Peters and Bartoi (1997) recommend supplementing the self-report with information from family, clinical observa-

tion, archival records, drug testing, repeated screening, and assessment.

Because of the sheer quantity of people, limited resources, and new and sometimes confusing research, there has been a movement to institute guidelines for placement and duration in various types of programs. The American Society of Addiction Medicine (forthcoming) is one organization developing criteria. Their manual will provide guidelines for five levels of service ranging from early intervention to medically managed intensive inpatient services. Addiction severity and related problems are broken down for each level, as well as structured guidelines about settings, staff, services, admission, and discharge criteria.

Integrating Assessment

It is important to manage an offender throughout the criminal justice system as well as between different areas within the system. Several sources have anecdotally described the disconnection between mental health providers, substance abuse providers, and criminal justice agencies. It is common for each to complete separate evaluations, without collaborating about co-occurring disorders and treatment plans. The Center for Substance Abuse Treatment's (CSAT) Treatment Improvement Protocol (TIP) 17 provides extensive information about treatment planning within the criminal justice system. It addresses the complexity of the criminal justice system and system differences among the criminal justice system, alcohol and drug abuse treatment providers, and the mental health system. Each group or system is guided by different goals and philosophical differences. During the past decade, these systems have begun to acknowledge the multidimensional problem of alcohol and drug addiction. Increasingly, there is an understanding that effective drug treatment can result in both reduced drug use and criminal behavior.

Literature in the drug and alcohol treatment field frequently mentions the importance of integrating treatment and criminal justice processing (Downes and Shaening 1993). Just as collaboration has become more popular and accepted within the criminal justice system (e.g., police-probation teams, community prosecution, comprehensive community initiatives), it also has been noticed in substance abuse treatment. CSAT, for example, launched an initiative in 1993 to link substance abuse treatment systems and the criminal justice systems at the state level.

"System integration" means that more than one "system," in this case, criminal justice and treatment,

are working together, organized by a purpose and acting as one unit. In theory, both systems can accomplish more than either system on its own. This new system has been conceived of as a "system for substance abusing offenders" (Downes and Shaening 1993, 2). While Downes and Shaening (1993) acknowledge that some states already have linkages in place, and that some states have "model programs" in place, few states have overcome the challenges of bringing all key players together to make plans and implement an intersystem collaboration. Many states do not collect screening and assessment information, much less transfer it or share it as offenders progress through the criminal justice system. In addition, many states have strict laws and confidentiality guidelines regulating the transfer of information.

A recent CASA report (Dennis 1998) describes the inefficiency of gathering new baseline data at each stage in the system and, in particular, the problem of nonintegrated clinical assessment. The problems center around repeated screening and/or assessment by multiple system actors (e.g., case manager, counselors, social workers, medical and prison intake workers, probation and/or parole officers). Indeed, it appears to be the norm rather than the exception that the same information is collected at different points throughout processing, and that different sources of information collected at one stage of processing will not be used at another. The integrated approach would involve developing an initial base of information that would be incrementally added to at each successive stage.

Although several reports document the importance of assessment databases and continuity of information flow throughout the justice system, little is known about the extent and sophistication of such data exchange. Dennis (1998) recommends that data collection be systematic and that standardized reports be generated on a regular basis. Documented procedures for data collection, including training, quality control procedures, standardized forms, data analysis, etc., are necessary for maintaining useful and transferable reliable data. Automated information systems are preferable to aid in analysis and management tasks.

The level and type of data collected in management information systems (MIS) vary from one state to another. States used computer systems for a variety of functions, from management (e.g., decisions about individual offenders and decisions about facility and system operations), classification determinations, and facilitation of assessments. Some systems simply "cap-

ture” (i.e., collect or warehouse) data while others had more sophisticated analytical capabilities.

Recently, detailed information about the type of needs assessment factors that the 52 correctional systems (50 state systems, the District of Columbia, and the federal Bureau of Prisons) collect became available through a collaborative study by the Association of State Correctional Administrators and the U.S. Department of Justice’s Office of Justice Programs, National Institute of Justice, and Bureau of Justice Statistics (1998). As table 2-8 shows, many systems do not collect a wide range of information.

For those systems that do collect needs assessment information, most collect the information in electronic format. However, many collect this information in paper format only. As of 1998, 39 systems collected “type of need” information in electronic format and 6 systems collected it in paper format. However, drug testing information is collected in only 22 systems, and of these only 12 maintain the information electronically, with the remaining 10 maintaining the information in paper format. The lack of drug testing information, as well as access to this information, is especially problematic because it is critical for “developing indicators of how well corrections institutions keep offenders involved in maintaining positive behaviors” (Association of State Correctional Administrators et al. 1998, 98).

Departments are more likely to keep information on classification decisions. Forty-eight departments keep information on security level at admission, 49 document the date of initial classification, and 47 document the classification index or score. Fewer departments keep track of assessment scores such as risk

assessment index or score (37 departments), medical classification index or score (31 departments), or psychological index or score (25 departments).

Consequences of Ineffective Screening and Assessment

The literature and anecdotal evidence suggests that, due to the recent increases in the past decade in the number of inmates, many states are conducting abbreviated screening and assessments, oftentimes relying on staff with inadequate training or experience. Indeed, only about 60 percent of state prisons and jails conduct a needs assessment process. What should be a structured process for some state prisons is often, in reality, a haphazard and incomplete process. Some correctional facilities are not able to complete a comprehensive battery of screening and assessment tests (including dynamic criminogenic needs) supplemented by interviews, and use this information, in an automated way, to help to guide treatment decisions. Because of the inability to comprehensively assess every individual that enters the correctional system, treatment invariably cannot reach those who most need it or be delivered efficiently. Indeed, improper treatment matching can significantly compromise treatment program integrity and thus effectiveness. This issue is particularly acute in cases involving co-occurring disorders.

ASSESSMENT PROCEDURES

A 1997 Survey of Correctional Facilities (SAM-HSA 2000) found that 63.6 percent of jails, 67.1 percent of state prisons, and 86.8 percent of federal prisons provide assessment for treatment need. Of the few sources of data that we found about assessment procedures, we found little to no data about assessment instruments and procedures in jails, other than drug testing in jails and general jail program information, such as detoxification programs.

State Assessment Procedures

Screening and assessment procedures can vary from state to state and within states (Inciardi 1993). There is little coordinated, standardized information about state-specific assessment tools and procedures. Indeed, a review of the literature, including consultation with researchers at the National Institute of Corrections (NIC), reveals no specific and exhaustive guides of this type. Several states list their own procedures (on a Website or in a publication), some in gen-

Table 2-8. State and Federal Corrections Information Systems

Data Elements	Number of Systems Not Collecting Specified Information
Type of need	7
Psychological history	15
Medical condition at admission	9
Program participation prior to commitment	32
Tested for drug use at admission	28
Results of drug tests at admission	29

Source: Association of State Correctional Administrators (1998, 30).

eral terms and some with more detail. NIC currently is in the process of conducting a 20-state study of tools and procedures, including collecting extensive information and providing technical assistance. The American Correctional Association produced a list of state diagnostic procedures as one of their monthly surveys; however, the information was not uniform or specific about instruments and populations for whom the instruments were used (ACA 2001).

A 1996 Center on Addiction and Substance Abuse's *Treatment Survey of Prison Facilities*, which included 963 state and federal correctional facilities, found that almost all jurisdictions (90 percent) are using more than one type of assessment method to determine the presence and severity of an inmate's substance abuse problem (CASA 1998). Most used self-reports (83 percent) and/or an objective screening instrument (82 percent). Facilities also relied on staff reports (two-thirds), pre-sentence reports (half) and urinalysis (half).

A recent American Correctional Association (2001) survey highlighted the lack of standardized instruments and procedures for diagnosing problems in the state prison systems. The survey showed that information about assessment instruments is not standardized and that within states there can be considerable variation in the types of instruments used. Some of the reported assessment processes include:

- Certified substance abuse counselor assessment, including SASSI and/or MAST
- Review central file and probation officer report; arrest history; self-admission
- Mental health evaluations; urinalysis; Immunoassay or Gas Chromatography Spectrometry
- Assessment tool used as a part of classification process at system entry
- Addiction Severity Index; DSM-IV criteria
- Testing; evaluation; records; self-reporting; observation
- Risk assessment
- Random drug screening
- SASSI; face-to-face with evaluator

Some states reported generic answers, such as “an assessment tool is used as part of the process,” while other states listed the specific name of the assessment

tool. Information was not provided on who conducts the assessment, when, or how the information is recorded or used.

Federal Prison Assessment

The Federal Bureau of Prisons (BOP) has a standardized intake and assessment process. Offenders are classified into two groups. The first group includes those who violate laws that prohibit the possession, distribution, or manufacture of illegal drugs, generally called “drug-defined” offenders. These individuals may not need drug treatment, although they may benefit from other treatment, such as drug education, value development, or anger management. The second group includes those who violate laws as a direct result of their drug use, generally called “drug-related” offenders. These individuals are more likely to need drug treatment.

For a three-month period, in the summer of 1991, all offenders ($N = 1,165$) who entered the federal Bureau of Prisons completed the Inventory of Substance Abuse Patterns (ISAP). Using the American Psychological Association's Diagnostic and Statistical Manual, Third Edition, Revised (DSM-III-R) as a guide, 20.9 percent of inmates met the criteria for psychoactive substance abuse (now termed “drug abuse disorder”) and 30.8 percent for psychoactive substance dependency (now termed “drug dependency disorder”), for a combined prevalence of 51.7 percent having either type of disorder (Murray 1991, 35). The BOP used this figure to develop and expand its treatment programs. The criteria for a diagnosis of drug dependency disorder, as well as for drug abuse disorder, is outlined in table 1-2 (in chapter 1), using the more recent DSM-IV definitions.

After the survey, BOP established minimum standards for entrance into a variety of prison programs: Drug Abuse Education, Residential Drug Abuse Treatment Programs, Nonresidential Drug Abuse Treatment, and Transitional Services.

In the federal system, an inmate's records are screened at entrance into the facility. If any of the indicators show up on the records—evidence in the Presentence Investigation that alcohol or other drug use contributed to the commission of the instant offense, the inmate received a judicial recommendation to participate in a drug treatment program, or the inmate violated his or her community supervision as a result of alcohol or other drug use—then the inmate is required to participate in a Drug Abuse Education Course. Inmates are interviewed to determine whether they meet

the diagnostic criteria, using the DSM-IV, for an alcohol or drug abuse or dependency disorder. If the following four conditions are met, the inmate is eligible for the residential program:

- Inmate has a DSM diagnosis for alcohol or drug abuse or dependence disorder and a record review supports this diagnosis.
- Inmate has no serious mental impairment that would substantially interfere with or preclude full program participation.
- Inmate signs the Agreement to Participate in the Bureau's Drug Abuse Programs.
- Inmate is within 36 months of release.

At year-end 1999, 47 of the 98 Bureau institutions had implemented the BOP's Residential Treatment Programs. (The Federal Bureau of Prisons has 98 institutions, six regional offices, a central office, three staff training centers, and 28 community corrections offices.) Nonresidential treatment programs, particularly drug counseling, take place at every BOP institution. An inmate is eligible for nonresidential drug-abuse treatment if he or she has a drug problem, minimal time left on his or her sentence, serious mental health problems, or is otherwise unable to participate in a residential treatment program. Nonresidential treatment includes individualized treatment based on an assessment by a licensed psychologist. Treatment can include individual and/or group therapy.

The Bureau is responsible, by law, for treating every "eligible" inmate prior to his or her release from Bureau custody (18 U.S.C. § 3621 (e)). At the close of fiscal year 1998, the Bureau reported meeting the demand of 18,022 "eligible" inmates through residential treatment. Additional staff and resources have helped the Bureau to maintain this 100 percent treatment requirement rate. The Bureau reported that a significant number of inmates volunteer for the residential treatment. One reason for the high volunteer rate is the one-year reduction in sentence incentive offered to inmates for successful completion of a residential drug abuse treatment program.

Assessment and Procedures for Therapeutic Communities

The Therapeutic Communities of America (TCA) recently produced standards for operating modified therapeutic communities (TC) in prison settings (Criminal Justice Committee of Therapeutic Communi-

ties of America 1999). The report recommends examining the inmate's history of substance abuse and criminal activity, and mental health, as well as an ongoing mental health screening capability. These standards include:

- Program has written eligibility criteria agreed upon by the sponsoring agency and correction officials to identify participants most likely to benefit from the program.
- Residents conduct outreach activities within the general prison population.
- There is a standardized admission screening and assessment format, which may include interviews with senior program participants.
- Mental health screening conducted by qualified staff.
- The program has the authority to reject inappropriate and unmotivated applicants.
- Staff conducts a thorough biopsychosocial assessment within 10 days of admission, which includes identification of the program participant's strengths and weaknesses.

BARRIERS TO EFFECTIVE SCREENING AND ASSESSMENT

Despite the critical importance of screening and assessment to efficient and effective criminal justice operations, the vast majority of jurisdictions throughout the United States still rely primarily on "professional judgement" and first-generation assessment instruments (Bonta 1996, 30). The question is, "Why?" Several researchers have reported barriers to screening and assessment (Gendreau and Goggin 1997; Peters and Bartoi 1997; Peters and Hunt 2000). These barriers are classified here into broad categories, specific examples of which are briefly outlined below.

Administrative and System Issues Impede Assessment

- Multiple and redundant assessments are conducted at various stages of processing.
- Time constraints prevent conducting screening and assessments.
- Information is collected that is not used.

- Staff are not trained adequately on the administration and use of screening and assessment instruments.
- Criminal justice personnel may lack familiarity with mental health or substance abuse disorders.
- There may be limited time and resources for codifying existing information, transferring it to various parts of the criminal justice system, or easily accessing existing information.

Inappropriate Use of Assessment Instruments

- Staff may not complete and use screening and assessment instruments appropriately.
- There may be a lack of consistency in questions or documentation to allow reliable analysis of program level needs or outcomes.
- Use of nonvalidated instruments.
- Use of instruments for populations for which they were not designed.
- Use of instruments that do not address criminogenic needs.
- Records may be incomplete, misleading, or mislabeled.
- Traditional, subjective “intuitive assessments” or “first-generation assessments” still are used widely, despite demonstration of their ineffectiveness.

Minimal Assessment of Co-Occurring Disorders

- The primary barrier to treating co-occurring disorders is the minimal attempts to screen and assess for these disorders.
- Mental health and substance use disorders have a waxing and waning course and may appear in different forms at different points in time. This variability leads to different, and often conflicting, diagnoses at different stages of processing.
- There is considerable symptom interaction between co-occurring disorders, leading to difficulties in interpreting whether symptoms are related to mental illness or substance abuse.
- Individuals in the criminal justice system may anticipate negative consequences related to disclosure of mental health or substance abuse symptoms.

Limited Guidance from Research about the “Best” Instruments

- Few studies comprehensively and comparatively examine the effectiveness of different types of screening and assessment instruments.
- We lack systematic research on which criminogenic needs most influence future offending.
- Research has not identified the combination of risk, needs, personality types, and responsivity needed for programming to be most effective, and how assessments can be devised that can be used feasibly to assist with decisionmaking.

KEY RESEARCH QUESTIONS

This review of screening and assessment in correctional settings indicates that a number of critical research questions have yet to be addressed. Key research questions that future research should address include the following:

- How are specific screening and assessment instruments selected for use in correctional settings?
- How, if at all, are the results from screening and assessment used?
- Are the results from screening and assessment helpful in assisting with decisionmaking and, more specifically, with placing offenders into appropriate types and levels of drug treatment?
- What are the major problems in conducting and using screening and assessment of prisoners?

CHAPTER 3.

Drug Treatment in the Criminal Justice System

There have been many changes in the criminal justice and treatment systems over the past 20 years. In contrast to the view that “nothing works,” researchers now know that treatment can work, but that no single treatment is right for every person. The key to treatment success lies in offering a comprehensive array of programs and then matching individuals and their unique needs to the appropriate treatment. Although drug treatment can be effective, during the past decade fewer and fewer offenders have participated in treatment in residential facilities or through professional counseling, detoxification units, and maintenance drug programs. At the same time, increasing numbers of inmates have participated in other, generally less effective, alcohol or drug abuse programs, including peer counseling groups, self-help groups, and educational programs. This chapter highlights these changes by reviewing literature bearing on several issues: the definition of treatment and how it fits in the criminal justice system; the types of treatment and non-treatment alcohol or drug abuse programs available to prisoners; the cost and availability of these programs in jails and state and federal prisons; the gap between availability and need; briefly, the relative effectiveness of alcohol and drug treatment programs; and barriers to drug treatment programming in correctional settings.

INTRODUCTION

There have been many changes in the criminal justice and treatment systems over the past 20 years. In contrast to the view that “nothing works,” researchers now know that treatment can work, but that no single treatment is right for every person. The key to treatment success lies in offering a comprehensive array of programs and then matching individuals and their unique needs to the appropriate treatment. Although drug treatment can be effective, during the past decade fewer and fewer offenders have participated in treatment in residential facilities or through professional counseling, detoxification units, and maintenance drug programs. At the same time, increasing numbers of inmates have participated in other, generally less effective, alcohol or drug abuse programs, including peer counseling groups, self-help groups, and educational programs.

This chapter highlights these changes by reviewing literature bearing on several issues: the definition of treatment and how it fits in the criminal justice system; the types of treatment and non-treatment alcohol or drug abuse programs available to prisoners; the cost and availability of these programs in jails and state and federal prisons; the gap between availability and need; briefly, the relative effectiveness of alcohol and drug treatment programs; and barriers to drug treatment programming in correctional settings.

DEFINING TREATMENT

The term “treatment” is widely used throughout jails and state and federal prisons, yet a concise, agreed upon definition of treatment is rare. Alcohol or drug abuse treatment refers to a wide range of services to help the client change behavior and lifestyle, and/or medically assist the recovery process to ultimately break the alcohol or drug abuse addiction and maintain abstinence. Different services are appropriate depending on the type of alcohol or drug abuse, client attitude and mental state, history, etc. Some researchers distinguish between “treatment,” such as therapeutic communities or pharmacological programs, and “non-treatment,” such as drug abuse education and self-help groups. Non-treatment services are viewed as less targeted than treatment services, but nonetheless can be an important part of drug treatment and/or support for a specific treatment plan.

Despite increased knowledge about “what works” in treatment programming, there is little readily avail-

able information about the provision of various types of programming, including what works, in correctional settings. At present, there are no large-scale, standardized assessments that provide detailed information about the type and quality of programs and services, treatment plans, and the characteristics of offenders in the programs.

TREATMENT IN THE CRIMINAL JUSTICE SYSTEM

Treatment Timing in the Criminal Justice System

Treatment in the criminal justice system can occur at a variety of “impact points.” Different models can occur at pre-trial, jail, and pre-sentencing; can be used as diversion programs; or can be provided with varying degrees of intensity while offenders are on probation or parole or in prison. Once an offender enters the system, he or she will most likely move through several of these impact points. The key to effective processing through the criminal justice system for offenders who need drug treatment is to provide assessments and comprehensive treatment; develop, adhere to, and monitor treatment plans; and implement an effective case management plan for post-release supervision and treatment.

Within and between System Differences in Treatment Orientation and Practice

There are cultural differences within correctional settings in the guiding goals and philosophies, ranging from a treatment orientation to a punitive/control orientation. More generally, across the criminal justice processing spectrum, and within each stage of processing, views about the competing system goals of deterrence, punishment, and rehabilitation are heterogeneous.

The philosophical differences between and within criminal justice systems can cause friction. However, they also can be used in a supportive way. Recently, there has been an evolution toward more of a shared understanding and partnership between the systems, reinforced by research and funding that shows that drug treatment can assist with long-term public safety goals (Vigdal 1995).

Principles of Treatment in the Criminal Justice System

A panel of experts convened to produce the Center for Substance Abuse Treatment’s *Planning for Alcohol or Drug Abuse Treatment for Adults in the Criminal Justice System*, part of the Treatment Improvement

Protocol (TIP) series by the U.S. Department of Health and Human Services (Vigdal 1995). The result was the development of a set of principles for guiding the delivery of alcohol or drug abuse treatment in correctional settings. The core principles are:

- Treatment should not represent a substitute for punishment or sanctions.
- Treatment should be universally available as needed for persons with drug treatment needs.
- Alcohol or drug abuse treatment services should be tailored to the needs of the specific offender, based on a thorough assessment at jail or prison intake.
- Offender supervision should continue once an individual enters treatment.
- Offenders should remain accountable to the sentencing judge or probation/parole authorities.

The first principle refers to the balance needed between punishment and treatment. In the criminal justice system, the two ideas should be viewed as complementary goals as opposed to two distinct and competing goals (Carter 1991). Treatment is not an “easy way out” for an offender sentenced to prison; it is a way to address a problem while the inmate serves his or her term of incarceration.

The second and third principles refer to the timing and placement of inmates into treatment in the criminal justice system. Treatment ideally should be available to individuals as soon as they come into contact with the criminal justice system. In this context, treatment includes the ability to assess properly all incoming inmates, to match each inmate to the appropriate course of treatment, to create a treatment plan, and to then implement the plan throughout processing.

The fourth principle reinforces the idea that punishment and treatment are not mutually exclusive in the criminal justice system. There is a need to not only assess the inmate for treatment needs, but also to assess the inmate for risk. The offender’s risk status should be considered in the placement decision, and supervision should remain a priority while an offender receives treatment.

The final principle focuses on accountability and case-management continuity. The goal is to assist inmates to navigate the system without “falling through the cracks,” as well as to ensure that the offender adheres to the prescribed treatment and supervision plan.

The Ideal Drug Treatment Approach in the Criminal Justice System

Offenders entering state or federal prisons are confined to a sentence of at least one year in most states (New York, California, Florida, and Illinois allow prison sentences of less than one year). This length of confinement suggests that prisons should offer a full range of alcohol and drug abuse treatment services. However, only recently have prisons begun to focus on rehabilitation (Cullen and Gendreau 2000). The new focus on rehabilitation raises the issue of what types of treatment should be implemented in correctional settings. According to Vigdal (1995), the range of alcohol and drug abuse programs and approaches should consist of one or more of the following:

- Comprehensive pregnancy management for alcohol or drug abusers to enable a woman to carry her baby to term while incarcerated. Foster care services may be needed and medical services should be available for both mother and child.
- Medical treatment for prisoners with chronic and communicable diseases, including TB and HIV/AIDS, should be available in prison.
- Pharmacotherapy for disorders such as bipolar disorder and major depression should be incorporated into these services.
- Alcohol or drug abuse treatment should extend across institutional boundaries when offenders are transferred to different correctional facilities, and to the community after release.
- Special arrangements should be made for alcohol or drug abuse treatment and health care services for offenders in protective custody and administrative segregation.
- Pre-release group programs and transitional community programming should be offered to all offenders, in particular to those who have been incarcerated for long periods of time.
- Education about HIV/AIDS and its risk factors should be a critical component of prison programs.
- Relapse prevention for alcohol or drug abusers should be part of transitional programming.

DRUG TREATMENT MODALITIES AND SERVICES

This section will address two topics. The first is treatment modalities, or models of treatment delivery within the criminal justice system. The second is treatment services, or the individual components that can be combined in a variety of ways to create a treatment plan. For example, “incarceration without specialized services” is a model of service delivery; this model can consist of a variety of components, including education and vocational courses.

Drug Treatment Models

There are five main types of treatment models in correctional settings (Brown 1992):

- **Incarceration without specialized services.** This is the most common model available to a drug user in correctional settings. That is, specific drug treatment programming frequently is unavailable for most drug abusers. Instead, offenders who need drug treatment frequently received educational programming, vocational counseling, casework services, and various types of individual or group counseling.
- **Incarceration with specialized services for problems other than drug abuse.** These programs provide specialized services for drug abusers but do not directly target drug abuse problems (e.g., education or literacy programs).
- **Incarceration with drug education and/or drug abuse counseling.** This approach represents the second most common model, according to Brown (1992) and supported by recent (1999) correctional data (Camp and Camp 1999a, b). These data indicate that approximately 70 percent of inmates receiving treatment reported participating in an addiction group or counseling that was provided by institutional staff.
- **Incarceration with dedicated residential units.** These units may exist as distinct programs within a facility or as secure units outside of the correctional complex. Examples of residential treatment programs and therapeutic communities (TC) include the Stay 'n Out program (New York, located inside of the facility) and the Cornerstone program (Oregon, located outside of the facility). In these facilities, staff are either from the correctional department or are contracted with from outside the

department. Some programs employ recovering addicts as staff.

- **Incarceration with client-initiated or client-maintained services.** This approach includes low-cost programs such as AA and NA, and can consist of self-help groups or support services. These programs are located in the majority of federal prisons (84.5 percent), state prisons (92.5 percent) and, somewhat less frequently, jails (59.7 percent) (SAMHSA 2000).

Drug Treatment Programs and Services

Research shows that highly intensive residential programs are the most effective in reducing drug and criminal behavior in the long term, yet most prison facilities do not offer this type of treatment, or offer it to only a small percentage of the population. Residential treatment is considerably less likely to be found in jails. Correctional departments blame budgetary constraints (71 percent) and space limitations (51 percent) as two of the major reasons for the limited treatment availability (CASA 1998).

The most prevalent types of programs in prisons, according to various surveys, are self-help programs such as Alcoholics Anonymous and Narcotics Anonymous, and education/awareness programs. These types of programs can address large groups at once, require relatively little ongoing investment, and can be staffed by inmates or volunteers.

The term “treatment” is used widely throughout jails and state and federal prisons. Uniformly defining treatment is a difficult task. Many correctional systems may refer to treatment as anything from self-help groups to residential therapy, while other systems may only consider residential treatment and counseling as “treatment.” Using a broad definition of treatment, an equally broad range of treatment programs and services are available in correctional settings. Table 3-1 outlines the most common approaches, which then are discussed in more detail below.

Detoxification refers to the physical and emotional removal of drugs from the body. It constitutes the first step to addressing drug and alcohol problems. The procedure occurs predominately in jails because they are often the offender’s first contact with the criminal justice system. The process refers to observation, support, and, when necessary, medical treatment associated with detoxifying the body. Although this treatment predominately takes place in jails, many state and federal facilities reported having detoxification centers,

although the centers generally operate below capacity (Peters 1993). Certain drugs can cause dangerous medical conditions such as seizures when leaving the body. Therefore, for drugs such as sedative-hypnotics, alcohol, benzodiazepines and barbiturates, it is recommended that a monitored medical detoxification take place (Vigdal 1995).

Self-help groups operate in almost every state and federal prison and jail in this country. The groups, such as AA and NA, are highly cost-effective. Frequently run by other inmates, they provide group support for recovering addicts. Self-help groups can offer peer support and confrontation of the problem. Some experts do not consider “self-help groups” a form of treatment; however, others in the field do consider such groups as treatment (Vigdal 1995). For offenders with alcohol or drug dependency/addiction, self-help groups ideally should be used in conjunction with or after treatment as a maintenance or reinforcement tool.

Drug testing is an essential part of any treatment program. Vigdal (1995) notes that drug testing in treatment programs can be used as a supervisory device, but that they also can be used as a “therapeutic tool.” As a supervisory tool, drug testing provides a way to monitor inmates, keep track of their progress,

and make decisions about their treatment plan. As a therapeutic tool, drug results can be a source of motivation for abstinence for some offenders, a way to prove to themselves and others that they are making progress. Drug testing is often discussed in the context of prison maintenance. Theoretically, drug testing can serve as a deterrent, yet there is little research to demonstrate a deterrent effect.

Education programs are considered “non-treatment” programs by most sources. They are a complement to treatment programs for alcohol or drug abuse offenders, as well as a useful awareness and prevention program for those offenders not involved with alcohol or other drugs. Education topics can include:

- medical effects and consequences of drug use and abuse
- the disease model of addiction (including the signs and symptoms)
- introduction to 12-step programs
- denial and other defense mechanisms
- effects of drugs on families, including co-dependency and issues faced by children of alcoholics

Table 3-1. Treatment Approaches in Correctional Settings

Type of Treatment	Approach
Detoxification	Where possible, remove drugs from system through detoxification as a first step before effective drug treatment can or should be undertaken.
Self-help groups	Peer support and problem confrontation in a group setting.
Drug testing	Deterrence and maintenance.
Education	Raise awareness of and understanding about a variety of topics, ranging from effects of certain drugs to illogical thinking patterns.
Individual counseling	Psychological counseling in a one-on-one setting, relying on any of a wide range of psychological approaches/modalities (behavioral, psychoanalytic, etc.)
Group counseling	Counseling in a group setting, with a focus on life skills rehearsal, role reversal, and stress management.
Outpatient drug-free	Can include a wide range of approaches, including counseling, education, self-help, 12-step, cognitive behavior therapy.
Milieu therapy	Intensive counseling and separate living conditions—more intensive than individual counseling but less intensive than therapeutic communities.
Family therapy	Therapy for both offender and family.
Inpatient short-term	Medical stabilization and focus on behavioral changes.
Residential programs	Long-term, isolated, comprehensive therapy including social learning, counseling, and education.
Pharmacological maintenance	Medical therapy to address long-term drug use, particularly heroin and alcohol.
Transitional services	Relapse prevention services to help with transition into the community.

- thinking errors or illogical thinking patterns
- human sexuality (When possible, there should be separate female and male groups. Issues pertaining to the problems experienced by gay men and lesbians may need special attention.).
- HIV/AIDS education
- coping skills
- communication skills.

Several researchers have suggested providing drug education for all prisoners. For those offenders with and without alcohol or drug addictions, education can serve as awareness and prevention (for non-addicted offenders). Education is very low cost and reasonable and can address other issues, such as AIDS, other infectious diseases, and risky behavior.

Counseling (group and individual) is the most common intensive treatment method in prisons (CASA 1998). Individual counseling is one of the least common programs available to inmates, and there is little evidence of its ability to reduce recidivism, although positive psychological changes have been demonstrated (Lipton, Falkin, and Wexler 1992). Group counseling, led by a trained professional, is more common than individual counseling, led by a psychologist, social worker, or perhaps a psychiatrist. If structured well, group counseling can provide a supportive and psychologically safe setting to discuss problems in a group environment. Unfortunately, according to Lipton et al. (1992), the group counseling model in most institutions is unable to overcome the “pro-criminal inmate subculture” within most prisons. Good program structure and a dedicated leader can help to alleviate this problem. Group counseling/therapy can include (Lipton et al. 1992):

- life skills rehearsal
- role reversal
- stress management
- social skill practice
- problem-solving skills training
- relapse prevention
- participation in AA types of groups.

There are many approaches to individual counseling, such as addiction counseling and psychotherapy. The counseling approach fits into a variety of other

treatment plans as it was designed to be a component of a comprehensive treatment plan. The four most common counseling and treatment approaches are psychoanalytical strategies, conditioning techniques, social learning models, and cognitive therapies (van Voorhis 1997, 109–185):

- **Psychoanalytical strategies.** Originally defined by Sigmund Freud and later by Walter Toman, this type of therapy addresses the conscious and unconscious thoughts and desires in the mind. The goal of psychoanalytical therapy is to make the person aware of their unconscious ideas and the effect of these ideas on their behavior.
- **Conditioning techniques/behavior modification.** Conditioning techniques are based on the assumption that behavior is learned; thus, problematic behavior is learned behavior that can be targeted for change. This approach deals with the present, whereas the psychoanalytic approach tries to understand and heal the past. Behavior modification deals with stimuli, reward, and punishments to target and change behavior. One common type of modification therapy is contingency management, which uses a voucher based system of positive rewards for remaining in treatment.
- **Social learning models.** These models are designed to provide therapy through observational learning, that is, through observing and imitating others. This process is also known as modeling. Social learning approaches frequently are used in therapeutic communities, where staff members are considered potential models.
- **Cognitive-behavioral therapy.** This approach uses the same “learning processes” that aid in the addiction process to aid in the recovery process as well. Techniques of cognitive-behavioral therapy include recognizing situations associated with drug X, avoiding these situations when appropriate, and coping with a range of problems and problematic behaviors associated with drug abuse. It focuses on the ways that people think and the content of their thinking. Counselors try to teach clients how to change their thinking patterns. This type of therapy can take place in individual and group settings.

According to van Voorhis (1997), these last three therapies (i.e., all but the psychoanalytic approach) provide the best chances of achieving success with offenders.

Outpatient drug-free therapy is a type of treatment that includes aspects of counseling, education, self-help, 12-step groups, and cognitive behavior therapy. The treatment can last several months or more. In an incarcerated setting, this type of therapy is similar to milieu or residential, without the separate living conditions. This type of treatment is recommended for users of drugs other than opiates and those with generally stable, well-integrated lives where there have been only brief histories of drug dependence and criminal behavior.

Milieu therapy incorporates intensive counseling and separate living conditions. The intensity of the program lies between the aforementioned counseling and the therapeutic community. It includes some components of group and individual counseling, peer interaction and “mildly confrontational group sessions” (Lipton et al. 1992). Success rates for milieu therapy are higher than rates for counseling alone, but less than rates for therapeutic communities (Falkin, Wexler, and Lipton 1990). Milieu therapy is best suited for recent multi-drug users with fewer than five years of addiction.

Family therapy is used to offset the effects on the family of criminal behavior. Institutionalization in particular threatens family stability for both the offender and the family, both of whom must adjust to the changing circumstances and additional stress. Therapy must address the individual and the family, since family conditions can contribute to criminal behavior (van Voorhis 1997, 219).

In-patient short-term therapy is a short-term, typically 30-day, intensive treatment plan focusing on medical stabilization (detoxification) and behavioral changes. A combination of medical professionals and counselors run the program.

Residential programs generally are run in separate facilities. They can vary greatly, from the timing to the physical environment to the philosophical approach. Residential programs are part of a continuous treatment plan; the programs usually incorporate post-treatment plans into their design.

Modified from the traditional community setting, therapeutic communities are the most popular and successful types of residential treatment programs in prison. Programs vary, but typically the therapeutic community is long-term, isolated, comprehensive residential program, involving education and therapy. Providers include peer staff (i.e., those who have successfully completed the program), treatment and mental health providers, and educational and vocational coun-

selors. New York’s Stay ’n Outmodel was one of the first and most prominent, as well as one of the first to undergo a large-scale evaluation. TCs generally offer a comprehensive array of services and approaches as well as a continuous treatment environment. Although programs vary, many programs contain a three-phased approach to treatment. These stages are incarceration, work release or “transitional TC,” and parole or another supervised post-release option. The programs offer comprehensive therapy, focusing on behavioral, cognitive, and emotional aspects of the person, in addition to medical and physical conditions of alcohol or drug abuse.

Pharmacological maintenance is a medically supervised service that involves administration of medication to replace the illicit drug or block its actions. There are several kinds of pharmacological applications. Methadone maintenance is the most common; the client is monitored and counseled while receiving methadone. This type of program is tailored for those addicted to heroin or other opiates for a long period of time (typically more than two years). Several other types of applications include:

- Naltrexone is an opioid antagonist that blocks the effects of opioids such as heroin, thereby discouraging their use. Naltrexone has also been used for alcoholism because it reduces the patient’s desire for alcohol when he or she stops drinking.
- Buprenorphine is a medication still in the experimental stage that exhibits mixed opioid-like and opioid-antagonist properties.
- Long-acting opioid maintenance compounds include drug treatments such as LAAM (levo-alpha-acetylmethadol) that overcome the need for the daily clinic attendance required for methadone maintenance.

Transitional services. A key to maintaining treatment success is to provide comprehensive services, particularly during the stressful transition away from prison to the community. Returning to old neighborhoods, old routines, and old friends can often be the catalyst to begin reverting back to “old ways.” Transitional services can include things such as “relapse prevention”; this is a strategy to help the alcohol or drug abuser learn about his or her own specific stressors or triggers that contribute to their drug use, as well as about strategies they can use to cope with these

(Vigdal 1995). Providing transitional services is an integral part of continuous case management.

Diversion programs. Extensive efforts have been made in recent years to divert alcohol or drug-involved offenders away from traditional incarcerated settings, when deemed appropriate. Drug courts have become increasingly popular over the past 5 to 10 years. The premise underlying most drug courts is that drug use represents as much a public health as law enforcement problem (Vigdal 1995). Other alternative programs include the Treatment Alternative to Street Crime program, intensive probation programs, and boot camps. Brown (1992) notes that, in addition to the five widely accepted treatment models for drug abusers in correctional settings, there are alternatives-to-incarceration models as well. The basic models include probation, with a mix of counseling, support, and surveillance (the most typical); surveillance, components of which include house arrest, electronic monitoring, and urinalysis; and diversion, such as programs like TASC.

COST OF DRUG TREATMENT

A report by the Center on Addiction and Substance Abuse (1998) indicates that it costs \$3,500, over and above incarceration costs, to provide residential drug treatment to inmates. The cost would be \$6,500 if education, job training, and health care were included. These costs would be substantially offset by increased productivity of offenders who not only do not return to prison but obtain employment. For example, CASA (1998) estimates that there would be \$68,800 in savings per inmate, assuming each inmate becomes a law-abiding citizen, avoiding incarceration and health care costs, earning a salary and paying taxes.

The 1992 CALDATA (California Department of Alcohol and Drug Programs) study is another well-known cost-benefit study (Gerstein et al. 1994). Several important findings came out of this report: each dollar spent on alcohol or drug treatment resulted in \$7.14 savings to the criminal justice system, mostly due to reduction in crime; treatment reduces drug use and drug-related illnesses; the “time in program” hypothesis was supported (i.e., the more time spent in treatment, the more effective treatment is); and treatment can be effective for everyone, cutting across all demographic groups and risk levels.

DRUG TREATMENT PREVALENCE IN CORRECTIONAL INSTITUTIONS

Prevalence Surveys

Information from recent survey sources was gathered to illustrate the state of knowledge of treatment programs in prisons and jails. Each source provides a different perspective on treatment in incarcerated settings. The sources include the following:

- *The 1997 Uniform Facility Data Set* (SAMHSA 2000). In 1997, SAMHSA conducted a special survey of correctional facilities in the United States, including state and federal prisons, jails, and juvenile facilities. The goal of the study was to document the prevalence of treatment in correctional settings and to document the various types of treatment being offered. Previous Uniform Facility Datasets gathered information from all treatment settings, predominately community-based treatment, and underrepresented correctional institutions. The 1997 data collection effort was the first comprehensive collection targeting correctional institutions. Treatment was defined as including services that attempted to initiate or maintain alcohol or drug abuse recovery, and included a range of approaches, such as individual and group counseling, detoxification, and pharmaceutical treatments. Correctional facilities and researchers sometimes include AA, NA, or other general education or self-help awareness groups as treatment. The SAMHSA study thus relies on a narrower definition of treatment.
- *The Corrections Yearbook 1999: Jails and The Corrections Yearbook 1999: Adult Corrections* (Camp and Camp 1999a, b). The yearbook for jails provides data compiled from a survey questionnaire to all jail systems housing more than 200 prisoners in the United States. Information presented about jails refers to the 124 jail systems (265 jails in 33 states) that completed surveys. The yearbook for adult corrections contains data from correctional agencies from all 50 states, the District of Columbia, the Federal Bureau of Prisons, and the Correctional Service of Canada, as well as information from parole and probation agencies. Information referenced in the state and federal prison sections of this report refers to answers from the correctional agencies and the Federal Bureau of Prisons.

- The 2001 American Correctional Association *Survey of the Adult Division of the Department of Corrections* (ACA 2001). A statewide drug treatment intervention survey of the Adult Division of the Department of Corrections (DOC) took place in 2000, with representatives from 42 state prison systems participating in the survey. DOC representatives for each state system answered questions about the state's drug testing, assessment, and treatment practices.
- The 1996 Center for Substance Abuse Treatment, *Treatment Survey of Prison Facilities* (CASA 1998). In 1996, CASA conducted a national mail survey targeting state and federal correctional systems. In total, 963 prison facilities responded to the survey, including 47 states, the District of Columbia, and the Federal Bureau of Prisons. Question topics include assessment, inmates in treatment, and treatment services. Treatment services were described as therapeutic communities, other intensive inpatient/residential, individual, and group counseling self-help, and drug education.
- The *1997 Survey of Inmates in State and Federal Correctional Facilities*, conducted by the Bureau of Justice Statistics (Mumola 1998, 2000). This survey interviewed inmates and asked them questions about their offenses, background, gun possession and use, prior drug and alcohol use and treatment, and services provided in prison, among other things. This source provided an inmate perspective on treatment.

Inmates in Drug Treatment Programs in State and Federal Prisons

Treatment should target inmates with a legitimate addiction problem. However, the prevalence data about people in treatment provides ambiguous information about addiction. As discussed in the prevalence section, during the past decade, there were increasing numbers of inmates in the correctional system in general, and increasing numbers of people with alcohol or drug abuse problems in the system. Unfortunately, we lack clear, standardized information about the severity of need and corresponding treatment options available.

Data from the *1999 Corrections Yearbook* illustrates the range of service prevalence for inmates in state and federal correctional facilities. The percent of inmates in a treatment program, as a percentage of all inmates, ranges from a low of .8 percent in Louisiana

to a high of 68 percent in Alaska. On average, 16.2 percent of all inmates have experienced treatment defined as separate unit treatment, addiction groups, or counseling.

A 1997 Uniform Facility Data Set (UFDS) survey documented that 99,000 inmates received substance abuse treatment in state prisons; 12,500 inmates in federal prisons received treatment at the time of the survey (SAMHSA 2000). The *1997 Survey of Inmates in State and Federal Correctional Facilities* (Mumola 1998, 2000) defines "treatment" as residential facilities, professional counseling, detoxification units, and maintenance drug programs. This survey found that, in 1997, 9.7 percent (101,728) of state prisoners received treatment since admission. By contrast, in 1991, 24.5 percent (169,700) of state prisoners received some form of drug treatment. Among federal prison inmates in 1997, 9.2 percent (8,100) received drug treatment, a decline from 15.7 percent (8,300) in 1991.

The *1997 Survey of Inmates* (Mumola 1998, 2000) data suggest that treatment programs target inmates who show signs of more intensive drug use. For example, in state prisons in 1997, 9.7 percent of all prisoners participated in drug abuse treatment since admission; 11.5 percent of those inmates who ever used drugs, 13.1 percent of those inmates who used drugs regularly, 14.6 percent of those who used drugs in the month before the offense, and 18 percent of those who used drugs at the time of the offense participated in drug treatment since admission. The numbers are similar for federal prisoners. The trend is similar for non-treatment programs as well (defined as self-help, peer counseling, and education/awareness groups); 20.3 percent of all state prisoners participated in these programs, while 38.0 percent of those that used drugs at the time of the offense participated in these programs. Overall, there has been a drop in participation in professional substance abuse treatment programs since 1991, but an increase in enrollment in other drug abuse programs, such as self-help or peer groups and drug education classes.

The SAMHSA (2000) study found that only 40 percent of correctional facilities (including federal, state, jails, and juvenile facilities) nationwide provided on-site substance abuse treatment, ranging from a low of 16 percent in Mississippi to a high of 71 percent in Delaware. This information is important because it helps to make sense of aggregate state statistics. In state-level surveys, a state could answer that they offer a particular service even if only a few institutions within the state offer it. However, using information

from SAMHSA's institution-level survey, it is possible to identify that only a certain percentage of institutions within the state actually offer the service.

Inmates in Drug Treatment Programs in Jails

In general, jails are unable to offer the full spectrum of services that longer-term, larger prison facilities are able to offer. Jails have been described as a less than ideal place for treatment because of the frequent turnover and short stays. However, some jails, particularly larger ones, are now offering comprehensive alcohol or drug treatment services. With additional resources, it is possible to provide treatment, or at least begin part of a treatment plan that, with proper linkages, can continue smoothly through the justice system. Detoxification services are among the first services offered to alcohol- or drug-abusing offenders because valid assessments cannot be made without detoxification.

According to the UFDS data (SAMHSA 2000), overall, 34 percent of jails offer drug "treatment." As table 3-2 shows, only 28 percent of jails offer detoxification to inmates. (According to the *1999 Corrections Yearbook*, 50 percent of jail systems housing more than 200 inmates offer detoxification programs.) The first priority for many jails is to monitor offenders. Monitoring through urinalysis or other tests can help to encourage a drug-free environment. According to the literature, maintaining a drug-free environment is a key to successful treatment programs. Yet the UFDS data indicate that fewer than half (42 percent) of jails use drug testing. And 36 percent of jails do not assess offenders for drug treatment needs.

According to the UFDS survey, a majority of jails provide individual (77 percent) or group counseling (64 percent). Family counseling is less prevalent, taking place in only 19 percent of jails. The *1999 Corrections Yearbook* tells a slightly different story: most jails (76 percent) offer group counseling programs, less offer individual counseling (57 percent), and 30 percent of jails offer therapeutic communities.

According to the UFDS survey, some jails offer a variety of "nontreatment" substance abuse services. Over half (60 percent) of jails provide self-help services, such as AA or NA, and many (43 percent) offer education and/or awareness programs. According to the *1999 Corrections Yearbook*, 70 percent of jails offered education programs and 70 percent provided community referral services.

Inmates in Drug Treatment in the Federal Bureau of Prisons

According to the 1997 UFDS (SAMHSA 2000), 93.8 percent of federal prisons provide "treatment." Almost all federal prisons provide group counseling (99.2 percent) and individual counseling (99.2 percent), with 11.6 percent offering family counseling. Table 3-4 presents information about nontreatment services in federal prisons. Most federal prisons offer what the study refers to as "nontreatment" services. The vast majority (86.8 percent) assess for treatment need and provide drug education (89.9 percent), conduct drug tests (87.6 percent), or offer self-help groups (84.5 percent), but only 22.5 percent have detoxification capabilities.

Almost all federal prisons offer a comprehensive treatment program to qualified inmates. The Bureau of Prisons (BOP) provides a standardized assessment,

Table 3-2. Correctional Facilities Providing Selected Nontreatment Substance Abuse Services, All Correctional Facilities and Jails

Selected Substance Abuse Service	Facility Type	
	All Facilities (N = 7,243)	Jail (N = 3,067)
Assessment for treatment need	63.7%	63.6%
Drug testing	55.9	42.2
AA, NA, other self-help	57.3	59.7
Education/Awareness	63.2	43.4
Detoxification	15.5	28.1

Source: Substance Abuse and Mental Health Services Administration. 1998. *1997 Survey of Correctional Facilities*, based on the Uniform Facility Data Set (UFDS). Washington, D.C.: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Office of Applied Studies.

placement, and treatment process to all inmates. This process began in 1989 in an attempt to create a continuum strategy for federal prison inmates. Inmates must participate in an alcohol or drug education program if:

- there is evidence in their pre-sentence investigation report that alcohol or drugs contributed to the commission of their instant offense;
- they violated supervised release, parole, conditions of a halfway house placement, or conditions of home confinement based on alcohol or drug use; or
- the sentencing judge recommended that they participate in a drug treatment program during incarceration.

The education program is a comprehensive program; however, those who are identified as needing more treatment are encouraged to participate in either nonresidential or residential drug treatment. Every BOP institution offers nonresidential drug abuse treatment and counseling, including individual and group therapy, seminars, and self-improvement groups. In addition, 47 Bureau institutions have residential, isolated, intensive drug abuse treatment programs. (The Federal Bureau of Prisons has 98 institutions, six regional offices, a Central Office [headquarters], three staff training centers, and 28 community corrections offices.) The residential program is comprehensive, and it follows the offender through treatment in prison to aftercare in the community.

Inmates are also encouraged to volunteer for the residential treatment. The Bureau reports that a significant number of inmates volunteer for the residential

treatment. One reason for volunteering is the one-year reduction in sentence incentive offered to inmates for successful completion of a residential drug abuse treatment program.

Treatment and Treatment Settings

In the UFDS survey, a total of 121 federal facilities, 716 state prisons and 1,047 jails reported providing treatment. These numbers represent approximately 94 percent of federal prisons, 61 percent of state prisons, and 34 percent of jail systems. Treatment can be provided in a variety of settings in correctional institutions. The UFDS refers to three treatment settings:

- Substance abuse treatment provided in a specialized unit within the institution, defined as a unit where those receiving substance abuse treatment live separate from the rest of the facility population while sleeping.
- Treatment or counseling in the general facility inmate population, defined as treatment for substance abuse that is provided other than in a specialized treatment unit or in a hospital or psychiatric ward, where the inmate or resident returns to his or her regular bed within the facilities at night.
- Substance abuse treatment provided in a hospital / psychiatric inpatient unit within the institution, analogous to hospital inpatient treatment.

These treatment settings are not mutually exclusive; an institution can provide any combination of treatment in various settings. Results from the survey, presented in table 3-5, show that most federal and state prisons as well as jails rely primarily on general facility

Table 3-4. Correctional Facilities Providing Selected Nontreatment Substance Abuse Services, All Correctional Facilities and State vs. Federal Prisons

Selected Substance Abuse Service	Facility Type		
	All Facilities (N = 7,243)	State Prisons (N = 1,069)	Federal Prisons (N = 129)
Assessment for treatment need	63.7%	67.1%	86.8%
Drug testing	55.9	88.4	87.6
AA, NA, other self-help	57.3	92.5	84.5
Education/Awareness	63.2	82.6	89.9
Detoxification	15.5	8.0	22.5

Source: Substance Abuse and Mental Health Services Administration. 1998. *1997 Survey of Correctional Facilities*, based on the Uniform Facility Data Set (UFDS). Washington, D.C.: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Office of Applied Studies.

population treatment. The next most popular model in federal prisons is the specialized unit and general facility population treatment (33.1 percent). Only 14.9 percent of state prisons and 9.6 percent of jails offer this mix of settings. Eighteen percent of jails, 15.9 percent of state prisons, and 5.8 percent of federal prisons offer a specialized treatment unit only. Very few prisons or jails offer hospital or psychiatric treatment unit only or the combination of a hospital or psychiatric treatment unit with a specialized unit or general facility.

TREATMENT PROGRAMMING ISSUES

Treatment Plans and Continuity of Care

The treatment plan is as important as provision of treatment. Without a plan, treatment can be disjointed, piecemeal, and, ultimately, ineffective. According to Vigdal (1995), treatment plans ideally should be:

- biopsychosocial in nature,
- multidisciplinary in delivery,
- comprehensive in scope,
- driven by ongoing assessments, and
- closely monitored.

The treatment plan includes a client profile (needs, risk, history, etc.) along with the prescribed treatment plan, including goals and objectives. Providers from all

systems—criminal justice, treatment, mental health, and medical—should be involved in the plan and share the information in the plan. To prevent “reinventing the wheel,” the plan should be automated and updated as risks and needs change and as progress is made. The plan is crucial for the period of time when the offender moves from the institution to the community.

It is also important for representatives from different services to collaborate. Active linkages should be established and maintained between criminal justice representatives, alcohol or drug treatment representatives, and mental health representatives, among others.

Case management is one way to efficiently supervise the treatment plan. Case management provides a variety of functions. First, it can be the bridge between sometimes competing systems, the criminal justice system and the treatment system. Second, it creates a network of service agencies, both public and private, which in turn creates a greater pool of resources of treatment options. Third, case management ensures continuity; it provides a single point of contact, a “navigator,” throughout the system. Vigdal (1995) presents five models. Case management that is provided by

- the justice system
- a treatment agency
- an agency separate from the treatment and justice agencies

Table 3-5. Correctional Treatment Facilities Providing Each Combination of Treatment Type, by Facility Type

Treatment Setting	Facility Type			
	All Facilities (N = 3,027)	Jails (N = 1,047)	State Prisons (N = 716)	Federal Prisons (N = 121)
Total, all treatment facilities	100.0%	100.0%	100.0%	100.0%
Specialized treatment unit only	14.3	18.2	15.9	5.8
General facility population treatment only	70.6	64.6	63.4	55.4
Hospital or psychiatric treatment unit only	1.1	1.9	1.1	0.0
Specialized unit and general facility population treatment	10.0	9.6	14.9	33.1
Specialized unit and hospital/psychiatric treatment unit	0.8	1.3	1.0	0.0
General facility population treatment and hospital/psychiatric unit treatment	2.0	2.6	2.5	4.1
Combination of all three settings	1.2	1.8	1.1	1.7

Source: Substance Abuse and Mental Health Services Administration. 1998. 1997 Survey of Correctional Facilities, based on the Uniform Facility Data Set (UFDS) survey, and the 1996 UFDS Survey. Washington, D.C.: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Office of Applied Studies.

Note: Figures may not add to totals shown due to rounding.

- a coordinator from the justice system who provides consulting services and technical assistance to support existing criminal justice case management
- multidisciplinary groups in the criminal justice system.

Maintaining a Drug-Free Environment

Although maintaining a drug-free environment in a correctional setting can set the stage for expectations of drug use (zero tolerance), only 29 percent of state and federal prisons are drug free. Many prisons provide free cigarettes to certain or all offenders. More important is the illicit drug trade reputed to be widely prevalent in prisons (Inciardi, Lockwood, Quinlan 1993). It is an issue that journalists and reporters have often addressed, but from an evaluation perspective, few researchers have documented the reality of drug use in prisons, in part because of the extremely sensitive nature of the topic. In fact, statistics about the results of drug monitoring tests portray a very optimistic picture about illicit drug use in correctional facilities.

A CASA (1998) report cites anecdotal evidence about the availability of drugs and alcohol in prisons and jails. A combination of surveillance (searching belongings, “patting down” inmates, exchanging clothes upon admission, and questioning visitors) and drug testing can help to enforce a drug-free environment (CASA 1996 study, cited in CASA 1998).

Although there is anecdotal evidence about the prevalence of drugs and alcohol in correctional facilities, drug tests tell a positive picture. Almost all facilities monitor some inmates by testing for drug use. Urinalysis is the most common tool that is used to screen for drug use and monitor the population. The cost per sample is relatively low, ranging from a few dollars to about \$26 in one state (the average cost to test a sample for drugs was \$6.91). However, the total cost can be quite high—in 1999, a total of 1,362,753 samples were collected. On average, 95.4 percent of samples among 41 agencies were drug free.

KEY RESEARCH QUESTIONS

- What exactly is the treatment need/services gap? To date we lack consistent and sufficiently detailed studies identifying how much of various kinds of treatment are available in jails and prisons, and how these have changed over time. Thus, it is difficult to state with a high degree of accuracy what the current treatment need/services gap is.
- Why do correctional facilities choose particular treatment programs? Among the many possible treatment approaches, why one particular approach? Who makes this decision? Are treatment programming decisions driven primarily by unique, one-time opportunities, legislation, correctional philosophy, and/or other factors?
- How many facilities evaluate their programs, including screening and assessing potential clients and matching that information to new and improved programs?
- What are the primary challenges to providing drug treatment?
- What are the challenges involved in linking substance abuse treatment to other aspects of correctional operations?
- Are there certain types of treatment that are easier to implement in a prison setting?
- Do correctional administrators stay current with the effectiveness of different treatment models and adjust their programs as information changes?

CHAPTER 4.

Drug Treatment Effectiveness in the Criminal Justice System

Research consistently shows that drug treatment can be effective for a range of offenders across a range of treatment modalities. Several longitudinal studies on drug treatment programs, including the Key-Crest program in Delaware and the Amity Program in California, provide strong evidence that drug treatment in prisons as well as aftercare programs in the community reduce recidivism and increase pro-social behavior. In addition, findings from the Drug Abuse Treatment Outcome Study (DATOS), the Treatment Outcome Prospective Study (TOPS), and the Drug Abuse Reporting Program (DARP) conducted over the past 30 years show that treatment can work in “real world” settings. However, many questions remain undressed or unanswered, including identification of the precise modalities, and combinations of modalities, that most successfully reduce drug abuse and criminal behavior. In addition, despite recent advances and developments in research, including meta-analytic techniques, there are still considerable methodological flaws in much research on treatment effectiveness.

This chapter outlines the most common positive outcomes for drug treatment, linking these to specific treatment approaches. It then explores the merits of compulsory treatment and identifies factors that influence treatment effectiveness across modalities. Finally, it discusses difficulties inherent in evaluating treatment effectiveness and identifies areas for further research.

INTRODUCTION

Research consistently shows that drug treatment can be effective for a range of offenders across a range of treatment modalities. Several longitudinal studies on drug treatment programs, including the Key-Crest Program in Delaware and the Amity Program in California, provide strong evidence that drug treatment in prisons as well as aftercare programs in the community reduce recidivism and increase pro-social behavior (Gaes et al. 1998; Harland 1996). In addition, findings from the Drug Abuse Treatment Outcome Study (DATOS), the Treatment Outcome Prospective Study (TOPS), and the Drug Abuse Reporting Program (DARP) conducted over the past 30 years show that treatment can work in “real world” settings (Cullen and Gendreau 2000; Gaes et al. 1999; General Accounting Office 1998). However, many basic questions remain unaddressed or unanswered, including identification of the precise modalities, and combinations of modalities, that most successfully reduce drug abuse and criminal behavior. In addition, despite recent advances and developments in research, including meta-analytic techniques, there are still considerable methodological flaws in much research on treatment effectiveness (Gaes et al. 1999).

This chapter outlines the most common positive outcomes for drug treatment, linking these to specific treatment approaches. In addition, it identifies key factors linked to treatment effectiveness and explores the merits of compulsory treatment and the issue of cost-effectiveness. Finally, it discusses difficulties inherent in evaluating treatment effectiveness and identifies areas for further research.

DRUG TREATMENT EFFECTIVENESS

Summary Assessment

In general, drug treatment can be effective in reducing drug use and criminal behavior. The effectiveness holds whether treatment is provided inside or outside of correctional facilities, and it holds across many, though not all, treatment modalities and offenders (Cullen and Gendreau 2000; Gaes et al. 1999; Lipton et al. 1998). Drug treatment can reduce drug use by 50 to 60 percent and decrease criminal activity by as much as 40 percent, as well as reduce other high-risk behaviors (NIDA 1999). It can also improve prospects for employment (DSHS 1998) and improve family and social relations (Rossman et al. 1999). In short, the

most successful drug treatment approaches can do the following:

- decrease relapse and increase times between treatments;
- improve pro-social behavior;
- decrease criminal recidivism;
- decrease high-risk behaviors;
- improve prospects for employment; and
- improve family and other social relations.

Major Types of Treatment: Pharmacological and Behavioral/Psychosocial

Although research shows that treatment works, which specific treatment approaches work is a more complicated question. The few studies that systematically address this question indicate that pharmacological treatments in combination with psychosocially or behaviorally based approaches work best in treating most drug problems (Crowe and Reeves 1994; Cullen and Gendreau 2000; Gaes et al. 1999; NIDA 2001). However, little conclusive research has been done to directly compare treatment effectiveness across treatment modalities.

There are four main types of pharmacotherapy that work to either block or mimic the effects of the abused drug (Crowe and Reeves 1994):

- **Agonists**, whose properties and actions mimic the effects of heroin. Examples include Levo-alpha-acetylmethadol (LAAM), Methadone, and Clonidine.
- **Antagonists**, which block the effects of heroin. Examples include Naltrexone and Buprenorphine.
- **Antidipsotropics**, which create an adverse reaction to the substance of abuse. An example is Antabuse.
- **Psychotropic medications** can control various symptoms associated with drug use and withdrawal. Examples include anti-anxiety drugs, anti-psychotics, anti-depressants, and lithium.

Behaviorally or psycho-socially based treatments can range from intensive residential and inpatient care to self-help groups and education programs (Cullen and Gendreau 2000). The following are the most common programs:

- in-patient or residential treatment, including therapeutic communities

- out-patient treatment
- self-help programs
- individual/group/family counseling
- behavior modification
- education programs

Effectiveness of Different Treatment Approaches

Table 4-1 summarizes those treatments that are most effective in treating specific types of drug abuse. For each of four types of drugs—heroin, cocaine, methamphetamine, and alcohol—there are pharmacological and behavioral/psychosocial treatments that can effectively assist with reduction of drug use, although

the evidence to date is less conclusive for pharmacological treatment of methamphetamine addiction. In each instance, the most effective treatment generally involves coupling pharmacological and behavioral/psychosocial interventions, especially cognitive-behavioral therapy.

What Works, What Is Promising, and What Does Not Work

Even when a given treatment has been shown to “work” (i.e., to result in a statistically significant “effect”), it is evident that not all treatments work equally well. For this reason, leading experts view program effectiveness as lying along a continuum, with levels of effectiveness ranging from low to high (Lipton et al. 1998).

Table 4-1. Effective Treatments for Specific Types of Drug Abuse and Addiction

Drug	Treatment
Heroin	• A combination of medication and psychosocial/behavioral therapy is most effective. • Medications are effective: LAAM, Methadone, Naloxone, or Naltrexone. • Other approaches that have proven effective in promoting positive outcomes: – Placement in residential treatment or in outpatient treatment or therapeutic community programs can be effective. – Cognitive-behavioral therapy and contingency management show promise. – Aftercare services and other links to community services may be an important part of addiction recovery.
Cocaine	• A combination of medication and psychosocial/behavioral therapy is most effective. • Although no medications currently are available to treat cocaine specifically, antidepressants, antipsychotics, and lithium are promising treatments for cocaine addiction. • Other approaches that can be effective: – Placement in residential treatment, outpatient treatment, or therapeutic community programs can be effective. – Cognitive-behavioral therapy and contingency management show promise. – Aftercare services and other links to community services may be an important part of addiction recovery.
Methamphetamine	• Psychosocial/behavioral strategies are the most effective. • Education, support groups, and cognitive behavioral therapy all show promise in treating methamphetamine addiction. • Antidepressants may also help alleviate depressive symptoms associated with recent abstinence, but research to date is insufficient to verify effectiveness. • Aftercare services and other links to community services may be an important part of addiction recovery.
Alcohol	• A combination of medication and psychosocial/behavioral therapy is most effective. • Antabuse provides a strong deterrent to alcohol abuse. • Brief interventions and counseling show promise in treating alcohol abuse. • 12-step programs, support groups, and behavioral treatment are promising treatments. • Aftercare services and other links to community services may be an important part of addiction recovery.

Sources: Crowe and Reeves (1994); GAO (1998); NIDA (2001); Rossman et al. (1999).

Table 4-2 summarizes treatment programs using the categorization system developed by Lipton et al. (1998). The categories include “successful,” “promising,” and “unsuccessful,” where the primary criterion is recidivism. As inspection of the table shows, the most successful treatments include but are not limited to cognitive-behavioral, social learning, incentive-based, and pharmacological approaches. Promising approaches include therapeutic communities and certain types of individualized treatment programming. Unsuccessful programs include boot camps, intensive probation and parole programs, guided group interaction and positive peer culture programs, and shock incarceration.

THE FOUNDATIONS OF EFFECTIVE TREATMENT

Significant advances have been made in the area of drug treatment, and considerable research testifies to the potential effectiveness of a diverse range of programs and interventions. Across treatment modalities and various programs, there are a range of factors that comprise the foundation of effective treatment. These factors are listed in table 4-3 and are discussed briefly below. (The discussion draws primarily on recent reviews by Gaes et al. [1999] and Cullen and Gendreau [2000], among others.)

Table 4-2. The Effectiveness of Different Treatment Approaches in Reducing Recidivism

Successful

- Behavioral or cognitive-behavioral approaches
- Reinforcement or incentive programs
- Cognitive and social-learning approaches
- Literacy training and GED training programs
- Experiential challenge programs
- Mentoring, as a correctional intervention
- Reality therapy
- Some group counseling programs
- Counseling treatments oriented to family treatment
- Individualized counseling programs
- Methadone programs

Promising

- Therapeutic communities and milieu therapy
- Individualized treatment programming

Unsuccessful

- Shock incarceration programs
- Scared Straight programs
- Restitution programs
- Boot camp programs
- Intensive supervision probation and parole programs
- College coursework programs
- Programs providing training in job-seeking skills and job placement services
- Guided group interaction and positive peer culture programs

Sources: Cullen and Gendreau (2000); Lipton et al. (1998).

Table 4-3. The Foundations of Effective Treatment

- Target dynamic/criminogenic needs.
- Provide multimodal treatment.
- Incorporate treatment responsivity.
- Address risk differentiation.
- Provide skills-oriented and cognitive-behavioral treatment.
- Provide integrated and comprehensive treatment.
- Provide continuity of care.
- Draw on external sources to promote completion of treatment.
- Apply appropriate dosages/levels of intervention.
- Provide effective program design, implementation, and monitoring.
- Involve researchers in program design, implementation, and evaluation.

Sources: Cullen and Gendreau (2000); Gaes et al. 1999; NIDA (1999).

Target Dynamic/Criminogenic Needs

Research increasingly shows that the most effective programs are those targeting so-called “dynamic” or “criminogenic” needs—that is, factors that both can be changed and have been linked to criminal behavior. Drug use clearly constitutes a criminogenic factor. But there are other criminogenic factors that influence drug use and criminal behavior. Gaes et al. (1999, 363) enumerate the primary factors identified by Andrews (1995) and others (see Cullen and Gendreau 2000):

- pro-criminal attitudes
- pro-criminal associates
- impulsivity
- weak socialization
- below-average verbal intelligence
- risk-taking tendencies
- weak problem-solving skills
- early onset of anti-social behavior
- poor parental practices
- deficits in educational, vocational, and employment skills

As Gaes et al. (1999, 363) emphasize, however, criminogenic needs should not be assumed to exist, but rather should be assessed to see if indeed they do exist. Treatment of a non-condition obviously represents an inefficient allocation of resources, and missed opportunities to provide more effective treatment.

Provide Multimodal Treatment

Treatment is most effective when it addresses not one but all criminogenic needs (Gaes et al. 1999, 364). This issue is particularly important in contexts where programming is designed to focus primarily on one need rather than all relevant needs. The failure to address all needs can undermine the effectiveness of any given treatment approach. Although detoxification generally is a necessary condition for effective treatment, the same may be true of many other conditions. Thus, a vocational program that does not address drug addiction is likely to be less effective in enhancing an offender’s employment prospects or curbing criminal behavior. Similarly, drug treatment approaches that do not address other relevant criminogenic needs may be considerably less effective in reducing drug use or criminal behavior, or in sustaining reductions over the long term (NIDA 1999).

Incorporate Treatment Responsivity

Tailoring treatment priorities to the needs and learning styles of individuals—what is termed “treatment responsivity”—is increasingly thought to be critical to treatment effectiveness (Cullen and Gendreau 2000), though systematic assessments of this common-sense idea are for the most part lacking (Gaes et al. 1999). Nonetheless, the basic notion is that effective services are those based on individual needs, motivation, and style of learning. Because an individual’s needs may change over time, continuing assessment and modification of the treatment program is important.

Address Risk Differentiation

Research shows that treatment is most effective when the intensity of treatment is adjusted to the risk level of the client. In general, higher risk offenders are more likely to benefit from treatment than lower risk offenders (Gaes et al. 1999, 364). However, some research indicates that high-risk offenders show greater improvements when they receive high-intensity treatment, and that low-risk offenders show greater improvements when they receive low-intensity treatment (Andrews and Bonta 1998).

Provide Skills-Oriented and Cognitive-Behavioral Treatment

Meta-analyses consistently support the finding that skills-oriented and cognitive-behavioral treatments are more effective than other types of treatment (Gaes et al. 1999). These approaches are particularly suited to addressing the types of values, attitudes, beliefs, and emotional and personality orientations that contribute to a range of negative outcomes, including drug use and criminal behavior (Cullen and Gendreau 2000).

Provide Integrated and Comprehensive Treatment

The most effective models for reducing drug use and criminal behavior involve providing integrated and comprehensive treatment (Cullen and Gendreau 2000). Unfortunately, the more typical approach historically has consisted of providing treatment in piecemeal fashion, at one stage or another of criminal justice processing, with coordination of efforts between agencies rare. The importance of integrated and comprehensive treatment is suggested by consideration of mental health issues.

Most offenders have a variety of social and mental health problems. Indeed, rates of mental health problems are much higher among jail and prison inmates than in the general population (Lurigio and Schwartz

2000; Peters and Bartoi 1997; Peters and Hills 1997). The most common mental disorders among inmates are psychosis, depression, and bipolar disorders. Despite the prevalence of mental illness among inmates, few correctional institutions assess for mental disorders. In one study, it was estimated that only 6 percent of prison inmates with co-occurring substance and mental disorders were identified (Dennis 1998). By contrast, the literature suggests that more than half of the people with substance use disorders have co-occurring mental disorders (Kessler et al. 1994) and more than 65 percent of those presenting for treatment have co-occurring mental disorders (Dennis 1998). Other studies (e.g., Chulies et al. 1990; Cote and Hodgins 1990) suggest that:

- 75 percent of addicted offenders have histories of depression;
- 25 percent of addicted offenders have histories of major depression, bipolar disorder, or atypical bipolar disorder; and
- 9 percent of addicted offenders are schizophrenic.

The recognition of co-occurring disorders is especially important because of the unique challenges in treatment that offenders with co-occurring disorders present. Peters and Bartoi (1997) describe the most prominent challenges:

- Use of alcohol and drugs can create mental health symptoms.
- Alcohol and drug use may precipitate or bring about the emergence of some mental health disorders. Mental health disorders can also precipitate substance use disorders.
- Mental health symptoms may be exacerbated, or worsened, by alcohol or drug use.
- Mental health symptoms or disorders are sometimes mimicked by alcohol and drug use.
- Alcohol and drug use may mask or hide mental health symptoms or disorders that are actually present. Mental health symptoms are often not identified until after a long period of time.

Criminal offenders who are alcohol or drug abusers and exhibit mental disorders need specialized, coordinated treatment. Yet it is common for substance abuse treatment programs not to admit offenders with mental disorders and, conversely, mental health pro-

grams not to admit offenders with substance abuse problems (Vigdal 1995). Programs for people with comorbid disorders have been called “inadequate,” with little to no research to date on the percentage of offenders receiving both substance abuse and mental health treatment (Lurigio and Schwartz 2000).

Provide Continuity of Care

The best treatments may fail if insufficient follow-up care is not provided. It therefore is critical that offenders continue to receive treatment or some type of aftercare upon release from prison (Cullen and Gendreau 2000; Gaes et al. 1999). Aftercare programs and post-release supervision can provide resources to help prevent relapse and criminal recidivism. Indeed, re-arrest rates are consistently lowered by as much as 50 percent for offenders who complete aftercare programs in the community after treatment in prison (Field 1998; Wexler et al. 1999). In addition, comprehensive monitoring and case management can help hold clients accountable and reduce re-arrest rates (Field 1998).

Draw on External Sources to Facilitate Completion of Treatment

Research suggests that pressure from external sources—including families, the criminal justice system, employers, and child and family welfare agencies—may lower dropout rates and increase length of time in treatment and program success in general (NIDA 1999). For Treatment Alternatives to Street Crime clients, legal sanctions contributed to a higher-than-usual success rate (Hubbard et al. 1998). In addition, it appears that treatment does not need to be voluntary to work and that, in fact, early intervention by the criminal justice system can play a critical role in preventing drug addiction even when the offender does not want to or is not motivated to participate (Field 1998; NIDA 1999).

Apply Appropriate Dosages/Levels of Treatment

Treatment generally is thought to be most effective when appropriate dosages/levels are applied, and can be ineffective if too little or too much are applied (NIDA 1999). Although some evidence supports this view, relatively little research has systematically addressed the issue of what constitutes an “appropriate,” “effective,” or “optimal” dosage/level of treatment (Gaes et al. 1999, 365).

However, across offender types and treatment modalities, one factor, without fail, has a strong impact on treatment success—length of time in treatment. For

most individuals, at least 90 days is required for treatment success and with some individuals, especially those in methadone maintenance, at least 12 months of treatment are required, sometimes with years of follow-up (NIDA 1999).

Provide Effective Program Design, Implementation, and Monitoring

Any treatment will fail if it is flawed in design or implementation. By contrast, with careful attention to design and implementation, programs can realize their full potential. Although not all treatment programs will be effective, appropriate implementation is essential. In addition, monitoring program operations can identify whether significant modifications have been or need to be made to improve treatment.

More generally, treatment quality generally depends on a range of factors, including organizational factors such as staffing, management, and resources. For example, in a study of the Treatment Alternatives to Street Crime (TASC) program, staff quality was more important to program success than any other organizational factor. Other organizational factors may play a role as well. In Harrison and Martin (2000), administrative commitment to the program, good oversight management, and well-funded implementation budgets were critical for program survival and success.

The quality of the program, not just the staff, is also critical for treatment success. According to several sources (Farabee et al. 1999; Field 1998), a high-quality program should include:

- comprehensive and descriptive screening and assessment tools
- clear and unambiguous program goals and rules of conduct
- strong positive incentives and equally strong negative sanctions
- cross-training and incentives for staff
- involvement of staff in selection of new admissions
- appropriate staff-client ratios
- use of former drug abusers and offenders as treatment staff and mentors.

Involve Researchers in Program Design, Implementation, and Evaluation

Despite increased interest in and commitment to drug treatment (Lipton 1995), there continues to be a

significant lack of involvement of researchers throughout all stages of drug treatment programming. Researchers can provide critical advice on treatment and program design and implementation. They also can help develop the groundwork for generating the types of data necessary to conduct evaluations, without which it becomes impossible to assess whether a given treatment approach is effective (Gaes et al. 1999).

THE FUTURE OF EFFECTIVE DRUG TREATMENT

Identifying What Works Best

Significant advances have been made in drug treatment, and considerable research testifies to the potential effectiveness of a diverse range of programs and interventions. However, little is known about the relative efficacy of many programs, or of what combinations of approaches work best. To this end, the National Institute of Alcohol Abuse and Alcoholism currently is undertaking a study aimed at systematically addressing the relative effectiveness of different approaches to treating alcohol addiction. The study, “Combining Medications and Behavioral Interventions” (COMBINE), involves testing different treatment combinations for alcohol addiction, including:

- acamprosate, an experimental pill used widely in Europe that normalizes brain chemical systems and that currently is under Food and Drug Administration (FDA) review in the United States
- naltrexone, an older pill that affects brain circuitry
- intensive cognitive/behavioral therapy, similar to residential therapy or therapeutic communities
- behavior therapy, encouraging patients to join support groups and participate in counseling

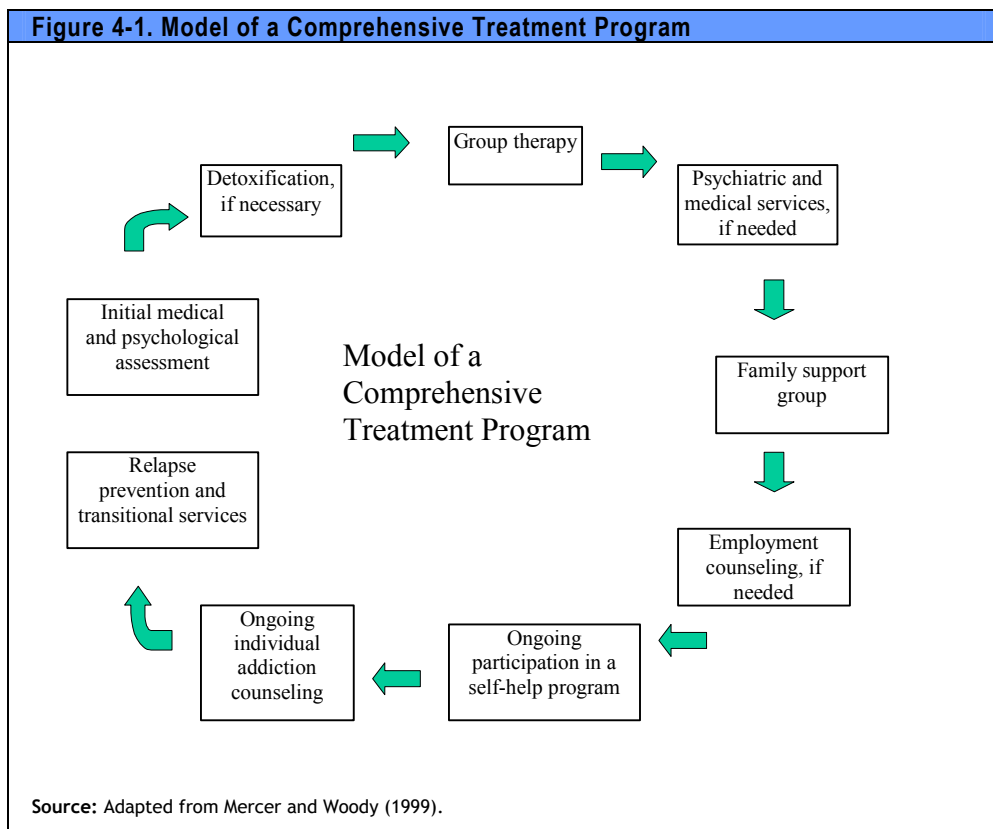
Study respondents will receive different combinations of drug and behavior treatments. The goal of the study is to identify precisely which approaches, in interaction with one another, prove most effective—which treatments, either in isolation or in combination, work best (i.e., are most effective in reducing drug use, criminal behavior, and other negative outcomes, and in increasing positive outcomes, such as education and employment). Similar studies have yet to be conducted for both drug and alcohol addiction, but they are precisely the type that researchers indicate are needed to advance scientific knowledge about treatment effectiveness.

A Comprehensive Model

A hypothetical treatment model, proposed by the National Institute on Drug Abuse and depicted in figure 4-1, could include many different services as part of a comprehensive strategy for drug treatment. This model, which incorporates many of the foundational components of effective treatment identified in the literature (NIDA 1999; Gaes et al. 1999; Cullen and Gendreau 2000), can include pharmacological approaches for treatment or psychiatric disorders when deemed necessary. Treatment matching includes matching the right components of treatment to the person. For example, if the client is in need of “life skills” and management, this component of education and counseling can be added to the plan. Similarly, if the person has relapsed several times before, special attention to relapse prevention interventions could be included in the treatment plan.

(Gaes et al. 1999; Harrison 2000). Although considerable advances in drug treatment have been achieved, few of these advances have been systematically incorporated into correctional practice. Criminogenic needs frequently go unidentified, and even if identified they frequently are not systematically addressed in treatment. Treatment responsiveness and continuity of care occurs far less often than research indicates they should. The absence of effective program implementation, monitoring, and evaluation continues to be the norm.

Although the gap may be explained in part by insufficient resources, these alone cannot account for the gap. To be sure, even if correctional institutions were aware of the latest advances in treatment research, it is not clear how many of these advances could be feasibly implemented in most correctional settings. Yet effective treatment is feasible and can be cost-



Linking Research and Practice

Effective drug treatment depends greatly on reducing the existing gap between research and practice

effective. Thus, the critical challenge for researchers and practitioners lies in identifying ways in which research and practice can be effectively linked.

COMPULSORY DRUG TREATMENT

Some offenders in drug addiction treatment do not choose to be there, leading to some discussion about whether enforced or coercive treatment can be effective, especially considering that client motivation may play a role in program completion. (There are, of course, potential ethical concerns as well, which are not reviewed here.) In a report on the California Civil Addict Program (CAP) (Anglin 1998), civil commitment for narcotic addiction and methadone maintenance appeared to be an effective intervention when applied appropriately. Although nearly everyone in the CAP treatment became addicted again at some point, they had fewer relapse episodes and when they did relapse, it was for a shorter duration. The CAP treatment group also reported longer non-addicted periods of drug use as well as periods of abstinence between relapse episodes.

Other research shows that treatment ordered by the criminal justice system can also be effective (Hubbard et al. 1998; NIDA 1999). In addition, they found that early criminal justice system intervention can force clients to stay in treatment, resulting in important long-term benefits for offenders and more substantial changes in behavior during treatment.

COST-EFFECTIVENESS

By most reports, the economic costs of American drug abuse run into the billions (Kauffman and Woody 1995), and substantial benefits and cost reductions for individuals and society may be realized through effective treatment. According to various estimates, drug treatment can be highly cost-effective, with some estimates indicating that every \$1 invested in addiction treatment programs yields between \$4 and \$7 in reduced drug-related crime and criminal justice costs (e.g., jail, processing, incarceration), as well as theft (Caulkins et al. 1997; CASA 1998; GAO 1998; Gaes et al. 1998; Gerstein et al. 1994; NIDA 1999). There are, of course, additional benefits that accrue in the form of savings to drug-addicted individuals and their families, their potential victims, and society as a whole.

METHODOLOGICAL ISSUES

Despite the abundance of literature on drug addiction treatment and its effectiveness, few studies have undertaken the enormous task of teasing out the causal

relationships between program characteristics and treatment success. Although the ideal model may be to have clinical trials in which the timing, dose, and administration can be randomly assigned (Gaes et al. 1998), this ideal has rarely been approximated. In addition, the study of drug addiction treatment effectiveness continues to suffer from a wide range of methodological problems (Gaes et al. 1999, 362). The main problems/challenges include:

- selection bias;
- measuring drug use vs. drug abuse vs. drug dependency/addiction;
- measuring drug treatment need severity/level;
- measuring recidivism; and
- poor data quality generally, including record-keeping and data management issues.

The most commonly reported challenge to research in this area is the fact that offenders may respond to treatment differently based on their addiction level, experience with the criminal justice system, motivation level, amenability to treatment, etc. Therefore, a study of treatment effectiveness must consider both treatment modality and offender characteristics. However, controlling for all relevant offender characteristics frequently is not possible, resulting in biased estimation of treatment effects (GAO 1998; Gaes et al. 1998; Pelissier et al. 1998).

Similarly, processing can introduce bias in studies of effectiveness. For example, according to a report by Gaes et al. (1998), selection bias can make it difficult to determine if the effect of treatment is a result of the treatment or simply of a by-product of a “weeding out” process that screens out offenders least likely to succeed in treatment (Pelissier et al. 1998).

In addition, a wide range of external and internal factors may affect the composition of both the treatment and the comparison groups. Thus, even if relevant controls are introduced, there can still be unmeasured characteristics that influence the assessment of an “effect.” And with quasi-experimental designs, in which a control group exists but offenders are not randomly assigned to the treatment or control group, compositional differences can be difficult to address through statistical modeling (GAO 1998).

Although selection bias is of paramount importance when considering the effectiveness of a treatment program, other issues also can reduce the extent to

which evaluations of treatment can be trusted. One major issue relates to the definition of what is being treated. In some studies, the “problem” is drug use; in others, it is drug abuse; and in still others it is drug dependency/addiction. In each instance, the terms frequently are used interchangeably. Even when they are not, the actual operationalization of the “problem” may nonetheless be similar.

This issue is critical because many programs may be treating entirely different groups. Drug use, for example, can entail a one-time episode of drug involvement, or it can represent a long-standing history of drug involvement. The distinctions are far from academic: According to the American Psychological Association’s *Diagnostic Statistical Manual*, fourth edition (DSM-IV), drug use does not rise to the level of a disorder, while drug abuse constitutes a separate disorder from dependency/addiction.

Although the severity of an offender’s drug problem would seem to be a critical element in evaluating the effectiveness of a treatment program, this dimension is rarely addressed in the outcome literature except to recommend that more severe cases be sent to more intensive treatment programs (Farabee et al. 1999). We know that treatment effectiveness is greater when offenders are matched to placements that address their risk levels (Andrews and Bonta 1998)—there are greater reductions in recidivism for high-risk offenders who are placed in intensive services than for high-risk offenders placed in minimal treatment services. By contrast, low-risk offenders matched with low-intensity programs experience greater reductions in recidivism compared with low-risk offenders in high-intensity programs.

At present, research focusing on the severity of the problem to be addressed (i.e., drug use / abuse / addiction), as opposed to risk level, remains a conspicuous gap in the extant literature. However, at least one study shows that intensive drug addiction therapy is more successful and cost-effective for those with severe drug addiction problems (Knight, Simpson, and Hiller 1999), while another study makes reference to the fact that outpatient treatment success may be attributed to the relatively low severity of the client’s drug abuse problem (Pearson and Lipton 1999). In short, the severity of the drug problem appears to be central to determining which treatment is appropriate and how likely treatment is to be effective, but considerably more research on the issue is needed.

Researchers increasingly recognize the importance of viewing treatment effectiveness in terms of harm

reduction—that is, reducing drug use from the level it would have been without treatment (GAO 1998, 15). Yet many studies do adopt this approach but instead assess effectiveness in a dichotomous manner. Further, even where a harm reduction approach is adopted, frequently the failure to adjust findings to reflect compositional differences can render comparisons difficult if not invalid. In addition, there is little agreement about the proper metric for defining equivalent levels of success. For example, in a situation where a drug-dependent user reduces his/her drug use by half and a non-addicted drug user reduces his/her use by half, it is unclear that these reductions should be viewed as equivalent (Pelissier et al. 1998). More generally, some studies rely on different periods of observation (three months, six months, etc.), or do not employ event history (hazard) modeling, ignoring qualitatively distinct differences in risks of recidivism (Pelissier et al. 1998).

There also is a need for development of more objective measures of recidivism. Traditionally, studies testing the effectiveness of drug addiction treatment have relied on self-reported drug use, yet self-reports can significantly understate the true amount of drug use. A review by the General Accounting Office (GAO 1998, 18), using data from the Treatment Outcome Prospective Study (TOPS), showed that only 40 percent of individuals testing positive for cocaine use during a two-year follow-up period reported using in the previous three days. Some research indicates that such biases can be corrected by introducing adjustments to self-reported data (GAO 1998, 18), but few studies do so.

The GAO (1998, 19) study also notes that drug treatment research rarely accounts “for the tremendous variation in program operations, such as differences in standards of treatment, staff level and expertise, and level of coordination with other services.” The lack of these types of process measures make it difficult to know whether the presence or absence of positive outcomes results from an ineffective treatment or from ineffective implementation.

Additional sources of biases exist. For example, comparing the recidivism of offenders under intensive supervision with those who are not requires careful attention to ensuring that the offending of both groups is equally likely to be reported or identified. Yet few studies include steps to provide this assurance. The problem is that one would expect offenders who are closely supervised to be much more likely to be caught if they commit a crime. Indeed, in the evaluation of the Opportunity to Succeed (OPTS) program (Rossman et

al. 1999), this discrepancy in supervision, which was part and parcel to the intervention, may have explained why a decrease in drug use and criminal behavior was not experienced by OPTS clients (see also Pelissier et al. 1998).

Other measurement problems arise from poor record-keeping and information management, as well as the lack of consistent and high-quality data collection in general. There is a need for standardized and rigorous program evaluation tools. Data on implementation procedures, goals, objectives, staff, and funding need to be collected in addition to outcome measures, including reductions in drug use and criminality; compliance with supervision requirements; and improvements in family and social relationships (Field 1998).

KEY RESEARCH QUESTIONS

This review of research on drug treatment effectiveness highlights several glaring gaps in the research literature. In particular, there are several critical questions that should be addressed in future research.

- Research shows that illicit drug use is likely to intensify and perpetuate a criminal career as opposed to initiate it, and that reduced illicit drug use is associated with reduced offending (Harrison 2000, 2). Yet there is much that remains unknown about the precise causal links. Two key questions are: How does use of illicit drugs intensify or perpetuate criminal activity? How does a reduction in the use of illicit drugs reduce criminal activity?
- What types of treatment approaches work in a jail setting vs. a prison setting? (Offenders in jail may require shorter interventions and education programs rather than longer-term phased-in treatment.)
- What are the primary obstacles to effective treatment in correctional settings?
- What are the unique challenges and programmatic issues involved in treating drug use, drug abuse, and drug dependency/addiction?
- What treatment approaches work best for high-severity drug abusers vs. low-severity drug abusers?
- How should recidivism be measured?
- What factors are most instrumental for preventing relapse?
- What factors are most instrumental for not only preventing relapse but also criminal recidivism?
- What are the relative cost benefit/effectiveness of different treatment approaches?

CHAPTER 5.

Post-Release Drug Treatment in the Criminal Justice System

Reducing criminal recidivism is a pressing issue for corrections, especially given the rapid growth in corrections during the past decade. Research indicates that 4 out of every 10 prisoners is re-arrested within the first year of release. Post-release supervision and reentry services to ex-offenders constitutes a key mechanism by which to prevent relapse and recidivism. Indeed, some research indicates that re-arrest rates can be lowered within the first year of release by as much as 50 percent for offenders who complete aftercare programs in the community. As a result, correctional institutions are beginning to focus on providing a continuum of treatment and services from incarceration to the community. However, many criminal justice systems still are in the early stages of developing this continuum, and the effectiveness of many programs remains largely unknown. This chapter will review the types of reentry and post-release supervision programs currently available. It will also discuss current program evaluations, methodological issues, and key research questions for future studies.

INTRODUCTION

Reducing criminal recidivism is a pressing issue for corrections, especially given the rapid growth in corrections during the past decade. By some estimates, 4 out of every 10 prisoners will be reincarcerated within the first year of release (Travis et al. 2001). Post-release supervision and reentry services to ex-offenders constitutes a key mechanism by which to prevent relapse and recidivism. Indeed, some research indicates that re-arrest rates can be lowered within the first year of release by as much as 50 percent for offenders who complete aftercare programs in the community (Field 1998; Wexler et al. 1999). As a result, correctional institutions are beginning to focus on providing a continuum of treatment and services from incarceration to the community. However, many criminal justice systems still are in the early stages of developing this continuum, and the effectiveness of many programs remains largely unknown.

This chapter will review the types of reentry and post-release supervision programs currently available. It will also discuss current program evaluations, methodological issues, and key research questions for future studies.

REENTRY OF OFFENDERS INTO THE COMMUNITY

Reentry and post-incarceration services range from providing educational and vocational services to programs specifically focused on drug treatment. Generally, the primary goal of these programs is to reduce drug use/relapse and recidivism among ex-offenders and help them adjust to life in the community. The most common reentry and post-release services generally include the following:

- **Vocational training and job placement services.** Provide job skills and create employment opportunities for ex-offenders.
- **Life skills programs.** Provide training on daily living skills without resorting to violence, drug abuse, or criminal behavior.
- **Family therapy.** Improve family ties and social relations.
- **Housing assistance.** Assist ex-offenders with housing issues, including finding and keeping adequate housing.

- **Drug treatment.** Use of one or more pharmacological, psycho/social, or behavioral therapies.
- **Intensive community supervision.** Increase contact between offenders and supervising agents. Offenders typically are required to submit to frequent urine tests.

Reentry and post-release programs vary in the types of services provided and the types of offenders targeted. As noted, most focus on reducing relapse and recidivism among ex-offenders and helping them adjust to life in the community. Although some programs involve post-release services, others do not, focusing instead on treatment, training, and education as strategies to assist the offender after release. Table 5-1 provides examples of the primary types of programs available for ex-offenders and the kinds of services each provides.

Most programs focus exclusively on drug treatment, job placement, or education. Programs such as Texas's Project Rio also provide life, family, and basic education training. Notably, however, many programs do not include case management or follow-up treatment or services.

Programs such as New York City's Center for Employment Opportunities (CEO), which is a common model, focus primarily on work, education, and basic life skills training as well as aftercare treatment. The CEO program provides day labor for participants, most of who have been released from boot camp (Finn 1998). The overall mission is to place ex-offenders in permanent, unsubsidized, full-time jobs in the hope that employability will increase stability and decrease recidivism. Participants in CEO receive life skills training, job placement support, and support services—which can include child care, housing, clothing, and driver's education. In addition, the program can pay for half of the employee's wages for eight weeks or more if specific criteria are met.

Other programs focus on providing treatment for substance abuse. In-patient treatment and therapeutic community programs provide 24-hour services for clients, while out-patient services or methadone maintenance programs provide treatment for the offender in the community. Often these programs provide a combination of detoxification, pharmacological treatment, and socio-psychological/behavioral therapies.

The Opportunity to Succeed Program (OPTS) is an example of a program that provides comprehensive post-release services to ex-offenders. According to

Rossman et al. (1999), the OPTS program was designed to reduce substance abuse relapse and criminal recidivism by providing comprehensive aftercare services to felony offenders with alcohol and drug offense histories. The program targeted offenders who were required to serve a minimum of one year of probation/parole; had a history of substance abuse; had completed a substance abuse treatment program while incarcerated or in a court-ordered residential community in lieu of jail; had felony convictions, excluding violent crimes or sex offenses; and were 18 years of age or older. The core services OPTS provided to clients on an as-needed basis included:

- **Substance abuse treatment**, ranging from 12-step programs to intensive residential placement.
- **Employment services** that assist clients in finding and maintaining legitimate employment.
- **Housing**, including adequate, drug-free supportive living situations, such as halfway houses, group houses, and shared apartments to assist clients in avoiding relapse.

- **Family-strengthening services**, such as parenting classes, family counseling, anger management counseling, and domestic violence counseling.
- **Health and mental health services**, ranging from regular visits to specialized care when needed.

The OPTS program also provided frequent supervision, contacts, and drug-use monitoring through urinalysis along with graduated sanctions that included incentives/rewards for positive behavior.

Finally, Intensive Supervised Probation (or Parole) (ISP) is designed to provide increased monitoring and control of offenders in the community (Sherman et al. 1997). Elements of ISP can include more frequent contact with the supervising probation or parole officer; the use of electronic monitoring devices; home confinement; more frequent urine tests; and curfew and community service requirements.

Table 5-1. Matrix of Reentry Programs for Released Offenders*

Program Title	Male/ Female	Drug	Work	Educ.	Life	Family	Basics	Case Mgt.	Relapse	After- care
OPTS	M/F	x	x			x		x		x
Oriana House	M/F	x	x	x				x		x
TPADP	M/F	x	x	x	x	x			x	x
Corr. Sub. Abuse	M/F	x		x		x		x	x	x
DE Life Skills	M/F			x	x	x				
Project Rio	M/F	x	x	x	x	x	x			x
RECAP	M/F	x	x	x					x	
CEO	M/F		x		x		x			x
Safer	M/F		x	x				x		x
Building Future	M/F	x	x							
Project Re-Enter	M/F		x	x						
DE Mentor	F		x	x		x			x	
Dismas	F	x	x	x		x				
OPTIONS	F	x		x		x		x		
Discovery	F	x	x			x		x	x	x
WPA	F	x	x			x		x		

Source: Mele (1998, 20).

Notes: OPTS = Opportunity to Succeed Program; TPADP = Turning Point Alcohol and Drug Program; RECAP = Rock County Education and Criminal Addictions Program; CEO = Center for Employment Opportunities; OPTIONS = Opportunities for Prevention and Treatment Interventions for Offenders Needing Support; WPA = Women's Prison Association.

MEASURING PROGRAM EFFECTIVENESS

Research indicates that reentry and post-release services may decrease recidivism and prevent relapse. A study of Delaware's Therapeutic Community drug treatment program found that clients who completed the secondary (work release) portion of the program as well as the tertiary (aftercare) portion of the program were significantly more likely to remain drug-free and arrest-free three years after release from prison (Inciardi, Martin, and Surratt 1999). In addition, findings from the Residential Substance Abuse Treatment (RSAT) program for state prisoners consistently indicate that clients who receive aftercare services fare significantly better than those who do not (Harrison and Martin 2000). These findings are mirrored for clients in the AMITY program in California (Wexler et al. 1999) and for clients who received treatment services after completing an in-prison therapeutic community program in Texas (Knight, Simpson, and Hiller 1999). However, few of these and other evaluations provide any basis for determining what components of reentry or post-release services facilitate reduced relapse and recidivism.

Many of the vocational training and job placement programs also report positive outcomes for participants. The Safer Foundation reported that, among those who were employed at 30 days, 58 percent were still employed five months later. The CEO program reports similar results. Although recidivism and relapse rates for these programs have yet to be examined, a meta-analysis by Lipton, Pearson, Cleland, and Yee (1998) did not find that vocational training or job placement programs were successful in decreasing recidivism.

Evaluation of the OPTS program echoes these findings. OPTS, which provides comprehensive services and monitoring, had a positive effect on employment—clients stayed employed for a longer period of time than individuals in the control group (Rossman et al. 1999). In addition, OPTS clients were significantly less likely to use alcohol and marijuana, but use of hard drugs was not statistically different from that of the control group. And while criminal activity for both OPTS clients and the control group declined considerably, OPTS did not appear effective in reducing criminal behavior beyond that of the control group. Indeed, OPTS clients had higher rates of technical violations, most likely the result of closer supervision than a negative outcome. As Sherman et al. (1997) have observed, increased surveillance is often associated with increases in technical violations.

Finally, increased surveillance and control, through Intensive Supervised Probation/Parole (ISP), does not appear to reduce recidivism (Sherman et al. 1997). However, combining drug treatment with ISP may lead to more positive results than either ISP or drug treatment alone.

TO WHAT EXTENT HAVE LINKAGES BEEN DEVELOPED?

The call for post-release structure, supervision, and treatment of offenders is pervasive in the treatment literature (Gaes et al. 1999; Travis, Solomon, and Waul 2001). Nevertheless, many researchers note that post-release supervision is inadequate and that few offenders receive reentry or post-release drug treatment or services (Crowe and Reeves 1994; Hubbard et al. 1998). In one example, clients in the Treatment Alternatives to Street Crime (TASC) program rarely entered outpatient methadone programs, despite having a high rate of heroin addiction. They also received fewer community services than other clients not referred by the criminal justice system (Hubbard et al. 1998).

A major obstacle to developing linkages with post-incarceration supervision and community services is the lack of coordination between correctional institutions, mental health providers, and other aftercare service providers in the community (Field 1998). According to Field (1998, 16), "The fragmentation of the various functions—arrest, diversion, conviction, probation, revocation, jail, prison and post-prison supervision—undermines the effects of treatment and of other aspects of offenders' rehabilitation"

To address these types of issues, Field (1998) has noted that case managers can play a critical role in assisting with post-release treatment by:

- assessing an offender's needs and ability to remain substance and crime free;
- planning for treatment services and other criminal justice obligations;
- maintaining contact with other criminal justice officials;
- brokering treatment and other services for the offender;
- monitoring and reporting progress to other transition team members;

- providing client support and helping offender with all aspects of treatment and reentry;
- monitoring urinalysis, breath analysis, or other objective tests of substance use; and
- protecting the confidentiality of clients and treatment records.

From this perspective, a case manager's role is to monitor and guide an offender's journey through the criminal justice system and into the community. The case manager also acts as the single point of contact for providing health and social services as well as advocates for appropriate programs and services when needed (Siegal 1998).

Although case management has the potential to overcome many of the barriers created by a fragmented criminal justice system, results from studies on the effects of case management are mixed. Some researchers find that clients with case-management have increased access to drug treatment and are less likely to recidivate, but others have found few, if any, positive outcomes from case management services (Rossman et al. 1999).

The more general issue at present is the lack of aftercare provided to released prisoners. A national evaluation of the National Institute of Justice's (NIJ) Residential Substance Abuse Treatment (RSAT) program found, for example, that few sites provided post-release aftercare (Harrison and Martin 2000, iv). In making decisions about allocation of RSAT funds, NIJ gave preference to programs that focused not only on treatment in prison but also on aftercare. Yet fewer than half of the RSAT-funded programs included provisions for placement in halfway houses, work release programs, or aftercare (Harrison 2000, 20, citing Lip-ton, Pearson, and Wexler 2000).

METHODOLOGICAL ISSUES

The methodological issues involved in evaluating post-incarceration service programs parallel those for evaluating treatment effectiveness. These issues include:

- selection bias
- measuring drug use vs. drug abuse vs. drug dependency/addiction
- measuring drug treatment need severity/level

- measuring recidivism
- poor data quality generally, including record-keeping and data management issues.

Selection bias represents a particular challenge when assessing post-release services because many programs rely on the motivation of the offender rather than institutional coercion (Farabee et al. 1999). Among offenders released from prison, the disappearance/drop-out rate from parole and/or treatment can be considerable, resulting in a highly motivated treatment group. The result is an inability to provide appropriate treatment vs. control group comparisons. A related and widespread problem is that participants in reentry and post-release programming may be removed from treatment because of their behavior. The problem again consists of removing those offenders who might fare least well on aftercare, creating the misleading appearance of a more positive effect of reentry services. In reality, only those who displayed the most appropriate conduct completed treatment and, consequently, were included in comparisons with a control group (Pelissier et al. 1998).

There are other critical problems as well. For example, few studies examine relapse rates for offenders participating in aftercare programs. And many studies do not distinguish between effects due to aftercare and effects due to other factors, such as in-prison treatment, duration of supervision, offender-level characteristics, or family or community characteristics.

KEY RESEARCH QUESTIONS

Given the relatively sparse literature addressing the new and emerging set of reentry and post-release programs, there is an obvious need for increased research on the effectiveness of these programs. Key questions future research should address include:

- Are the linkages between prisons and communities adequate? If not, why?
- How are treatment priorities set for individual offenders as they reenter society?
- What are the major obstacles to providing drug treatment aftercare?
- How effective are reentry and post-release supervision and aftercare programs in reducing recidi-

vism, preventing relapse, and promoting positive outcomes?

- Among existing reentry and post-release programs, which are the most effective?
- What types of reentry and post-release programs work best for which type of offenders, especially for level of drug problem (use/abuse/addiction) and risk of re-offending (prior criminal history)?
- What types of policies will promote and allow for coordination and cooperation among the criminal justice system practitioners, mental health providers, and community service providers?
- How can reentry of violent offenders with drug treatment needs best be managed?
- What are the rates of aftercare attendance among parolees? How does aftercare attendance affect long-term treatment goals?
- What is the overall quality of service provided by aftercare treatment centers?
- Does case management make a positive difference? What elements of case management are most important?
- How does an increase in the prison population, as well as subsequent releases, affect the capacity to implement quality aftercare services?
- How, or to what extent, do factors such as race, sex, family structure, neighborhood conditions, and other contextual factors influence the effectiveness of post-release drug treatment services? How, or to what extent, can they assist with these services?

CHAPTER 6.

Barriers to Drug Treatment in the Criminal Justice System

In the past decade, an increasing number of offenders in correctional settings needed and could have benefited from drug treatment. Yet drug treatment, especially *effective* drug treatment, has not kept pace with the increasing demand. The question is, Why? This chapter addresses that question by examining a range of barriers both to drug treatment and to *effective* drug treatment in corrections. These barriers touch on almost all aspects of corrections and the administration and provision of drug treatment to offenders.

INTRODUCTION

In the past decade, an increasing number of offenders in correctional settings needed and could have benefited from drug treatment. Yet drug treatment, especially *effective* drug treatment, has not kept pace with the increasing demand. The question is, Why? This chapter addresses this question by examining a range of barriers to drug treatment and to *effective* drug treatment in corrections. These barriers touch on almost all aspects of corrections and the administration and provision of drug treatment to offenders.

POLITICAL BARRIERS

Declining Public Concern about Drug Abuse

Although the relationship between drug treatment in correctional facilities and public support for drug treatment is not necessarily direct, examination of changes in public opinion can help provide a broader context in which to situate correctional drug treatment services. As table 1-3 (in chapter 1) shows, public concern about drug abuse peaked during the late 1980s and then subsequently and dramatically returned to considerably lower levels. Specifically, in 1989, 38 percent of the American public viewed drug abuse as the single most important problem facing the country. A decade later, only 5 percent of the public expressed this view.

Thus, one might speculate that one reason correctional drug treatment has not kept pace with increased demand is that there has been decreasing public concern about drug abuse. The decreasing concern does not mean that the public supports only tougher sanctioning. Indeed, public opinion polls show that the public consistently supports rehabilitation and treatment, even as they support “get tough” sanctioning of serious and violent offenders, as was the case during much of the 1990s (Roberts and Stalans 1997).

No Federal Requirements for Coordinated Case Management or Aftercare

Although drug treatment is required in correctional settings in states that receive federal Residential Substance Abuse Treatment (RSAT) and Violent Offender and Truth-in-Sentencing (VOTIS) funds, the use of case management is not. Similarly, despite the importance of aftercare to effective treatment, few treatment programs include an aftercare component. Yet both case management and aftercare are critical for effective

drug treatment (Inciardi et al. 1992; NIDA 1999; ONDCP 1999).

Lack of Intra- and Inter-Governmental Coordination of Efforts

Criminal justice actors often duplicate efforts already performed by others within the criminal justice system or others in local and state health and welfare agencies. Assessments and diagnostic reports may be duplicated several times. Once completed, they may not be forwarded to the appropriate parties. The result is an accumulation of costly and unused information that ideally could facilitate treatment placement and planning (Goldcamp et al. 1999). This issue is especially acute as prisoners progress from jails to prisons to parole. Professionals and long-term observers of the criminal justice system have observed that the lack of coordination between the levels of correctional systems represents a lost opportunity to effectively treat offenders in need (ONDCP 1999).

A related issue is that states without treatment resources may contribute to criminal activity and treatment demands in other states. Consequently, practitioners have called for a computerized booking system to monitor offenders across states. Such a system would track assessments, drug testing, and progress through treatment (ONDCP 1999). This information could be shared among police departments, courts, jails, prisons, and all other levels of the justice system.

Prioritization of Bed Space Management Over Drug Treatment

Correctional population management represents the primary concern to most administrators. Indeed, correctional executives generally view bed space as taking priority over treatment, and some view treatment as contributing to increased management problems, by reducing the number of general bed space slots available (Lipton 1996, 11). The lack of commitment from correctional executives and state policymakers poses one of the biggest challenges to providing not only drug treatment, but effective and sustained drug treatment.

Opposition and Skepticism about the Effectiveness of Drug Treatment

In general, support for correctional drug treatment in general faces considerable political opposition (Reuter 2001). The opposition in part is due to public and political beliefs that drug addiction is not a public health problem; instead, many view addiction as a moral problem and are even more suspicious when it is

linked to criminal behavior. In addition, despite the creation of the Office of National Drug Control Policy, which operates with a \$20 billion budget, federal drug policies are “highly fractionated”—a large number of agencies have responsibility in one form or another for drug policy, but in each instance “drug policy is a minor responsibility and a poorly regarded one” (Reuter 2001, 374).

Despite research demonstrating the effectiveness of drug treatment, many legislators and correctional executives believe that “nothing works” (Cullen and Gendreau 2000), and see little reason to support programs that in their view receive little public support. As Lipton (1996) has noted, “legislators, as well as correctional authorities, are often skeptical about the effectiveness of correctional treatment and reluctant to spend tax dollars on efforts that net no votes and likely, in their minds, to produce little change in behavior” (11). These attitudes have led treatment stakeholders to call for an education campaign targeting essential elected officials (ONDCP 1999).

RESOURCE BARRIERS

Lack of Funding for and Prioritization of Treatment

In the past decade, the federal government has provided considerable funding for drug treatment in prisons, through programs such as the Residential Substance Abuse Treatment (RSAT) for State Prisoners Formula Grant Program, the Violent Offender Incarceration and the Truth in Sentencing Incentive (VOI/TIS), the Substance Abuse and Treatment Block Grant Program, and the like (Corrections Program Office 1998; ONDCP 2001). However, despite the considerable infusions of federal dollars into state drug abuse programs, lack of funding for treatment constitutes a key barrier to treatment. Indeed, more than 70 percent of state and federal prison administrators cite inadequate funding as the greatest challenge to providing substance abuse treatment in correctional settings (CASA 1998).

The lack of funding is directly linked to another barrier to correctional treatment—the lack of prioritization of treatment among correctional executives. As Lipton (1996, 11) has noted,

It is evident that senior State-level correctional executives have another overriding concern [besides drug treatment]: ensuring adequate space to house inmates. Their

budgets reflect that priority: additional prison space takes priority over rehabilitation programs. It is also clear that some correctional officials are in conflict as to where to treat offenders; that is, they need to determine whether resources should be allocated to community-based or prison-based programs.

Although these factors affect the amount of drug treatment in prisons, they also substantially affect the quality of treatment. With fewer funds and a lack of commitment to treatment, substance abuse program delivery and quality can decline significantly (Farabee et al. 1999).

Uncertainty and Certainty about How Best to Utilize Scarce Resources

Despite significant advances in research, we currently lack precise information about which programs, including drug treatment, result in the greatest benefits, are the most cost-effective, and can be feasibly implemented in a correctional setting (ONDCP 1999). At the same time, certain programs that have been shown to be ineffective, or whose effectiveness has not been determined, nonetheless receive considerable ongoing political support. Thus, on one hand, there is uncertainty about precisely what programs are most beneficial, cost-effective, and feasible in correctional settings; on the other hand, there is certainty among key correctional executives and legislators about the benefits of unproven programs.

A Need for Integrated Community-Based Services

Some communities have forged linkages among mental health, substance abuse, and criminal justice systems (Field 1998). However, most communities do not have the services necessary for diverting offenders from prison or for continuing ex-offender treatment. When services are available, they frequently are not coordinated or easily accessible to offenders. In many instances, potential providers have little incentive to work with offenders. In others, correctional, health, welfare, and other agencies are unwilling or unable to cooperate with one another to provide continuity of treatment.

ASSESSMENT BARRIERS

Despite the critical importance of screening and assessment to efficient and effective criminal justice operations, the vast majority of jurisdictions throughout the United States still rely primarily on “professional judgment” and first-generation assessment instruments (Bonta 1996, 30). The question is, “Why?” Several researchers have reported barriers to screening and assessment (Gendreau and Goggin 1997; Peters and Bartoi 1997; Peters and Hunt 2000). These barriers are classified here into broad categories, specific examples of which are briefly outlined below.

Administrative and System Issues

- Multiple and redundant assessments are conducted at various stages of processing.
- Time constraints prevent conducting screening and assessments.
- Information is collected that can not easily be used.
- Staff are not trained adequately on the administration and use of screening and assessment instruments.
- Criminal justice personnel may lack familiarity with mental health and/or substance abuse disorders.
- There may be limited time or resources for codifying existing information, transferring it to various parts of the criminal justice system, or easily accessing existing information.

Inappropriate Use of Assessment Instruments

- Staff may not complete and use screening and assessment instruments appropriately.
- There may be a lack of consistency in questions and/or documentation to allow reliable analysis of program level needs or outcomes.
- Non-validated instruments may be used.
- Instruments may be used for populations for which they were not designed.
- Instruments may not address criminogenic needs.
- Records may be incomplete, misleading, or mislabeled.

- Traditional, subjective “intuitive assessments,” or “first-generation assessments,” still are widely used, despite demonstration of their ineffectiveness.

Minimal Assessment of Co-Occurring Disorders

- The primary barrier to treating co-occurring disorders is the minimal attempt systemwide to screen and assess for these disorders.
- Mental health and substance use disorders have a waxing and waning course and may appear in different forms at different points in time. This variability leads to different, and often conflicting, diagnoses at different stages of processing.
- There is considerable symptom interaction between co-occurring disorders, leading to difficulties in interpreting whether symptoms are related to mental illness or substance abuse.
- Individuals in the criminal justice system may anticipate negative consequences related to disclosure of mental health or substance abuse symptoms.

Limited Guidance from Research about the “Best” Instruments

- Few studies comprehensively and comparatively examine the effectiveness of different types of screening and assessment instruments.
- There is little systematic research identifying which criminogenic needs most influence future offending.
- Research has not shown the combination of risk, needs, personality types, and responsivity needed for programming to be most effective, and how assessments can be devised that can be feasibly used to assist with decisionmaking.

ADMINISTRATIVE AND ORGANIZATIONAL BARRIERS

Legislative or Policy Restrictions on Treatment Access

Legislative or policy requirements frequently limit treatment to inmates who have a lifetime history of substance use or have been convicted of drug sales or drug trafficking, irrespective of their current use pattern

(Farabee et al. 1999). Programs also may be required to exclude violent and/or sex offenders and those involved with prison gangs. These exclusions assume, incorrectly, that all drug-involved offenders have substance abuse problems, that only those offenders with lifetime histories of use need treatment, or that offenders who engage in drug trafficking require treatment.

In addition to the above exclusions, there may be policies that limit treatment access by restricting the movement of inmates to facilities with treatment services (Farabee et al. 1999), even though treatment may be indicated and could be effective (Field 1998; NIDA 1999).

Difficulties in Implementation and Delivery

Implementation represents one of the most formidable challenges to providing drug treatment in corrections. Treatment programs often encounter opposition because they run counter to the established punishment/control culture in correctional settings. For this reason, successful implementation requires counselors who have strong leadership skills and can retain skilled and committed staff (Inciardi et al. 1992; Farabee et al. 1999).

The involvement of experienced treatment providers is crucial at all stages of implementation, including design and monitoring of both the program and its budget. Without this involvement, programs frequently suffer from a wide range of additional challenges, including failure to obtain appropriate materials and supplies, placement of inappropriate clients, and an inability to anticipate and address fluctuations in available resources (Inciardi et al. 1992).

Unfortunately, even the best designed programs will be ineffective if they are inappropriately delivered. Delivery suffers, for example, when programs rely on inexperienced staff or have too few staff. In addition, insufficient funding can result in misplaced emphasis on certain aspects of treatment to the exclusion of others. The result is compromised and likely ineffective treatment, as well as an inability to evaluate the “true” impact of a specific treatment approach. Many evaluations indicate that program delivery is frequently and significantly compromised.

Challenges in Institutionalizing Effective Treatment

Treatment programs too often rely on specific individuals to motivate and sustain them (ONDCP 1999). As a result, when these individuals leave, programming frequently suffers. Program operations, for example,

may become inefficient or ineffective, and support for programming may decline. As Lipton (1996) and others have noted, sustained and effective treatment requires institutionalizing several aspects of treatment programming, including commitment to treatment, documentation of program policies and procedures, and hiring of trained counselors.

Overcrowding and Security Issues Compromise Treatment

Security issues in correctional facilities represent a persistent problem for drug abuse programs (Farabee et al. 1999). If inmates with different risk classifications are placed in the same program, lower-risk offenders are put at risk and treatment is compromised. However, because of limited general population bed space, treatment programs frequently become a primary source for relieving overcrowding (ONDCP 1999).

Many facilities address these problems by denying treatment to high-security inmates in a process called “dumping”—moving difficult inmates to other facilities to avoid correctional disruptions (Farabee et al. 1999). Sometimes treatment is not offered to inmates in high-security facilities due to costs associated with providing treatment in these settings. The result is a failure to provide drug treatment to those who might most benefit from it (NIDA 1999; Wexler et al. 1999).

Limited Treatment Access within Corrections Due to Location

The frequent placement of correctional facilities in remote areas or a limited set of institutions, as a cost-savings strategy, can undermine treatment. It is sometimes difficult to attract qualified treatment counselors to remote locations and, as a result, these facilities are forced to hire locals who usually lack the qualifications to administer treatment programs (Farabee et al. 1999). In addition, to reduce the cost of establishing a residential facility that can handle the security needs of the highest-risk inmates, treatment programs generally are located in a small number of facilities within state correctional systems, as opposed to all facilities that need them. Therefore, many inmates who need treatment may have to be transported long distances and thus not receive treatment. Those who do are frequently placed far from family and settings in which they may be able to address family issues pertaining to substance abuse (ONDCP 1999).

Challenges in Training and Retaining Treatment Staff

Effective treatment requires well-trained staff and a certain level of consistency in staffing (Lipton 1996; Farabee et al. 1999). Yet many programs are lacking in both areas. Often, programs have difficulty attracting well-trained and motivated counselors due to the low pay, the conflict of working within a correctional setting where treatment is not always supported, and the remote location of many prisons. Among well-trained counselors, many may not be trained in the particular treatment modalities that are most effective or that a particular correctional facility uses. When high-quality staff are hired, they frequently leave for better paying or more attractive positions.

Lack of cross-training between treatment counselors and treatment officers has also been observed as a barrier to effective treatment (Farabee et al. 1999). Effective treatment is facilitated by mutual understanding among treatment and correctional staff. The goal of cross-training is to have treatment counselors respect and support the correctional process and, conversely, to have correctional officers understand and support the treatment process, as well as administer treatment sanctions when appropriate.

Conflicting Treatment and Correctional Cultures

Treatment and control/management of offenders represent two distinct orientations of philosophies toward inmates. Although the two can be compatible, historically they have been viewed otherwise (Lipton 1996). Thus, many correctional officers do not understand, appreciate, or support treatment, while many treatment providers view correctional philosophies as fundamentally inappropriate, unnecessary, and ineffective. Frequently, there are no clear definitions of when a treatment vs. a correctional response is needed (Farabee et al. 1999). Ultimately, the conflicting cultures of correctional and treatment staff typically work against treatment programming and efficacy because correctional goals usually “win” in this exchange (Morrissey, Steadman, and Kilburn 1983). Indeed, few institutions directly address this conflict (Inciardi et al. 1992; ONDCP 1999).

Privately Run Prisons May Not Prioritize Treatment

Although there are no definitive studies of treatment provision or effectiveness in privately vs. government-run correctional facilities, evidence to date

suggests that privately run facilities do not prioritize treatment (General Accounting Office 1996). The GAO (1996) report, which analyzed five previously conducted studies, concluded there was no clear evidence that privately operated facilities were cheaper or of better quality than their locally or state-run counterparts. One reason for less treatment or lower-quality treatment in private prisons may be an intrinsic conflict of interest: Privately run facilities earn profits by having more “customers” (i.e., inmates), not by removing them from the potential supply of future “customers.”

Key System Gaps Contribute to Lack of Treatment

Inadequate Pre-Sentencing Investigations

Pre-sentencing investigations can highlight the needs of offenders. In turn, they can affect whether offenders are diverted from correctional settings or whether the drug treatment need is brought to the attention of correctional officials. Frequently, however, pre-sentencing reports do not focus on drug treatment needs or call attention to the need for treatment (ONDCP 1999).

Lack of Diversion to Drug Treatment Programming

One of the major barriers to drug treatment in correctional settings is the fact that need exceeds demand by a ratio of 5 to 1 in state and federal prisons (CASA 1998). Diversion to available non-incarcerative treatment programs can alleviate this problem, yet diversion often is not supported or is not available. Successful diversion efforts require proactive advocacy from public defenders and the understanding and willingness of prosecutors to access such programs. However, caseloads alone can overburden defenders and prosecutors, and many communities lack the resources to provide treatment locally (ONDCP 1999).

Failure to Provide Treatment Aftercare

Three-fourths or more of offenders with histories of heroin and cocaine abuse relapse within three months of release from prison and engage in criminal activity (Lipton 1996). The growth in prisons, driven by increased incarceration of drug offenders (Blumstein and Beck 1999), has resulted in an exponential growth in the ex-offender population, few of whom receive any type of treatment. The likely result is a return to criminal behavior and, with tougher sentencing laws, a return to prison. In turn, the absence of effective drug treatment in prisons, coupled with limited to no aftercare treatment, can contribute both to

prison growth and to the demand for correctional drug treatment (ONDCP 1999).

PROGRAMMATIC BARRIERS

Limited or Low-Quality Case Management

For most treatment programs to be effective, there must be successful coordination of services and transitions from one stage of processing to another (Field 1998). For this reason, case management is an essential part of the treatment process (Lipton 1996). However, case management frequently is not provided or suffers from several problems. For example, although a ratio of 1 case manager to 25 offenders is ideal, the ratio typically is much higher, with some jurisdictions reporting staff-to-offender ratios of 1 to 300 (ONDCP 1999). In addition, case management plans rarely are fully developed and often do not include relapse prevention strategies (Field 1998).

Lack of Monitoring or Drug Testing

Research shows that frequent monitoring and drug testing can significantly reduce relapse and recidivism rates, yet many drug-abusing offenders released from correctional facilities are not monitored closely or tested (Farabee et al. 1999; ONDCP 1999). With the enormous expansion of offenders placed on parole (Blumstein and Beck 1999), this issue assumes particular importance because it constitutes a missed opportunity to enhance correctional drug treatment and ultimately to reduce overcrowding in prisons.

Availability of Drugs in Correctional Settings

Correctional drug treatment can be significantly undermined by the availability of licit and illicit drugs (ONDCP 1999). Inmates in treatment, as well as inmates not in treatment but who have drug abuse problems, frequently have access to drugs. For example, in an evaluation of the Delaware KEY program, Inciardi et al. (1992) noted the ease with which inmates could move, unimpeded, from one building to another and engage in illicit drug trade. The inattention to security issues and control of drug trade in turn compromised treatment goals and reduced the program's effectiveness.

Inappropriate Treatment or Delivery of Treatment

Treatment ideally should be based on empirical evidence on what works and for whom, but frequently correctional facilities rely on programs that are not effective or have not been evaluated. These programs also frequently are not implemented or delivered as they were designed. Many, for example, do not incorporate key features of effective programs, features that are known to contribute to treatment effectiveness, including case management, continuity of care, inclusion of families in the treatment process, and use of well-trained staff (Field 1998; Lipton 1996; ONDCP 1999).

Client Resistance to Treatment and the Balancing of Rewards and Sanctions

Because inmates are held against their will and sometimes are forced to enter treatment, they may not be willing to participate in treatment. Although voluntary participation in treatment is not always necessary for treatment to be effective (NIDA 1999), it nonetheless can contribute to it and, over the long term, may be necessary to reduce relapse. However, many correctional treatment programs fail to incorporate a system of rewards and incentives, such as linking release to treatment completion (Lipton 1996). They also do not systematically address the ways in which stigma, from inmates or staff, can contribute to the unwillingness of inmates to participate in treatment or, if in treatment, to participate actively (Farabee et al. 1999; Field 1998).

Rewards and sanctions constitute effective strategies for engaging inmates in the treatment process (Field 1998; Lipton 1996). However, arriving at an effective balance of the two can present considerable challenges (ONDCP 1999). As a result, correctional and treatment facilities frequently rely on one or the other or, more generally, emphasize sanctions rather than rewards (Farabee et al. 1999).

Insufficient Levels of Treatment and Reentry Preparation

Program completion is one of the major predictors of successful treatment. Inmates must be in treatment long enough—generally 12 to 18 months—to end the physical addiction and to allow the full course of treatment to take effect. Yet many inmates do not complete treatment because of behaviors while in treatment or termination of their sentence (ONDCP 1999). In addition, inmates who complete treatment frequently are transitioned directly into society without

any type of reentry programming or development of plans for maintaining continuity of care.

Lack of Treatment Responsivity

Few correctional treatment programs provide individualized treatment, and no single treatment is appropriate for all individuals (Cullen and Gendreau 2000; Gaes et al. 1999; NIDA 1999). Treatment programs generally must meet the needs of individual inmates and accommodate their particular personality, circumstances, and learning style, sometimes referred to as “treatment responsivity” (Bonta 1996; Cullen and Gendreau 2000). Responsivity includes addressing issues such as co-occurring disorders, racial/ethnic and gender differences in both needs and in the effectiveness of specific treatment modalities, and cultural competency and differences (Field 1998).

A COMPREHENSIVE CORRECTIONAL DRUG TREATMENT STRATEGY

There is no one solution to enhancing drug treatment in correctional settings. Rather, for any sustained strategy of correctional drug treatment, a comprehensive and systematic approach holds the most promise. Lipton (1995) has identified key issues that should be addressed in developing a comprehensive treatment strategy in corrections. These issues are presented in table 6-1.

The comprehensive strategy consists of five levels, each of which can be conceptualized as stages that build on one another in stepwise progression. For example, to establish treatment as a priority in corrections, a necessary first set of steps is to obtain support at a state level. Within each level, there are concrete steps that can be taken to enhance the provision, delivery, and, ultimately, the effectiveness of correctional drug treatment.

KEY RESEARCH QUESTIONS

- Of the many barriers to correctional drug treatment, which are the most pervasive, the most important in affecting the provision or effectiveness of treatment, and the most amenable to change?
- What are the major barriers to providing effective drug treatment in prisons? What issues have to be addressed to increase effective drug treatment in prisons?
- How prevalent are key barriers to effective drug treatment in correctional systems?
- Which barriers are the most important in affecting the provision or effectiveness of treatment? Which of these are the most amenable to change?
- Do correctional officials perceive that there is a need for more effective drug treatment in correctional settings?
- Are research findings used in the development of policies and programs, and if not, why not?
- What types of policies encourage collaborative efforts to provide drug treatment?
- To what extent are offenders with substance abuse and dependency needs identified?
- To what degree do correctional institutions cross-train correctional and treatment staff? How effective is cross-training in facilitating effective drug treatment?

Table 6-1. A Comprehensive Correctional Drug Treatment Strategy

STATE LEVEL (Necessary First Steps)

- *Alignment* - Align support from all criminal justice agencies.
- *Endorsement* - Obtain the endorsement of key state policymakers.
- *Advisory Board* - Develop an advisory board with key state policymakers.
- *Agreement* - Create a common level of understanding about the mission and goals of treatment.
- *Attention* - Establish a structure for disseminating information about the state's efforts.
- *Evaluation* - Begin establishing process, outcome, and cost-effectiveness evaluation groundwork.

INSTITUTIONAL LEVEL (Before Programming)

- *Assessment* - Screen and assess inmates using validated instruments.
- *Diagnosis* - Conduct comprehensive assessments to diagnose accurately inmate needs.
- *Assignment* - Assign inmates to treatment, matched on intensity, duration, primacy of need, and cost.
- *Sequencing* - Sequence treatment according to sentence and time needed for type of treatment.
- *Involvement* - Involve offenders in treatment planning and assessment.
- *Recruitment* - Provide incentives to inmates for participation in treatment.
- *Case Management* - Assign case managers to manage all treatment components.
- *Communication* - Hold regular case conferences with treatment and custody personnel.

INSTITUTIONAL LEVEL (During Incarceration)

- *Isolation* - Separate program participants from general population.
- *Environment* - Create clean and safe environments for inmates.
- *Ownership* - Develop a sense of program ownership among inmates.
- *Contact* - Reduce contact between treatment and general population inmates.
- *Rules* - Establish clear rules and consequences for rule violations.
- *Contingency Contract* - Develop contracts with behavioral consequences for rule violations.
- *Reinforcement* - Reinforce prosocial behaviors.
- *Rewards/Sanctions* - Use a system of positive and negative reinforcements.
- *Motivation* - Provide incentives (privileges, jobs, early release) for positive behavior.
- *Role Models* - Employ ex-offenders and inmates as counselors.
- *Teams* - Use teams of rehabilitation counselors and ex-addicts.
- *Confidentiality* - Maintain confidentiality in dealing with sensitive topics.

INSTITUTIONAL LEVEL (Preparing for Release)

- *Duration* - Retain participants for the duration needed for treatment to be effective.
- *Continuity* - Establish continuity of care from custody to post-release.
- *Reentry* - Incorporate a reentry phase within the correctional treatment programming.
- *Transition* - Assist with transition from corrections to community-based treatment.
- *Urinalysis* - Conduct frequent (3 or more times per week) urinalysis tests.
- *Understanding* - Evaluate relapse/slips in context and address directly as they occur.
- *Self-Help Groups* - Involve addicts in self-help groups to facilitate continuity of treatment.

ORGANIZATIONAL LEVEL (Program Characteristics)

- *Integrity* - Maintain commitment, especially from leadership, in the treatment vision and delivery.
- *Flexibility* - Be open to ways to adapt programming to changing fiscal and administrative conditions.
- *Autonomy* - Limit institutional restrictions and placement of general population inmates.
- *Adaptability* - Operate by cooperating with administration and security structures.
- *Openness* - Encourage access to program and develop outside funding sources and supporters.

Source: Adapted from Lipton (1995).

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