

**RESEARCH FINDINGS AND BEST PRACTICES IN
SUBSTANCE ABUSE TREATMENT FOR OFFENDERS
A Review of the Literature**

Prepared for the NC DOC Substance Abuse Advisory Council

**North Carolina Department of Correction
Office of Research and Planning
Sandy C. Pearce, Manager
Douglas Holbrook, Analyst
August 2002**

Treating Offenders with Alcohol and Other Drug Dependencies

The research literature and best practices literature uses a variety of terms to refer to treatment for excessive alcohol and drug use: alcohol and other drug dependency (AOD) treatment; chemical dependency treatment; substance abuse treatment. In this review, the terms are used as the researchers/authors reference them.

The purpose of substance abuse treatment for offenders is to stop the alcohol and/or other drug abuse and to return the individual to productive functioning in the family, workplace, and community. Measures of effectiveness typically include levels of alcohol and/or other drug use, criminal behavior, family functioning, employability, and medical conditions (NIDA, 1999). This report provides a summary of the research literature on offender substance abuse programs and a description of best practices literature.

Risk, Needs and Responsivity

Andrews, Bonta, and Hoge (1990) describe a science-based correctional model for assessing and intervening with alcohol and other drug dependencies that uses the assessment of the individual to drive the treatment plan. This model is founded on the principles of risk, needs and responsivity. The “risk principle” states that the most costly and intensive resources should be reserved for the highest-risk cases. High-risk offenders have more to gain from treatment in terms of reducing their risk for future involvement in crime. The “need principle” states that future criminal activity can be reduced by identifying and intervening with the criminogenic or crime-producing needs of the offender. Research indicates that criminogenic needs include cognitive (thinking) distortions, deficits in problem-solving ability, egocentricity, employability, substance abuse and antisocial attitudes, sentiments and values. The “responsivity principle” refers to offender characteristics that influence the offender’s individual response to treatment. Examples of responsivity factors include the following: learning style, personality characteristics, and treatment motivation. Research indicates that addressing these three areas with offenders, through assessment and individual treatment planning, can reduce recidivism (Andrews, 1995).

Screening, Assessment, and Treatment Planning

To provide effective services to offenders, treatment providers must understand the special characteristics of this population. Alcohol and other drug-involved

(AOD) offenders are not a homogenous group. These differences include personality, patterns of AOD abuse, health status, socialization, education, family, job training, urban and rural influences, and mental functioning. They range from seriously antisocial individuals to those who are more pro-social and have family and community support systems. Therefore it is critical to screen and assess offenders prior to placing them in treatment programs. This screening and assessment should determine the range of services needed by the offender to learn to cope in society and should assist in developing an individualized case plan (CSAT, 1995).

Screening and assessment is a multi-stage process. Screening is the initial activity that identifies offenders who are likely to have AOD problems. Many screening and tools exist to gauge an inmate's need for treatment services. Research indicates that inmates with substance abuse problems are at higher risk for a number of problems and conditions that, left unidentified and unaddressed, can increase the probability of relapse and reincarceration. Screening instruments recommended by researchers for criminal justice populations include the Alcohol Dependence Scale and the Drug Use section of the Addiction Severity Index, the Texas Christian University Drug Dependence Screen, and the Simple Screening Instrument. They found these instruments to be superior to the SMAST and the SASSI (Rounds-Bryant et al., 2000).

An assessment is a process that helps determine the extent of an individual's problem with alcohol and other drugs and the appropriate level of treatment. Assessments should be biopsychosocial in nature and should address medical, psychiatric, psychological, emotional, social, familial, nutritional, legal and vocational areas to determine the levels of treatment intervention and services that will be needed (CSAT, 1995).

While AOD screening is generally a one-time event, an AOD assessment is an on-going process. Commonly used assessment instruments include the Offender Profile Index, which is used to determine the appropriate type of AOD abuse treatment for the offender and the Addiction Severity Index, which is probably the most widely used standardized diagnostic instrument in the field. Assessment is repeated throughout treatment and throughout the offender's involvement in the criminal justice system. Changes in the offender's severity of addiction and in problems related to addiction, as well as new life problems and crises, require modifications in the treatment plan (CSAT, 1995).

CARF (2001), the Rehabilitation Accreditation Commission, promotes the quality, value, and optimal outcomes of rehabilitative services, according to their mission statement. The Commission develops and maintains standards that enable rehabilitative programs to attain accreditation. These standards are "consensus" standards from the involvement of providers, consumers, and purchasers of services. Screening, assessment, and case planning are required components of a criminal justice treatment program under CARF standards.

CARF standards require screening and require that qualified personnel conduct assessments. The assessor may draw information from the offender, family members, peers, and other collateral sources. The assessment should include, at a minimum, the following information on the offender:

- 1) age or developmental level
- 2) gender
- 3) sexual orientation
- 4) social preferences
- 5) cultural background
- 6) psychological characteristics
- 7) physical condition
- 8) spiritual beliefs
- 9) employment history
- 10) family history, and
- 11) history of abuse

Case Management

Case management is the process of linking offenders with needed services in the treatment system, including services other than AOD treatment. Supplementary services can include medical, dental, mental healthcare, housing, education, and vocational training. Critical case management issues include identifying those who have a specific responsibility for the offender and those who make treatment decisions. Written agreement must be reached about the roles of involved parties. Cross training and memoranda of agreement between treatment providers and other providers is essential. There are various case management models – case management provided by the justice system, case management provided by the treatment system, case management provided by a separate entity from the treatment or justice systems, and case management provided by multidisciplinary groups in the criminal justice system for offender management (CSAT, 1995).

The Treatment Accountability for Safer Communities (TASC) Program is a national model for case management. Case management in substance abuse is the process that links individuals in treatment with ancillary community services. It is often viewed as an adjunct to primary treatment and as an enhancement to treatment. Enhancements often include eliminating barriers to treatment participation, expanding access to complementary social services, making referrals and coordinating the services obtained, monitoring progress, adjusting plans as required, and serving as an advocate. TASC programs usually provide all of these elements of case management. TASC case management provides structured linkages between the criminal justice system and the treatment system. This structure is defined by ten critical elements and is programmatically measured by performance standards associated with each element. Over 40 local program evaluations of TASC took place between 1972 and 1982 and most

found TASC effective in linking the criminal justice and treatment systems (Cook, 1992).

Treatment Modality Definitions and Examples

There are two primary theories for treating substance abuse. One is the disease /medical model and the other is the social learning model. Substance abuse treatment programs are usually based on one of these two models, though some programs combine elements of the models. The disease theory describes alcohol and/or drug addiction as a chronic, primary illness. It is viewed as a no-fault three-part disease: physical, mental and spiritual. The focus is on teaching alcoholics and addicts how to live with the condition for a lifetime through abstinence, with the help of the 12 steps of Alcoholics Anonymous (Spicer, 1993).

Social learning theory describes addiction as learned maladaptive behavior that can be treated by teaching and modeling prosocial behavior. This view holds that offenders learn antisocial thoughts and actions as a means of coping with life. These behaviors are maintained by strong internal reinforcers such as feelings of excitement, pleasure, and power offering immediate gratification which is a stronger controlling force than the delayed negative consequences. This theory stresses modifying the individual's behavioral coping skills and cognitive processes to improve the individual's ability to function in the social environment. Treatments based on this model include reducing the availability of substances through restricted access, interdiction, and treatment (Parks et al., 1999).

Treatment programs for offenders vary in terms of setting, length of stay, intensity, modality, and treatment theory of behavior. There are many program models such as outpatient methadone maintenance, short-term inpatient Minnesota Model, therapeutic communities, cognitive behavioral interventions, relapse prevention, and reality therapy. The three most common programmatic models for substance abuse treatment for offenders are the Minnesota model (also referred to as 12-step), therapeutic community, and cognitive behavior therapy (Rounds-Bryant, 2000).

The Minnesota model, based on the disease theory, is popular nationally, and is widely used, both in and out of prison. It is based on the 12 steps and 12 traditions of Alcoholics Anonymous (AA). The program's goal is for recovering individuals to abstain completely from using any substances (Rounds-Bryant et al, 2000).

The Minnesota model is delivered in a formal setting and contains the following elements: multidisciplinary treatment team, a therapeutic community milieu, small group therapy, psycho-education, and aftercare. Although this model is traditionally a self-help approach with non-professional, recovering addicts as

group leaders, it can be facilitated and delivered as a formal, curriculum-based treatment component. The model can draw on other models as needed to facilitate the recovery of the addict. No evaluations of this model in a prison setting were found (Spicer, 1993).

Cognitive behavior therapy, based on social learning theory, assumes that substance abuse is a learned, maladaptive behavior pattern that can be changed by training and practicing appropriate skills. The counselor presents didactic information and coaches the offender to acquire new skills. This group-based therapy is usually intensive and short-term, typically less than three months. During this period, participants work in the group to learn better thinking and behavioral approaches that reduce both alcohol and other drug dependence and other antisocial behaviors (Rounds-Bryant, et al, 2000). Most cognitive behavior programs require ongoing practice, and frequently encourage graduates to participate in AA or NA as an adjunct to their treatment. The actual delivery of the curriculum is a combination of instruction, practice within group, and homework. The sessions are highly directive. This type of curriculum can be offered as a component of a therapeutic community or a 12 step program. One type of CBT programs is Moral Reconciliation Therapy (MRT), which focuses on moral reasoning and development. MRT has been demonstrated to be effective in reducing recidivism in Washington state (MacKenzie, 1998).

Therapeutic communities (TC) are residential programs with a stay ranging from 15 to 24 months; modified TCs last from 6 to 12 months. The therapeutic community model focuses on global rehabilitation in which alcohol and other drug (AOD) treatment is incorporated. The TC views AOD abuse and other problems as reflections of chronic deficits in social, educational, vocational, familial, economic, and personality development. The principle aim of a TC is global life-style change; including abstinence from AODs, elimination of antisocial behavior, enhanced education, constructive employment, and development of pro-social attitudes and values. A TC frequently includes AA or other 12-step groups as a tool to recovery. All TCs include the following elements: community structure, hierarchy, and confrontation in order to rehabilitate clients (CSAT, 1995).

Moderation or abstinence is a controversial issue in the treatment of substance abusers. Lightfoot (1999) describes the debate between the disease model proponents, who believe that alcohol and other drug addiction is a progressive disease which requires a commitment to lifelong abstinence, and the controlled drinking proponents, who believe that moderate drinking is feasible for some substance abusers. Research conducted in 1984 and 1987 demonstrates that young single males are more likely to comply with moderation goals than abstinence. Controlled drinking is usually defined as some limit on amount and frequency of consumption, and drinking that does not result in physical dependence, or social, legal, or health problems (Sanchez-Craig et.al, 1984, 1987). This research has led some to adopt harm reduction versus abstinence as a treatment goal. Marlatt's (2001) clinical work with adolescent and young

adults who binge drink found that these youth were not ready to admit the extent of their problem or to accept an abstinence-only goal. He asserts that a harm reduction strategy in treating many problem drinkers is important if they are otherwise unable or unwilling to pursue the abstinence goal.

Research Findings on AOD Treatment Outcomes

Program evaluations and meta-analyses of substance abuse treatment programs indicate that while treatment can be effective, not all programs are effective. Reviews of the effectiveness of substance abuse treatment consistently conclude that there is no “magic bullet.” In other words, no single treatment is effective for all persons with an alcohol or other drug disorder. Some data indicates that providing more treatment than needed may reduce treatment effectiveness; some data indicates that clients with more severe problems do better in residential treatment (Lightfoot, 1999).

Rounds-Bryant et al., (2000) indicated that one of the strongest, most consistently replicated findings of treatment effectiveness is the importance of longer stays in treatment. Program effectiveness also varies based on program characteristics, program completion, aftercare completion, and length of stay. Recent research consistently shows that superior outcomes are found when offenders complete all phases of treatment, including aftercare.

Anglin and (1990) found that different treatment modalities yield different results with offender populations. Therapeutic communities have the best results generally in reducing drug use and criminal recidivism, and methadone maintenance programs show some positive effect. All programs' outcomes are improved by longer durations. A 1979 study by Simpson found that six months of treatment in a therapeutic community or an outpatient program had significantly better outcomes than methadone maintenance for the same duration.

Duration of participation has been shown to be a more important factor in treatment success than voluntary participation. Several studies have shown that the effectiveness of the treatment does not differ between offenders who enter programs voluntarily and those who are ordered to participate (Anglin and Hser, 1990; Anglin and Maugh, 1992; Falkin, Wexler, and Lipton, 1990).

MacKenzie (1998) reviewed of literature on effectiveness of correctional treatment programs and grouped them into three categories: what works, what doesn't work, and what we don't know. According to this review, programs that combine in-prison therapeutic communities with post-release aftercare are most effective. Conversely, programs based on referral, monitoring, and case management in the community, such as TASC without intensive TC while incarcerated, do not reduce drug use or recidivism. There is not enough research on community-based outpatient programs without in-prison treatment to draw any conclusions.

Lightfoot (1999) and Pelissier et al., (2000) note that outcome evaluations of alcohol and drug programs have suffered from design problems. These problems include selection bias of treatment participants, lack of appropriate comparison or control groups, retrospective rather than prospective study designs, inadequate baseline data, inadequate outcome measures, and insufficient follow-up periods. Since field research is unlikely to ever be implemented ideally, researchers have to address the methodological problems of the past to improve estimates of the impact of treatment.

Prison-Based Treatment

In 1996 Lipton published a report that described evaluations of model drug treatment programs for inmates in prison and jail. His review focused on the therapeutic community (TC) model in which inmates were within a year of their release date and the treatment lasted 9-12 months with a strong aftercare component. He reported outcomes for Amity Right Turn (California, 1994), Stay'n Out for males (New York, 1977-1984), Stay'n Out for Females (New York, 1977-1984), Cornerstone (Oregon, 1984), Wharton (New Jersey, 1980), In-Prison Therapeutic Community (Texas, 1990), Key-Crest (Delaware, 1995), and the Bureau of Prisons (Federal, 1995). Most of the evaluations indicated lower reincarceration or rearrest rates for the treatment group versus the comparison group.

Two later evaluations were conducted on programs in Lipton's original report. In 1999, Butzin, et al., studied the CREST Outreach Center in Delaware, a six-month residential community-based therapeutic community for prison inmates with histories of substance abuse. It serves males and females and has been operating since the early 1990's. It was the nation's first combined therapeutic community and work release facility. In an evaluation to examine the habilitation effects of the program, the researchers compared outcomes such as recidivism, drug use, and employment of CREST residents with a comparison group of drug-involved inmates who entered Delaware's traditional work release program. In this 1999 study, the same researchers found that the recidivism rate (any arrest) during an 18-month prison release follow-up was significantly lower for the CREST completers (30%) than for the CREST non-completers (52%) and for the comparison group (57%). Sixty one percent of the CREST completers experienced relapse, 73% of the CREST non-completers experienced relapse, and 85% of the comparison group experienced relapse. Offenders who completed CREST had a statistically significant higher average income for the previous year than the comparison group.

In 1997 Simpson and Knight, with Texas Christian University's Institute of Behavior Research, examined Texas in-prison therapeutic community treatment. In a 12-month after prison release follow-up, they found that TC/Aftercare

completers had a lower rearrest rate (18%) than did TC/Aftercare non-completers (29%) and the Untreated Comparison Group (33%).

Between 1992 and 1997 Wexler conducted outcome evaluations of the Richard J. Donovan Correctional Facility Substance Abuse Program in California. The program is a 9-12 month 200 bed modified therapeutic community substance abuse program. The experimental designed study involved 715 male volunteers for the program who were randomly assigned to the treatment and control groups. The study groups included a control group, a program drop group, a prison treatment only group, a community drop group, and a community program completer group. The data shows that return-to-custody rates 24 months after release were lower for groups spending a longer time in treatment; 67% for the control group, 56% for program dropouts, 49% for prison treatment only, 60% for continuing care dropouts, and 14% for continuing care completers . At 36-months post-parole, there was little difference between the groups on return-to-custody, except for the Continuing Care Completer Group (California Department of Corrections, 1999).

The Forever Free Program at the California Institution for Women was evaluated in 1999 by Lowe. Forever Free is a 4 month intensive residential program which uses a multi-dimensional treatment approach including behavioral change, the 12-steps, relapse prevention and a focus on women-specific topics. Lowe studied inmates who exited the program during 1995 and 1996. The analysis showed that 24 months post-parole, 60% of the program drops had returned to prison, 55% of the in-prison treatment only group returned, and 48% of the in-prison and continuing care in the community group returned to prison (California Department of Corrections, 1999).

Lightfoot and Hodgins (1993) developed a typology of substance-abusing offenders based on an extensive review of the literature. They identified the following typologies based on severity and substance type: nonabusers , drug abusers, alcohol abusers, emotionally distressed polysubstance abusers, and organically impaired alcohol and drug abusers. Using these typologies as a risk continuum, in 1992 the Correctional Service of Canada introduced a model to identify and treat substance abuse; the model has five components which are designed to address the offender's treatment needs from entry into prison to release from supervision in the community. Offenders are screened using the Computerized Lifestyle Assessment Instrument, an introductory education module is provided to all new offenders, and they participate with their case manager to determine the most appropriate treatment based on risks and needs. Offenders with no-to-low levels of substance abuse problems or who were involved in the sale and distribution of drugs are referred to nine 6-hour sessions as part of the Alcohol, Drugs and Personal Choice program. Offenders with low-to-moderate problems are referred to CHOICES, a brief treatment program with three-month follow-up. Those with moderate-to-high problems are referred to the more intensive Offender Substance Abuse Prerelease program; follow up and

support are provided after the completion of treatment participation in maintenance groups, which are available both in the institution and the community.

The Offender Substance Abuse Prerelease program serves offenders within one year of release. They participate in 26 half-day group sessions and three individual counseling sessions. The modules are alcohol and drug education, self-management training, social skills training, substance use and work, leisure and lifestyle, and prerelease planning. Lightfoot (1999) conducted a 15-month followup of 324 participants in the Offender Substance Abuse Prerelease Program in 1994. More than 90% of offenders who completed the program were released, and 30.2% who were released were reincarcerated within the 15-month follow-up period. Rates of reincarceration varied directly as a function of substance abuse severity level, more severe substance abusers were more likely to be readmitted to prison. In addition, readmission rates were directly related to the number of pre-post measures on which offenders showed improvement. Only 19% of offenders who improved on pre- and posttest measures were readmitted, while 36% of those who showed no improvement were readmitted, as demonstrated by survival analysis.

The Federal Bureau of Prisons operates a three-phase residential program which has been shown to be effective in a 2000 evaluation study by Pelissier, et al., (2000). This program is based on the biopsychosocial model of treatment that recognizes the complex interrelationships between psychological, biological, and social variables.

The inmates receive nine months of treatment in a drug abuse treatment unit, a transitional period, up to a year, in the general population with relapse prevention planning and review of treatment techniques, and a required community transition period following release into a community halfway house. The treatment has a standardized curriculum comprised of modules including screening and assessment, treatment orientation, criminal lifestyle confrontation, cognitive skills building, relapse prevention, interpersonal skill building, wellness, and transitional programming. The main finding in the evaluation was that offenders who completed the residential drug abuse treatment program, and had been released to the community for three years, were less likely to be re-arrested or to test positive for drug use than were similar inmates who did not participate in the drug abuse treatment program. Of the male inmates who completed the program, 44% were re-arrested or revoked with three years after release to supervision in the community compared to 52% of the inmates who did not receive such treatment. For women, 25% of those who completed the residential program, were arrested or revoked with three years after release, compared to 30% of the untreated women. As far as drug use, 50% of men who completed the program used drugs within 3 years following release while 59% of those who did not receive treatment used drugs. Among female inmates, 355 who completed the program used drugs with the 3 years after release and 43% of

those who did not receive treatment used drugs. While the FBOP intervention occurs near the end of incarceration, it demonstrates that length of time in treatment and completion of treatment are critical factors in success in the program.

Community Treatment Evaluations

Anglin et al., (1999) reviewed research on five Treatment Alternatives to Street Crime (TASC) programs. TASC is a case management model implemented in various forms since the early 1970's to facilitate treatment for substance abusing offenders in the community. TASC provide a bridge between criminal justice agencies and community-based treatment programs through coordination of services. TASC identifies, assesses, and refers substance abusers to appropriate community treatment services as an alternative to or a supplement to criminal justice sanctions. After referring offenders to treatment, TASC monitors their progress and compliance, especially through drug testing. The courts treat dropping out of treatment or other noncompliance as a violation of release or probation. Early process evaluations of TASC programs were generally positive. Researchers found that programs screened and identified large numbers of drug users in the criminal justice system and served as an effective link between criminal justice and treatment systems. There was also evidence that TASC increased treatment retention. The Treatment Outcome Prospective Study (TOPS) conducted by Hubbard et al. (1988) found that TASC clients remained in treatment longer than non-TASC clients, and the length of stay resulted in a more positive outcome on treatment. A more recent evaluation began in 1991 with funding from the National Institute on Drug Abuse. The programs included in the study conformed to the TASC model as represented in the Ten Critical Program Elements and Performance Standards of the Bureau of Justice Assistance and served a high risk population (e.g. crack cocaine users). Five programs were selected for the study, two adult programs using a randomized design, two adult programs using a quasi-experimental design, and one juvenile program using a quasi-experimental design. TASC participants were followed up after six months and interviewed about treatment services received, drug use and criminal activities. Researchers also verified self-reported information through drug tests, treatment records, and court records. The evaluation found favorable effects of TASC programs on service delivery and offender's drug use. Findings on criminal recidivism were mixed and difficult to interpret; this may be due to the intensive monitoring that these offenders received while in the program, similar to evaluation results on Intensive Supervision Probation programs.

In an extensive review of the literature from 1980 to 1997, Lightfoot (1999) reports on the evaluation of the Drug Abuse Reporting Program in 1982 by Simpson and Sells. The study involved more than 4,000 subjects (nonoffenders and offenders) involved in five different types of treatment including: methadone maintenance, therapeutic community, out-patient treatment, out-patient detoxification and intake only (no treatment). Clients with the greatest criminal

involvement had the poorest outcomes. Methadone maintenance, therapeutic community, and out-patient treatment did not differ significantly in outcomes, but were more favorable than completing outpatient detoxification and intake only. Specialized programs designed for offenders were likely to have better outcomes than nonspecialized programs or generic substance abuse programs since criminality is a significant factor that independently affects a treatment outcome.

Lightfoot (1999) reports that in 1989 Vito studied the Kentucky Substance Abuse Program that provided self-help counseling sessions and referrals to appropriate community agencies for probationers and parolees on a service contract with a private provider. The nature and dose of treatment was not described. One-year outcomes were compared for treatment graduates, treatment dropouts, and a comparison group. Treatment graduates had significantly lower arrest and conviction rates than the comparison group, but not a lower reincarceration rate. Latessa made similar findings in a study of alcoholic probationers in the Ohio STOP Program. In 1994 Moon and Latessa evaluated an outpatient drug treatment program, the Chemical Offender Program for felony offenders. This was a three phase program including education, a 12-step component, and a drug testing component. Results indicated no differences in rates of arrest and conviction for misdemeanor and felony offenses. The study was limited by small samples and a short follow-up period.

Lightfoot (1999) reported on the 1993 study of the Multiple Offender Alcoholism Program, a treatment program for violent criminal offenders by Funderbank, MacKenzie, DeHaen, and Stefan. Outpatient treatment consisted of contingency management, rewards for program attendance and participation, and frequent drug tests. An individualized cognitive behavioral treatment plan was developed and then implemented using behavioral counseling and contingency contracting. Treatment goals included reducing alcohol-related problems such as social functioning and employment and reducing alcohol-related criminal activity. A quasi-experimental design to compare outcomes for a treatment group, a national sample, and two independent control groups. The results indicated that active treatment clients engaged in significantly fewer violent crimes (61% decrease) and had improved employment and social functioning significantly during program participation.

Lightfoot's examination of research indicates that some programs, such as therapeutic communities, advocate the use of peer counselors. However, empirical studies in the general psychotherapy literature and the substance abuse literature suggest that therapists who are judged more skilled and competent by peers have the ability to form a therapeutic alliance. These professionals tend to foster a better client outcome.

CHOICES is a brief (five sessions) treatment and relapse prevention program developed in 1993 for parolees in the Canadian correctional system. CHOICES was originally designed to be delivered to offenders released to the community

on parole but it is also offered in minimum security prisons. It is delivered to low-to-moderate substance severity offenders. Offenders are referred by their parole offices for a structured interview and testing prior to admission. A novel aspect of the CHOICES program is that parole officers are given training in program delivery, and they function as co-facilitators for the treatment and maintenance groups in the community. The program was developed around Miller's dynamic concept of motivation for changes. The modules consist of motivation to change, the ABC learning model of addiction, relapse triggers, problem-solving techniques, and cognitive coping skills. After they complete the five sessions, offenders are required to attend weekly maintenance sessions for a minimum of 3 months. Preliminary evaluation results with a sample of 95 parolees indicated that during a 12-month follow-up, recidivism rates are comparable to those seen in more intensive treatment; 48% had no new convictions, suspensions, or revocations (Lightfoot, 1999).

Project MATCH (1998) studied whether different types of alcoholics (not necessarily offenders) respond differently to particular treatments. There were 1,726 patients recruited from treatment facilities across the country were divided into an outpatient group (recruited directly from the community) and an aftercare group (just completed an inpatient or intensive day hospital treatment). Participants in both groups were interviewed and tested to assess 20 individual characteristics. Participants were randomly assigned to one of three treatments: 12 Step Facilitation, Cognitive Behavior Therapy, and Motivational Enhancement Therapy. In a 36-month follow-up, the three treatments were found to be about equally effective in terms of reducing drinking. Participants averaged 25 drinking days per month before treatment and decreased to six drinking days per month after treatment; they reported less drug use, less experience of depression, and their liver function improved. Four participant characteristics were related to successful treatment matching: anger, psychiatric severity, anger, and support of drinking (Project Match Research Group, 1998).

Faye Taxman (1998) presented a paper on the reduction of recidivism through a seamless community system of care at a conference sponsored by the Office of National Drug Control Policy. Taxman evaluated twelve jurisdictions that participated in the High Intensity Drug Trafficking Area project (HIDTA), funded by the Office of National Drug Control Policy. Based on this research, Taxman advocates moving from an individual case management approach to a systemic case management approach which focuses on resource development, social action plans, policy formation, data collection, information management, program evaluation, and quality assurance. This approach integrates traditional case management functions within the roles and responsibilities of appropriate treatment and criminal justice staff. Twelve jurisdictions participated in the HIDTA project, with the purpose of developing a seamless system between criminal justice and treatment agencies by providing a continuum of treatment care for the target population, drug testing and monitoring, and implementing graduated sanctions to increase compliance with treatment. The study showed

that 72% of offenders completed the first phase of treatment and 62% continued treatment in the second phase. The researchers found that 12% of the offenders were arrested for new crimes during 9 months in the community. This is a lower rate than expected based on the history of the clients.

In an article on substance abuse and restorative justice practices, Schwebel and Zaslaw (2002) describes a cognitively based substance abuse program for adolescents called Seven Challenges. This program, used both in the community and institutional settings in Florida. The Seven Challenges Program is philosophically compatible with restorative justice – helping young people to examine their behavior and make good decisions. It is an experiential program that uses cognitive behavioral activities such as role-playing, active discussion, work books and, exercises relevant to young people. Ancillary treatment includes social skill development, cognitive processing, anger management, problem-solving techniques, and pre-vocational and vocational training. In a study by Arizona State University researchers in 1999, Schwebel states that the outcomes for the 83 males and females who participated in an intensive Seven Challenges outpatient program were positive. There were statistically significant reductions in drug use and criminal behavior and improvements in family relationships.

Breaking the Cycle (Kennedy, 1999) is a project begun in 1996 with funding from Office of National Drug Control Policy and the National Institute of Justice. There are four sites: Birmingham, Alabama; Jacksonville, Florida; Tacoma, Washington; and Eugene, Oregon. This initiative is a systemic intervention strategy to identify, supervise and treat drug users in the criminal justice or juvenile justice system. The Breaking the Cycle (BTC) model creates a system of integrated testing, treatment and graduated responses, and supervision to reduce drug use and recidivism in the offender population. The goal of the program is to identify offenders at the point of arrest and begin treatment services in jail that continue into the community, whether the offender is on probation supervision or not. Treatment is provided based on clinical assessments of problem severity. Drug treatment is paired with enforced abstinence which is monitored through regular drug testing linked to specific sanctions for continued drug use. The key components of BTC are early intervention, judicial oversight, graduated sanctions, and collaboration between justice and treatment agencies. The Urban Institute conducted a process evaluation of the projects and an impact evaluation is under publication. A preliminary report of Jacksonville's BTC program found reductions in criminal activity and drug use among drug-involved defendants based on surveys conducted with felony defendants shortly after arrest and again nine months later. The responses of a sample of BTC defendants were compared to a sample of similar defendants arrested in the year before BTC was implemented (Harrell, 2001).

Listwan et al., (2002) summarized the research on drug courts from the 1997 U.S. General Accounting Office (GAO) report. Drug courts developed in the 1990's as an alternative to incarceration and a supplement to community supervision. Today, almost every state in the United States has a drug court, though they differ from jurisdiction to jurisdiction. Drug courts are judicially-based interventions in which offenders are required to participate in substance abuse treatment, drug testing, and in some cases comply with the conditions of probation. A team approach is used to manage the offender's case and frequent court appearances are held so that the judge can assess progress and provide rewards or sanctions based on treatment participation and compliance with court requirements.

According to Listwan et al., (2002), the GAO report and other updated reviews of the research conclude that drug courts are successful in reducing recidivism and substance abuse. However, some studies have found that drug courts failed to reduce recidivism. The conflict in these findings is likely due to the differences in programs from one jurisdiction to another. It is difficult to determine which components or combination of features of the drug court model are most important for determining success. Generally, the research suggests that drug courts have been moderately successful at reducing drug use and recidivism among offenders participating in programs. However, since most drug courts contract with available service providers, the evaluations do not provide information on which treatment models are most effective.

Transition From Prison to the Community

Research previously discussed in this report indicates that treatment in prison is less likely to have a long-term impact if treatment and aftercare in the community do not follow it up for a substantial period of time. Fields (1998) notes that there is research on institution pre-release models of treatment that work, and on community treatment models that work, but too little research on the process of successful transition from the institution to the community. The transition for offenders who have been in treatment in prison to successful living in the community is crucial and difficult.

Vaillant (1988) conducted a long term study of 100 hospital-treated heroin addicts and 100 hospital-treated alcohol-dependent individuals. The two groups were prospectively followed for 20 and 12 years respectively. The individuals in the study were followed up every 18 months, and criminal and hospital records were checked. Vaillant examined factors that contributed to relapse and freedom from relapse. He found that relapse is usually the result of poorly patterned social behavior and thus to avoid relapse, these individuals needed to alter their whole pattern of living. For both groups, encountering one or more of the following – community compulsory parole supervision, methadone maintenance, a substitute dependence (e.g. meditation, compulsive gambling, overeating), new social support relationships (e.g. employment, new marriage), and inspirational group

membership (e.g. fundamentalist religion, Alcoholics Anonymous) - appeared associated with freedom from relapse. Long term structure in an addict's life when he or she is released to the community can interfere with drug-seeking behavior and prevent relapse.

Fields (1998) describes a 1990 Oregon Department of Corrections project to show the effects of a structured transition program from institution to community treatment. Inmates are treated for 3-6 months in prison and then followed intensively for 6-9 months in community treatment and supervision. Key program elements include the following:

- Service providers “reach in” to the institution – Parole and drug treatment services begin in prison several months before the release.
- Joint institutional/community-release planning – Prison staff developed release plans with inmates, their parole officers, and drug treatment coordinators.
- Intensive supervision – Once released, the offender is supervised on intensive parole.
- Continuity of treatment – Group treatment is continued in the community, often with members of the offender's prison treatment group. Peer support for abstinence and recovery is an important part of these groups.
- Careful management of incentives and sanctions – Offenders are offered incentives for treatment participation in prison and in the community (e.g. desirable housing, earn extra pass time, were provided special job skills counseling). They lost privileges according to a graduated scale if they did not cooperate in treatment. In the community, graduated sanctions were applied as needed and incentives included assistance in housing, employment, and other specialized services.

Outcome studies showed a drop in the arrest and conviction rates of participating offenders during the year following treatment. There was also improvement in employment and community adjustment.

Best Practices

National Institute on Drug Abuse

The National Institute on Drug Abuse (NIDA) compiled a booklet in 1999 that outlines principles of effective treatment, both in the community and in the institutional setting. This document is based on review of several studies and meta-analyses. NIDA identified the following thirteen principles of effective treatment:

1. There is no single treatment modality that is appropriate for everyone. Treatment settings, interventions, and services should be matched to each person's particular problems and needs.
2. Treatment needs to be readily available and accessible so that willing persons can participate.

3. Effective treatment addresses the multiple needs of the individual, the drug use and any associated medical, psychological, social, vocational, and legal problems.
4. An individual's treatment and services plan must be assessed continually and modified as necessary to ensure that the plan meets the person's changing needs.
5. Remaining in treatment for an adequate period of time is critical for treatment effectiveness. Research indicates that for most patients, the threshold of significant improvement is reached at about 3 months in treatment.
6. Counseling (individual and/or group) and other behavioral therapies are critical components of effective treatment for addiction.
7. Medications are an important element of treatment for many patients, but only when combined with counseling and other behavioral therapies. For patients with mental disorders, both behavioral treatments and medications can be critically important.
8. Addicted or drug-abusing individuals with coexisting mental disorders should have both disorders treated in an integrated way. Offenders presenting for either condition should be assessed and treated for the co-occurrence of the other type of disorder.
9. Medical detoxification is only the first stage of addiction treatment and by itself does little to change long-term drug use. This is also true for abstinence.
10. Treatment does not need to be voluntary to be effective. Strong motivation can facilitate the treatment process. Sanctions and enticements (family and employment, for example) can increase treatment entry, retention, and the success of drug treatment.
11. Possible drug use during treatment must be monitored continuously. The monitoring of drug and alcohol use during treatment can help the patient withstand urges to use drugs and also provide early evidence of drug use so that the individual's treatment plan can be adjusted.
12. Treatment programs should assess for HIV/AIDS, hepatitis B and C, tuberculosis and other infectious diseases, and provide counseling to help patients modify or change high-risk behaviors.
13. Recovery from drug addiction can be a long-term process and frequently requires multiple episodes of treatment. As with other chronic illnesses, relapses to drug use can occur during or after successful treatment episodes. Participation in self-help support programs during and following treatment often is helpful in maintaining abstinence.

NIDA also published the following four findings specific to prison-based treatment:

- 1) The therapeutic community model of treatment can be highly effective in reducing drug use and recidivism.
- 2) Treatment participants should be segregated from the general prison population to protect them from "prison culture."

- 3) Treatment gains can be lost if inmates are returned to the general population after treatment; this suggests that treatment, to be most effective, should occur late in the incarceration.
- 4) Relapse and recidivism are significantly lower if inmates continue with treatment in the community following release.

Etheridge, Rounds-Bryant, Hubbard Research

A research project by Etheridge and Hubbard, designed to collect outcome measures for community-based treatment services, yielded a table of core components and comprehensive services necessary for effective, holistic treatment.

Substance Abuse Treatment: Core Components and Comprehensive Services	
Core Treatment Components	Comprehensive Services
Intake processing/client assessment	Medical Services
Treatment plan	Mental health services
Abstinence-oriented counseling	Housing
Supportive group & individual Counseling	Transportation
Substance use/urine screening	Child care
Clinical & case management	Family services
Pharmacotherapy	Financial services
Discharge plan	Legal services
Aftercare/continuing care	HIV/AIDS risk services
Self-help/mutual help meetings (AA/NA)	Educational services
	Vocational services

In an evaluation of North Carolina's SARGE program, Rounds-Bryant, Etheridge, and Hubbard cite several studies that demonstrate that superior outcomes are achieved when inmates complete all phases of planned treatment, including aftercare. They identified thirteen elements present in in-prison treatment programs that effectively reduce recidivism:

- a comprehensive, intensive therapeutic approach aimed at the criminal and substance using lifestyle rather than a focus on substance abuse alone
- programs having a clear and consistent treatment philosophy
- a program environment characterized by empathy and security
- a committed and qualified treatment staff
- clear and unambiguous rules of conduct
- the use of ex-addicts and ex-offenders as role models
- use of peer pressure and peer role models
- inclusion of self-help principles
- incorporation of relapse prevention
- aftercare/continuity of care during the post-release period

- adequate administrative support from correctional staff
- separation of treatment participants from general prison population
- a treatment model with an integrated evaluation component

Additionally, Rounds-Bryant, et al., offered guidelines for program development based on these components:

- valid standardized assessments designed to identify multiple disorders that are often present in incarcerated populations
- individualized treatment plans and treatment matching based on intensity and service needs
- an array of treatment alternatives including cognitive-behavioral, social learning, self-help, and therapeutic community approaches that address the dual problems of substance abuse and criminal thinking and values
- random urine screening during treatment
- use of peer pressure and peer role models

High Intensity Drug Trafficking Study

Based on the results of a study of 12 jurisdictions in the High Intensity Drug Trafficking Area project, Taxman (1998) recommends 12 principles for effective systems of treatment, supervision, and transition services in the community.

These principles are:

1. Recidivism reduction should be the goal of the criminal justice and treatment system. This shared goal would bring the systems into alignment. It requires each system to rethink operations and priorities and to jointly reallocate resources.
2. Treatment and criminal justice system features must be policy driven. The systems must develop integrated screening, placement, testing, monitoring, and sanction policies. They must form a policy team to develop these joint policies.
3. Treatment and criminal justice must function as a team. After policies are developed, team members must put them into practice on an on-going daily basis.
4. Use drug testing to manage offenders. Urinalysis allows for immediate confirmation of an offender's drug use. It is a tool for screening, treatment matching and monitoring compliance. Joint policies on drug testing are crucial.
5. Target offenders for treatment where treatment can "work." Target high risk, high need offenders, because treatment is more likely to have an effect on this population and on crime
6. Use treatment matching practices. Use screening and assessment information to make informed decisions about the type of offender who should be placed in residential, intensive outpatient, and outpatient programs. The American Society of Addiction Medicine (ASAM) has developed a protocol for treatment placement.

7. Create a treatment process and extend the length of time in treatment. Research affirms the importance of length of time in treatment for substance abusers, with better results usually occurring from longer participation in treatment programs. Add less intensive outpatient service to residential services upon release.
8. Allow behavioral contracts to bind the offender, the treatment system and the criminal justice system. A behavioral contract can specify the expectations for the offender, treatment staff, and criminal justice staff. It is an explicit set of expectations with rewards and sanctions for compliance.
9. Designate special agents for supervising offenders in treatment programs. Train specialized probation officers to supervise offenders in treatment programs. In order to have a close working relationship, both probation and treatment staff need to be specialists.
10. Sanction non-compliant behavior. Use contingency management, token economies, and behavior modification techniques to address compliance. Use sanctions to hold offenders accountable under their behavioral contract.
11. Reward positive behavior. The criminal justice system does not often acknowledge positive achievements made by offenders. Yet an incentive system that is swift, certain, and progressive can increase positive behavior.
12. Focus on quality, not quantity. Don't lose sight of the goal, to reduce recidivism. Instead of trying to serve the maximum number of offenders, try to serve fewer offenders better in order to produce intended outcomes. Don't provide cheap services if they don't work, provide services that work, even if they are more costly.

Taxman concludes by saying that effective treatment services are synonymous with effective criminal justice services.

REFERENCES

- Andrews, D.A., 1995. The Psychology of Criminal Conduct and Effective Correctional Treatment. In J. McGuire, (ed), *What Works: Reducing Reoffending*. New York: Wiley.
- Andrews, D. A., J. Bonta, and R. Hoge. 1990. Classification for Effective Rehabilitation: Rediscovering Psychology. *Criminal Justice and Behavior*. 17, 19-52.
- Anglin, M.D., and Y, Hser. 1991. Treatment of Drug Abuse. In M. Tonry and J.Q. Wilson (eds.), *Drugs and Crime*. Chicago, IL: University of Chicago Press.
- Anglin, M.D., and T.H. Maugh. 1992. Ensuring success in interventions with drug-using offenders. *The Annals of the American Academy*, 521, 66-90.
- Anglin, M. D, D. Longshore, and Susan Turner, Susan. 1999. Treatment Alternatives to Street Crime: An Evaluation of Five Programs. *Criminal Justice and Behavior*. 26 (2), 168-183.
- Butzin, C. A., F.R. Scarpitti, A. L. Nielsen, S. S. Martin, S. S, and J. A. Inciardi. 1999. Measuring the Impact of Drug Treatment; Beyond Relapse and Recidivism. *Corrections Management Quarterly*, 3 (4), pp. 1-7.
- California Department of Corrections, 1999. Overview of Substance Abuse Programs, Office of Substance Abuse Programs.
- CARF. 2001. Behavioral health standards manual. Commission on Accreditation of Rehabilitation Facilities.
- CSAT (Center for Substance Abuse Treatment. 1995. Planning for Alcohol and Other Drug Abuse Treatment for Adults in the Criminal Justice System. U. S. Department of Health and Human Services, Public Health Service, Substance Abuse and Mental Health Services Administration.
- Cook, F. 1994. TASC: Case Management Models Linking Criminal Justice Treatment. Report: Rockville, MD.
- Falkin, G.P, H. K. Wexler, H.K, and D.S. Lipton. 1992. Drug Treatment in State Prisons. In D.R. Gerstein and H.J. Harwood (eds.). *Treating Drug Problems* (Vol. II, 89-132). Washington, DC: National Academy Press.
- Field, G. 1998. From the Institution to the Community. *Corrections Today*, October, 94-97.

Harrell, A., 2001. The Impact of Jacksonville's Breaking the Cycle Demonstration on Drug Use and Crime: Findings from Offender Interviews. Urban Institute Report.

Hubbard, R.L., J. J. Collins, J. V. Rachal, J.V., and E. R. Cavanaugh. 1988. The Criminal Justice Client in Drug Abuse Treatment. In C.G. Leukefel and F.M. Tims (eds.), *Compulsory Treatment of Drug Abuse: Research and Clinical Practice*. Research Monograph Series 86. Rockville, MD: National Institute on Drug Abuse.

Kennedy, S. 1999, The BTC Review, Issue 2. U. S. Department of Justice, Office of Justice Programs, National Institute of Justice.

Lightfoot, L.O., 1999. Treating Substance Abuse and Dependence in Offenders: A Review of Methods and Outcomes. In E. Latessa (ed) *Strategic Solutions: The International Community Corrections Association Examines Substance Abuse*. American Correctional Association.

Lightfoot, L.O. and D. Hodgins. 1988. A survey of Alcohol and Drug Problems in Incarcerated Canadian Offenders. *International Journal of the Addictions*. 23 (7), 687-706.

Lipton, D.S. 1996. Prison-based Therapeutic Communities: Their Success with Drug-abusing Offenders. *National Institute of Justice Journal*, 12-22.

Listwan, S.J., D. K. Shafer, and E. J. Latessa, E.J. 2002. Drug Courts and Treatment: Fad or the Real Deal? *Offender Programs Report*, 6 (2) 17-32.

MacKenzie, D.L. and Hickman, L.J. 1998. What Works in Corrections? An Examination of the Effectiveness of the Type of Rehabilitation Programs Offered by Washington State Department of Corrections. University of Maryland.

National Institute on Drug Abuse (NIDA). 1999. Principles of Drug Addiction Treatment: A Research –based Guide. NIH Publication No. 99-4180.

Owen, P and G. A. Marlatt. 2001. Should Abstinence Be the Goal for Alcohol Treatment? *The American Journal on Addictions*. 10,289-295.

Parks, G.A. and G.A. Marlatt. 1999, Keeping "What Works" Working: Cognitive Behavioral Relapse Prevention Therapy with Substance Abusing Offenders. In Latessa (ed) *Strategic Solutions: The International Community Corrections Association Examines Substance Abuse*. American Correctional Association.

Pelissier, B, W. Rhodes, W. Saylor, G. Gaes, G, S. D. Camp, S. D. Vanyur, and S. Wallace. 2000. Triad Drug Treatment Evaluation Project: Final Report of Three-year Outcomes: Part 1.

Project Match Research Group, 1998. Matching Alcoholism Treatments to Client Heterogeneity: Project MATCH Three-Year Drinking Outcomes. *Alcoholism Clinical and Experimental Research*, Vol. 22 No. 6, 1300-1311.

Rounds-Bryant, J, R. M. Etheridge, and R. L. Hubbard. 2000. Process evaluation of the RSAT State Alliance for Recovery and General Education (SARGE) Program, Draft Report..

Sanchez-Craig, M. and H. Lei 1987. Disadvantages to Imposing the Goal of Abstinence on Problem Drinkers: An Empirical Study. *British Journal of Addiction*. 81,505-512.

Sanchez-Craig, M. and D. A. Wilkinson, 1993. Guidelines for Advising on the Goals of Treatment: Abstinence or Moderation. In B. A. Howard, S. Harrison, V. Carver, and L. O. Lightfoot, eds. *Alcohol and Drug Problems: A Practical Guide for Counselors* Toronto: Addiction Research Foundation.

Schwebel, R., and J. Zaslaw. 2002. Substance Abuse Treatment and Restorative Justice Practices. *Perspectives*, Summer 2002.

Simpson, D. D., K. Knight. 1997. Research Focus of the IBR at TCU. Research Summary, Special Issue April, 1997.

Simpson, D.D.; Savage, J.; and Lloyd, M.R. 1979. Follow-up Evaluation of Treatment of Drug Abuse During 1969 to 1972. *Archives of General Psychiatry*, 36: 772-780.

Taxman, F. S. 1998. Reducing Recidivism Through a Seamless System of Care: Components of Effective Treatment, Supervision, and Transition Services in the Community. Office of National Drug Control Policy Conference, Washington, D. C.

Vaillant, G.E. 1988. What Can Long-term Follow-up Teach us About Relapse and Prevention of Relapse in Addiction? *British Journal of Addiction*, 83, 1147-1157.