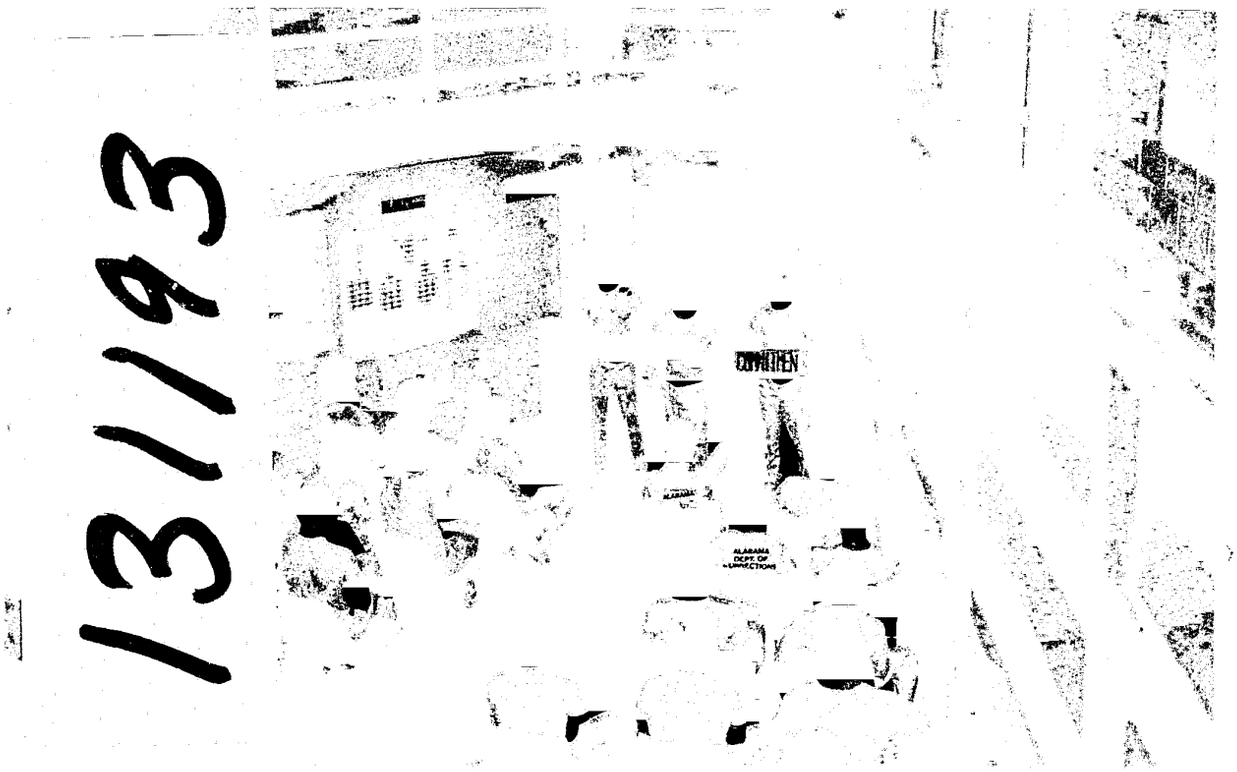

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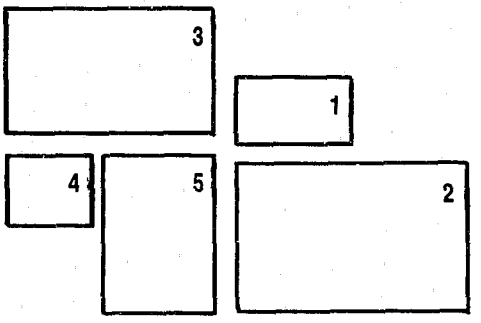

PHOTO REFERENCES

1. Crack cocaine. Photo courtesy of John J. Boyle, U.S. Department of Justice, Drug Enforcement Administration.
2. Therapeutic community at St. Clair Correctional Facility (maximum security), Springville, Alabama. Photo courtesy of John H. Hale, Public Information Officer, Alabama Department of Corrections.
3. Therapeutic community at St. Clair Correctional Facility (maximum security), Springville, Alabama. Photo courtesy of John H. Hale, Public Information Officer, Alabama Department of Corrections.
4. Drug testing equipment. Photo courtesy of John H. Hale, Public Information Officer, Alabama Department of Corrections.
5. Inmates in a substance abuse class at Florida Correctional Institution, Lowell, Florida. Photo courtesy of Paula Tully, Information Specialist, Florida Department of Corrections.

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INTRODUCTION

Prison populations have grown 55 percent over the last eight years, leading not only to overcrowding, but also to a major influx of drug abusing offenders. More than 605,000 adults are in state or federal correctional facilities. Many of these prisoners committed their crimes while abusing drugs.

- It has been estimated that 62 percent of the total prison population used drugs regularly prior to their arrest.
- Twenty-seven percent of the total population had used drugs daily;
- Twenty-two percent were under the influence of a drug at the time of their offense. (See Figure 1.) [1, p.1] [2, p. 50-51]
- National Institute of Justice's Drug Use Forecasting Program (see Figure 2) tested 80 percent of all male arrestees in 10 major cities during 1987 and early 1988 and revealed the following:
  - —In all 10 cities 55 percent or more of the arrestees tested positive for one or more of 10 drugs (mainly cocaine, marijuana and heroin);
  - —Between 58 percent and 82 percent or more of the arrestees in seven of the cities tested positive; and
  - —Over a six-month period, six of these cities showed an increase in drug use by arrestees of from four to 14 percent. [3, p. 8]

A relatively small number of severe substance abusers are thought to be responsible for an extraordinary amount of crime. Drug abuse has been shown to be one of the best indicators of serious criminal careers. The National Institute of Justice (NIJ) sponsored research which found that a majority of the "violent predators" among prison and jail inmates had histories of hard drug abuse, frequently in combination with alcohol and other drugs. California prison and jail inmates who were addicted to heroin, when compared to non-drug users, committed:

- 15 times as many robberies
- 20 times as many burglaries
- 10 times as many thefts [4, p. 1]

In addition, NIJ research indicates that drug use accelerates criminal behavior. For example, studies in Baltimore show addicts committed four to six times more crimes during periods of heavy drug use than when they were relatively drug-free. Similarly, research in New York City indicates that drug abusers are at least as violent, and perhaps more violent, than their non-drug-using counterparts. [5, p. 1-2]

State criminal justice systems are faced with a major influx of drug abusing offenders, many of whom are repeat offenders who receive their punishment and are released but not rehabilitated. The limited evidence available suggests that more than 60 percent of arrested heroin abusers return to heroin and/or cocaine use and crime within three months after release from detention; the great majority of these offenders never receive any drug treatment. [6, p. 18]

This report focuses on the challenges facing state legislatures as they determine policy to deal with the growing numbers of drug abusers in prison. The following strategic options for drug treatment will be explored:

- Comprehensive statewide programs for drug treatment in prisons, consisting of drug education, counseling and intensive therapies; and
- Treatment outside of prisons.

States estimate that approximately 70 to 80 percent of inmates need some level of substance abuse treatment. Even so, criminal justice agencies rarely focus on reducing drug abuse. In fact, treatment and rehabilitation generally are not used to reduce the criminal tendencies of drug-involved offenders. A Bureau of Justice Assistance (BJA) report shows states spending their grant funds from the Anti-Drug Abuse Act of 1986 for the 1987-88 fiscal year in the following manner:

- More than 64 percent to upgrade police activity;
- 16 percent to prosecute drug offenders;
- 8 percent to treat offenders; and
- Less than 5 percent to detain and rehabilitate. [5, p. 1]

Even though federal spending on drug control activities overall tripled from $1.2 billion to $3.9 billion from 1981 to 1988, spending on treatment and prevention declined from $200 million in 1982 to $126 million in 1986. [7, p. 2955]

According to Nicholas Demos, Program Manager for Corrections, with the Bureau of Justice Assistance:

> It seems axiomatic that we should treat [drug using inmates] while they're institutionalized—or recidivism occurs. The drug epidemic is to some extent driving the whole system right now. You can't run a corrections institution without dealing with addicts. Drug treatment must become an inherent part of every corrections institution from maximum security state prisons to local jails. . . The more serious the drug problem of the inmate, the deeper the level of intervention must be both in the institution and in the community. The cost for all this will be substantial, but the benefits are much greater. [8, p. 5]

The prison environment provides a controlled, monotonous, and often threatening existence for most inmates, which can go far toward motivating criminals to seek treatment—whether it is a short, two-hour session or a nine-month intensive program—provided that the treatment program is seen as an attractive alternative to their current prison existence. Prisoners may see treatment programs as providing better living conditions, a safer environment, parole release considerations, and/or an opportunity to change their lifestyle. [6, p. 7-8]

DRUG TREATMENT AND REHABILITATION: THE RECENT HISTORY

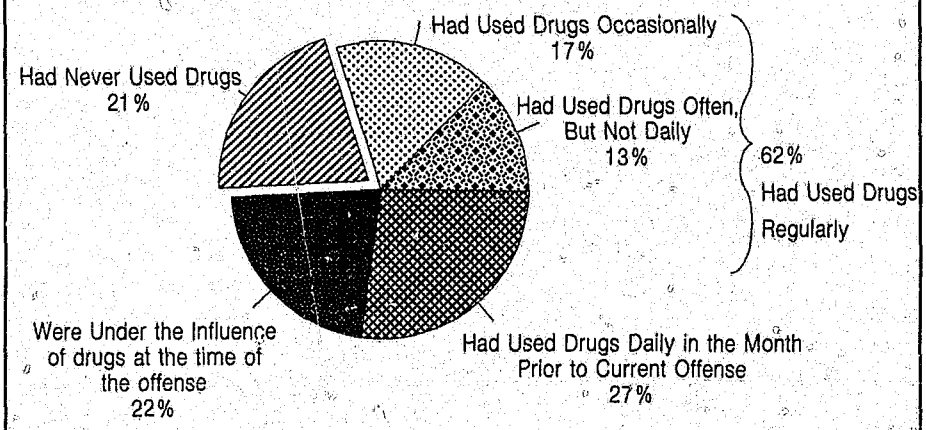
States such as Arkansas, Missouri, Oregon and New York initiated innovative drug treatment projects within prisons in the 1970s, when federal funds were plentiful and enthusiasm for rehabilitation and treatment was at a fairly high level. Treatment became a necessity in the 1970s and 1980s in states like Arkansas, for example, where samplings of new prison commitments showed that, on the average, more than 60 percent of incoming inmates admitted they had been using alcohol or drugs when they committed their crimes, and more than 80 percent of the new commitments showed psychological characteristics typical of an addictive personality. By 1979, all but five states had some form of inmate drug abuse program. [9, p. 3]

Many of the treatment concepts were originally borrowed from successful (and sometimes not so successful) alcohol treatment programs such as Alcoholics Anonymous, as well as the private therapeutic community programs such as Phoenix House in New York City. Most of these early prison drug treatment programs were modest activities, typically including some individual and group counseling, voluntary self-help groups, weekly or more frequent meetings of Alcoholics Anonymous or Narcotics Anonymous, and alcohol/drug education classes. Most of these efforts, however, did not claim significant impact on heavy users of drugs or persons with serious drug and crime histories.

Successful programs often were dependent on state funds or funds from the federal Law Enforcement Assistance Administration (LEAA). When LEAA folded and state funds shrunk in the early 1980s, and as prison and jail populations escalated, most of these innovative drug treatment efforts disappeared or were overwhelmed with sheer numbers of inmates. In California, for example, the major treatment facility at Chico State Prison became just another prison and its population eventually doubled.

With the drug explosion in the early 1980s came the enactment of the Anti-Drug Abuse Act of 1986. The Act made increased funds available to the states for drug enforcement, prevention, education, and treatment—especially correctional drug treatment. The BJA is responsible for expenditures for correctional drug treatment.

FIGURE 1.
PRE-INCARCERATION USE OF ILLEGAL DRUGS BY STATE PRISON INMATES, 1986
(Based on 1986 State Prison Population of 447,185)



Source: Bureau of Justice Statistics Profile of State Prison Inmates, 1986.

Seeking current data on what treatment options are available in correctional settings, the following organizations have attempted to survey states' programs in this area: National Criminal Justice Association, Narcotic and Drug Research, Inc., National Institute of Corrections and Abt Associates, Inc. Although their surveys are primarily in the data gathering and analysis stages and complete data has not been received from some states, a rough portrait can be sketched from their preliminary findings:

- 39 states use preliminary assessment procedures with newly sentenced inmates.
- 44 states have either Narcotics Anonymous, Cocaine Anonymous, or Alcoholics Anonymous self-help groups meeting once or twice a week.
- 44 states have some form of short term (35 to 50 hours) drug education programming.
- 31 states have individual counseling, where an inmate meets with a therapist (usually a psychiatrist or counselor) occasionally during the week.
- 36 states have group counseling, where small groups of inmates meet with a therapist occasionally during the week.
- 30 states have some type of intensive residential program, often based on the therapeutic community model (discussed below).

Even with this variety of treatment options available to inmates, in most states less than 20 percent of identified substance abusers are participating in institutional substance abuse programs, according to surveys.

OVERVIEW OF DRUG TREATMENT OPTIONS

A comprehensive corrections drug treatment strategy would be set up similarly to the diagram in Figure 3, so that all prisoners first go through testing, assessment and assignment. Afterward they can be assigned to the most appropriate option in the hierarchy. At the bottom of the hierarchy are interventions that can be employed with minimal disruption to the criminal justice apparatus. At the top of the hierarchy are the most expensive treatment options that require the greatest structural changes and which are designed for the hardest-to-treat drug abusers. These options can be combined into a comprehensive drug treatment strategy. The following is a description of these elements and how they work in current practice:

- *Assessment and Assignment*

  Assessment and assignment involves (1) the evaluation of inmates to determine the severity of substance abuse addiction as well as the inmate's readiness for treatment and ability to benefit from treatment (urine testing is often used to determine the level of abuse), and (2) assignment to one of a series of treatment options.

- *Self-Help Groups* (Narcotics Anonymous [NA] or Alcoholics Anonymous [AA])

  These peer groups provide models for a drug-free lifestyle, as well as help in maintaining the resolve to remain drug-free. They also provide a focus for drug-free social activity. Groups typically use the 12-step plan of AA and emphasize discussion of the shared problems of drug dependence, constructive ways of dealing with the powerful urge to resume use, and positive alternatives to drug dependency. After release from prison, similar community NA and AA groups provide an important aftercare link between the inmate on parole and the prison treatment program. The cost per inmate is minimal, especially if volunteers from the community serve as group leaders. Many experts in the field believe that these groups are successful with abusers who are usually first-time offenders or offenders in their late 20s who have a serious desire to change.

- *Drug Education and Information*

  This option provides information about drugs and their effects. Often-used modes of instruction include literature, discussion groups and films. Such programs assume that knowledge about drugs will deter drug use, impede the escalation of drug misuse, and enable clients to make well-informed, rational choices. Drug education programs often offer inmates an opportunity to examine and clarify their values and attitudes and to learn problem-solving and decision-making skills. The emphasis is on providing individuals with a good understanding of themselves so that they will be able to deal with the various concepts presented in the course. Most of these programs are short-term, lasting from 35 to 50 hours. These programs work best when combined with self-help groups or other treatment. The costs per inmate are low. The main expense is for materials and instructors' salaries. As with self-help groups, research has shown that education programs work best with first-time offenders or offenders in their late 20s who have a serious desire to change.

- *Counseling*

  Individual and group counseling are used to explore problems, feelings, attitudes and behaviors. The setting can be informal and relaxed with inmates being encouraged to "drop in" to a counselor's office whenever they wish, or it can be more structured group therapy. The one-to-one interviews are usually with a professionally trained psychologist, counselor or social worker. The ultimate goal is to improve the inmate's self-image and his or her ability to function, usually within a period of less than a year.

  Group counseling usually has eight to 10 members meeting one to two days a week with a trained professional. High expectations of involvement and participation exist, and intense personal problems are the main concern. Material for discussion is offered voluntarily by the inmates; the environment is generally supportive and non-confrontational. Costs are moderate based mainly on professional salary expenses and length of time in treatment. Because of the higher degree of intensity, the greater amount of time involved in the therapeutic process, and the more highly trained professional staff, most experts see that these groups are likely to be more effective in helping the recidivist drug abusers than are either the self-help or education options.

- *Comprehensive Drug Treatment*

  Commonly called milieu therapy, this program is a mixture of the earlier drug education and counseling for inmates who have been identified as having a serious substance abuse problem. Participation is voluntary although inmates are strongly encouraged to get involved. The objectives of this treatment option are as follows:

  —Achieve abstinence from psychoactive substances.

  —Achieve psychological improvement, since there is a significantly greater likelihood of remaining in treatment with early gains.

  —Achieve improved social adjustment, such as defined employment interests or educational interests.

  —Continue linkage with other treatment or self-help programs to establish aftercare.

  These objectives are met largely by removing inmates from the social environment of the main prison and placing them in a separate drug-free living area with others who also are trying to give up drug use. Supportive individual therapy, peer interaction and mildly confrontational group sessions are essentials in the program. Costs can be higher than other options because of the ratio of professionals to inmates (1:8 usually) plus the added expenses of maintaining a separate unit. Success rates will be higher mainly because of the longer time in treatment, the more intensive treat-

ment, the small inmate to counselor ratio, and the frequent employment of ex-addict offenders as counselors and role models.

- *Intensive Therapeutic Community (TC)*

  This more intensive treatment option is a longer program (usually nine to 12 months) that provides a blend of confrontation and support that enables residents to undergo the arduous changes necessary for successful rehabilitation. The program is intended for the most difficult group of drug abusing offenders—those who have extensive prior involvement in crime, substance abuse, and drug treatment. These chronic offenders have been through other treatment options, and nothing has worked. They are the "hard-core" that need the TC's intensity, isolation, lengthy duration, and continual aftercare. They are the ones that reappear in the worst statistical profiles and continually reappear in prison. The intensive TC program incorporates most of the treatment options mentioned above and will be analyzed in more detail later in this paper.

COMPREHENSIVE STATEWIDE STRATEGIES

Clearly, there are a number of different drug treatment program options. One of the major objectives of the BJA is to get all states to develop comprehensive statewide strategies to include all or most of these options. One of these efforts is BJA's Comprehensive State Department of Corrections Treatment Strategy for Drug Abuse. This program is being administered by NDRI and is called Project REFORM. (See Resources) Currently there are 11 states involved: Alabama, Connecticut, Delaware, Florida, Hawaii, New Mexico, New York, Oregon, New Jersey, Washington and, most recently, California. In these states, a number of drug treatment options are available to inmates. Having such options available has several advantages:

- Costs are kept down; for example an inmate needing basic drug education and self-help is not put into a more expensive program just because there are no other options available.
- Inmates with short sentences, who normally would be out the door before more complex treatment was completed, can at least have access to short-term education and self-help groups before release.
- Inmates who drop out of, or cannot fit into, one option have other options to try, instead of nothing at all.
- Inmates who need more intensive treatment can be referred from one treatment level to the next more intense level, providing continuity of care.

Florida's Substance Abuse Program can serve as an example of the implementation of a statewide comprehensive strategy. It consists of four tiers of options and was developed between 1985 and 1987 in meetings of Florida's Substance Abuse Policy Advisory Council and later the Crime Prevention and Law Enforcement Study Commission. These meetings involved representatives from the Department of Corrections, the governor's office, and legislative leaders from the Corrections Committee.

This group focused on the size and complexity of Florida's drug problem. This year more than 38,000 offenders will be sentenced to Florida's prisons with approximately 53 percent having drug problems, according to self-reports. The group examined assumptions underlying services as they existed in the state, and the need for continuity of care in program design. Participation in BJA's Project REFORM helped establish the credibility of efforts aimed at expanding correctional drug treatment. The Florida Legislature responded to drug programming needs by expanding the correctional treatment budget for fiscal year 1988-89, allocating an additional $1.5 million to fund 60 substance abuse counseling positions and assist with outside contractors' services. [10, p. 5] Florida's program includes the following elements:

- *Assessment Procedure*

  Inmates are evaluated at all reception locations to determine the degree of substance abuse addiction as well as readiness for treatment. As part of classification, inmates are assigned to a prison with the appropriate treatment available.
- *Tier I: Drug Education*

  This is a 40-hour program specifically designed to address the needs of offenders who either do not have a severe substance abuse history; are believed to have a severe problem but deny it and therefore are not considered ready for treatment; or, because of a very short sentence, will not have the opportunity to go through a longer term program. The program provides drug information and education, and an introduction to group counseling techniques. Participants are encouraged to follow up with continued group counseling in Alcoholics Anonymous, Narcotics Anonymous or other support groups, and referral, as appropriate, to a more intensive level of treatment.
- *Tier II: Modified Therapeutic Community*

  This is an intensive eight-week residential modified therapeutic community program housed within a correctional institution, but isolated from the greater

institutional population. It is designed for inmates with serious substance abuse problems who will not be in the correctional system long enough to participate in a more extensive program. It provides frequent individual and group counseling with continuous intervention. The program also serves as a referral mechanism to other levels of treatment, such as long-term follow-up treatment, referral to Tier III, or referral to a community-based program.

- *Tier III: Therapeutic Community*

  This is a full-service residential therapeutic community program in which offenders are enrolled for nine to 12 months. It is modeled after New York's "Stay 'n Out" program described later in this paper.

- *Tier IV: Community Aftercare*

  This program provides counseling services to inmates assigned to community correctional centers. It provides 10 weeks of outpatient/aftercare treatment, stressing relapse prevention and supportive therapy. The program focuses on preparing participants to re-enter the community through group, individual, and family counseling sessions. A major program emphasis is on developing and cementing connections with community-based drug treatment programs, self-help support groups, and other aftercare.

- *Drug Abuse Treatment Resource Center*

  The center is responsible for producing and distributing materials on substance abuse for counseling staff and for inmate use. A newsletter provides for information exchange and listings of new films, tapes, and publications, thus creating a network for best use of resources. [11, p. 4-6]

THERAPEUTIC COMMUNITIES (TC)

As the Florida program demonstrates, the TC option can be an integral part of any comprehensive strategy. The traditional TC provides a residential setting for drug abusers, criminal offenders and the socially dislocated. Its basic goal is to offer a complete change in lifestyle to include:

- Drug abstinence;
- Elimination of antisocial behavior;
- Development of employment skills; and
- Development of positive attitudes, values and behaviors. [12, p. 825)

The TC model assumes that for successful rehabiiitation to take place, a "community" must be developed where socially acceptable behaviors will be learned to replace the deviant criminal behavior. The TC's main elements are:

- Self-help through sequenced stages of learning and gradual assumption of responsibility, characterized as stages of growing up or maturation;
- A self-help network which acts as a new community of peers to replace the old gangs and anti-social peers;
- Prescribed rewards and punishments which seek to reinforce socially acceptable behaviors;
- Individual commitment to the community, whereby members accept the idea that their individual problems are primarily in relation to others;
- Role modeling accomplished through the TC's primary staff, both clinical and custodial, who might include ex-offenders or ex-drug addicts successfully rehabilitated in therapeutic community programs.
- Linkages with external support agencies, both for aftercare treatment and employment, to provide continuity of care for the released individual. [12, p. 841]

Therapeutic Communities Incorporated in State Corrections Systems

State corrections systems are looking at ways to effectively incorporate the therapeutic community. Oregon and New York have adapted TC models to fit their needs.

Oregon's Cornerstone Program

Begun in 1976 on the grounds of Oregon State Hospital, Cornerstone is a pre-release residential treatment program for chemically dependent recidivists. It is an intensive, 32-bed residential program with a six-month follow-up aftercare program. Clients are referred from the three state prisons. To be eligible for the program, inmates must have a history of alcohol or drug abuse; they cannot have psychotic or sex offense histories; they must be willing to make a commitment for at least six month's community follow-up after release from the residential part of program; they must have six to 12 months left before parole date; and they must have minimum security status. Jointly administered by the state mental health and corrections divisions, Cornerstone consists of:

- By design, therapeutic communities have clearly understood rules and consequences, formal participation by residents in the daily operation of the community, strong community support for growth and change, individual responsibility for one's own behavior, and a clear system for earning freedom a little at a time. The concept also includes family organization in which members are accountable to each other for their actions and behaviors, and the group is used in problem-solving and planned activities. There also is peer confrontation, self-examination and support for desirable behaviors.
- Emphasis on practicing appropriate behaviors, not on punishment.
- Drug testing every three days and random breath tests.
- Self-governing through the "resident

council" (to learn skills of negotiation with peers and authority).

- Responsibility for development of one's own treatment contract which is reviewed and challenged by peers.
- Counseling interventions including group therapy, community support groups (AA, NA) are part of treatment.
- Basic skills training to help offenders develop life survival skills, leisure and work skills.
- Discharge and six-month follow-up requires individuals to have a job, a residence, a drug free support network, and attend weekly group sessions at Cornerstone.

In a three-year follow-up study of Cornerstone graduates, more than 70 percent had not returned to prison, and more than 54 percent had not been convicted of any crime, including minor violations with fines. [13, p. 50-54]

New York's "Stay 'n Out" Therapeutic Community

The Stay 'n Out programs at Arthur Kill Correctional Facility for men on Staten Island and at the Bayview Correctional Facility for women in Manhattan were begun as a joint effort of the New York State Division of Substance Abuse Services (DSAS), the New York Therapeutic Communities (NYTC), the New York Department of Correctional Services (DOCS), and the New York State Division of Parole. Currently, NYTC, a private agency under contract with DOCS, operates the programs and DOCS supplies funding.

Currently, there are three treatment units for male inmates in Arthur Kill with 35 beds per unit, and one treatment unit with 40 beds for women inmates at Bayview. Each unit is staffed by a unit director and two to three counselors, including both professionals and paraprofessionals; the counselor to prisoner ratio is roughly 1:8. Inmates selected for the programs are recruited at the state correctional facilities. Participants must be at least 18 years old, have a history of drug abuse, evidence of positive institutional participation, and no history of sex crimes or mental illness. Established in 1976, Stay 'n Out consists of the following:

- Program components: an isolated unit, separated from the general prison population, to establish psychological and physical safety; the use of ex-offenders and ex-addicts as staff for role models; a hierarchical structure where clients are given progressively higher-level positions and increased status through proven work and involvement; confrontation and support groups; individual counseling; community and relationship training; program rules and penalties with opportunities to learn from misbehavior; development of pro-social values of honesty, responsibility, and accountability; continuity of care through networking with community TCs.
- Administrative components: a contract arrangement with a private agency, having administrative offices outside the prison.

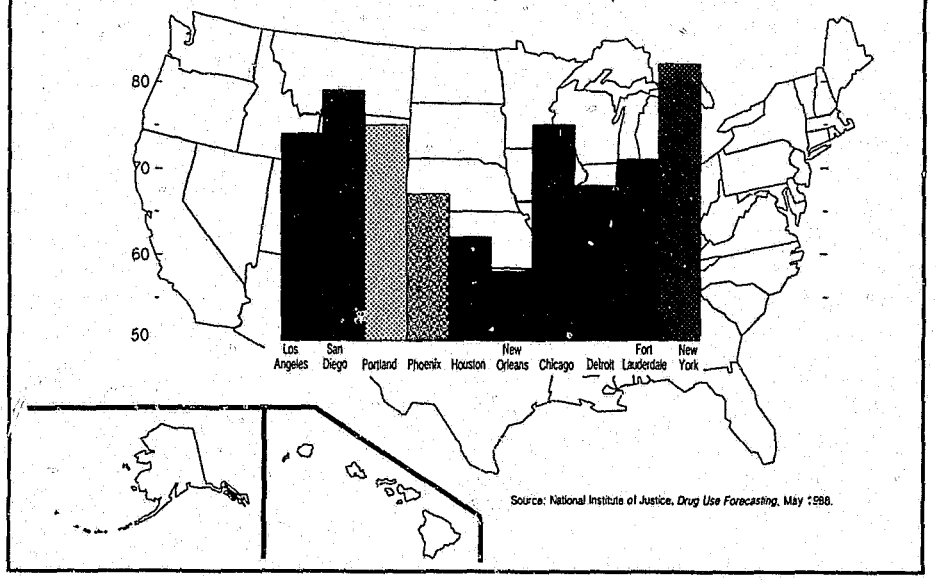
According to NDRI, the average cost per inmate treated in this TC is roughly $4,500 a year more than basic inmate imprisonment costs.

The DSAS Bureau of Research and Evaluation was initially responsible for monitoring the project. A large scale evaluation of the program has recently been completed by Harry Wexler of NDRI; it is one of the few such programs to be so extensively evaluated. The study shows a positive correlation between participating in Stay 'n Out for nine to 12 months and successful completion of parole without rule violations. Seventy-seven percent of the 1,626 men studied successfuly completed parole as did 92 percent of the women who spent nine to 12 months in the program. [14, p. 7] Furthermore, the odds of recidivism for clients who remained in treatment for the optimal duration of nine to 12 months was nearly three times less than for clients who spent less time in treatment. [15, p. 4]

Policy Issues Regarding Prison Drug Treatment Programs

Addiction specialists agree that if programs are to be valuable, they must be well conceived and based upon substantial consultation, founded in the scientific literature, rooted in organizational concern for the abuser, and woven into the very fabric of the organization's daily operation. With this in mind, when considering implementing a treatment approach, state legislators need to consider a number of policy issues:

FIGURE 2.
PERCENTAGE OF MALE ARRESTEES TESTING POSITIVE FOR ANY DRUG, INCLUDING MARIJUANA
(Results from January-March, 1988)



Source: National Institute of Justice, *Drug Use Forecasting*, May 1988.

(1) "Coddling" of prisoners. With the extra support given to inmates in a TC program, including separate facilities, an increasing role in daily decision-making, and chances to earn social status not available to most inmates, the first-time observer may cry prisoner "coddling." However, TC inmates are:

- Subject to a disciplined routine and held accountable in a manner unknown in most prisons (outside of the recent "boot camp" units for young offenders);
- Required to perform the same types of prison jobs as before;
- Required to wear the same uniforms, sleep in the same type beds and eat the same food as the rest of the prisoners; and
- Rigorously evaluated by their peers and counselors and disciplined by being returned to regular prison units for major infractions of TC rules.

(2) Costs and Benefits. Estimated costs per inmate per year for a prison TC average $3,000 to 4,000 beyond the basic prisoner maintenance costs. But this money could be considered an investment in the overall well-being of the institution. Warden Larry Burton at Alabama's maximum security St. Clair Penitentiary sees the TC contributing to prison management because it:

- Reduces tension;
- Reduces violence among inmates and toward officers; and
- Sets standards of behavior for the entire inmate population.

Burton notes that the TC is "the cleanest, quietest, most manageable unit I have. The attitude of inmates is 100 percent better than the rest of the inmate population." [16, p. 6]

The TC is intended for hard-core drug and alcohol abusers who commit a substantial amount of crime, and for whom other less expensive and less intense treatment options have not worked. Targeting these offenders while they are in prison is cost effective because it can reduce the immense social and legal costs put on the system if these criminals are recycled without treatment.

TC programs require a higher level of professional staff, and thus higher salaries, plus the need for some additional equipment. However, recruitment and retraining costs are cut because staff remain on the job longer. Burnout for regular custodial staff is around 24 months, but TC staff remain long after 60 months. [17, p. 160]

(3) Prison Security. Research conducted by Narcotic and Drug Research, Inc., on institutional environments indicates that treatment programs create an atmosphere of safety. Rule infractions, violence and threats of violence decline. [15, p. 152] These programs are usually instituted in minimum to medium security prisons, and as such are governed by the rules and regulations established for those security levels. Prisoners who volunteer for these programs must be classified as having no violent criminal background and having no sex offenses. When a TC is established in a prison unit, it must accommodate itself to the existing security requirements, including numbers of officers, locking requirements, inspections and curfews. In fact, prison safety and security may be enhanced when a TC unit is developed. According to one Pennsylvania corrections official, "Not only do the programs have a direct effect on rehabilitation, but they also have a direct effect upon the climate of the facility, the morale of staff and inmates, the humaneness of incarceration, and the safety of our facilities." [18, p. 30]

(4) Program Effectiveness. The effectiveness of most of these programs is difficult to determine because of their relatively recent application to the prison setting. In place for more than 10 years, the Stay 'n Out TC has some proof of success: in a one year follow-up study of more than 400 released TC inmates, almost 80 percent showed no parole revocations. [14, p. 7] This is significant because the first six months following release from incarceration seem to be the most critical time in determining success or failure to adjust to free society. [13, p. 52] In a similar follow-up on TC inmates released from the Cornerstone program in Oregon, 71 percent had remained out of prison after three years, and 54 percent had avoided any crime (including minor violations). [13, p. 50-51] These programs have kept between 50 percent to 80 percent of convicted criminals out of the revolving door.

(5) Selection of Inmates. Although the initial volunteers for the typical prison TC may not fit the profile of the average inmate, the program attracts a more diverse group of participants the longer it is in place. As more TC graduates are hired as program staff, and as more prisoners see these graduates leading productive "straight" lives, having status, and receiving a salary, average prison inmates want to participate. Importantly, the Stay 'n Out study showed that success rates hold for almost 80 percent of the participants, both the "cream" of the prisoner crop who were the first to enter the program, as well as the later "average" prisoners who enter the program later.

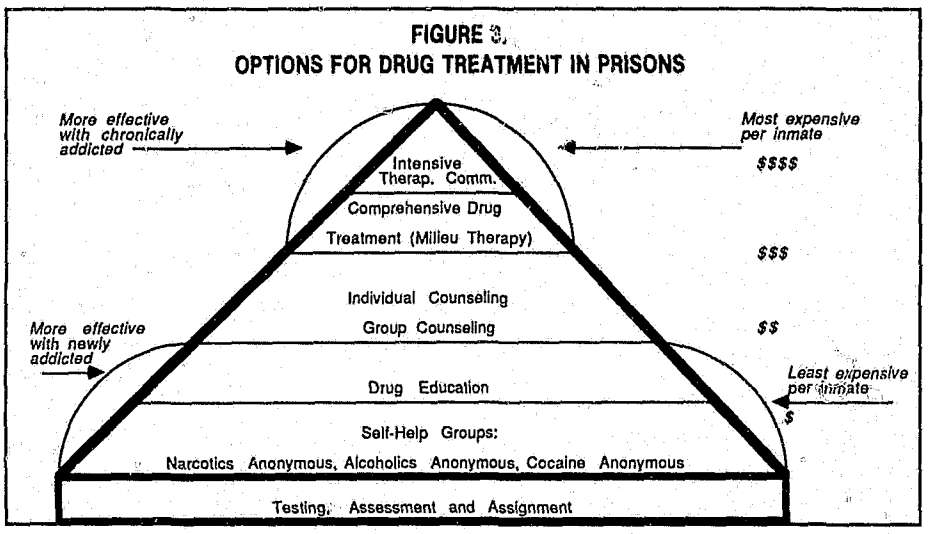
NON-PRISON TREATMENTS

Continuing to incarcerate people convicted of drug related offenses threatens to overwhelm the system. In contrast, placing drug abusing misdemeanants (such as user-dealers convicted of low-level street sales or drug possession) in treatment while under community supervision is considerably less expensive than incarceration. This more than offsets the costs of both treatment and field supervision in terms of money saved in crimes not committed. [6, p. 9] Three promising options are:

Intensive Supervision Probation and Parole (ISP).

Under this program, non-violent offenders are confined to their homes for periods that may be the equivalent of prison sentences. The program includes careful monitoring of their location as well as periodic drug and alcohol testing, counseling and appropriate training.

FIGURE 3.
OPTIONS FOR DRUG TREATMENT IN PRISONS



Costs have been figured at one-half that of imprisonment, while still satisfying the objectives of punishment, public safety, and treatment. A study by the National Council on Crime and Delinquency showed that drug offenders did better under ISP than under regular probation supervision, suggesting that the frequent contacts during evenings and weekends and the urinalysis monitoring may be particularly effective in supervising this type of offender. [19, p. 6] Demonstration projects are currently being established in California, Georgia, Iowa, New Mexico, Virginia and Washington.

- Intermittent sentencing (weekend or evening incarceration)

  Offenders spend part of their time in prison and part of it in the community. The individual achieves release status more quickly by providing drug-free urine samples, routinely attending and participating in treatment sessions, reimbursing victims, and providing evidence of positive behavior. [6, p. 13]

- TASC (Treatment Alternatives to Street Crime).

  Many non-violent offenders are referred by the courts to residential drug treatment, often because of negotiated pleas whereby the offender agrees to enter treatment instead of receiving a prison sentence. TASC provides a bridge between the justice system and the treatment community. Begun in Illinois in the late 1970s, TASC is a comprehensive case management system operating in many cities that works with law enforcement, court and corrections officials to identify and assess the substance abusing offenders entering the criminal justice system. TASC has developed a mechanism for screening both pretrial detainees and post-trial offenders to determine the seriousness of their drug dependence and the likelihood of success if offered appropriate treatment. Twenty-four states have established statewide TASC programs that can reduce the burden placed on the criminal justice and corrections systems. [6 p.8]

CONCLUSION

Research indicates that serious drug and alcohol abusers constitute a large and growing proportion of the criminal justice population; that they are responsible for a considerable proportion of the crime in American cities; and that their involvement in criminal activities is highly correlated with drug use. A noticeable reduction in their drug use and criminality can occur with an alliance between the criminal justice system and treatment agencies, including AA and NA, self-help groups, counseling, and therapeutic community programs.

Chief Justice Warren Burger sums up the issue by pointing out, "We must accept the reality that to confine offenders behind walls without trying to change them is an expensive folly with short-term benefits—a winning of battles while losing the war." The American Correctional Association points out that more than 95 percent of drug and alcohol offenders will be discharged, most without receiving any treatment. Thus, the immediate need for effective treatment and rehabilitation programs is even more pressing.

RESOURCES

The Comprehensive State Department of Corrections Treatment Strategy for Drug Abuse, called Project REFORM, is a national effort administered by the federal Bureau of Justice Assistance. It was begun in 1987 to assist state departments of corrections in developing comprehensive institutional drug treatment and related rehabilitation programs. The strategy is to use the latest research and the best current models of drug treatment in prison. Narcotic and Drug Research, Inc. (NDRI) in New York, is responsible for providing technical assistance and training for Project REFORM. NDRI is a non-profit drug research and technical assistance agency, formerly associated with the Division of Substance Abuse Services in New York, specializing in drug research, training, and outreach.

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Selected programs that have received technical assistance and planning and implementation grants from the Bureau of Justice Assistance under the Comprehensive State Department of Corrections Treatment Strategy for Drug Abuse:

Alabama's Department of Corrections opened a 50-bed inpatient treatment program for repeat offenders, a 48-bed therapeutic community and prerelease program. Structured self-help programs are to be implemented at institutions.

Connecticut opened a 150-bed therapeutic community at the Fairfield Hills facility and has strengthened Project FIRE, an inmate re-entry program. State funds have supplemented BJA dollars to run the Addiction Services Division of the Department of Corrections. Included were funds to continue operation of halfway houses for released drug and alcohol dependent offenders.

Delaware now operates "The Key," a special learning center/therapeutic community, at its Multi-Purpose Criminal Justice Facility. The program has 20 male volunteer participants. A less intensive program for longer-term inmates also is planned and will be connected to an extensive community corrections component.

The **Florida** Department of Corrections operates the four-tier treatment program described earlier in this document. The comprehensive effort is supported with state as well as federal funds. The Florida Alcohol and Drug Abuse Association provides contractual services for drug education, treatment and aftercare, and a Drug Treatment Resource Center has been established.

New Mexico is establishing a therapeutic community at the Albuquerque Penitentiary, and modified TCs are being developed in other prisons. The New Mexico Substance Abuse Project and the University of New Mexico Hospital's Drug/Alcohol Treatment Program are involved with the project.

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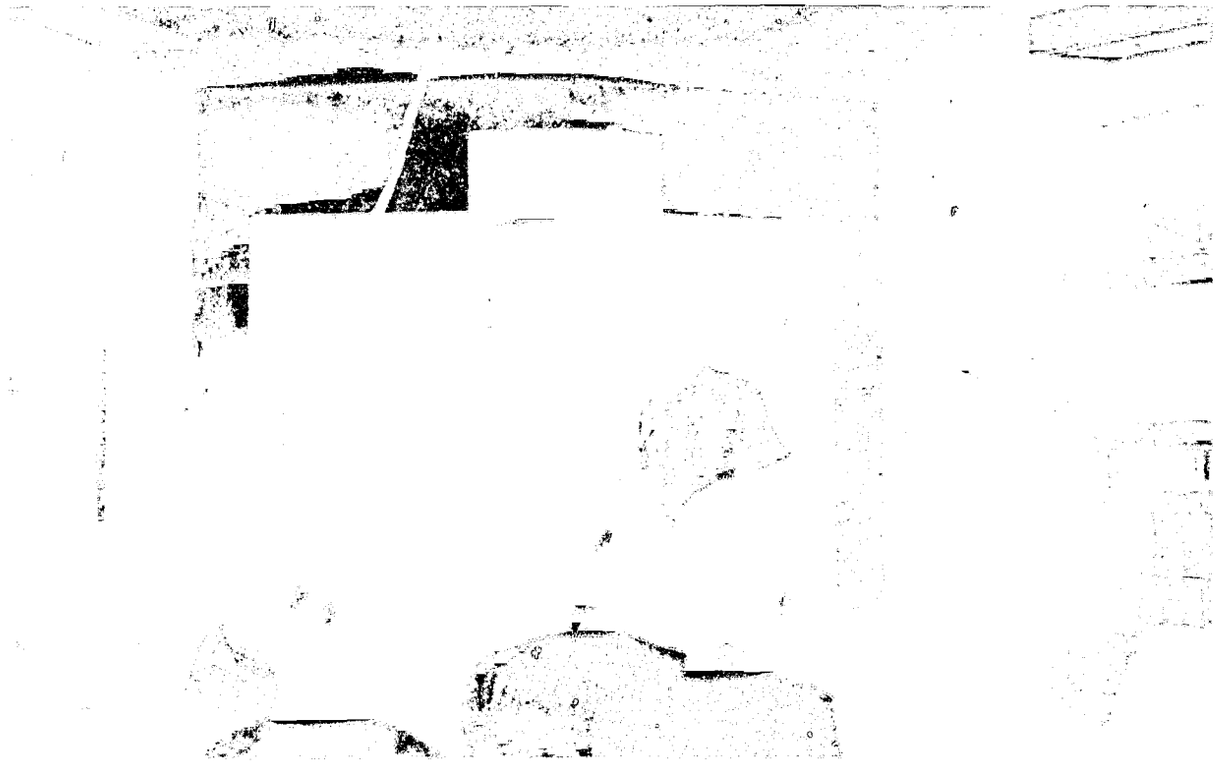

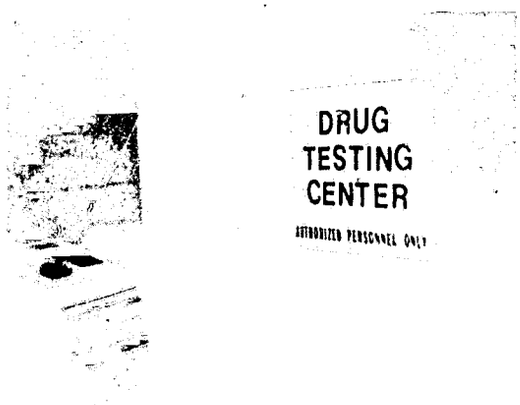
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