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Legal Developments

by Margaret R. Moreland

Treatment Status Is Privilege, Not a Right

Classification Changed for Inmate Who Refused Treatment.

While 70% to 85% of state inmates are estimated to be in need of substance abuse treatment, less than a quarter of those identified are actually receiving treatment (Belenko, 2000). As a result, departments of corrections' regulations often have a two-fold purpose: to (1) encourage participation in drug treatment programs while (2) ensuring that those who are most likely to benefit from treatment are the ones given places in the programs. Charles Moore, a state prisoner in New Jersey, had an opportunity to participate in such a program. The N.J. Department of Corrections uses the Addiction Severity Index to rate an offender's level of addiction. The threshold score is 5 out of 10, and Moore scored 7. He was then assigned to a therapeutic community program at the correctional facility, Persons Incarcerated Entering Recovery (PIER), and eight days later his custody status was reduced to "full minimum custody." Two days after that, Moore refused to begin treatment.

New Jersey regulations state that inmates who refuse substance abuse treatment "shall not be eligible for minimum custody status," or shall lose that classification if it has already been granted, regardless of how they
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Therapeutic Community Treatment for Women in Prison: Some Success, But the Jury Is Still Out

by Nena P. Messina and Michael L. Prendergast

Growing Number of Incarcerated Women Raises Drug Abuse Treatment Issues

The number of incarcerated women in prisons and jails more than doubled between 1990 and 1999, outpacing the rise in the number of incarcerated men (Bureau of Justice Statistics, 2000). Drug offenders accounted for the largest source of the total growth (36%) among incarcerated women during that time period (BJS, 2000). The growth in the female prison population has largely been due to the increased use of incarceration for drug-related offenses, which has also created a need for appropriate drug treatment within prison settings. The therapeutic community (TC) treatment model has become the preferred method of substance-abuse treatment in American prisons today. As more and more women participate in this treatment, it becomes critically important that we assure ourselves that TCs work well for them.

Rehabilitation in the TC focuses on maintaining a drug-free existence and developing prosocial attitudes and values (DeLeon, 2000).

Peers and treatment staff challenge TC participants to confront their problems directly and to take responsibility for their actions. Traditional TC programs were male-oriented programs, initially tailored to treat substance-abusing men. While TC programs have been treating both men and women substance-abusing inmates for some time, researchers have speculated that the treatment issues for women prisoners are quite different and more complex than those for men (Langan & Pelissier, in press; Peters et al., 1997). Compared with incarcerated men, women inmates are more likely to have a coexisting psychiatric disorder, to have lower self-esteem, to have more severe substance abuse histories (e.g., using hard drugs, using more frequently, or taking drugs intravenously), and to test HIV-positive (BJS, 1999; Henderson, 1998; Langan & Pelissier, in press; Peters et al., 1997). The extent to which traditional TC methods meet the specialized treatment needs of drug-dependent women in prison is largely unknown. No research studies have directly examined this issue. To date, much of the
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existing research has focused on the differences between men and women entering prison-based TC treatment (Straussner & Zelvin, 1997). However, the rising number of drug-dependent women entering prisons poses a variety of treatment issues for prison-based treatment providers.

This article pieces together the available research on the effectiveness of prison-based TCs for women. A small body of literature has evaluated post-treatment outcomes for women in prison-based TCs and is summarized in the next section. The final section discusses the treatment needs of women offenders, with recommendations for addressing these needs.

Treatment Outcomes for Women in Prison-Based TC Programs

Only six studies (either published, in preparation, or in press) could be found that reported post-treatment outcomes for women who participated in prison-based TCs. The earliest post-treatment outcome study was conducted at the Stay'n Out program in New York, three others were conducted at the Forever Free program at the California Institution for Women, and two are from the federal Bureau of Prisons. These evaluations are summarized in chronological order in Table 1 (see p. 54).

Stay'n Out. Findings from 247 incarcerated women who participated in Stay'n Out, a prison-based TC program in New York, demonstrated effectiveness for reducing recidivism (Wexler et al., 1990). Women

in the TC had significantly lower rearrest rates (18%) compared with 29% of the 113 women who participated in other types of prison-based programs (e.g., counseling and milieu therapy). The women's TC group also had a significantly higher percentage who were positively discharged from parole (77%) compared with 53% of the 38 women in the no-treatment control group (i.e., those who volunteered for the program but did not participate). In addition, longer time in the TC program was associated with positive discharge from parole.

Forever Free. Another study compared 196 women who participated in the Forever Free program in the early 1990s at the California Institution for Women (CIW) with 107 women from two other California prisons (i.e., the matched subjects group) and with 110 women at CIW who did not apply for the Forever Free program. Forever Free participants could volunteer to enter continuing residential treatment following release to parole for up to six months. In terms of background characteristics, the women who volunteered for Forever Free had more severe problems than women in the comparison groups initially. No significant differences in success on parole were found between the TC participants and the comparison groups. However, 62% of those who graduated from treatment had increased success on parole compared with 38% of the program drop-outs (Jarman, 1993). It should be noted that at the time this study was conducted, the Forever Free program used a treatment model that was closer to a

psychoeducational 12-Step approach than to a traditional TC.

A different evaluation of the Forever Free program reported the post-treatment outcomes of 47 program graduates compared with a control group of 49 women who applied to Forever Free but were not able to enter (Prendergast et al., 1996). Those who completed the prison-based treatment had significantly higher levels of successful discharge from parole than did women in the comparison group (52% vs. 27%). Results for post-treatment drug use are not as clear. Compared with women in the no treatment group, women who completed the prison-based treatment self-reported less use of heroin and amphetamines at follow-up, but larger percentages reported use of marijuana and cocaine.

Preliminary findings from the most recent evaluation of the Forever Free program (treatment participants from 1998) appear promising (M. L. Prendergast, Ph.D., personal communication, February 12, 2001). Post-treatment (12-month) interviews from 101 Forever Free participants (85% of the target sample) were compared with 77 interviews from a matched comparison group of women recruited from a substance abuse education class (84% of the target sample). Preliminary results show that the women who participated in Forever Free had better post-treatment outcomes on a number of measures than women in the comparison group. Forever Free women were significantly more likely to be employed, and less

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The TCU Model of Treatment Process and Outcomes in Correctional Settings

by D. Dwayne Simpson and Kevin Knight*

Introduction

Scope of Problem. According to the Bureau of Justice Statistics (BJS), the U.S. adult prison and jail inmate population has reached the two million mark, with drug-involved offenders comprising the majority of the incarcerated population (BJS Bulletin, 2000). In a 1997 BJS survey, approximately half of all state and federal inmates reported that they had used drugs in the month before their offense, and over three-quarters indicated that they had used drugs during their lifetime (BJS 1999). Almost one in three prisoners said they had committed their current offense while under the influence of drugs (not including alcohol), and about one in six had committed their offense to get money for drugs. In addition, a quarter of state and a sixth of federal prisoners had experienced problems consistent with a history of alcohol abuse or dependence. For example, 41% of state prisoners and 30% of federal prisoners reported having consumed as much as a fifth of liquor in a single day, and 40% state and 29% of federal prisoners said they had a past alcohol-related domestic dispute.

Along with contributing to a record level for inmate capacity, offenders with serious drug problems are having a profoundly negative impact on our nation's public safety and financial health. For example, in a report by the National Center on Addiction and Substance Abuse (1998), 43% of those identified as "regular drug users" in state correctional systems were incarcerated for a violent

offense, including murder, manslaughter, rape, robbery, kidnapping, and aggravated assault. Financially, the U.S. spends \$246 billion annually in direct costs related to alcohol and drug abuse (Harwood et al., 1998), with an additional \$30 billion spent each year to incarcerate offenders with drug problems (National Center on Addiction and Substance Abuse, 1998).

Positive Impact of Treatment Programs. By providing therapeutic intervention, however, criminal justice agencies have a unique opportunity to identify and rehabilitate (or habilitate) drug-involved offenders who are likely, if untreated, to return to a personally and socially destructive pattern of drug use and criminal activity following release from prison. Indeed, research has shown that focused rehabilitation-oriented treatment services can lead to favorable outcomes following incarceration (Andrews et al., 1990; Gendreau, 1996). Particularly within correctional settings, intensive long-term treatment programs (such as modified in-prison therapeutic communities) have been found to reduce post-incarceration relapse (i.e., return to drug use) and recidivism (i.e., arrests, reconviction, and reincarceration). For example, a Bureau of Prisons' outcome evaluation based on 1,866 inmates treated at 20 institutions showed they were 73% less likely than an untreated comparison group to be rearrested in the first six months after release from prison (Pelissier et al., 1998). Results of urinalysis tests also suggested that treatment was associated with a 44% reduction in use of drugs during those months. Likewise, recent evaluations of Delaware's Key-Crest, California's Amity, and Texas' Kyle New Vision prison-based therapeutic community (TC) treatment programs have shown that, compared to their untreated counterparts, drug-involved inmates who complete in-prison drug treatment are significantly less likely to return to a life of drug use and crime following release from prison (Knight et al., 1999; Martin et al., 1999; Wexler et al., 1999). Furthermore, these findings are even more pronounced among those who participate in aftercare treatment (Griffith et al., 1999; Hiller et al., 1999).

Not Enough Treatment Spots. Nevertheless, the majority of offenders with substance abuse problems continue to return to

society untreated, and go back to a life of alcohol and drug use and criminal activity. Simply put, there are not enough treatment slots within the correctional system to meet the demand. In a 1997 survey of state departments of corrections, 70% to 85% of state prisoners were found to be in need of substance abuse treatment; yet only 13% were receiving treatment prior to release (National Center on Addiction and Substance Abuse, 1998). Even with the recent initiatives to expand the availability of treatment to criminal offenders, it is unlikely that the demand for treatment can be met fully.

Delivering and Managing Effective Treatment

Given the limited availability of treatment, therefore, it is critical that treatment institutions identify individuals who are the most appropriate candidates for their programs and determine which of their treatment components are the most likely to lead to positive behavioral changes. These goals can be realized, in part, by looking into the "black box" of treatment process; that is, by documenting and critically examining what occurs during treatment. Should treatment programs target only inmates who recognize they have a drug problem, who see the need for help, and have the desire to be treated? Or are the greatest gains to be achieved by targeting the less motivated, higher-risk inmates (perhaps the ones who also commit a disproportionately higher number of crimes) with programming specifically tailored to their needs? In addition, are inmate perceptions of self, peers, counselors, and/or custodial staff related to how well they participate in the treatment program and how successful they are at refraining from post-treatment drug use and criminal activity? Only through examination of the therapeutic process will there begin to be trustworthy answers to these questions.

At issue is a widely shared interest in improving the overall effectiveness and efficiency of correctional drug treatment in this country. Some call it "matching clients (or offenders) with treatment," but simply stated it means providing services that are appropriate to the needs of offenders. Stud-

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ies of treatment process and its therapeutic components, including how individuals become engaged in treatment, are fundamental to reaching these goals. In order to disaggregate the ingredients underlying treatment retention effects, better assessment and dynamic process models are required. By conceptualizing treatment in discrete phases—e.g., outreach, induction, engagement, treatment, and aftercare—intervention and evaluation strategies come into sharper focus (Simpson, 1997).

Client sociodemographic and other pre-treatment characteristics traditionally have not been strong predictors of outcomes. However, improved assessments of client functioning and analytic techniques in recent years are modifying this view. Addiction severity (particularly cocaine use), alcohol use, criminal history, social resources, and psychological dysfunction at treatment intake influence engagement and retention. Of particular importance are the client's motivation for treatment and readiness to change (Simpson & Joe, 1993).

The TCU Treatment Process Model

A major focus of drug abuse treatment research at the Institute of Behavioral Research (IBR) at Texas Christian University (TCU) has been to develop a model of "treatment process" (Simpson, 2001; see Figure 1). The TCU Treatment Process model is intended to identify key therapeutic components involved in the delivery of effective treatment, establish their functional linkages and sequential stages, and document how they are related empirically to client outcomes (Joe et al., 1994, Sells et al., 1977; Simpson, 1998). Improved assessments of these indicators and their systematic monitoring over time by treatment program staff therefore are very important, especially when examined in association with particular interventions and therapeutic stages.

The foundation for the TCU Treatment Process Model began over three decades ago with the beginning of large-scale public funding for community-based drug abuse treatment in the United States. Over these years, basic and applied research in this arena has been carried out and reported at an unprecedented rate, based in part on the requirements of federal agencies to evaluate the effectiveness of our national drug abuse treatment system. Beginning in the early 1970s with the Drug Abuse Reporting Program (DARP), followed by the Treatment Outcome Prospective Study

(TOPS) a decade later, and continuing through the 1990s with the Drug Abuse Treatment Outcome Studies (DATOS), national evaluations have examined over 65,000 admissions to 272 treatment programs using multimodality and multisite sampling plans that allow the study of treatment in natural settings. These national projects comprise only part of the large body of evidence accumulated over the past 30 years that supports the general effectiveness of drug treatment (Gerstein & Harwood, 1990; Hubbard et al., 1989; Simpson & Brown, 1999; Simpson & Curry, 1997; Simpson & Sells, 1982).

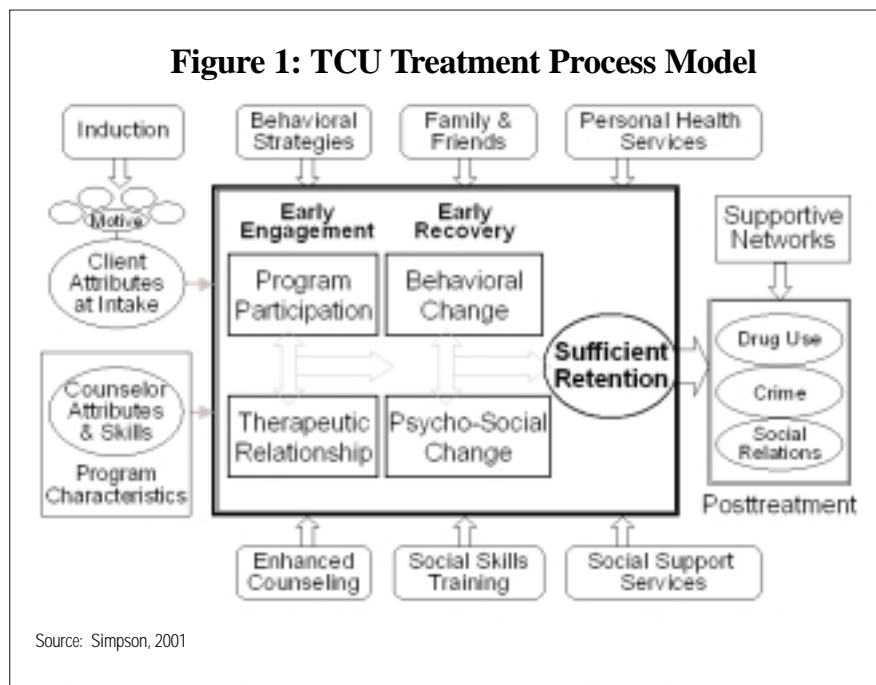
Key to effective treatment process, an individual's length of stay in drug abuse treatment has been found to be one of the most consistent findings across these evaluations. It has been one of the best predictors of follow-up outcomes, with the general relationship between treatment retention and outcomes being replicated across all major modalities in all three national evaluation studies funded by the National Institute on Drug Abuse (NIDA). Retention represents a convenient index of several client, therapeutic, and environmental factors that contribute to treatment effectiveness. Factors that influence a person to remain in treatment include interactions among individual needs, motivation factors, social pressures, and aspects of the treatment program itself such as policy and practices, counselor assignment, accessibility, and level of services offered. In general, these represent an "engagement" process that occurs in sev-

eral sequential phases.

As illustrated in Figure 1, the TCU Treatment Process Model describes these phases, including several key ingredients in the so-called "black box of treatment." In general, there are sequential therapeutic elements that link together over time to help sustain treatment retention and thereby improve outcomes after discharge. More specifically, higher program participation as measured by counseling session attendance is associated with better therapeutic relationships (including rapport with counselor and confidence in treatment), and these factors promote positive behavioral changes and psychosocial functioning later in treatment. These indicators of early recovery, in turn, are related to longer retention. Understanding these dynamics is particularly important because clients who stay in methadone treatment for at least a year are *five times* more likely to have favorable follow-up outcomes on drug use and criminality measures (Simpson, Joe, & Rowan-Szal, 1997). Multivariate analytic models tested in a variety of community and correctional settings have helped to establish more clearly the directional relationships between client motivation, treatment process variables (i.e., therapeutic rapport, program participation, behavioral compliance, and psychosocial improvements), retention, and follow-up outcomes (Broome et al., 1997; Joe et al., 1999; Simpson, Joe, Dansereau, & Chatham, 1997; Simpson et al., 2000; Simpson, Joe, Rowan-Szal, & Greener, 1997).

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Figure 1: TCU Treatment Process Model



Source: Simpson, 2001

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Special Interventions and Counseling Manuals

Because offenders enter correctional drug treatment programs with different levels of motivation and problem severity, it is not surprising that many can benefit from special "induction" efforts to clarify the needs and purpose of treatment during the initial planning stage (Blankenship et al., 1999).

Several interventions also have been applied successfully to impact treatment engagement and early recovery indicators for clients. For example, counseling based on a cognitive visual representation technique (called node-link mapping) improves client engagement, progress during treatment, and follow-up outcomes (Dansereau et al., 1995; Dansereau et al., 1993; Joe et al., 1997; Pitre et al., 1998).

"Contingency management" protocols that offer social recognition, small gifts, or treatment supportive items—e.g., bus tokens or cab fare—can increase counseling attendance and the rate of drug-free urine screens, thereby strengthening positive behaviors early in treatment (Rowan-Szal et al., 1994; Rowan-Szal et al., 1997).

Specialized group education materials—such as HIV/AIDS prevention, sexual health and communication skills training for women and men, and transition to aftercare training—were shown to improve knowledge and psychosocial functioning (Bartholomew et al., 2000; Bartholomew et al., 1994; Boatler et al., 1994; Hiller et al., 1996).

Each of these modules for special needs has counselor manuals that provide detailed guidelines on group discussions and procedures. Likewise, we have found that positive change in the family and social support networks of clients accompanies therapeutic engagement and early recovery (Knight & Simpson, 1996).

Process Evaluation Can Lead to Better Outcomes

Improving drug abuse treatment effectiveness requires an understanding of the dynamic components of therapeutic process, including client strengths and deficits, program participation, therapeutic relationships, psychosocial functioning, and behavioral compliance. Our research has identified several measurable domains with direct connections to better treatment retention and outcomes:

- **Progress reports.** The findings suggest that *client-level reports* on needs and progress throughout treatment as

well as *program-level reports* based on aggregated client records could improve clinical care and program management. More specifically, each offender's cognitive and behavioral responses to services can be used to evaluate progress through successive stages of engagement and recovery.

- **Program statistical reports.** At the agency level, efficient assessment systems that include routine monitoring of client retention (or drop-out) rates, services delivered, and therapeutic interactions are feasible for better accountability of program functioning. In the long run, this will facilitate efforts to match client needs with appropriate services and manage clinical care.

Disseminating and Applying Research Findings

Comprehensive instruments for assessing clients throughout treatment, counselor and client interactions, delivery of services, and outcomes are available free-of-charge at the IBR website (www.ibr.tcu.edu). Also included are comprehensive lists of publications and instructions on how to obtain electronic versions (via free downloads from the website) or hard copies (at cost of printing) of the series of counseling manuals developed and being disseminated to the field. Collectively, these materials are intended to help improve treatment assessments and targeted interventions that can raise the overall quality of services for individuals with drug-related problems.

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likely to have been arrested during parole, to have tested positive for drugs, and to have been incarcerated at the one-year follow-up interview.

Bureau of Prisons. This study reported six-month outcome data from an evaluation of the federal Bureau of Prisons residential programs serving both men (n=2,099) and women (n=547). Preliminary analyses compared 150 women who entered residential prison treatment to 131 women who did not enter the treatment program (98 comparison inmates had prison treatment available but did not enter and 33 had no treatment available). Although preliminary analyses were not conducted separately for men and women, results indicated that individuals who entered and completed the prison-based treatment had substantial reductions in drug use and rearrest during the first six months following release (Pelissier et al., in press). However, the long-term (three-year) evaluation results were not as promising. Findings from the full sample of women (n=547) indicated that treatment was not effective for reducing recidivism or relapse to drug use for women over time (Rhodes, Pelissier, Gaes, Saylor, Camp, & Wallace, in press).

Women's TC Findings Mixed and Still Uncertain. All of the above evaluations used quasi-experimental designs in which

selection bias is a possible explanation for the findings. That is, in the absence of random assignment, the background characteristics of women who volunteer for treatment differ from those of the comparison group in ways that would bias the outcomes (although not necessarily in favor of the treatment group). Only the Bureau of Prisons evaluation explicitly controlled for selection bias in its analysis, so greater confidence can be placed in its findings.

The existing research on prison-TC outcomes for women is limited and findings are sometimes contradictory. This small body of research does not provide a clear answer to whether drug-dependent women can benefit from traditional TC treatment in prison. It has been previously established that completion of community-based treatment is associated with successful outcomes for both men and women (DeLeon & Jainchill, 1981; Messina et al., 2000), but it is difficult to generalize the findings from community-based programs to prison-based programs. TC programs within prisons may also vary. For example, as part of its expansion of treatment opportunities for inmates, the California Department of Corrections has established prison-based TC programs in many of its prisons, including all of the institutions that house women (CIW, California Rehabilitation Center, Central California Women's Facility, Northern California Women's Facility, and Valley State

Prison for Women). Although the overall treatment for both women and men follows the TC model, each provider adapts the model to its own treatment philosophy and the needs of its population, including providing special programming for women. It should also be noted that the Forever Free program, at the time of evaluation, had a much stronger emphasis on a cognitive-based curriculum and 12-step orientation than is typical in the therapeutic model. Also, the Bureau of Prisons programs, while consisting of long-term (9-12 months) residential treatment, adheres closer to a cognitive model than to a traditional TC model.

Rigorous post-treatment evaluation of prison-based programs for women is still needed. Some success in using the TC model to treat women in prison has been reported, but the ability of these programs to fully meet the specialized treatment needs of drug-dependent women offenders remains to be seen. Treatment issues for the female offender are discussed in the next section, with recommendations for addressing these needs in prison-based drug abuse treatment programs.

Treatment Issues for Women Offenders

Research specifically examining the treatment needs of drug-dependent women offenders is limited, but the existing research

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Table 1: Prison-Based TC Outcomes for Women (W)

Study	Year	Sample Size	Prison-TC Program	Comparison Group(s)	Findings
Wexler et al.	1990	N=398	Stay'n Out	1) W in other trt. 2) W with no trt.	TC W had reduced recidivism, compared with (1). TC W had higher with % positive parole discharge, compared with (2). Longer time in trt. associated with positive parole discharge.
Jarman	1993	N=413	Forever Free	1) W in 2 other prisons 2) W with no trt.	No differences in outcome were found between TC W and comparison groups. TC W who completed trt. had increased success on parole, compared to TC drop-outs.
Prendergast et al.	1996	N=96	Forever Free(graduates)	1) W with no trt.	TC graduates had more success on parole than (1). Post-trt. drug use patterns are less clear.
Prendergast	Preliminary	N=178	Forever Free	1) W with no trt.	Preliminary results: TC W had increased employment rates, decreased rates of incarceration, drug use, and arrest, compared with (1).
Pelissier et al.	In press	N=281	Federal Bureau of Prisons	1) W with no trt.	Preliminary 6-month outcome: W in trt. had substantial reductions in drug use and rearrest, compared with (1). Short-term positive impact for women.
Rhodes et al.	In press	N=547	Federal Bureau of Prisons	1) W with no trt.	No differences between trt. W and (1) at 3-year evaluation. No evidence of long-term trt. effectiveness for W in program.

Note: "treatment" is abbreviated "trt." in this table.

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has depicted a population with special problems and needs. Conversely, there is much published discussion about the treatment needs of drug-dependent women in the community (Grella et al., 1999; Prendergast et al., 1995; Staussner & Zelvin, 1997; Stevens & Glider, 1994). Since a large number of drug-dependent women become involved in the criminal justice system, many of the issues addressed for women in community treatment are relevant for drug-dependent women offenders. In fact, one study found that adult women who reported using drugs the previous year were six times as likely as women who had not used drugs to have been arrested in that same year and four times as likely to have committed any criminal activity in that year (Su et al., 1997). Important issues for drug-dependent women offenders are discussed below, with recommendations for addressing these needs in prison-treatment programs.

Medical Issues. Women entering prison treatment appear to have more severe histories of drug abuse than men (e.g., using hard drugs more often prior to incarceration and earlier use of needles) (Langan & Pelissier, in press; Messina et al., 2001; NIJ, 1998). Women are also at greater risk than men of venereal disease and HIV due to their increased participation in prostitution for money or drugs (Stevens & Glider, 1994). In addition, some women may be pregnant and in need of prenatal and postpartum care, as well as proper nutritional training (Grella, 1999). Drug-dependent women often suffer from a variety of chronic health problems including anemia, hepatitis, toxemia, hypertension, and diabetes (Stevens & Glider, 1994). The medical issues that drug-dependent women offenders experience require knowledgeable treatment staff and suitable referral services for medical care. Program services should also provide health-education and promote proper hygiene and nutritional practices.

Psychological Issues. Drug-dependent women in prison have higher levels of emotional disturbance than their male counterparts (Peters et al., 1997). Women offenders are more often diagnosed with comorbid disorders than men, specifically depression, panic disorders, and eating disorders (Henderson, 1998). Moreover, incarcerated women are more likely than incarcerated men to be taking prescribed medications for psychological problems (Messina, et al., 2001). It is believed that psychiatric disor-

ders are a major factor in post-treatment relapse to drug use for both men and women (Forrest, 1992). Proper diagnostic assessment at intake is essential to inform staff of the diverse psychological needs of the women entering treatment.

Drug-dependent women in prison often come from highly dysfunctional families, with histories of mental illness, suicide, violence, and substance abuse (Langan & Pelissier, in press). Although reports vary depending on the study, many drug-dependent women in prison report incest and molestation as children (19% to 55%) prior to their substance abuse (Langan & Pelissier, in press; Messina et al., 2001; NIJ, 1998; Peters et al., 1997). Up to 70% of drug-dependent women in general have reported childhood sexual abuse (Wasilow-

boyfriends (Brown et al., 1996; NIJ, 1998). Women offenders also tend to form intimate relationships with other inmates that mirror their relationships prior to incarceration (Owen, 1998). These relationships could interrupt the treatment process if they become predatory or co-dependent. Therefore, treatment programs should focus on developing strong interpersonal skills that will help drug-dependent women confront, cope, and handle future relationship issues.

Employment/Educational Issues. Drug-dependent women in prison, and in general, are more likely than their male counterparts to be financially dependent on family members and in need of public assistance (Hser et al., 1987; Messina et al., 2001). Drug-dependent women offenders also report illegal activities as the primary source

Proper diagnostic assessment at intake is essential to inform staff of the diverse psychological needs of the women entering treatment.

Mueller & Erickson, 2001). Many believe that sexual trauma is a key contributor to a women's chronic drug abuse (Henderson, 1998; Stevens & Glider, 1994). Sensitivity to these types of issues is necessary for women to form trusting relationships with treatment staff. Treatment staff training should include information about how to avoid inappropriate relationships and sexual misconduct. The high percentages of women reporting histories of sexual abuse highlights the importance of addressing these underlying issues during treatment.

Some program providers believe that an all female counseling staff is the best practice for women participating in prison TCs. Gender specific staff can promote a strong therapeutic alliance and provide strong female role models, supportive peer networks, and attention to women's patterns of abuse from childhood to adulthood (NIJ, 1998).

Relationship Issues. Women's patterns of substance abuse are more closely linked to their opposite sex relationships than they are for men (Henderson, 1998; Langan & Pelissier, in press). Women tend to define themselves and their self-worth in terms of their relationships, and relapse to drug use is often related to failed relationships (Stevens & Glider, 1994). In addition, a high percentage of drug offending women report physical or sexual abuse by husbands or

of income prior to incarceration (Messina et al., 2001). Most drug-offending women have not completed high school and have inadequate vocational skills (Langan & Pelissier, in press; Prendergast et al., 1995). Women drug offenders who do report employment prior to their arrest typically work at low-paying jobs (Peters et al., 1997; Prendergast et al., 1995). Incarcerated women in general have more difficult economic circumstances than incarcerated men prior to entering prison. Women in prison are nearly two times less likely to have been employed full-time prior to their arrest and almost four times more likely to have been receiving welfare assistance than men (BJS, 1999). Basic education, literary skills, and *marketable* vocational training are particularly important components of treatment programs for women.

Parenting Issues. Exacerbating the need for appropriate education and vocational training is the fact that most women offenders have children and are typically the primary childcare providers (Henderson, 1998; Stevens & Glider, 1994). Many of these women are faced with the loss of, or the threat of the loss of, custody of their children and are in need of legal advice (Grella et al., 2000; Prendergast et al., 1995). Incarcerated women often experience feel-

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ings of guilt regarding their ability to provide for their children, which increases existing beliefs of low self-worth (BJS, 1998). The greater incidence of mothers' involvement in their children's lives makes parenting programs a critical part of treatment for women. Incarcerated mothers are in need of activities that increase contact with their children and that strengthen the mother-child relationship.

Conclusion: More Research Needed

Definite conclusions as to the TC model's ability to provide appropriate care to drug-dependent women offenders are difficult due to the limited amount of empirical research in this area. An additional limitation of the existing research is that most of the analyses are bivariate comparisons, which do not allow for the control of pre-existing differences that might mask treatment effects. A few studies of prison-based TC treatment for women have found some success, as indicated by reduced recidivism and increased positive discharge from parole. However, other findings are less clear, and the evaluation of Bureau of Prison programs found no evidence of treatment effectiveness for women offenders at the three-year follow-up.

A larger question concerns the extent to which the TC approach itself is appropriate to women inmates—or at least whether the TC model should be significantly modified to address the specific needs and learning styles of women offenders. What is evident from the literature is that these women are a population with special problems and needs. Women offenders treated in prison-TCs might show substantial benefits with additional services focusing on the needs of these women.

Gender has been the subject of increasing concern among clinicians seeking to identify the appropriate setting for rehabilitation of drug-dependent women. Based on the knowledge that many women in community programs have criminal histories (or are referred directly from the criminal justice system), treatment programs for incarcerated women are being developed and implemented. The rapidly increasing numbers of incarcerated women, the findings from the above outcome studies, and the previous discussion of the treatment needs of women clearly indicate that future research is needed to evaluate the provision of traditional and modified-TC services for incarcerated women.

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score on an objective classification instrument. However, if the Institutional Classification Committee (ICC) determines that a particular inmate should be discharged from a substance abuse program for medical reasons, "it shall reassign the inmate ... without viewing the discharge in a negative light." Moore's status was changed to "medium custody," but he then claimed that he had left the substance abuse program because it was too stressful, especially because he was HIV-positive. The examining psychologist subsequently examined Moore and concluded that he was "not a good candidate for the PIER program ... due to the emotional and stress factors that he is struggling with." The ICC reconsidered Moore's status and concluded that, although his objective classification score was good, he should remain in medium custody status. This decision was not made because Moore had left the substance abuse treatment program. Rather, it was based on the psychologist's conclusions that were contained in his report.

No Due Process Violation. In *Moore v. Department of Corrections*, 761 A.2d 107 (N.J. Super. 2000), Moore first argued that he had been denied due process in the revocation of minimum custody status. The court rejected this argument, referring to the U.S. Supreme Court's ruling in *Sandin v. Conner*, 515 U.S. 472, 484 (1995): "[A] change in a prisoner's conditions of confinement does not trigger the need for due process safeguards unless the change imposes 'atypical and significant hardship on the inmate in relation to the ordinary incidents of prison life.'" New Jersey regulations clearly state: "A reduction in custody status is a privilege and not a right." Further, previous case law had established that the loss of greater freedoms than those enjoyed by the majority of the prison population is not the imposition of "atypical and significant hardship."

Status Change Not a Punishment. The court rejected Moore's argument that the revocation of his minimum custody status was actually punishment for withdrawing from the PIER program. The court restated the rule that "an appellate court will not disturb the ultimate determination of an agency unless it was arbitrary, capricious or unreasonable or it was not supported by substantial credible evidence in the record as a whole." Here, it called attention to the fact that the objective classification score is just one of several factors that the ICC "may" consider in determining status. Since the record showed ample reason for its decision, the ICC's action was upheld.

COMMENT: This decision makes it clear that the privileges granted for participants in substance abuse programs are not entitlements. Revocation will not trigger due process safeguards, and refusal to continue those privileges can be based on subjective criteria.

Mission to Reach All Offenders With Co-Occurring Substance Abuse

Many current state laws require the placement of offenders in substance abuse programs if there is a belief that they can be rehabilitated. As an example, California's statute is quite clear. Section 3051 of the Welfare and Institutions Code provides:

Upon conviction ... if it appears to the judge that the defendant may be addicted ... to narcotics the judge shall suspend the execution of the sentence and order the district attorney to file a petition for commitment of the defendant to the Director of Corrections for confinement in the narcotics detention, treatment, and rehabilitation facility ... unless, in the opinion of the judge, the defendant's record and probation report indicate such a pattern of criminality that he or she does not constitute a fit subject for commitment

The question raised in *People v. McGinnis*, 87 Cal. App. 4th 592 (1st App. Dist., Div. 2 2001), was: What is "such a pattern of criminality"? McGinnis, the 22-year-old defendant seemed to be just the type of offender that these provisions were intended to help. At 13 he began using marijuana and just three years later he was using methamphetamines, but he had never received any substance abuse treatment. He had a history of nonviolent theft-related crimes, taking place over a period of about a year. These crimes all seemed to be motivated by McGinnis's need for money to supply his drug habit. However, the trial court sentenced the defendant to six years in state prison, holding that he was not even eligible for a treatment evaluation because of his "excessive criminality." The appellate court disagreed.

Judges have broad—but not unlimited—discretion to determine eligibility for substance abuse treatment. Here, the trial court's reference to the defendant's "excessive criminality" was too ambiguous in light of the evidence in his favor in the record. In a previous California case, *People v. Cruz*, 217 Cal. App. 3d 413, 421 (1990), it was stated that the assessment of "fitness" for rehabilitative efforts must be "based upon the defendant's record and probation report, whether the defendant's main

problem is drug abuse or a criminal orientation as reflected in a pattern of criminality." Judged by this standard, McGinnis seems to be the "quintessential candidate" for substance abuse treatment. The court particularly noted the fact that, after a previous conviction, he had asked his mother to help him find treatment for his addiction. Unfortunately, the available programs were beyond his family's means. In light of all this, the appellate court reversed the imposition of the six-year sentence and remanded the case for further action consistent with its opinion.

COMMENT: Evidence shows that treatment of substance abuse, the root cause of much crime, can be successful. There is a widespread national policy favoring an attempt at rehabilitation over warehousing defendants for long, expensive periods of time. If a judge is going to deny a defendant an opportunity for rehabilitation, that decision must be supported by the record.

Conditions of Release May Be Stringent

While it may be true that public policy favors the opportunity for rehabilitation, a realistic opportunity takes the defendant's weaknesses into account. In *United States v. Kingsley*, 241 F.3d 828 (6th Cir. 2001), the defendant had a history of two decades of criminal activity. It included firearms violations, at least 14 "reckless vehicular crimes," continuing alcohol and substance abuse with seven "non-vehicular controlled substance offenses," and psychological problems. In fact, it took the circuit court judge more than 10 pages to describe the consistent pattern of criminal activity that "earned" Kingsley a federal Sentencing Guidelines ranking of VI with respect to his criminal history, the highest ranking that exists for that category. His most recent conviction involved the possession of firearms, and he was sentenced to 78 months in prison followed by a three-year period of supervised release.

Federal law provides that any non-mandated conditions of supervised release must be "reasonably related" to the factors of an appropriate criminal sentence, must involve "no greater deprivation of liberty than is reasonably necessary" to adequately deter future criminal conduct, and must be consistent with the general policies of the Sentencing Commission. Here, the conditions of the defendant's supervised release provided that he would refrain from criminal activity, that he would not own or possess any firearms, that he would not possess or use alcohol or any controlled substance, that he would partici-

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pate in mental health and substance abuse treatment, that he would be tested for drug and alcohol use, that he would be subject to random warrantless searches, and that he would be prohibited from driving any motor vehicle for a period of three years. It was the last two, non-mandatory, terms of his supervised release to which Kingsley objected.

Warrantless Searches Upheld. First, the Circuit Court found that the ability to search without a warrant was "necessary and justifiable" in order to ensure that the defendant was not violating his probation by possessing alcohol, controlled substances, or weapons. This is "related directly to the defendant's rehabilitation and the hindrance of his future criminal activity." Given Kingsley's protracted history of violence, this condition was also necessary to protect the probation officer who would be supervising the defendant, as well as the general public. The condition is also reasonably related to the nature of his offense, his history and character, which is described as "a dangerous anti-social personality potentially capable of any act of violence or felonious behavior."

Driver's License Suspension Upheld. The defendant's argument that suspension of his driving privileges was an illegal deprivation of liberty, and that it would unduly interfere with his ability to attend mandated mental health and substance abuse treatment programs,

was also rejected by the circuit court. Here the majority's incredulity and indignance at this argument seem obvious. Kingsley's "multiple episodes of reckless operation while chemically impaired and/or in the possession of dangerous weapons," as well as his long history of "wanton automotive violations" are cited to support the conclusion that the restriction on driving was reasonably related to Kingsley's own history and characteristics. It also restates the principle that driving on public roads is a privilege granted by the government, not a right, and that it may be curtailed or suspended by that government to further any legitimate public purpose. Given the defendant's history, suspension of his driving privileges during the term of his supervised release is "a comparatively modest cautionary prophylactic measure" in furtherance of a legitimate public interest in community security. Finally, in case Kingsley was not aware of them, the court conveyed some practical information about all of the other means he can avail himself of to get to his treatment programs. "[E]ven if ... public transportation is unavailable in his rural locality ... the defendant may walk, peddle a bicycle, or engage the driving services of a relative, friend, neighbor, or professional taximan, to travel to and from his treatment session."

COMMENT: There was a dissent by one judge with regard to the suspension of the defendant's driving privileges. Judge

Gilman felt that the connection between this condition and the crime for which he was convicted was "too tenuous." He also noted that Kingsley's last conviction for driving while intoxicated was more than four years before his most recent arrest. Gilman stated that the majority opinion "belittles" the argument that suspension of his driving privileges will interfere with Kingsley's ability to get to his treatment sessions, and stated that it "seems to be based on the assumption that Kingsley is beyond any hope of rehabilitation." However, it was the job of the trial court to evaluate the facts of the case. The majority opinion noted that the law specifically limits an appellate court's review to the question of whether or not the sentencing court has abused its discretion. This standard is very stringent. Quoting earlier decisions in the circuit, the court stated that an abuse of discretion will only be found if the lower court has "relie[d] on clearly erroneous findings of fact, or when it improperly applie[d] the law or use[d] an erroneous legal standard."

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From the Literature . . .

by Frank J. Cesario*

Helping Clients Succeed in Drug Treatment

Drug Abuse Treatment in Criminal Justice Settings: Enhancing Community Engagement and Helpfulness

by Micheal Czuchry and Donald F Dansereau

26(4) *American Journal of Drug and Alcohol Abuse* 537 (2000)

They say that every addict must hit bottom before he is really willing to enter treatment. For some, that bottom could be financial loss whereas others never see bottom until their lives spiral so far out of control that they have cheated death numerous times. If, however, the treatment community could give the recovering addict the tools to succeed in treatment, sobriety could be obtained more frequently. Treatment is intended to give the client the tools not only to succeed today but also to prepare for the roadblocks that lay before him. This article examines the effectiveness of treatment readiness training in assisting clients into the transition of treatment.

The criminal justice system is notorious for increasing hurdles based on performance. For example, a client fails outpatient treatment and relapses, he is briefly incarcerated, and the hurdle is raised to inpatient status until the client once again is facing prison. Since the path that awaits many clients is a return to prison any counseling techniques that increase a client's chance of success are a valuable resource. The most common form of therapy in criminal justice is a treatment community approach. This is "a unique form of treatment that emphasizes the role of the entire community in the treatment process." The cohesion and team approach is believed to lead to bonding and support that in turn leads to a stronger success rate. The program stresses the concept of community readiness for treatment. Clients with little experience in treatment should not enter into a program without the basic skills or background knowledge required to fully understand what a program entails.

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The authors examined an inpatient treatment facility in Texas, dividing the participants into two groups. The first group received standard treatment at the facility that included substance abuse therapy as well as life skills training. The second group received the same level of treatment but also received readiness training. This readiness training included enhancing mood and self esteem, developing techniques to get the most out of treatment, and developing a need for positive change. These activities corresponded with exercises created to facilitate interaction and thought about treatment readiness issues.

The researchers used several different measures in determining results. Intake assessments were given to the participants to assess previous treatment experience, thus helping to divide the levels of experience of the group. A community survey was administered to gauge the community member's perception of others in the group. The members rated each other on a peer rating scale and an evaluation of the community.

The results of the surveys found that probationers who completed the treatment readiness training "rated community members as more engaged and helpful than those that received the standard treatment alone." Use of a readiness-training program, according to the research, helps treatment community members develop healthy views of treatment and promote a more cohesive group for treatment. Overall, a treatment readiness curriculum appears to have a beneficial effect on the clients and could provide the cohesion that all treatment programs look for in developing a successful treatment program.

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Drug Treatment Effectiveness: An Examination of Conceptual and Policy Issues

by Michael L. Prendergast and Deborah Podus

35(12-14) *Substance Abuse and Misuse* 1629 (2000)

The field of rehabilitation has been inundated with new programs that promise to increase the chances for client sobriety. The

criminal justice system has become the testing grounds for state and federally funded drug treatment programs. Treatment programs vary greatly not only in structure, but also in how they look upon drug addiction and its causal roots. Whether programs consider drug use a disease or a social, economic, or moral problem will greatly affect how the program is managed and what services are provided. The focus of this research article is on policies and approaches to substance abuse and their relation to drug treatment. The article is an excellent resource for understanding the dimensions of drug addiction for any criminal justice or treatment professional.

Drug treatment effectiveness is "what does or does not produce desired outcomes within practical settings." Several observations about drug user treatment effectiveness include:

- Treatment reduces drug use during and after treatment;
- Some drug programs are more suited for certain addicts;
- Considerable variation in effectiveness exists across programs within a specific modality; and
- The length of treatment positively affects the client's abstinence.

The authors' synopsis of drug treatment effectiveness is congruent with most research on treatment programs. Programs across the nation will claim a success rate of anywhere from 10% to 90% based on their effectiveness criteria. If the effectiveness criteria is graduation from the program regardless of maintained sobriety, a higher success rate will be reported as compared to a program that completes longitudinal studies of client sobriety.

This research provides a good explanation of the differences between efficacy and effectiveness in treatment evaluations. Efficacy is "concerned with determining whether a treatment has an intended effect when studied in controlled clinical settings." The goal of efficacy studies is to establish if the treatment is effective in very controlled clinical settings. When the treatment is transferred to real-world settings, effectiveness becomes the measurement.

Treatment evaluation criteria such as length of treatment, the costs of treatment,

Moving From Correctional Program to Correctional Strategy: Using Proven Practices to Change Criminal Behavior

by Mark Gornik*

A considerable amount of research in the corrections arena has now established that cognitive behavioral and social learning approaches have answered the question "What works?" to change undesirable offender behavior. "What works" is a term used nationally by correctional agencies in reference to research principles and practices common to effective public safety and offender programming. "What works" research also has identified "criminogenic risks and needs" that successful correctional programs must target. (Gendreau & Andrews, 1990). Although the principles and practices discussed in this article are approached as general strategies to change offender behavior, they have been found to be effective especially in the area of substance abuse treatment.

Attributes Associated With Criminal Behavior and Recidivism

First, research with offenders (Id.), including substance abusers, has shown clearly that attributes associated with criminal behaviors and recidivism include:

- Anti-social attitudes, values, and beliefs (criminal thinking);
- Pro-criminal associates and isolation from pro-social associates;
- Particular temperament and behavioral characteristics (e.g., egocentrism);
- Weak problem-solving and social skills;
- Criminal history;
- Negative family factors (i.e., abuse, unstructured or undisciplined environment,

- Criminality in the family, substance abuse in the family);
- Low levels of vocational and educational skills; and
- Substance abuse.

Elements of Effective Programs

Meta-analysis (Id.) also has identified common characteristics that must exist in programs if they are to be successful. These include:

- Support by community and policymaker partnerships;
- Support by qualified and involved leadership who understand program objectives;
- Being designed and implemented around proven theoretical models, beginning with assessment and continuing through aftercare;
- Use of standardized and objective assessments of risk and need factors to make appropriate program assignments for offenders;
- Targeting crime-producing attributes and using proven treatment models to prepare offenders for return into the community;
- Delivery of services in a manner consistent with the ability and learning style of the individuals being treated;
- Implementation by well-trained staff who deliver proven programs as designed; and
- Regular evaluation to ensure quality.

Although most correctional agencies have come to accept and are attempting to implement these practices, many jurisdictions are frustrated in their ability to combine these "best practices" in a complementary continuum of services. Understanding the various elements of effective offender intervention and integrating them into substance abuse treatment is the challenge before us.

To accomplish this goal, effective substance abuse treatment should be guided by the principles that are known to maximize their effectiveness. Programs should:

- Target the criminogenic risk and need (discussed below) emphasizing a clear understanding of criminal logic;
- Incorporate the principle of responsibility (also discussed below);
- Be cognitive behavioral in nature and incorporate social-learning practices;
- Incorporate a balanced integrated approach to sanctions and interventions and, when appropriate, relapse prevention strategies;
- Have therapeutic integrity.

Applying Theoretical Principles to Practice

The Criminogenic Risk Principle. The risk principle embodies the assumption that criminal behavior can be predicted for individual offenders on the basis of certain factors. Some factors, such as criminal history, are static and unchangeable. Others, such as substance abuse, antisocial attitudes, and antisocial associates, are dynamic and changeable. With proper assessment of these factors, practitioners have demonstrated that it is possible to classify offenders according to their relative likelihood of committing new offenses with as much as 80% accuracy.

Application of the risk principle requires matching levels or intensity of treatment with the risk levels of offenders. High-risk offenders require intensive interventions to reduce recidivism, while low-risk offenders benefit most from low-intensity interventions or no intervention at all. (Gendreau & Andrews, 1990)

The Criminogenic Need Principle. Most offenders have many needs. However, certain needs are directly linked to crime. Criminogenic needs constitute dynamic risk factors or attributes of offenders that, when changed, influence the probability of recidivism—e.g., in the case of substance abusers, peer associations related to drug using behavior. Noncriminogenic needs such as interpersonal anxiety may also be dynamic and changeable, but they are not directly associated with new offense behavior (Id.).

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The Responsivity Principle. The responsivity principle refers to the delivery of treatment programs in a manner that is consistent with the ability and learning style of an offender. Substance abuse treatment effectiveness (as measured by recidivism) is influenced by the interaction between offender characteristics (relative empathy, cognitive ability, maturity, etc.) and service characteristics (location, structure, skill and interest of providers, etc.). Characteristics such as the gender and ethnicity of an offender also influence responsivity to treatment.

Interplay of Principles. Application of the risk principle helps identify *who should receive treatment*. The criminogenic need principle focuses on *what should be treated*. The responsivity principle underscores the importance of *how treatment should be delivered*. (Id.)

Cognitive Behavioral Intervention

Criminal Thinking—Understanding the Logic and Rewards. When surveyed, most correctional practitioners admit that dealing effectively with antisocial logic is the single most important part of public safety and offender change. While they admit it is important, staff also report lacking the necessary understanding and skill to deal with criminal thinking. (Gornik, et al., 1999)

Antisocial thinking is very seldom simply a matter of imagining crimes or plotting assaults. With most offenders, there is almost always a subtler network of attitudes, beliefs and thinking patterns that create an entitlement and righteousness about selfish and harmful acts. Antisocial thinking provides a self-validating and rewarding escape from responsibility and social norms. Many offenders are accustomed to feeling unfairly treated and have learned a defiant, hostile attitude as part of their basic orientation toward life and other people. Hostile responses and victim-stance thinking are learned cognitive behaviors. For the offender, feeling like a victim creates a sense of outrage, power, and self-gratification. These powerful emotional experiences create cognitive reinforcement. Conversely to admit a mistake would be a sign of weakness and vulnerability.

Relationships with other people are adversarial and dominated by a struggle for power. Cooperation is seldom more than a passing convenience. A win-lose (us vs. them) orientation dominates offenders' personal relationships. In their minds, winning is defined as forcing someone else to lose. The grati-

fication that comes with this kind of winning is, for some offenders, the only real satisfaction and gratification they have ever learned. This need to win is exaggerated in the offenders' interactions with security staff. Whether they win or lose, the underlying cognitive structure is reinforced. This self-serving logic creates a vicious cycle. (Bush & Bilodeau, 1994) As offenders progress through treatment, respect for custody staff is an important measure of change

Targeting Offender Behavior—Social Learning and Behavioral Intervention.

Offender change and re-socialization provide direct instructional methods, modeling and observation of the individuals in the environment. Behavioral psychologists such as Albert Bandura have shown us the value that social learning plays in teaching and modeling socially acceptable behavior.

Many, if not most, offenders have significant deficits in understanding what to do and how to act in a socially responsible manner. In fact, most offenders see little value in socially responsible behavior, either because it is not supported within their peer culture or it doesn't provide the immediate gratification and excitement of crime. Often, offender thinking patterns are so entrenched that they cannot break free without a considerable period of de-conditioning followed by re-conditioning. Old patterns of behavior are extinguished and new behaviors reinforced by the process of appropriate application of punishment and rewards. Ultimately, offenders learn to practice self-regulation and self-management skills.

The elements that support the environment in which social learning can take place are *structure* and *accountability*. Structure organizes the behavior of members toward a common goal of "right living." Staff, operating as a rational authority, provides an organized structure of values, rules, roles, and responsibilities. The necessary information is provided to increase awareness and knowledge of behavioral, attitudinal, and/or emotional consequences. Accountability teaches respect for structure and moves the offender from an observer stance (strong denial and resistance), to a participant stance (willing to comply, but attitudinally still in criminal thinking mode), to a member stance (a willing participant who shares the new values of right living). The environment provides the opportunity for practice and success. This process continually reinforces gains and builds self-efficacy.

Models of Social Learning

Community Model of Resocialization for Offenders. The community model is an environment within a correctional institution that both supports and provides offenders with the experience in living a pro-social lifestyle as a strategy to combat the traditional "convict code" and lifestyle found in traditional prison populations. Community models incorporate the evidence-based principles and practices of social learning and behavioral programs such as social learning principles and practices that include: empathy; encouragement of self-efficacy; non-authoritarian, non-blaming, effective modeling; effective reinforcement; effective disapproval; self-regulation and self-management skills; relapse-prevention strategies; advocacy; brokerage; planned practice; extinction; concrete verbal suggestions; token economy; resource provision; and effective use of punishers. (Bush & LaBarbera, 1995).

Types of Community Models. Community models can take many shapes and designs. The most familiar interpretation of the community model is the Therapeutic Community or TC. The TC has shown success with the most severely drug-abusing and criminogenic offenders. TCs have also been used in modified forms to help develop pro-social behavior among other special needs populations, such as sex offenders, mentally ill offenders, and dually diagnosed offenders. The TC has shown success with these populations. There is some evidence that offenders who are more pro-socially oriented (low-risk offenders) do not require the highly structured, long-term, and expensive therapeutic community modality. Although modified therapeutic community models are sometimes employed with low-risk offender populations, successful correctional programs treat low- and high-risk offenders separately.

Elements of Successful Cognitive Programs

Basic Program Essentials. Cognitive programs operate with the following assumptions:

- *Cognitive behavior is the key to social behavior.* Problem behavior is almost always rooted in modes of thinking that promote and support that behavior. Permanent change in problem behavior demands change at a cognitive level, i.e., change in the underlying beliefs, attitudes, and ways of thinking.
- *Authority and control that increases*
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resentment and antisocial attitudes is counterproductive. Punitive methods of controlling behavior all too often reinforce modes of thinking that were responsible for the initial antisocial behavior. The alternative to punitive measures is not permissiveness but, rather, a rational strategy of authority and control combined with programs of cognitive change.

- *Authority and control can achieve both compliance and cooperation.* Authority can define rules and enforce consequences while reminding and encouraging offenders to make their own decisions. As offenders learn to make conscious and deliberate decisions they accept responsibility for their behavior.
- *Pro social thinking can be taught.* Programs of cognitive change can teach pro-social ways of thinking, even to severely criminogenic and violent offenders. The effectiveness of cognitive programs in changing antisocial behavior has been demonstrated by practical application over time.
- *The values of cognitive strategies extend well beyond the correctional environment.* Cognitive principles can be applied to victim restitution, educational settings, personal development, and as an overall approach to public safety and offender change.

Cognitive Approaches. There are two main types of cognitive programs: cognitive skills and cognitive restructuring. Cognitive skill training is based on the premise that offenders have never learned the “thinking skills” required to function productively and responsibly in society. This skill deficit is remedied by systematic training in skills such as problem solving, negotiation, assertiveness, anger control, and social skills focused on specific social situations like making a complaint or asking for help.

Cognitive restructuring is based on the premise that offenders have learned destructive attitudes and thinking habits that point them to criminal behavior. Cognitive restructuring consists of identifying the specific attitudes and ways of thinking that point to criminality and systematically replacing them with new attitudes and ways of thinking.

Cognitive restructuring and cognitive skills approaches are complementary and can be combined in a single program. When practiced in a community model, resocialization can be enhanced and accelerated. Both cognitive strategies take an objective and sys-

tematic approach to change. Change is not coerced; offenders are taught how to think for themselves and to make their own decisions.

Cognitive corrections programs regard offenders as fully responsible for their behavior. Thinking is viewed as a type of learned behavior. Dishonesty and irresponsibility are the primary targets for change. Limit-setting and accountability for behavior do not conflict with the cognitive approach to offender change, they support it. These programs are particularly useful for substance abusers because acceptance of limit setting is a primary need associated with early recovery.

Incorporating the Principle of Responsivity. Responsivity addresses the importance of delivering treatment services in a manner that facilitates the learning of new pro-social skills by the offender and creates appropriate competencies in staff. Thus, successful programs (1) match the treatment approach with the learning style and personality of the offender; (2) match the characteristics of the offender with those of the treatment provider; and (3) match the skills of the treatment provider with the type of program.

One aspect of responsivity often overlooked in correctional programs is appropriate communication. Communication is the primary means of getting and using information needed to treat and manage offenders effectively. Cognitive/behavioral communication strategies provide both custody and treatment staff with the competencies necessary to make use of what we know about antisocial logic. In order for staff to communicate in a manner that has an effect on the offender’s view of the world, the communication must intrude on, disrupt, or confront the offender’s normal thought process. A critical correctional communication competency is to know when to use behavioral confrontation and when to use cognitive confrontation. Behavioral confrontation describes the behavior and is followed by appropriate disapproval/approval. On the other hand, cognitive confrontation must come through personal self-disclosure, awareness, and the connection between thoughts, behavior, and consequences. Competent communication also requires combining confrontation with the appropriate application of positive and negative reinforcers. Understanding antisocial logic and the effective use of these techniques can mean the difference between failure and success in offender programs.

Effective communication defines the interpersonal relationship between staff and offenders as one of accountability and support. For maximum treatment outcome custody, treatment, and administration staff

must all become competent in the use of the various correctional communication skills. Some of the more promising techniques include cognitive reflective communication, motivational interviewing, and a social learning application of behavioral confrontation.

Taking an Integrated Approach

Relapse Prevention Strategies. Essential to any integrated approach is the inclusion of relapse prevention strategies that typically incorporate the following elements:

- Development of an individualized plan and rehearsal of alternative pro-social responses that are specific to the behaviors or circumstances that increase the risk of re-offending for the offender in question;
- Development of self-monitoring skills and the ability to anticipate problem situations; and
- Training of significant others such as family, friends, and employers to reinforce pro-social behavior and to recognize triggers and risk situations regardless of the risk factors.

In addition, it is often important to provide booster sessions to offenders after they leave formal treatment or are released into the community.

Sanctions and Treatment: Accountability and Change. Currently, sanctions are seldom used intentionally as companions to offender treatment or strategies to modify behavior. These include such things as intensive supervision, home confinement, frequent drug testing, restitution, shock incarceration, electronic monitoring, and mandated 12-Step programs.

The primary intent of most sanctions is for purposes other than their impact on re-offense behavior. For example, drug testing and intensive supervision are often employed to monitor compliance (or detect noncompliance) with conditions of probation or parole. Restitution is a component of restorative justice rather than an attempt at crime control. Similarly, interventions such as home confinement, electronic monitoring, and short periods of shock incarceration are sometimes imposed because they are less expensive forms of punishment. None of these strategies have shown any significant results. Further, sanctions—if not accompanied by appropriate treatment—have shown or little or no evidence of reducing recidivism.

The key idea is simply this: Effective correctional intervention must produce a change in the offenders’ fundamental worldview,

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especially their perception of authority, rules, and accountability. This marks an essential difference between pro-social and antisocial attitudes and behaviors. Addressing this aspect of antisocial logic is a vital part of effective program strategy.

This part of a correctional strategy should be conceived as three messages with one voice:

1. Our society's determination to enforce social limits and the law;
2. Extension of a genuine opportunity to change; and
3. Respect for offenders' capacity to make their own choices.

In this message, security (in the broad sense of the term, including law enforcement and accountability) and treatment are complementary. Neither is an isolated component, able to stand alone. Each derives its meaning by its relation to the other. The same applies to the condition of respect. Society must not impose an insurmountable barrier between itself and the guilty offender. This is not a matter of altruism, but rather a matter of effective strategy and social learning theory applied. Each of the three messages qualifies and defines the others. Consequently, the message provides closer monitoring, better supervision, and has positive effects on recidivism. With a clear understanding of these principles even punishment and retribution can be combined appropriately with interventions to produce enhanced outcomes. (Bush. & Bilodeau, 1994)

Evidence-Based Program Structure

The Cognitive Community. Treatment models that maximize outcomes as part of correctional strategy incorporate an in-depth understanding of antisocial logic, social learning, cognitive/behavioral programs, and appropriate communication. Such a program could be referred to as a "cognitive community." Programs producing maximum results have developed competence in the concept skills and attitudes of these program elements. Competence includes appropriate situational and interchangeable application of these methods. One example of application is knowing when and how to confront crime producing attitudes and beliefs thinking (cognitive restructuring and cognitive skill-building) and when to use the behavioral confrontation tools of the therapeutic community. In a cognitive community, cognitive behavioral programs are not simply a type of group to be placed into a therapeutic

environment as a learning experience or a group activity and social learning must not become rote compliance or peer coercion. The treatment model employed must be flexible enough to encompass self-actualization, but structured enough to create a climate for peer accountability and consequences. (Gornik, et al., 1999)

The cognitive community is especially useful for substance abusers because both substance abuse and criminogenic risk factors must be addressed simultaneously for optimum treatment outcomes.

In the cognitive community, thinking and behavior are both exposed to the larger community. The community then becomes the baseline and milieu in which new learning and change can take place. Once implemented, the cognitive community is as much like real life as possible. All staff, including custody, participates in the cognitive community practices. Thoughts and behaviors that typically lead to relapse are discovered more quickly. Staff's ability to recognize the internalization of offender change is more efficient. The cognitive community operates 24 hours a day, seven days a week, and 365 days a year. Social learning and cognitive change operates as the oxygen and lifeblood of the community and fosters a "no place to hide" philosophy. Cognitive/behavioral practices form the lifestyle in which all other operations and activities exist including; work both on and off the living unit, educational programming, drug treatment and counseling, specialized programs and groups, visitation, family reunification, and transition planning.

Staff and offender growth is measured in stages, and competency is measured in three domains (knowledge, skills, and attitude). Competency measured in this way insures the full range of abilities necessary for internalized and lasting change. This type of competency measurement can track offender progress more effectively through the process from compliance to endorsement. Initially, staff will be primarily responsible for modeling and enforcing pro-social values and behaviors. However, as the community matures, the community itself becomes the primary agent of change. This is the core of social learning.

Staff as Community Members and Agents of Change. In healthy communities, the involvement and support of every member is important. Within correctional treatment communities it is essential. Correctional officers, probation and parole officers, teachers, counselors, and volunteers all make excellent members of the treatment

team and are considered part of the community. The authority represented by correctional staff, including uniformed officers, is a positive enhancement—not a detriment—to the credibility and effectiveness of cognitive behavioral social-learning programs. People with good interpersonal skills, but no clinical training, can be trained to deliver and benefit by cognitive social learning programs. The crucial element is consistent modeling by staff that practices and believes in the principle they are espousing. As staff participates in the principles and practices of the correctional programs, they are less likely to burn out, lose job satisfaction, or use authority inappropriately. Multidisciplinary involvement is one more critical element of integrated correctional strategy and becomes a one voice-one message philosophy..

Maximizing Results

After some 30 years of involvement with the criminal justice system, from personal incarceration to state program administrator, I have come to some conclusions about offender treatment. Over time, these opinions have been validated by research and experience in my various roles: addict, offender, counselor, program manager, administrator, and justice-treatment consultant.

Effective programs require an understanding of self-centeredness and oppositional behavior, not only in offenders but also in staff and the organization as a whole. Successful programs utilize competent, well-trained, and well-supervised staffs which possess good communication skills. However, program failure is more often due to an attitudinal problem than a lack of skill or knowledge. Everyone in the organization and its community partners must believe in and practice the values given to offenders in the change process. Social learning principles practiced at the organizational level provide a safe atmosphere for staff to disclose, seek help, and correct personal and program problems. Staff health goes hand in hand with good offender treatment

A balanced integrated approach to security and treatment must go beyond practices targeted at offender change and management. Accountability and change must become a system norm supported and practiced by leadership. Implementing a seamless continuum of service between prison programs and the community means participation by leadership and involvement by the community. Proper assessment of need and appropriate ongoing care should

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client progress, and treatment efficiency are also listed as ways to identify treatment effectiveness. The authors note that there is "no consensus on what the standards for efficacy within psychotherapy should be." It is this lack of standardization and clear-cut definitions that has led to skepticism toward treatment. The authors state that society generally looks at drug addiction as a moral weakness and expects total abstinence, whereas a relapse by smokers or alcoholics often draws a sympathetic response.

The article concludes with an explanation of the various concepts of treatment effectiveness and how drug problems are defined. Many schools of thought are addressed, including the disease, cognitive, sociologi-

cal, moral, and employment models. The authors acknowledge that "although no one model may be absolutely superior, some models are more popular or acceptable at certain times, due to shifts in political interest of ideological views among policy makers."

The article is an excellent resource for the criminal justice practitioner. It explains the various methods of establishing program effectiveness in a very clear and concise manner. The authors' compilation of the various theories of drug use helps the reader to understand the treatment profession's difficulty in defining effectiveness in treatment.

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be seen as a universal practice good for all people in the system

Practices used to promote public safety and offender change should be understood and continuously evaluated by all stakeholders from policymakers to offenders. Informed decision-making demands responsible examination of one's own attitudes and beliefs prior to evaluating others. The combination of these best practices provides therapeutic integrity. The challenge before us is to translate the various roles of an integrated system into role specific language so that can be valued, used, and passed on.

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