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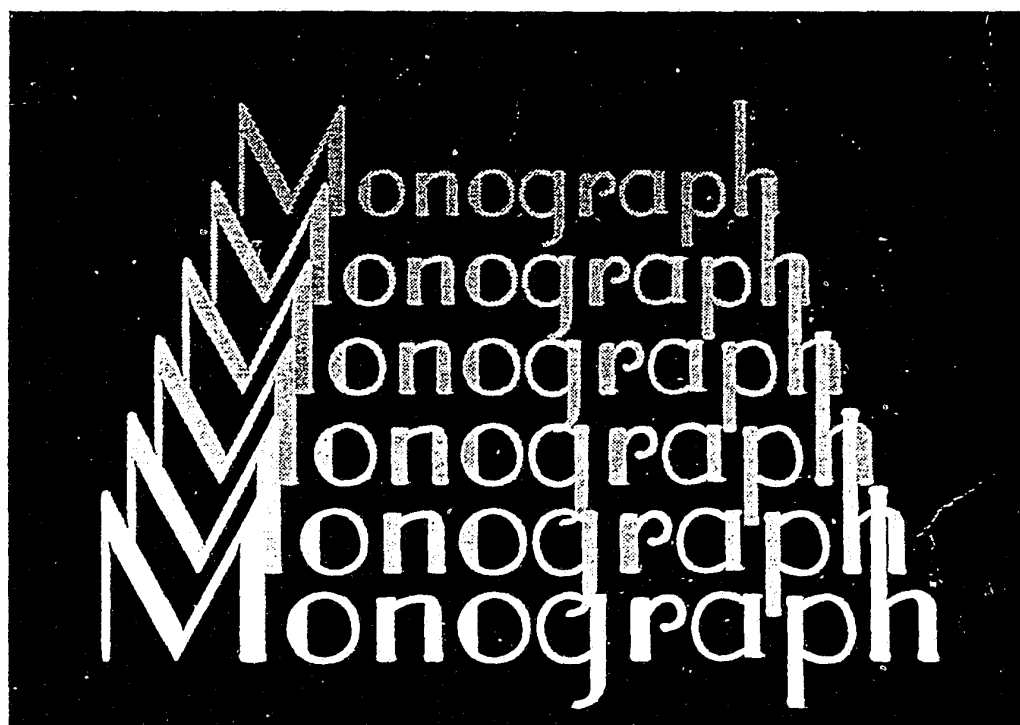
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Design and Implementation Issues For Drug Treatment in the Jail Setting



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Design and Implementation Issues for Drug Treatment in the Jail Setting

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A Monograph to be published
by the Bureau of Justice Assistance

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I. Introduction

The Problem

Until recently, drug abuse treatment in local corrections has been virtually ignored as an area of concern. This should not be surprising, since drug treatment did not receive significant federal support until President Nixon declared a "war on drugs" in 1971. Subsequently, the National Institute of Drug Abuse (NIDA) was founded in 1974, there was increased focus on the connection between street crime and heroin addiction, and institutionalization of public drug abuse treatment was expanded. The penetration of drug treatment programming into the country's offender population was limited, however. The programs that were started in the 1970s for drug offenders were primarily found in state prison systems, with very few at the county level. Services that were offered in county jails typically took the form of AA groups or educational materials for those who requested them. Certainly, comprehensive drug treatment services for jail-based offenders before 1980 were virtually non-existent.

Then, as federal and state legislatures began to pass new "get tough on drugs" legislation that required stiffer sentencing for the sale and possession of drugs, and groups like Mothers Against Drunk Drivers (MADD) were able to influence legislation for stiffer sentences for the drinking driver, the jails and prisons began to fill. Currently, jails and prisons across the country are in a state of crisis due to overcrowding from increasing numbers of individuals arrested and convicted for drug-related offenses. This has placed a great strain on the resources of our prisons and jails, and has led to overcrowding in almost every jurisdiction in the United States and its territories. In California, for example, the state prison population is projected to increase by 700% between the years 1980 and 1996. Nationally, the prison population has increased by almost 134% in the past decade. States are finding it impossible to build new facilities to handle the increases. By 1995, California will have committed and spent over 3.9 billion dollars on state prison construction and will still house 232% more prisoners than is appropriate.

The extent of crowding in the nation's jails is difficult to determine precisely because there is no uniform measure for defining capacity. Capacity is often measured by the architectural design capacity of the institution. However, it could just as easily be measured as the number of inmates that can be accommodated based on a facility's staff, existing programs, and services. Or the facility may have a rated capacity given it by a rating official within the jurisdiction. But by any measure, jail administrators acknowledge that jail crowding presents an ever-present crisis.

Federal and state officials have long concluded that there is "overwhelming evidence" linking drug use to criminal activity. As levels of illicit drug use (especially cocaine and heroin) increase, there is a parallel increase in the numbers of both drug distribution offenses and non-drug-related serious offenses (Wish and Johnson, 1986). The Profile of Jail Inmates: 1989 reported that 40% of the 1983-to-1989 rise in the jail population resulted from increases in the number of jail inmates accused or convicted of drug offenses. One would speculate that the percentage would be much higher if **drug-related** offenses (such as crimes committed while under the influence of drugs, etc.) were included along with the actual drug offenses. A recent study of state and federal prisoners (Frohling, 1989) indicated that 62% used drugs on a regular basis prior to incarceration. Current data from the National Institute of Corrections Information Center suggest that about 80% of the nation's correctional population is composed of substance abusers. Drug Use Forecasting program information (DUF; National Institute of Justice, 1990) indicates that as many as 80% of male arrestees, and up to 88% of female arrestees, test positive for drug abuse in metropolitan areas, although the most recent DUF figures (April 1991) indicate a downward trend in metropolitan DUF cities. Drug use clearly increases the likelihood for involvement in criminal activities. The NIC Information Center reports that over half of all crimes are committed by persons under the influence of drugs and alcohol. Information from the District of Columbia indicates that 80% of homicides investigated in 1988 were related to drug use (National Association of State Alcohol and Drug Abuse Directors, 1990).

Given the unprecedented jail and prison population pressures, and rising costs to create new capacity for offenders (up to \$100,000 per bed), jurisdictions are faced with the dilemma of either building new facilities or releasing drug-involved offenders to the community. While incarceration may remove offenders from the community for short or intermediate lengths of time, it is of no benefit if it does not reduce the likelihood of a return to drug use and crime. Drug treatment for offenders may not answer all the problems of overcrowding, but it is an important alternative to simply warehousing drug-involved offenders within the criminal justice system.¹

Treatment Works

Drug treatment provides an effective vehicle for preventing offenders from returning to chronic patterns of drug abuse and crime. However, early reports of program outcomes did not meet initial expectations (Lipton *et al.*, 1975) and some evaluators concluded that correctional drug treatment did not work. As the "nothing works" philosophy of drug

treatment began to circulate and as federal funding sources dried up, state correctional systems chose to divert more resources to other areas, and many drug treatment programs were significantly reduced or canceled. More recent studies of treatment efficacy have suggested that drug treatment does indeed work if it is implemented properly. For example, results from the Drug Abuse Reporting Program (DARP; Simpson, Joe, and Bracy, 1982; NASADAD, 1990) indicated that arrest rates for individuals receiving drug treatment decreased by an average of 74%, and that 63% of the sample remained abstinent for a period of at least three years.

The evaluation findings from the National Model Demonstration: In-Jail Drug Treatment Program: Final Report (1991) prepared by Peters *et al.*, indicated that offenders treated in the Hillsborough County (Florida) Substance Abuse Program spent a significantly longer period of time in the community until rearrest, in comparison to untreated offenders. Treated offenders had a mean elapsed duration of 221 days prior to rearrest, in comparison to a mean duration of only 180 days for untreated offenders, and were arrested less frequently (mean = 1.1 arrests) during the one-year follow-up, in comparison to the untreated group (mean = 1.5 arrests). Finally, the treatment group served significantly fewer days in jail during the one-year follow-up (mean = 32.2) in comparison to offenders in the control group (mean = 44.9).

Other longitudinal studies of specific correctional drug treatment programs demonstrate the efficacy of these approaches with drug-involved offenders. Follow-ups on participants who completed the Cornerstone Program (Oregon) indicated that only 26% returned to prison, as compared to 85% of inmates who returned to prison who had completed fewer than 60 days in the program (Field, in press). Only 6% of offenders enrolled in the Drug Abuse Treatment Unit in Wisconsin returned to state prison, compared to 33% of untreated inmates (Willoughby, 1990). Results from the Stay 'n Out Program (Wexler, Falkin, and Lipton, 1990) indicate that only 20% of offenders completing the intensive residential program received a parole violation during follow-up; in contrast, 50% of inmates who did not complete treatment violated parole.

In addition, results from the Treatment Outcome Perspective Study (TOPS; Hubbard *et al.*, 1989) provide clear evidence that involvement of the criminal justice system helps to retain individuals in treatment while in the community, and that involvement by offenders in TASC programs (Treatment Alternatives to Street Crime) can extend time in community treatment by six to seven weeks. The TOPS study demonstrates that reductions in recidivism due to drug treatment of offenders result in significant crime-related cost

savings. Predatory crime was reduced substantially across all modalities of treatment in the study, as measured during a follow-up of three to five years.

Availability of Drug Treatment

There is considerable evidence that the demand for correctional drug treatment programs exceeds the number of program slots currently available. Much of this evidence is based on self-report information gathered from jail and prison inmates. Despite evidence that enrollment in state correctional drug treatment programs is increasing (Chaiken, 1989), only 30% of prison inmates report prior involvement in substance abuse treatment (U.S. Department of Justice, 1986). Recent evidence indicates that only 11% of jail inmates referred for drug treatment reported past involvement in alcohol treatment, and only 31% received prior drug treatment (Peters and Dolente, 1989). The absence of in-jail drug treatment programs presents a significant problem, particularly for the large number of drug-involved inmates who have a history of repeated contact with juvenile detention facilities (Chaiken, 1989), and who are likely to commit numerous offenses for each year they are free in the community and are using drugs.

In addition to evidence of significant drug abuse among offenders, the need for drug treatment in jails and prisons is underscored by several other differences between this population and those already receiving treatment services in the community. The TOPS study indicated that in comparison to others examined, drug-involved offenders were younger, male, and were less likely to have participated in prior treatment (Hubbard *et al.*, 1989). Among jail inmates, fewer than a third of those referred for treatment have received treatment in the past (Peters and May, in press). The majority of this group is indigent or without private insurance to cover the cost of drug treatment. They face serious environmental risk factors upon their release from prison and jail such as lack of employment, housing, poor reading and employment skills, estrangement from spouse and family members, and exposure to multiple cues for drug use associated with inner-city neighborhoods and housing projects. Drug treatment offers an opportunity to reduce the high rate of recidivism among this population, and to slow their revolving-door cycle through the criminal justice system. Because only a small number of drug-involved felony offenders are convicted and sent to state prison, the absence of in-jail treatment programs, or linkage to community treatment agencies following release from jail, means that the vast majority of serious drug abusers will return to the streets without gaining the skills to prevent a relapse into drug use. With multiple untreated problems associated

with drug dependency, these individuals are extremely likely to reoffend and to return to jails and prisons (Wexler, Lipton, and Johnson, 1988).

Overview of Current Issues

The passage of the Anti-Drug Abuse Act of 1986 saw a renewed interest in correctional drug treatment and new revenues to fund programs. In the fall of 1987 the Bureau of Justice Assistance (BJA) awarded a grant to the American Jail Association entitled "Drug Treatment in the Jail Setting: National Demonstration Program." Model jail-based drug treatment programs were developed at demonstration sites in several metropolitan jails. Much of what is known specifically about jail-based drug treatment has come from these first experimental programs and the many jail-based programs that have followed.

The following chapters of the monograph will discuss issues in the design and implementation of drug treatment programs in the jail setting. This discussion will be based on the collective experience of treatment and corrections personnel and consultants who worked closely with the national demonstration sites. The approach will aim at the kinds of practical considerations that a Sheriff, a Jail Programs Officer, a county administrator, or a drug treatment specialist would encounter in starting or fine-tuning a jail-based drug treatment program.

Chapter II describes the partnership that logically exists between corrections and drug treatment professionals and details the benefits to the jail environment, the correctional staff, the inmate, and the community derived from jail-based drug treatment of offenders. Chapter III provides a closer look at five models of offender drug treatment. This chapter will suggest a methodology that will allow jail administrators and drug treatment personnel to match their fiscal, staffing, facility, and community resources with a suitable drug treatment model. Benefits and expected outcomes of each model will be discussed. Chapter IV will explore the critical issues in program development and implementation. These issues include management concerns, staff selection and training, client selection, special treatment issues, and continuity of care. Chapter V will take a closer look at program evaluation -- why it is important and how it can be accomplished. Finally, Chapter VI offers an overview of the possible points of linkage between the criminal justice system and drug treatment. These issues are especially important in considering the development of a more comprehensive approach to service delivery and program outcomes. A glossary of terms is included to cross-reference the two distinct languages of criminal justice and drug treatment.

The authors believe this monograph will offer the reader practical advice on designing, implementing and maintaining an effective drug treatment program in a jail-based setting. The information presented represents the experience and opinions of the authors, all of whom have worked as clinicians, jail management personnel, or consultants to existing jail-based drug treatment programs. As such, it is not intended as a scholarly treatise on jail-based treatment, but rather as a helpful "how-to" guide for drug treatment and corrections professionals.

II. Partnerships Between Treatment and Corrections: A Rationale

A. Overview

It is generally recognized that incarceration should strive for more than the warehousing of offenders. Society can be served not only by separating offenders for a period of time from the community in which they offend, but by returning them to that community less likely to reoffend.

At various times the pendulum has swung from an emphasis on detention to an emphasis on corrective activities. The last ten years have seen an increasing courtship, albeit tentative, between the criminal justice system and substance abuse treatment. These two disciplines have historically aligned with differing philosophies: punishment versus treatment. Currently, a window of opportunity has opened for that relationship to develop. The basis for this partnership is the same as for any other: the two disciplines share common goals and, by working together, are better able to meet their common needs.

A number of factors have coincided to promote the effectiveness of a partnership between treatment and corrections. Primary among these factors are overcrowded jails, due to a growing substance-abusing offender population; discoveries made with the introduction of the direct supervision style of inmate management; and advances in chemical dependency treatment effectiveness.

The remainder of this section will define these factors and describe how their interrelationship has molded the partnership between treatment and corrections.

B. The Substance-Abusing Offender Social System

The relatively recent advent of jail overcrowding is attributed to the evolution of a growing substance-abusing offender social system. Local jails are overcrowded with substance abusers who commit crimes. This group is not homogenous. One model of classification breaks substance-abusing offenders into four categories: **Early Stage**, **Addicts**, **Mentally Ill Chemical Abusers (MICAs)**, and **Criminogenic**.

1. Early stage refers to experimental, recreational, and habitual substance abusers whose crimes result from impaired judgement or disinhibition while under the influence of drugs and/or alcohol.

2. **Addicts** are those for whom daily life is dedicated to drug-seeking behavior. Petty crime has become their primary means to support their addiction. Serious or violent crime is generally avoided by the addict group.

3. **MICA** is an acronym for **mentally ill chemical abusers**, often referred to as the dually diagnosed (concurrent mental illness and substance abuse). Offenders classified as MICA do not comprise a homogenous group. The severity of the mental disorder and baseline functioning after stabilization, need for medications, and the level of substance abuse or addiction determine the treatment prognosis and appropriateness for inclusion or exclusion from certain treatment regimens.

Appropriateness of Inclusion of Dual Diagnosed Offenders in Traditional Substance Abuse Programs

Dual Diagnosis, Diagnostic Matrix
DSM-III-R

Axis I					Axis II			
Psychoactive	:	Thought	:	Mood	:	Psychoactive	:	Personality
Substance Use	:	Disorder	:	Disorder	:	Substance Induced	:	Disorder
Disorder	:	(Schizophrenia)	:	(Bipolar,	:	Organic Mental	:	(Borderline)
	:		:	Dysthymic)	:	Disorder	:	
	:		:		:	(Delusional)	:	
Experimentation	:	+/- Rx	:	+ Rx	:	+/-	:	+ N/Rx
Recreation	:	+/- Rx	:	+ Rx	:	+/-	:	+ N/Rx
Habitual	:	+/- Rx	:	+ Rx	:	+/--	:	+ N/Rx
Abuser	:	+/- Rx	:	+ Rx	:	-	:	+ N/Rx
Addict	:	+/- Rx	:	+ Rx	:	-	:	+ N/Rx

Coding: "+" May be included in traditional substance abuse programs.
 "+/-" Appropriateness in traditional programs is marginal, depending on baseline functioning.
 "-" Innapropriate in traditional programs, requires specialized treatment settings.
 "Rx" Stabalizing medication may be required.
 "N/Rx" Potential for abuse of medications is high. Prescriptions to be avoided unless essential.

4. Criminogenic substance abusers are those who do not wish to be part of mainstream society but have chosen to become members of outlaw subcultures. Their substance abuse is incidental to their criminal behavior. Many believe that even if their addiction were treated, they would still choose to continue criminal behavior. However, for some, growing older, having children, and feeling their lives are "going nowhere," may motivate them to enter mainstream society. Decade markers (thirty, forty, or fifty years old) seem to be the times of greatest reflection and motivation for change. Because of their more extensive criminal histories, most in this group pass through local jails en route to state prison. This group often requires longer, more intensive periods of treatment.

For the majority of early stage, addicts, and micas, their crimes are misdemeanors perpetrated to maintain their addictions or as a result of criminal behaviors performed while under the influence. This is due in great part to impaired judgement or disinhibition. Studies report that 60% to over 90% of local jail inmates are arrested for crimes directly or indirectly resulting from substance abuse.

The subculture of substance-abusing offenders while residing in the community is characterized by unemployment, negativity, educational deficits, and destructive peer influence. An unstable residence or homelessness is common. Substance abuse is pervasive as both a cause and effect of the lifestyle shared by this group. Some are born into the lifestyle or grow up in the environment. Others come from mainstream environments but fall prey to addictions and sink into the lifestyle. The demands of addiction require that one's values be compromised. This leads inevitably to preying on others as a means to gain money to buy drugs. Criminality leads to arrest, court, incarceration, probation, and parole.

Jail has been incorporated as an acceptable consequence in the substance-abusing offender's lifestyle. Incarceration is a predictable event. It is a nuisance but not without benefits. It is a time to reduce one's addiction, obtain neglected medical and dental care, eat regularly and regain lost weight, and renew old relationships. It is a "time out" from street chaos, or rest and recreation.

In or out of jail, the lifestyle remains the same. In the traditional jail setting, the focus of correctional staff is to maintain a secure perimeter. This allows inmates to define the internal social system. Negativity, destructive peer influences, manipulation, drug seeking, and a predator-prey hierarchy characterize traditional inmate social systems. The majority

of those released from jail return to their social group, in which substance abuse leads back to criminality.

Loss of self control in the addict is a primary factor that continues the abuse of substances and other destructive behaviors, despite dire consequences. Therefore, incarceration alone, as a punishment, has been shown to be neither an effective deterrent from the substance abusing offender social system nor an exit from the addict lifestyle.

C. Jail Overcrowding

All elements of the criminal justice system, including the police, courts, jails, and probation and parole, have been severely impacted by an increased emphasis on the arrest and incarceration of substance-abusing offenders, coupled with a fairly consistent 70% recidivism rate. Critical jail overcrowding has reached levels in recent years that create unsafe institutions for both inmates and staff.

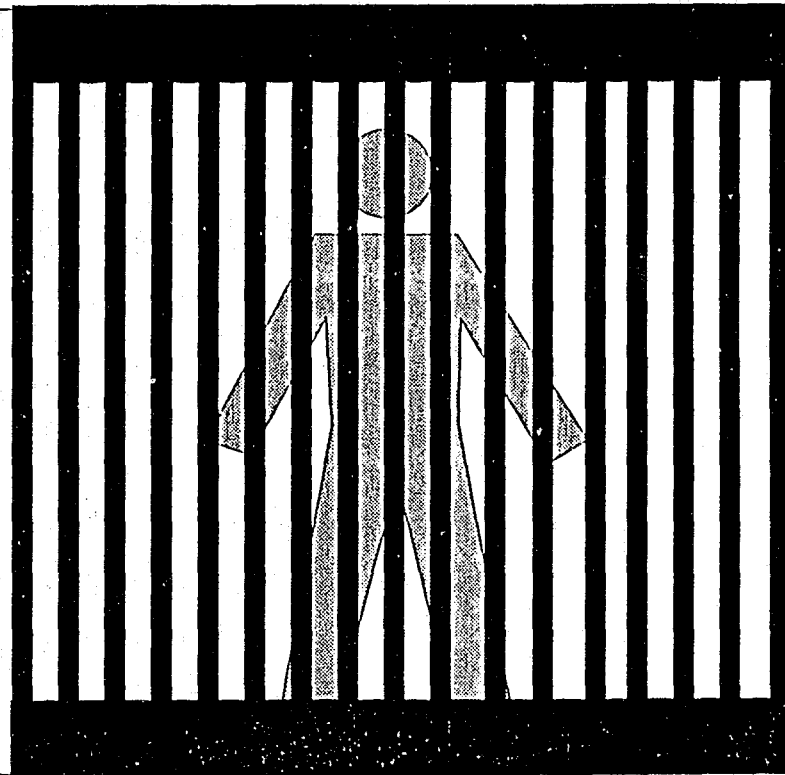
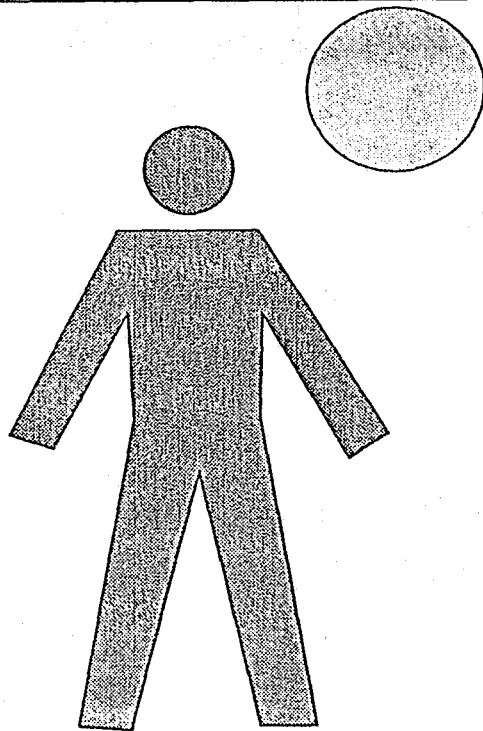
Decision makers have been willing to consider drastic means to deal with overcrowding. Short-term "quick fixes" include abrupt release of selected offenders when a maximum census is reached, and sentencing practices that direct offenders to prisons or local jails dependent upon which is less crowded. Longer-term solutions include the construction of more institutions, the loosening of restrictions on diversion, early release mechanisms, and alternative-to-custody programs. Despite these measures, jail populations continue to rise.

From a systems perspective, strategies to reduce jail crowding must address reducing the numbers at the points of entry into and exit from the criminal justice system. However, the model of the substance-abusing offender social system illustrates that, in effect, the substance-abusing offender never leaves that social system and that jail is incorporated as an acceptable element in his/her lifestyle. For this person to exit the system, the entire lifestyle, not just a behavior, must change.

The criminal justice system finds itself in a dilemma, with enforcement and incarceration working at odds. The community is demanding increased enforcement and longer sentences, assuming this will remove offenders from the community and thereby make the streets safer. The police are responding quite effectively by increasing their arrest rates. The legislature is passing more severe penalties and the courts are proffering longer sentences. The resultant institutional overcrowding, however, means that the

Substance Abusing
Offender
Social System

In or out of jail, lifestyle remains the same.
The only difference is the bars.



incarceration of one requires the release of another only to find that he or she soon enters the system once again.

D. Direct Supervision

In part, to meet the challenge to more effectively manage overcrowded institutions, the "direct supervision" style of inmate management was introduced in the past ten years. Direct supervision, initially controversial, has proven highly effective in improving working conditions and the custody environment in overcrowded jails for both staff and inmates.

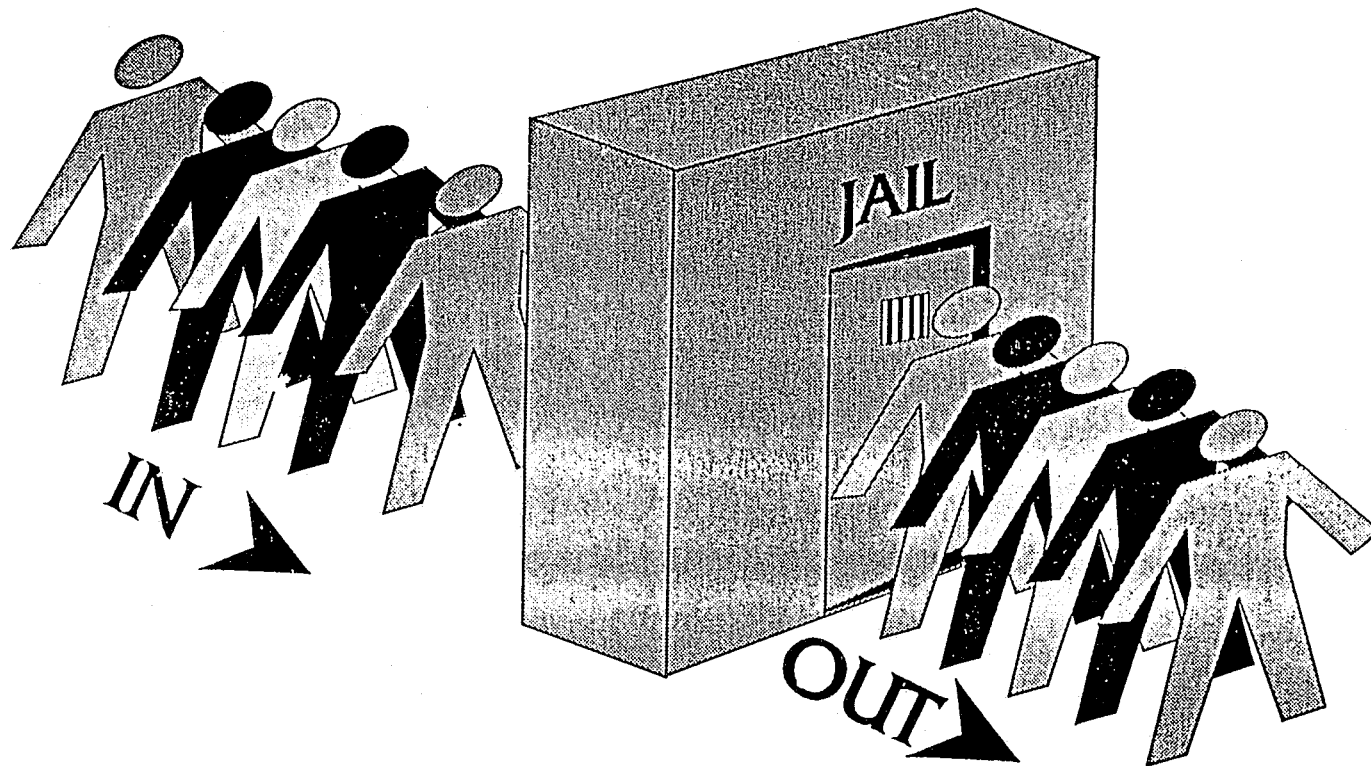
A jail's architecture, whether the traditional linear model or the more recent podular designs, defines to a great extent the inmate management style for that institution.

The linear design allows indirect observation. Cells are configured in long rows, generally housing four to twelve inmates per cell. Aside from showers, work, and recreation, inmates spend most of their time locked in their cells. Supervision is by listening or observation from overhead catwalks or central corridors. Officers must make rounds to view the activity inside individual cells and predominantly react when rule violations are detected. Inmates easily recognize when they are or are not under observation. This style affords good perimeter security but allows inmates significant control over activities inside the cell. As such, inmates control the social system inside the institution to a great extent.

Direct supervision facilities, the model predominating current construction, are designed in clusters of pods or modules housing forty to sixty inmates each. Modules comprise sleeping quarters arranged in an arc around a central day room, with adjacent activity/interview rooms. During the day, inmates are allowed to move freely between their sleeping quarters and the day room. Supervision is provided by one or more unarmed correctional officers who roam throughout the module. The officers' role is more that of an "inmate manager" than a "jailor." Officers are trained to be attuned to the mood of their module and make proactive decisions when they sense that something is amiss. As a result, supervision is more intrusive into inmate social interactions. The officers significantly control the social system within their module.

To increase control, the traditional jail management response is to increase institutional structure (more officers, longer lockdowns, and fewer inmate freedoms). Antithetically, direct supervision taps the individual inmate's own capabilities for internal structure

Because our county jails are overcrowded all the time, the incarceration of one requires the release of another.



(responsible behavior and self-control). Through the use of more sophisticated inmate classification instruments and a system of rewards and punishments, structuring inmate time via programming, and changing the role of the correctional officer from "jailor" to "inmate manager," the majority of inmates in direct supervision jails are capable of responding cooperatively to institutional rules. Institutions become easier places to manage, safer environments for inmates, and better work settings for staff.

As direct supervision officers become more a part of the institutional social system, they have come to realize that inmates find or create activities to structure their time in jail. If programs are not provided by the staff, inmates will create their own. Left to their own devices, inmates will attempt to replicate the social structure and activities they know from the streets: negativity, drug seeking, manipulating, predator-prey hierarchy. When offered programs and services, inmates tend to participate if for no other reason than that it is something to do. Jail managers have learned that participation in programs impacts inmate attitudes and behavior in general.

Sophisticated inmate classification systems have identified that the overwhelming majority of inmates can behave responsibly and want to do so. If given the opportunity, all but a small percentage of inmates tend to live up to positive expectations coupled with clear and immediate sanctions for transgressions. The success of direct supervision, based on inmate cooperation, has "rehumanized" inmates and has changed the thinking about inmate potential. This changing attitude of correctional administrators has opened the door once again to treatment within the custody setting.

E. Substance Abuse Treatment Advances

Coincidentally, over the past ten years, dramatic advances have occurred in the effectiveness of treatment for chemical dependency. With new treatment technology, it is generally accepted that addiction is no longer an untreatable condition. Though the condition is still considered progressive and the prognosis guarded, debilitation can be successfully arrested through techniques that achieve and maintain abstinence. Abstinence affords the opportunity for treatment of related physical and emotional conditions, development of education and skills, and reintegration into mainstream society.

F. Synergy Between the Treatment Programming System and the Criminal Justice System

The criminal justice system is looking for long-term solutions to its system backlog and especially to jail crowding. Treatment proponents are looking for opportunities to access those suffering from chemical dependency at a time when motivation for treatment is high. With the crisis of overcrowding by an identifiable substance-abusing offender population coinciding with advances in chemical dependency treatment effectiveness, jail doors have been opened to treatment proponents in hopes that successful programs can be one means to reduce overcrowding by reducing recidivism.

Concurrently, treatment providers have been quick to recognize that jail has become a catchment area for substance abusers. Direct supervision alone has improved inmate management and, certainly, treatment in jails does not have to be limited to a direct supervision setting. However, it has been found that treatment programs operating within direct supervision settings are complemented and enhanced by direct supervision and vice versa.

Treatment programs and the custody setting complement each other because program goals and custody management goals are the same:

- to promote responsible and mature inmate behavior, and
- to provide positive structure for inmate time.

Considering short-term goals, especially subsequent to the development of direct supervision, jails benefit from having programming available, while programs benefit from the milieu that can be developed in which inmates support each other's treatment progress free of the negative influence of general population inmates.

Considering long-term goals, treatment staff find that jail is an opportune time for intervention into a substance abuser's lifestyle. Jails have become a catchment area for society's more serious substance abusers. Jail provides a controlled environment, similar to a residential treatment setting, where medical and psychological stabilization occurs and daily exigencies, such as food, clothing and shelter, are provided. Inmates have the time to focus on treatment issues. With the courts representing society at large, and confronting the offender with his/her problem of substance abuse, a natural intervention process occurs with effective reduction in denial. The desire to be released from custody

or to make a favorable impression on the court provides motivation for the offender to enter treatment if for no other reason than to present him or herself in the best light. Treatment professionals are familiar with this type of motivation, since the overwhelming majority of clients enter community programs because they have been threatened with such consequences as divorce, loss of job, or incarceration. Direct supervision facilities optimize the effectiveness of treatment programs by providing a controllable environment, isolated from the general population, in which a milieu can be developed. Lastly, the criminal justice system offers the tool of constructive coercion that not only motivates substance-abusing offenders to enter treatment but enforces continuity of treatment following release to the community.

1. Continuum of Treatment

With coordination between treatment and corrections, the most effective continuum of treatment currently identified includes the following steps:

- identification of the offender as a substance abuser as soon as possible after entry into the criminal justice system,
- screening for diversion into treatment as an alternative to custody (such as the TASC model) or in-custody treatment for those not eligible for diversion,
- linkage through case management re-entry treatment planning services with appropriate community treatment providers prior to release,
- early release to the community conditioned upon a commitment to fulfill a treatment plan negotiated voluntarily by the offender and counselor with concurrence of the releasing authority (probation, county parole, the court),
- treatment plan monitoring by probation or county parole in close cooperation with the case manager and community treatment provider, and
- a series of clear and rapidly implemented intermediate sanctions available to the supervising authority as alternatives to return to custody if conditions are violated.

The long-term goal for custody, the courts, and probation and parole is that successful treatment will provide an exit from the criminal justice system for the substance-abusing offender population.

2. Benefits of Treatment

The potential for recidivism reduction is only one area of benefits that may occur when jails incorporate treatment programs. Programs have been shown to create benefits to the following four areas:

- the jail environment
- the correctional staff
- the inmate
- the community

a. The jail environment, including the building and general operations, has been shown to benefit by programming in the following ways:

- there has been a noted reduction in the following:
 - noise, tension, and stress
 - vandalism
 - graffiti
- cleanliness in the facility is improved
- fewer inmate incidences occur, necessitating fewer write-ups
- exposure to liability is reduced overall

b. The correctional staff has been shown to benefit by programming in the following ways:

- greater job satisfaction and sense of accomplishment and control:
 - officers manage proactively rather than reactively
 - officers see their roles as "inmate manager" rather than "jailor,"
 - officers feel they control the environment, not just the perimeter,
- officers report an improved working environment:
 - job stress is reduced
 - officer safety is improved, with fewer assaults and threats to officers and fewer inmate fights
- officers gain added inmate management tools:
 - programs structure inmate time
 - program staff provide an additional set of eyes and ears

- programs promote responsible behavior
- recidivists return with a more responsible attitude

c. **The inmate** has been shown to benefit by programming in the following ways:

- an opportunity for treatment and lifestyle change is provided
- jail programs break the cycle of the substance-abusing offender's social system
- jail is less dehumanizing
- the "predator-prey" system is interrupted; inmate assaults and victimization are reduced
- goal-oriented behavior, rather than "killing time," is promoted
- an expectation of responsible, mature behavior (rather than criminal-mindedness) is provided (inmates tend to live up to this expectation)

d. **The community** has been shown to benefit by jail programming in the following ways:

- for treatment providers, jail is an opportune time to intervene in the offender's cycle of alcohol and drug dependence:
 - jail provides detoxification, and medical and psychological stabilization
 - inmates consider new clean, sober, and crime-free goals
 - "constructive coercion" in the form of criminal sanctions increases motivation for treatment
 - community providers find jail programs an efficient catchment area for clients
- families of offenders see jail as:
 - an opportunity for the inmate to get help
 - a reprieve from chaos and domestic violence
 - an opportunity to consider their own options
- recidivism is shown to be reduced when jail treatment is followed by a conditional release plan including community treatment
- conditional release plus community treatment provides for rapid identification of offender behavior for monitoring agencies such as probation and county parole
- those who recidivate show a tendency towards longer noncriminal periods and less severe offenses rather than the expected pattern of escalating severity

III. Five Models of Jail-Based Treatment: Design Choices, Resources Needed, and Benefits/Outcomes

A. Overview

If the rationale for incorporating drug treatment into the correctional setting has been persuasive, the decision to pursue developing jail-based programming can be made at any level in a county hierarchy: concerned citizens, counselors, correctional officers, the county substance abuse program administrator, the sheriff, a judge, a county supervisor, etc. Technical assistance has been available in the past through, "Drug Treatment in the Jail Setting: A Model Demonstration Project" of the Bureau of Justice Assistance, the agency sponsoring this monograph. Technical assistance is currently available through the Office of Treatment Improvement, the Department of Health and Human Services. Assistance can be provided in a variety of ways, from helping to devise strategies for promoting the concept of jail-based programming to developing program protocols.

Among numerous factors necessary to develop programs, the following major parameters must be considered which are the focus of this chapter:

- resources,
- target population(s),
- treatment models.

B. Resources

Resources include not only routine tangible items such as staff, space, equipment and materials, services, and funding. A critical intangible is the commitment level of administration. Because the programs in question take place within a correctional setting, the support of the sheriff (or head of the department of corrections) is essential.

Many jail programs exist solely under the authority of the sheriff. Others are managed under a partnership between the sheriff and other interested entities that benefit from jail programming. Other entities might include the county alcohol and drug administration, granting agencies, jail industries, and treatment providers. When multiple entities are involved, each of their levels of commitment should be seen as critical resources. (A more extensive discussion of level of commitment is included in the section of this monograph entitled "Critical Issues in Program Development and Implementation.")

C. Target Populations

Substance-abusing offenders are not a homogenous group. The substance abusing offender population has been broken into four identifiable subgroups:

- Early Stage
- Addict
- MICA (Mentally Ill Chemical Abuser, or Dual Diagnosis)
- Criminogenic

(For definitions, refer to the section in this monograph entitled "The Substance Abusing Offender Social System.")

Experience with jail-based treatment indicates that certain treatment models tend to be more effective with each of these types of offenders. With this knowledge, the more sophisticated programs match the treatment model with the target population. Improvement in outcome effectiveness is expected.

1. Formal Screening Systems

If the goal is to match offenders to treatment models, offender substance-abuse screening is necessary. Custody classification levels are inadequate for this purpose. Most custody facilities (aside from medical/psychiatric) classify inmates on factors related to severity of criminal history, need for special housing (protective custody, isolation, infirmity), and ability to adjust to incarceration. Even though early stage substance-abusing offenders tend to be first time, minor offenders; addicts tend to be multiple, nonviolent property offenders; and criminogenic tend to be multiple, more serious and violent offenders, custody classification alone is insufficient to screen for treatment purposes. However, custody classification does tend to cluster a preponderance of a certain substance abusing offender subgroup.

Formal screening systems require a battery of screening instruments that must be administered, scored, interpreted, and recorded. The amount of staff time necessary must be weighed against the benefits of formal versus less formal screening. Programs with formal evaluation systems are more likely to require a formal screening system. For further discussion of screening instruments, see the section entitled "Program Evaluation."

2. Less Formal Screening Systems

Many programs do not emphasize the importance of a sophisticated screening and program-matching process. Motivation, sincerity, and willingness to follow rules can be assessable factors in a less formal screening process when attempting to predict an applicant's appropriateness for admission. The first few days of participation will usually confirm or refute impressions gained during the assessment. This is similar to the majority of community-based programs that provide a single treatment model and screen applicants based primarily on motivation, willingness to abide by program rules, and the screener's overall clinical impression. Jail-based programs incorporating a similar philosophy often use the following screening factors:

- whether or not applicants admit a substance abuse problem,
- motivation level for treatment,
- amenability level to treatment,
- applicants meet minimum custody classification requirements,
- applicants meet the required minimum length of time remaining in custody.

There are drawbacks to a less formal screening and program-matching process. Treatment effectiveness for members of certain substance abusing offender subgroups may be compromised by a less than ideal program match. The program may be disrupted by not truly motivated or by greatly mismatched participants. Residential model programs mitigate this negative influence by creating a candidacy or probationary stage where most "washouts" occur without impacting the primary treatment group. Offenders who are not sufficiently motivated or who are greatly mismatched will usually self screen within a short period of time. If there is a strong core group of positive program participants, manipulative candidates (primarily criminogenic or others in deep denial who are used to controlling an environment) rapidly become a "fish out of water" and either act out or request to be removed once they have sized up the situation.

Though MICAs are often screened out, some jail-based programs include MICAs. MICA is not a homogenous classification. Once stabilized, baseline functioning can exhibit various levels of severity and acuity between clients.

Exclusion is based on offenders' exhibition of acute psychiatric symptoms (active hallucinations or delusions, bizarre behaviors), behavior too disruptive to the program, an inability to fit in socially, or impairment too great to benefit from the model of treatment provided. A close working relationship with the forensic mental health staff, including

agreement on medication policies, must be developed if MICAs are to be included. As scarce as treatment services are for substance-abusing offenders, services for MICAs, other than behavior control through medication, are all but nonexistent in most jail settings.

D. Treatment Models

There is sometimes confusion in the use of a term like "model." Among the definitions for the word offered in Webster's Dictionary is "a tentative description of a system or theory that accounts for all of its known properties" and "a style or design of an item." When the word "model" is paired with the word "treatment," it could mean "a system or theory of treatment that accounts for all of its known properties" or "a style or design of treatment." The use of the term "treatment model" in Chapter III carries the latter meaning and is characterized by the following: 1) A treatment model has goal(s); 2) it incorporates the tenets of a particular philosophy of change; 3) it is composed of elements that differentiate it from other models; and 4) it incorporates one or more treatment modalities to implement its goals.

For example, a self-help treatment model would have "the development and maintenance of a chemically-free lifestyle" as its goal. The primary tenet of its philosophy of change are the 12 steps. The elements of the self-help model are structured peer support groups, non-professional leadership, common goals (drug/alcohol free), etc. Treatment modalities employed in the self-help model share common tenets with rational emotive approaches, etc. In any event, the reader can substitute the words "style" or "design" for "treatment model" in the following discussion of the five basic treatment models.

A primary concern is to determine what model of programming to develop. The decision should be specific to the situation. The following factors suggest areas of consideration when making this decision:

1. What outcomes or benefits will be the goals?
2. What inmate population(s) will be targeted?
3. What is the level of commitment of the administration?
4. Of the program options, which will fit this specific situation best?

Once a program design is selected, suggestions on implementation will be addressed. See Chapters IV, V, and VI, which focus on critical development issues, program evaluation, and linkages between treatment and the criminal justice system respectively.

As program planning progresses from program model to design concept to treatment techniques, innumerable program possibilities arise, limited only by the creativity of staff experienced in treatment and corrections. Of these possibilities, five treatment models will be discussed:

- the Self-Help Model
- the Education Model
- the Outpatient Model
- the Residential Model
- the Case Management/TASC Model

Refer to the chart "Drug Treatment Options in Correctional Settings" as a tool that illustrates, in a general way, the relative intensity of these models, comparative difficulty in development, and level of effectiveness for each substance-abusing offender subgroup.

1. Self-Help Model

This model most commonly takes the form of 12-step programs (or combinations of them). These programs include Alcoholics Anonymous (AA), Narcotics Anonymous (NA), Cocaine Anonymous (CA), and other anonymous fellowships. These programs refer more generally to groups of peers, not professionally led, who join together to support each other towards common goals: primarily eliminating substance dependency and criminal behavior. An example of a non-12-step self-help program is a group of "outmates." Though designed in a 12-step format, with most members having close ties to AA or NA, the goal of outmates is for offenders who have been released after completing an in-custody program to support each other in remaining clean, sober, and crime free in the community.

Self-help groups can stand alone but are commonly incorporated within or as an adjunct to most other program models.

2. Education Model

This model refers to a program led by an instructor and defined by a curriculum of alcohol, drug, and recovery-related education. Offenders enroll in classes and may identify themselves as students or program participants. This self-identification is important, as it indicates whether the purpose is to increase knowledge (students), or to recovery (participants).

This type of program occurs in a classroom setting. Information is presented primarily didactically, in handouts and/or workbooks, and through videos and films. The information presented becomes the basis for group or individual discussion. These individual and group discussions, in effect, become counseling sessions.

Educational programs are organized in cycles with an identifiable completion, often terminating in graduation. When one cycle ends, that group of students is replaced by another class. The program size is easily controlled. This reduces many logistical problems such as predicting resource needs, especially space. Ongoing recruitment (registration) is necessary. Unless other programming is available, graduating student/participants blend back into the general population. Follow-up programming, such as Self-Help or Outpatient Programs, is important so that student/participants do not lose the gains made during the classes.

Determining the participant's literacy level is essential to successful education model programs. Within the pool of eligible offenders for drug treatment services may be functionally illiterate or non-English-speaking or -writing inmates. These offenders will fare poorly in treatment unless program requirements are matched with skill levels. Those individuals assigned the task of screening individuals to drug treatment should avoid self-reported offender data on reading/writing efficacy. Inmates will hide illiteracy. They may appear non-motivated in programming or self-select out of the program so as not to expose their illiteracy. To the extent possible, programs should reflect designs that address the needs of these special population inmates, rather than excluding them from treatment. The use of oral as well as written assignments, offender tutoring, availability of native language literature, translators, and bilingual staff are all ways to accommodate this treatment need.

Educational programs can stand alone or can be excellent adjuncts or lead-ins to Outpatient or Residential model programs.

3. Outpatient Model

This model is presented here in two forms: as a general Outpatient Program (OP) or an Intensive Outpatient Program (IOP).

OP/IOP programs do not attempt to create a milieu within which all participants live. Programming takes place in a location other than the housing area or, when program

space is within or adjacent to a housing area, does not necessarily include all offenders in that housing area.

In contrast to the Educational Model, OP/IOP programs are led by counselors and focus more on individual and/or group counseling. With this emphasis on counseling, treatment is more intense than in the Educational Model. Education may be an adjunct to counseling.

OP programs are often open ended; inmates can participate throughout their custody stay. This allows participants to maintain their identity and gain continual support from the program. Open-ended programs continue to grow in size, requiring the setting of size limits. Waiting lists often result, which are complicated by the need to track applicants who may be transferred to other between locations or facilities due to custody housing needs.

- a. **General Outpatient Model Programs** require minimal reorganization of the institutional schedule. They call for one to three contacts per week, often in the evenings. Thus the greater amount of participants' time is structured by institutional activities. A drawback in general outpatient programs is that participants may maintain denial of their own chemical dependency and its impact on their behavior because the treatment offered is not sufficiently intense and confrontational.
- b. **Intensive outpatient model programs** predominate the offender's daily schedule, in contrast to general outpatient programs. As such, participants identify more with the program than with the general inmate population. Sessions may occur five days a week and take up the bulk of the participant's waking hours. This requires greater reorganization of the institution's schedule. In addition to their program participation, offenders in an Intensive outpatient program often feel more involved than they would in a general outpatient program and strongly identify as addicts in recovery. As a rule, when the intensity and confrontation levels of a program model increase, offenders' denial is reduced.

4. Residential Model

Residential Model programs can also be referred to as "milieu therapy" programs. A milieu is a generic term that refers to a defined environment. An institution's general population has its own milieu. (Refer to the discussion on the substance-abusing offender social system in the section entitled "Five Models of Jail Based Treatment" for a

description of the general population milieu.) In jail-based treatment, milieu therapy or a residential program has come to represent a self-contained housing unit dedicated as a treatment unit. The concept of maintaining a "sterile environment," separated from the negative influences of general population inmates, is endemic to developing the positive milieu in residential programs.

Residential Programs serve inmate groups of twenty-five to, in some cases, over one hundred. Most commonly, programs serve groups of forty to sixty inmates. Inmates volunteer and are screened prior to being housed in the program unit. Participants are held to a higher standard of responsibility than general population inmates are and, in turn, are rewarded with a more comfortable living environment and privileges and opportunities not available in the general population.

The milieu can be treatment in itself. A self-contained, "sterile" unit, housing inmates voluntarily seeking help for admitted substance abuse problems, will provide a community of support. Within this community residents can develop the trust and freedom to be more honest with themselves and others while turning their attention to recovery goals. The spirit of self-help naturally develops in this environment.

The residential environment, or milieu, facilitates the efficient delivery of services to a highly receptive inmate population.

Two types of Residential Programs will be discussed: Therapeutic Communities and Shock Incarceration, also known as Boot Camp.

a. Therapeutic Communities (TC) are the most common residential model program in jail-based substance abuse treatment. They are the most complex to develop, implement, and manage, requiring the greatest commitment from administration, resources, and financial investment. TCs require the development of a management structure, including a program director and a paid counseling staff. Adjunct staff may be incorporated, including volunteers and interns, outreach workers from community agencies (such as AIDS, Dual Diagnosis, prenatal health care, infectious disease agencies, etc.), and staff from job training, remedial education, and community treatment programs.

Therapeutic communities attempt to facilitate the effective delivery of a combination of treatment and self-improvement services. The goal is to create an intensive treatment

environment within which motivation increases, attitude improves, and skills develop that increase the participants' ability to remain clean, sober, and crime free upon return to the community. TCs are considered the most effective single treatment model for the broadest spectrum of the substance-abusing offender population.

Treatment is provided through the milieu and a combination of the services discussed above, including Self-Help programs, individual and group counseling, and substance abuse education. Additionally, skill development services such as remedial education and employment development are common. And special interest programs, such as AIDS education, relaxation and stress reduction, biofeedback, acupuncture, nutrition, meditation, etc., can be provided.

Institutional management activities (such as counts, laundry exchange, sick call, commissary, visiting, lockdowns, meals, recreation, etc.) are organized to coordinate, not interfere, with program activities. Program activities can take up twenty or more hours per week.

- b. Shock Incarceration/Boot Camps** are another type of milieu or residential program. Such programs are currently high profile and controversial. The literature on Boot Camps suggest that such programs appeal to administrators who remember the intensity of their own life-changing experiences from military boot camp and believe that experience can generalize to the inmate population. If so, this may be a strategy that encourages program development within an administration that expresses little commitment to treatment in general.

Boot Camps are highly structured, highly disciplined, milieus with an emphasis on strenuous physical training. As such, they require strict medical screening. The physical requirements and strong discipline are seen as meeting the abilities and needs of a younger population of undisciplined, immature offenders.

The literature also indicates that the discipline and physical training inherent in Boot Camp alone have shown no evidence of any positive therapeutic outcomes for substance-abusing offenders. In response, programs seeking positive treatment outcomes have incorporated substance abuse treatment, and remedial education, into the Boot Camp structure. When structured this way, Boot Camp can then provide a positive (albeit strenuous) milieu along with treatment.

Since the Boot Camp concept is not strictly defined, some jurisdictions are creatively modifying the concept in an attempt to meet the desires of both administrators, to whom discipline and physical training appeal, and treatment staff, who see developing an avenue to provide treatment to offenders as the program's goal. A creative twist promoted in one jurisdiction was to incorporate physical challenge techniques such as those found in "ropes courses" or the Outward Bound program to substitute for the PT while reducing the emphasis on discipline.

5. Case Management/TASC Model

Transition programs can also be referred to as **Case Management** Programs. The most common example of a Transition Program is **TASC** (Treatment Alternatives to Street Crime). TASC was initially established by the Special Action Office for Drug Abuse Prevention in 1972. The TASC model can be described as both a diversion program and as a case management (Leukefeld, 1989). TASC provides identification, assessment, referral, case management, and monitoring services for drug/alcohol-dependent offenders accused or convicted of nonviolent crimes (BJA, 1988). Much literature is available on the TASC model. Refer to the sections in Chapter VI on "The Case Management/TASC model" and "Pre-Release/Transition Planning" for a more in-depth discussion of this model.

Transition Programs are intended to create a bridge between inmates and treatment programs in the community. Continuity of treatment following release to the community is critical to sustain the benefits gained during in-custody treatment. Current research indicates that in-custody treatment alone exhibits its most positive impact during the initial 90 days after release, with decreasing benefits up to one year after release. Following one year after release, little impact over incarceration alone on long-term recidivism can be measured. Effective in-custody treatment will increase the length of time before reoffense, decrease the severity of the reoffense, and return the offender to jail more motivated to re-enter treatment again, with a greater understanding of why he/she failed, and more accepting of responsibility for that failure. However, to impact long-term recidivism, offenders must continue in treatment upon return to the community.

E. Benefits and Outcomes

1. Overview

In this section, various treatment models will be correlated with such elements as types of substance abusers, custody staff, the facility, and the community. Four charts will be

used to illustrate the benefits and outcomes that may result from choices and decisions to be considered when planning the introduction of drug treatment programming into a jail setting.

It is the thesis of the contributors to this monograph, as well as of others operating drug treatment programs in correctional settings, that the benefits and outcomes of treatment are directly related to the matching of certain treatment models with certain client types. The field of addictions technology is a relatively new field and, at this time, drug treatment programming is not an exact science. To date, there has been limited empirical knowledge as to which theoretical framework, treatment model, or treatment modality is most efficacious for different types of clients (Hubbard et al., 1988).

Yet, even without the comfort margin of supportive research, there is sufficient anecdotal and experiential information in the field regarding the rather specific treatment effectiveness of different treatment models and modalities that it would be remiss to omit these vital hypotheses. As research continues, more knowledge will be gained regarding the matching of drug treatment to offender subgroups. In the meantime, the following discussions may assist criminal justice system administrators to anticipate the likely impact and outcomes of various treatment models on selected groups of drug-abusing offenders, as well as on the facility and the community, and thus help them make more informed and successful decisions in the selection of treatment options.

In general, facility administrators should maintain realistic expectations regarding jail-based drug treatment programming. No single therapy can cure all substance abusers. The substance-abusing offender often has many problems to overcome, of which substance abuse is but one. In addition, it should be recognized that the time inmates participate in jail-based drug treatment may not be sufficient to ensure long-term behavioral change, but it can be a significant beginning of the recovery process.

Chart 1 addresses program characteristics and general issues when choosing a program model. It correlates treatment models with management characteristics. Chart 2 correlates various treatment models with inmates, custody staff, the facility, and the community. Chart 3 illustrates the matching of substance-abusing offender subgroups to treatment models. Chart 4 illustrates the changes that may occur in four types of offender subgroups as a result of drug abuse education.

The charts are filled in either with abbreviated descriptive terminology that can be interpreted without explanation, or a coding system that uses the symbols "+," "-", or a combination of "+/-." For example, "High" indicates a "high level of difficulty or commitment" required to achieve the outcome; "Mod." indicates a moderate level; and the terms "Easy," "Little," or "None" are self explanatory. A "+" indicates "highly effective," "+/-" indicates "somewhat effective," and "-" indicates "minimally effective." The codes "+ +/-" and "+ /--" indicate intermediate levels.

In charts 1, 2, and 3, the two columns shown under the column head "Outpatient" refer to general outpatient (O.P.) and intensive outpatient (I.O.P.). The initials T.C. under the column head "Residential" refers to therapeutic community.

Chart 1: "Program Characteristics: Issues When Choosing a Program Model"

This chart illustrates the impact five treatment models may have on five management functions.

Self-Help Programs

As shown in Chart 1, self-help programs are generally more effective with Early Stage and Addict groups. These programs are relatively easy to implement and operate. Since they are often staffed by volunteers (from Alcoholics Anonymous [AA] and Narcotics Anonymous [NA], for example) a staff budget is not required. Many agencies provide orientation and training to new volunteers. AA and NA have their own organizational structure known as the Hospital and Institutions Division (H and I) and the newly developing Contact Services Division, which requires little more than a contact person (usually at the sergeant level) within the security staff. At a minimum, security checks are required for volunteer staff.

Reading materials are provided by some jurisdictions through a small literature budget. In other jurisdictions, literature may be funded through donations by the general AA/NA membership in the community.

The most significant challenge faced with this programming is the need for security staff to identify and escort participants to and from meeting locations. Self-help programs are often incorporated as adjuncts to other treatment models.

Educational and Outpatient Programs

These forms of treatment programming are moderately difficult to implement and operate. They require installing an organizational structure that would include a supervisor and one or more instructors or counselors. Staffing would probably be accomplished either through hiring or by coordinating with community services to obtain volunteers. The frequency and length of meetings and number of participants will determine security and space requirements.

Residential Programs

This form of treatment programming is the most complex and costly to operate. It requires a strong commitment from custody administration, probably in coordination with political and legitimizing entities, joint ventures, and advocate groups. Such entities may include the county alcohol and drug program administration, the probation department, the judiciary, the public defender and district attorney, the county manager, criminal justice and alcohol and drug advisory boards, and the board of supervisors. A policies and procedures manual will be necessary. An organizational structure will be required, with a steering committee, treatment program and custody managers, and counseling staff (often with multiple levels and specified roles). There should be coordination with resources such as jail school programs, county outreach programs (AIDS education, etc.), self-help volunteers, and community treatment providers.

In planning a residential treatment program, funding sources and a budget must be developed to support the hiring of staff; the purchase of materials, equipment, supplies, and services; training and cross-training; curriculum and treatment manuals; and required remodeling or new construction. For the inmate participant group, a housing area must be set aside and dedicated to programming. The routine daily custody schedule is often modified for the dedicated housing area. It is advisable that security staff most often participate in cross-training with treatment programming staff, in addition to their routine training. Some or all of the above may also be necessary for Educational and Outpatient models depending on the program size and frequency of sessions.

Transition/Case Management Programs

These programs are not actually forms of treatment, but serve as a bridge between in-custody treatment and community treatment. Case management can be stand-alone or it can facilitate transition of offenders to the community. Unfortunately, case management is commonly the weakest aspect in jurisdictions with in-custody treatment programs. The function of case management represents an opportunity for an effective continuum of

Chart 1 "Program Characteristics: Issues When
Choosing a Program Model"

Treatment Model

Management Characteristics		Self-Help	Educational	Outpatient		Residential		Transition/ Case Management
				O.P.	I.O.P.	T.C.	Boot Camp	
	Cost	Little to None	Low / Mod.	Low / Mod.	Low / Mod.	High	High	Moderate
	Target Population	Early Stage Addicts	Early Stage	Early Stage	Addicts, MICA	Addicts, Crimino-genic	Early Stage	All
	Difficulty Implementing	Easy	Mod.	Mod.	Mod. +	High	High	Easy / Mod.
	Difficulty Operating	Easy	Mod.	Mod.	Mod. +	High	High	Easy
	Administrative Commitment	Little	Mod. (-)	Mod.	Mod +	High	High	Moderate

Chart 2 "Outcome Expectations for Treatment Models:
Who Benefits?"

Who Benefits?	Treatment Model						
	Self-Help	Educational	Outpatient		Residential	Transition/	
			O.P.	I.O.P.	T.C.	Boot Camp	Case Management
	Inmate	+	+	++	++	++	++
	Custody Staff	-	+/-	+	+	++	+
	Facility	-	-	-	+/-	++	+
	Community	+	+/-	+/-	+/-	+	++

+ Highly Effective

+/- Somewhat Effective

- Minimally Effective

Substance Abusing Offender Sub-Groups		Treatment Model					
		Self-Help	Educational	Outpatient		Residential	
				O.P.	I.O.P.	T.C.	Boot Camp
Early Stage		+	+	+	+/ -	+/ -	+
Addict		+	+/ -	-	+	+	+/ -
MICA		+/ -	+/ - - (careful screening)	-	+	+/ - (screening, special services)	-
Crimino-genic		-	+/ - (Focus on cause-effect)	-	+/ - (structure, conditions, sanctions)	+	-
		+ Highly Effective		+/ - Somewhat Effective		- Minimally Effective	

+/- Somewhat Effective

- Minimally Effective

Chart 4 "Effectiveness of the Educational Model
with Selected Sub-Groups"

Educational Model Goals

Substance Abusing Offender Sub-Groups	Knowledge	Beliefs	Attitudes	Behavior
	+	+	+	+/-
	+	+	+	-
	-	-	-	-
	-	+/-	-	-

+ Highly Effective

+/- Somewhat Effective

- Minimally Effective

Early
Stage

Addict

MICA

Crimino-
genic

+

+

-

-

+

+

-

+/-

Emotion ridden,
fear/anger, great
difficulty processing
information

+

+

-

-

Flexible, responds
to convincing
information

Somewhat flexible,
defensive

Inflexible, rigid
and highly
defensive

+/-

Point of decision,
what is level of
self control?

-

Conflicts:
support vs helplessness,
hope vs hopelessness

-

-

Determined by
immediate
cause-effect
relationship

treatment from custody to return to the community. The Drug Abuse Treatment Outcome Study² indicates that most gains from in-custody treatment are lost within ninety days after release and that there is very little difference between populations that received in-custody treatment and those that did not. Conversely, positive correlations have been found between the length of treatment continuation and recidivism reduction.

Most often, case management requires the hiring of screening counselors, such as that done in TASC programs. The extent of the organizational structure necessary to support the program depends on the number of case managers. A needs estimate might be based on a ratio of one case manager per an inmate population of five hundred, a case load of thirty-five active clients, and a target of six new screenings per day, for example. However, case management objectives can be achieved by facilitating access to inmates via outreach workers from community treatment programs.

Chart 2: "Outcome Expectations for Treatment Models: Who Benefits?"

Chart 2 depicts the benefits to the inmate, the custody staff, the facility, and the community of each of five treatment types.

Self-Help Programs

These programs are somewhat effective with Early Stage subgroups and most effective with Addict subgroups (when denial is minimal). They benefit the facility only minimally, while increasing supervision and escort duties for custody staff. Self-help programs, such as AA/NA, benefit the community by encouraging ongoing recovery. They may provide a direct link (especially through contact services) to post-release community meetings.

Educational and Outpatient Programs

These programs may benefit inmates somewhat by improving the in-custody social system. However, this will probably depend on the intensity of the program (as indicated with the intensive outpatient program) and the opportunity for participants to socialize at times other than during program sessions (rather than being thinly scattered throughout the general population). The benefit to the community is marginal but can be increased with the incorporation of AA and NA groups due to their ties back to the community and transition/case management programs. Addicts and some MICAs respond better to Intensive Outpatient participation due to the increased structure, time commitment, self-identification, and therapeutic focus associated with this model, in contrast to less intensive general Outpatient or Educational programs.

Residential Programs

Residential programs maximize in-custody programming benefits to inmates, facility, and custody staff. Residential programs are generally considered to be the most effective treatment model for the largest variety of substance-abusing offender subgroups. Additionally, ease and safety of overall facility management are greatly enhanced with the residential program.

Transition/Case Management Programs

The greatest benefit to the community in reducing recidivism and the seriousness and frequency of reoffense ensues from an effective transition/case management program. Conditions of supervision and treatment are ordered by the criminal justice system.

Chart 3: "Matching Substance-Abusing Offender Subgroups to Treatment Models"

Early Stage Subgroup

This subgroup can benefit from most any of the treatment models. A key factor may be the offender's level of denial. If denial is low, Intensive Outpatient and long-term Therapeutic Communities treatment may be more intensive than is necessary. Brief in-custody treatment may be most beneficial, especially to reduce denial and increase motivation. Along with in-custody treatment, case management that facilitates early release under supervision to community outpatient treatment would be incorporated. Short-term "shock incarceration" Boot Camp programs usually follow this same rationale and are often targeted to Early Stage subgroups.

Addicts

Addicts often require more intensive treatment to break through feelings of helplessness and hopelessness. Even when highly motivated, practical plans coupled with adequate external structure are necessary to support an addict through the process of habilitation. Education alone and regular outpatient programs are not intense enough. Boot camps are too short, and severe discipline may be an obstacle that many addicts may be unable to appreciate in the short term. In-custody Therapeutic Communities coupled with Self-Help appear to be the most promising models for this group.

Mentally Ill Substance Abusers (MICA)

For the more severely disordered MICAs, Intensive Outpatient treatment appears the most effective option when it is necessary to mix MICAs with other subgroups. In an ideal

world, MICAs would probably benefit most from a Therapeutic Community designed specifically for the mentally ill substance abuser; however, few county jails can afford this. The less severely disordered, and those whose hallucinations and/or delusions can be well controlled with appropriate medication support, have been shown to benefit from AA/NA and Therapeutic Communities programs. Careful screening not only for the benefits of treatment for the offender, but also for the impact of the mentally disordered offender on other participants and the treatment milieu, is important. Cognitive treatment models do not appear good options for MICAs.

Criminogenic

Members of this subgroup can be destructive to a program or milieu due to their manipulative nature, need to control, hostile challenges to authority, and subversive negativity. Even highly motivated criminogenic clients typically have difficulty controlling their destructive coping mechanisms. Structure, clear conditions and expectations, and immediate sanctions seem to help this group focus on positive goals and control destructive behaviors. The minimal structure of Self-Help and regular Outpatient programs are inappropriate for this group. Short term, highly disciplined boot camps address conflict with authority too directly for many criminogenic types to tolerate. However, Educational programs that focus on immediate cause-effect relationships, such as relapse prevention and rational emotive treatment models, appear to provide cognitive skills that this group can learn while in custody. The ability to actualize these skills in the community is dependent on an environment with strong external structure. This structure can be provided primarily by probation and parole supervision with the threat of suspended sentences that can be imposed rapidly when clear expectations and sanctions have been violated. The treatment of choice for this group is highly structured therapeutic communities incorporating cognitive skill treatment models coupled with case management that leads to conditions of release.

Chart 4 - Effectiveness of the Educational Model with Selected Subgroups

The Educational model has been addressed because most in-custody treatment models incorporate educational sessions as staples in the first phases of programming. Four progressive steps compose the goals of the educational, or cognitive, model:

1. Knowledge
2. Beliefs
3. Attitudes
4. Behavior

With the cognitive model, it is generally believed that education imparts knowledge which, when processed, affects beliefs, attitudes, and behavior. Many treatment models are based on this hypothesis.

Conversely, behaviorists believe that by practicing conscious control over a specific behavior for a long enough period of time, learning can take place in the reverse order of the traditional hypotheses described above. In the behaviorist model, the sequence of steps to accomplish change is 1) behavior, 2) attitude, 3) beliefs, and 4) knowledge. Cognitive-behavioral models of treatment combine both learning theories.

Early Stage

Members of this subgroup are generally more open to new information and more flexible in considering new ideas. With accurate, logically presented information, Early Stage offenders may be convinced and motivated to pursue goals that are productive rather than destructive.

Addicts

These individuals are somewhat less open and have greater difficulty processing new information. As a result, attitudes are less flexible and defenses are stronger. Despite this, in-custody treatment, especially therapeutic communities, has facilitated remarkable attitude changes in addicts previously considered incorrigible. Custody staff gains some of their greatest benefits from the resultant attitude changes in this generally large portion of the in-custody population. However, without the support of strong external structure, non-habilitated addicts are rarely able to maintain these attitude changes independently upon return to the community. Habilitation through a multitude of practical life skills is essential in the treatment of this population. Long-term residential treatment can provide

structure and time for habilitation to take place. Without this structured time, many addicts succumb to their underlying feelings of helplessness and hopelessness and revert to previous destructive coping mechanisms.

MICA

Many educational program providers have found mentally ill substance abusers to be intolerant of didactic approaches and to have difficulty participating in discussions, and in processing information. Overall, education does not seem to effectively impact behavior in this subgroup.

Criminogenic

Members of this subgroup are typically less capable of responding to convincing logic than are members of addict or early-stage subgroups. Many propose that the criminogenic client's beliefs are cemented by fear, anger, and other emotions, leaving them with great difficulty in processing new information. Attitudes are often inflexible and defenses are rigid. This group, however, is extremely vulnerable to immediate cause-effect situations. Treatment models that also incorporate cause-and-effect strategies, such as cognitive-behavioral models, show the most promise with this group. This would tend to reinforce the behaviorists' reverse-order learning theory.

Also representative of behaviorist theory, the Delancey Street program³ in San Francisco, which treats parolees, is recognized as one of the most successful in treating the criminogenic population. The originators of the Delancey Street program noted that after offenders had spent even two years in prison, parolees "looked, walked, and talked prison" as a result of "living" the prison socializing experience. The Delancey Street program requires a minimum two-year commitment from every applicant, and it requires that all participants behave according to a rigid set of positive social standards, regardless of whether the participant understands "why." What they have found is that after two years of positive social behavior, the participants' attitudes and beliefs change, and positive behavior patterns become automatic and the norm. The synergy between positive behavior and the awareness of improved self concept, positive attitudes, and respected beliefs, creates a self-reinforcing system within the participant.

F. Treatment Modalities

Each of the five treatment models described herein employs various treatment modalities. While it is not possible or even useful to mention all the treatment modalities currently employed in jail-based drug treatment programs, the authors feel some mention should be made of certain modalities that have shown promise with a jail-based clientele.

1. Cognitive Modality

In a study of programs for juvenile delinquents conducted by Izzo and Ross (1990), it was found that programs that included a cognitive component were more than twice as effective as programs that did not. Cognitive programs were programs that employed more than one of the following intervention modalities: problem solving, negotiation skills training, interpersonal skills training, rational-emotive therapy, role-playing and modeling, and cognitive behavior modification. Most success with these cognitive programs was noted in community rather than institutional settings. Fifteen of the sixteen cognitive programs were effective (94%), whereas only 10 of the 34 non-cognitive programs were effective (29%) and 71% failed.

The cognitive model that was adapted for a study included adaptations of the following techniques: structured learning therapy to develop social skills, lateral thinking to teach creative problem-solving, critical thinking, values education, assertiveness training, negotiation skills training, interpersonal cognitive problem-solving skills, role-playing, modeling, social perspective training, and a host of audio-visual presentations, reasoning exercises, and group discussion techniques designed to foster the offender's social-cognitive development.

The 80-hour program focused on modifying the impulsive, egocentric, illogical and rigid thinking of the offenders, on developing their social perspective-taking values, and on teaching them to stop and think before acting, including considering the consequences of their behavior on other people (including their victims). A group put through this program by probation officers had a 9-month reconviction rate of 18%, compared to 48% for a life skills group and compared to 70% for a group on regular probation. This type of program could have value if adapted for the jail-based setting.

2. Cue Exposure and Craving Therapy

A study by Strang, Gossop, and Bradley in 1988 developed exposure therapy formerly used on alcoholics and adapted it for opiate addicts. During exposure treatment, the 53

addict is exposed for long periods of time to objects and situations which set off cravings, while refraining from using drugs. Prolonged exposure leads to a reduction in self-reported craving to take a drug (Bradley and Moorey, 1988). The findings so far suggest that prolonged exposure is effective in breaking the link between the sight of drug-related cues and subjective craving. Separate from direct application of cue exposure treatment, it may also fulfil a valuable function in the pre-discharge assessment of cue vulnerability, in which form it would not only be a valuable research tool, but would also assist in post-detoxification rehabilitation.

3. Chemical Adjunctive Therapies

At the Fair Oaks Clinical Research Center, it was learned that the use of Clonidine in opiate withdrawal made it possible to withdraw opiate addicts efficiently without the disadvantages of traditional Methadone treatments (Miller, Gold, and Pottash, 1989). The use of the opiate antagonist Naltrexone is useful for relapse prevention in opiate addiction. Naltrexone is an opiate receptor antagonist; it produces a chronic opiate receptor blockade. As a result, it effectively blocks the effects of opiates, such as euphoria and opiate intoxication. The sequential use of Clonidine and Naltrexone, in conjunction with drug treatment, appears to be a viable and effective adjunct to treatment for opiate addiction in motivated addicts.

IV. Critical Issues in Program Development and Implementation

A. Management Issues

1. Mission Statement

Prior to beginning the development of a drug treatment program, a very important step --often overlooked--is to establish a direction for development, or "mission statement." The mission statement will define what is to be done, how it will be accomplished, who will be responsible for treatment, and who is being targeted for treatment. With a clear mission statement, the staff involved have guidance in directing the development of programs.

The mission statement is best prepared in a group process. This allows maximum input and creates a feeling of "ownership" on the part of the participants. Once completed, the mission statement should be distributed to development staff, management, and correctional/treatment staff. The mission statement should remain fluid throughout the development stages of the program to allow for ongoing improvements in it.

2. Policy and Procedures Development

For a drug treatment program to operate successfully, it must have clear policy and procedures. Policy and procedures set the stage for consistent operation, accountability, training, and program evaluation.

The successful development of policy and procedures is best accomplished by use of a task force process. This allows maximum input from staff and creates a framework for a team approach that will enhance the ultimate operation of the unit. This approach reflects the philosophy "people support what they help create." The task force should consist of personnel from treatment as well as security in order to address treatment and security issues. One of the group's first tasks should be to create a table of contents that is in essence an outline for the development of the manual.

Co-coordinator positions can play an important part in the development of policy and procedures. One co-coordinator represents corrections and the other, treatment. During this process, the co-coordinators act as overall managers, setting assignments and suspense dates, and developing post orders.

3. Selection of Treatment Provider

When considering the implementation of a drug treatment program within a correctional setting, one of the most important issues is whether to contract with a private provider for delivery of treatment service or to develop treatment service internally.

Both options have their pro's and con's; what works better for one correctional institution may not for another. The decision must be based on the availability of staff and facility space, departmental rules, funding, treatment modality, and type of program being considered.

If program developers decide to contract for treatment services, the contract must state unequivocally all requirements concerning purchase of equipment and supplies, maintenance of equipment, budgetary limitations, licensing requirements, regulatory standards, number and type of personnel, selection criteria, hours of operation, program schedule, and any after-care services to be provided.

a. Selection Criteria

Program developers should use the following criteria in selecting a treatment provider:

- Stability in the community
- Involvement in the community
- Proven track record
- Previous criminal justice system involvement
- Financial stability
- Expertise in treatment modality
- Employment selection criteria
- Aftercare services offered
- Connection with other treatment providers

b. Communication

Clear and open communication is very important when selecting a treatment provider. It is also important, of course, once the program is in operation, for management to meet regularly to discuss operational problems, suggest improvements, and solve problems. Good communication facilitates the monitoring of the contract service to assure quality control. It also helps security and treatment staff avoid "turf" problems. For example, if all parties approach problem-solving with a "win-win" attitude, they may overcome the perception that the two disciplines' missions are irreconcilably at odds.

4. Organizational Chart

The structure, coordination, and management of the program may be expressed most clearly in an organizational chart. Such a chart also lends itself to problem-solving at the grassroots level. The organizational chart should depict who has the responsibility for coordination of the program both from the security side and from the treatment side. It should also depict management/supervision responsibility. All positions within the program should be included on the chart.

5. Job Descriptions

In order to develop a program function, including policy, procedures, and organizational chart, job descriptions are needed that clearly state the tasks that staff are expected to perform. These job descriptions should be reviewed prior to implementation to ascertain that they do not cause a conflict with other staff's job duties, jurisdictional personnel policies, union guidelines, etc.

6. Administrative Commitment

In developing a drug treatment program, it is imperative to have the support of top administration. Administrators and managers are responsible for setting the program's mission. They also carry out the mission and educate their peers and subordinates about it. Staff, criminal justice system personnel, and members of the community may have preconceived notions about the need for drug treatment programs in corrections. They may view such programs as "coddling" or not "punitive" enough. They may view most inmates as "unsalvageable." It is for these reasons that administrators must educate staff, the criminal justice system, and the community about the need for drug treatment and the expectations of staff and the program.

By "setting an example," administrators engender support for the program mission among institutional staff. They must also enlist support within the criminal justice system: it is critical to meet with probation department directors, judges, prosecutors, and public defenders. By sharing their program expectations with members of other criminal justice agencies and the public and educating them as to the need for drug treatment within the jail, program administrators can then elicit cooperation and assistance in the successful development and implementation of the program.

7. Facility Considerations

a. Designated/Isolated Unit

The housing of program participants together in a dedicated housing unit that is separate from the general population inmates, helps to form an environment that is consistent with the program goals and objectives. Such a housing environment should allow institutional work assignments, recreation, relaxation, sleep, meals, and counseling to take place apart from the general jail population. This separation helps program participants achieve positive behavioral changes and avoid the many elements of a jail environment that make drug treatment difficult. Among these may be the availability of drugs in the general population; the prevailing "jail culture" values, and intimidation and violence, especially as associated with inmate gangs. In some jurisdictions, gangs form alliances to establish and maintain "turf," control the flow of drugs within the institution, and provide "protection" for other offenders. These environmental attitudes and activities are disruptive to drug treatment goals.

b. Designated Treatment Areas

Program and jail administrators need to allow for adequate programming space. They must carefully match available space with proposed programming, examining the issue both from a programming and a security perspective. Not all correctional facilities are appropriate for milieu or therapeutic community programming. This can be especially true of older facilities in which space is being converted to meet the needs of a treatment environment. Where existing space cannot meet the requirements for a milieu modality, another treatment modality must be chosen (a drug education program, for example). The expected treatment outcomes for another modality, however, will be different from those of a milieu modality.

8. Program Quality Control

Quality control is an upper management function that ascertains whether program goals and objectives are being met. Quality control involves both program evaluation and accountability. It entails frequent visits by the program administrator or director to the program unit, to check the environment and monitor program outcomes. Quality control should be built into the management of the program in the form of a thorough program evaluation study. Monthly reports that indicate the type of activity that is occurring in the program (from treatment to incidents) are another essential aspect of quality control.

9. Licensing or Certification

Many states issue standards with which jail drug treatment programs much comply. Licensing or certification will vary depending on state statute. State standards may address such disparate elements such as staff training and qualifications, housing, diet, budget, case management, and documentation.

State licensing can influence program design and effectiveness positively by requiring professional and structured program service. For example, qualified personnel may be required to operate and work within the housing unit. In addition, licensing or certification may facilitate the acquisition of program funding and support the program in the face of possible legal challenges.

10. Legal Review

In any jail, the operation and programs are subject to legal challenges by inmates and outside agencies. Once the drug treatment program is developed, the agency's legal advisors or the district attorney should review it to ensure compliance with all applicable regulatory standards and protection of inmates' civil rights.

11. Program Costs

Program costs can vary widely. Surveys conducted by the American Jail Association have indicated that treatment programming typically costs eight dollars per day, per inmate, above the costs of basic inmate housing.

The costs of a jail drug treatment program will be affected by many variables, including:

- Program type
- Personnel needed, including program-specific treatment staff
- Contract vs. non-contract staff
- Program participants - types and numbers (sentenced, unsentenced, or both)
- Program space and housing requirements
- Equipment and supplies requirements

a. Program Type

Costs will vary based on the type and intensity of the program. For example, if an agency selects an intensive therapeutic community, then more staff and resources will be needed than for an educational program. Multi-layered programming that offers treatment tailored to specific classifications of inmates has been shown to be quite effective.

b. Personnel

For many programs, the assignment of corrections officers is an "in place" expense and additional security staff are not needed. For other programs, additional staff may be required, depending on the type and intensity of programming offered, the types of inmates participating, and the structure or housing unit in which the program will take place. The need for clerical support, whether full- or part-time, must also be considered.

c. Contract or Non-Contract Staff

The decision to use contract or non-contract staff for the provision of treatment services will affect the costs of the program. Close attention should be given to the overall program plan in terms of allocation of responsibilities among staff.

The staff structure of program delivery will also effect costs. For example, will counseling staff be supported by less experienced, and less costly interns?

d. Program Participants

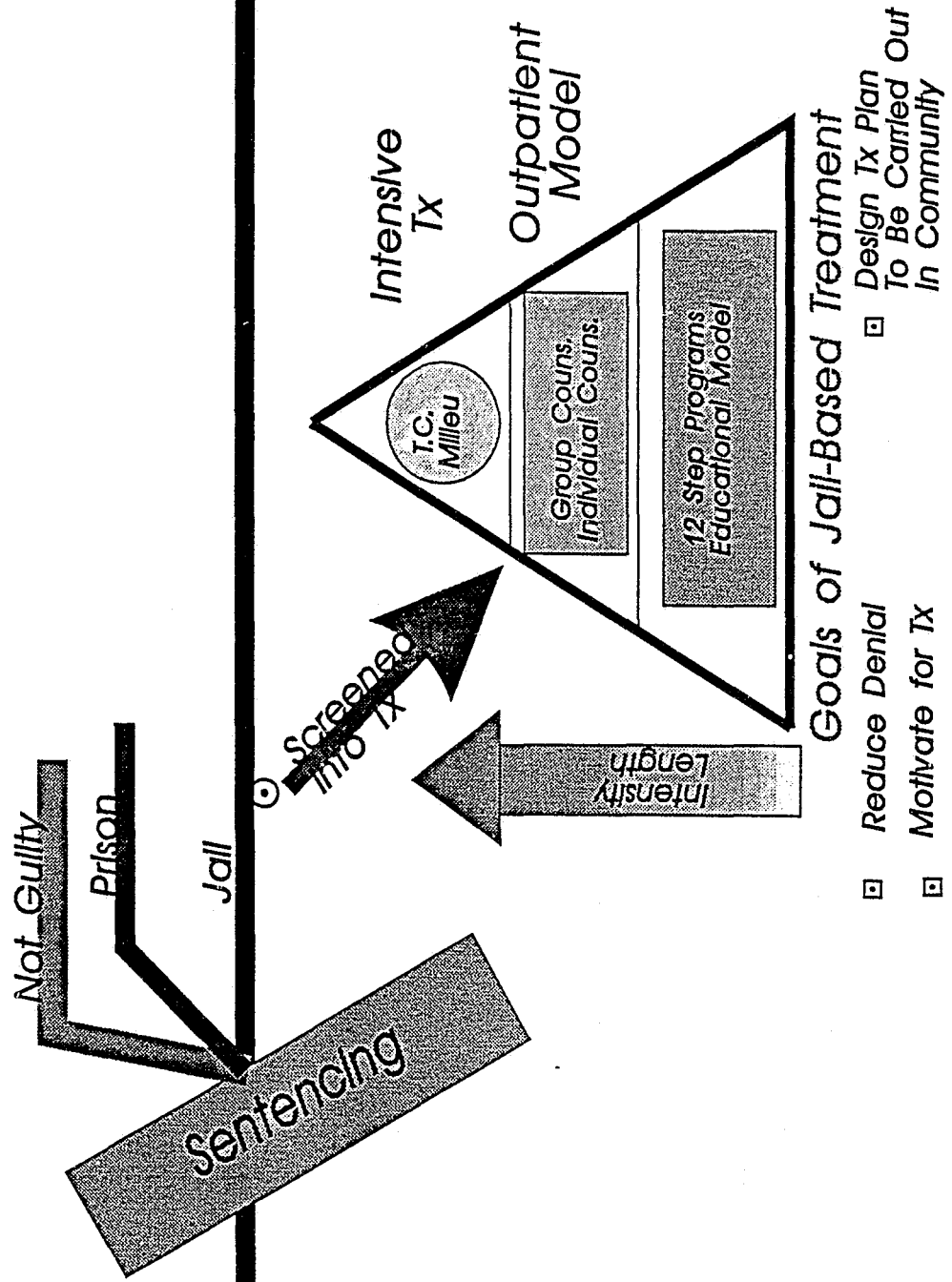
The type and number of inmates participating in the program directly affect program costs in terms of staffing, the size and type of housing unit used, program space, type of program, and service delivery. The agency must decide what type of inmate (pre-trial, sentenced, or both), will receive treatment service.

e. Program Space

Program space -- including, if required, a designated housing unit -- will affect program costs. If existing housing or program space is already available, costs will be minimal. Should a newly constructed or remodeled area be needed, costs will be greater.

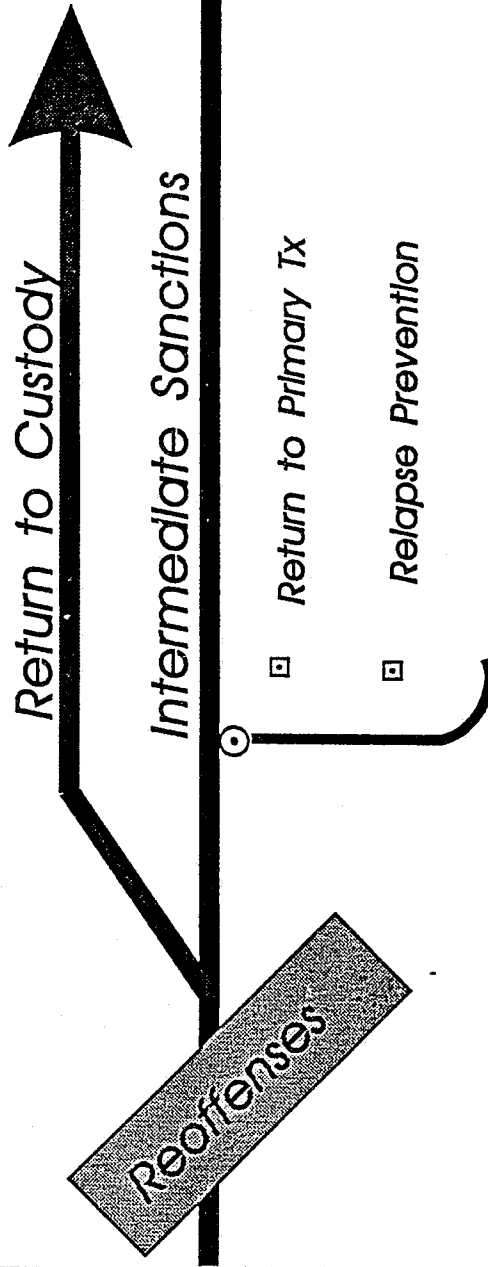
Points of Linkage In the Criminal Justice System

Sentenced



Points of Linkage In the Criminal Justice System

Reoffenses



f. Equipment and Supplies

Equipment, such as furniture and recreational equipment, must be considered. Supplies, for example, educational materials, will be needed. Maintenance costs of the program space and equipment must be included.

B. Perpetuation of Program

Many jail-based programs have found it is easier to find start-up funding than to find long-term funding commitments. Federal and state agencies often fund the initiation of local drug treatment programs; when the funding period expires, local programs must turn to the community for continued funding. Several successful jail programs have been forced to close or significantly reduce their programming in light of funding shortages. The following ideas have proved useful to jail-based programs in sustaining their offender drug treatment mission.

1. Public Relations and Politicking

The continued funding and support of a drug treatment program goes hand in hand with public relations. Involving the community, educating the community, and using the media to accomplish this are critical to continued program longevity. The perpetuation of any treatment program relies on the efforts of the administration to convince the community and key public officials of the importance of the program. Several basic sources of support and communication can be employed to meet this challenge.

a. Citizen Information/Advisory Board

This board should consist of legitimizers; i.e., persons in the community who have an interest in drug treatment, and the betterment of the community and who have political, financial, or moral clout. Persons to be considered should be key officials in government and the courts, representatives from the community at large, mental health agency directors, media representatives, etc. The group should meet formally every few months to discuss the program. Meetings can comprise briefings on current program strengths and weaknesses or program participant graduations, for example. Other agenda items may include discussion of drug treatment by keynote speakers, or other efforts to educate and inform the board and the community. Meetings also afford opportunities to recognize persons with special awards. They should be open to the public and should welcome the media.

b. Program Newsletter

A newsletter should be used to present articles written by program staff and participants. Guest authors and a "winners' circle" could also be featured. Distribution of the newsletter is critical. Circulation should be widespread and should include newspaper, radio, TV stations, key county officials, judges, legislatures, community action groups, and civic organizations involved in drug education and treatment.

c. Public Service

Representatives of the program, including selected participants, should be available to make speeches regarding the program and drug treatment to civic groups and schools and at public meetings.

2. Modified Program Design

When long-range funding prospects are uncertain, programs that are designed with stand-alone treatment components, or interlinking independent modules, offer the best chance of maintaining continuity of effort. For example, if a treatment program offers a therapeutic community with a stand-alone drug education component and strong 12-step programming, it is likely that one or two of the components could survive a funding reduction intact. Then, if programming is reduced, the program goals and objectives could be modified -- with expected treatment outcomes altered as well. These stand-alone components lend flexibility in a reduction so that a complete disruption of programming is not inevitable.

3. Funding Partnership Model

One model of funding jail-based drug treatment programs is a shared-cost approach. Partial funding might come from health services, from state and county alcohol and drug program funding, from the local sheriff's inmate welfare funds, and from county general funds. This multiple-funding model reduces dependency on any one source of funding.

4. Income Generating

Some jail-based programs have employed the jail-industry concept to generate additional operational and programming funds. Jail industries often attract start-up funding that is not a part of the jail's operational budget. Local and regional foundations can sometimes provide the one-time funding needed to purchase equipment or materials for the jail industry. Inmate welfare funds might also be allocated for this purpose.

5. Shared Staff

Jail-based drug programs can often reduce staffing costs by sharing staff with other agencies or other jail programs. Examples have included the use of community AIDS outreach personnel within the jail program; the use of community drug, health, and mental health providers for specialized programming; and the sharing of jail education program and/or mental health program personnel with the drug treatment program.

6. Volunteer/Interns

The contribution of volunteers and interns can maintain and enhance the goals of a treatment program. Volunteer organizations can provide both physical and human resources to supplement programming. In fact, in a survey of jails conducted by the American Jail Association, 12-step programs provided by volunteers were one of the programming options most commonly offered to offenders. Other resources that treatment jails have used include churches and religious organizations, local colleges, and civic and fraternal groups.

Jail-based programs should consider the use of interns from local and regional drug counseling training programs, particularly if this can be coordinated with jail mental health personnel. Generally, a psychologist or a counselor with at least a master's degree is needed within the jail to supervise the interns.

The staff selection standards used to select volunteers and interns should be in line with those required by general department policy. Personal interviewing is imperative to assure that expectations are realistic and compatible with program goals.

7. Evaluation

One reason to evaluate a drug treatment program within the jail is to determine whom it benefits. As mentioned previously in this monograph, benefits are experienced within the jail environment, within the correctional staff, within the participating inmate group, and, finally, within the community. By carefully examining what benefits accrue to other publicly funded agencies from the jail-based drug treatment intervention, the jail administrator can develop a case for shared funding or shared personnel from the benefiting community agency.

Consider the following hypothetical example. A jail-based drug treatment program performed drug assessments widely within the jail population on sentenced and unsentenced offenders. The obvious beneficiaries of this service would be the courts,

probation, and the public defenders. The courts would have access to information from the assessment that would make sentencing options easier. The probation department would be able to provide more comprehensive pre-sentence investigations and would not need to hire a separate drug treatment specialist to perform the tasks undertaken by the jail. The public defenders would have access to treatment planning and recommendations generated by the assessment. This information would prove valuable in preparing their cases.

An evaluation of the drug program might reveal that 230 inmates were assessed in one year at a savings of \$20,000 to probation, \$4,000 to the courts, and \$11,000 to the public defender's office. A jail administrator could approach the agency department heads, the justices, and/or the county manager with these arguments and suggest shared funding.

8. Development of a Non-Profit Organization

Another approach to obtaining funding may come from the development of a jail drug treatment non-profit organization. Some funding sources would not ordinarily be available to corrections agencies, but may be available to a non-profit entity. This may make accessible both private and public sector funding. Development of such an organization should include a legal review in regard to appropriateness within a jurisdiction or department.

C. Program Staffing

1. Co-coordinators

The relationship between corrections and its concerns on the one hand and treatment and its concerns on the other is obviously a central issue in the success of jail-based drug treatment. One successful model, the Amity/Pima County Program, employs co-coordinators for its in-jail drug treatment program: one for treatment and one for security. This experiment with dual leadership has proven to enhance teamwork and increase staff members' effectiveness. The typical behavior of program participants is very manipulative. The day-to-day management and problem-solving efforts of two co-coordinators also help frustrate inmate attempts to manipulate staff and disrupt the program.

The successful relationship between treatment and corrections at Amity/Pima County was not accidental. Great care was taken by both treatment and corrections to assign the co-coordinator roles to individuals with strong communication skills and sensitivity to the

concerns of others. The co-coordinators spent considerable time together prior to the onset of programming to discuss potential issues and to establish a close working rapport.

2. Staff Selection

Without clearly defined selection criteria for treatment and security staff, the program will suffer from inconsistencies.

a. Security Staff

Correctional officers must be willing to work in the treatment program unit. They must understand the relationship between programs and security, exercise flexibility and good judgement, and have excellent interpersonal communication skills. They must perform their job duties without jeopardizing security.

b. Treatment Staff

Treatment staff recruitment problems can have a great impact on a jail-based drug treatment program. In many communities there is an acute lack of qualified and experienced drug counseling personnel with corrections experience. Among jail-based programs, there is often a debate as to which staffing model is preferable: the "professional" model or the "recovering addict" model. The "professional" model calls for the selection of staff who are educated, trained, and experienced in counseling, psychology, or social work. The "recovering addict" model promotes the use of ex-addicts/ex-offenders in key leadership and clinical positions (Inciardi, 1990). Professional counselors are more costly but generally have clinical skills and a detachment not found in the recovering addict counselor. Recovering addict counselors, however, are excellent role models. They have developed coping skills, in terms of living in the community while abstaining from drug use, that drug-dependent offenders may find meaningful. Recovering counselors also provide offenders with a credible role model that they can relate to.

In all cases, treatment staff must be thoroughly screened and interviewed to confirm that they have the skills and ability to work in a correctional setting. Should previous offenders and/or recovered substance abusers be employed, they must have successfully completed any probation requirements and must have demonstrated and verified a substance-free lifestyle for at least two years. In some jurisdictions, convicted felons cannot work in correctional facilities. This prohibition can sometimes

be circumvented by having the contract agency (the agency that provides the treatment) hire the recovering addict counselor.

c. Role Definition: Mutual Support of Security and Program Staff

In order for staff to function in an effective manner in any job, they must have clearly defined roles and expectations. Most commonly, this definition comes from management, which should clearly communicate its views and support for a particular function or program. It is also important to involve security staff in the treatment aspect of the program; treatment staff must be equally able to abet the security of the housing unit. (See the discussion of cross-training in "Staff Training" below.) By involving both, mutual support and teamwork are fostered, which ultimately enhance both treatment and security.

It is important to remember that "without security there are no programs and without programs there is no security."

D. Staff Training

Nothing is more crucial to the success of a drug treatment program than training. The need for training is often disregarded, however, because training requires time and money. Without a comprehensive training program, though, the costs of a program can skyrocket, or the program can fail.

Generally, a training program should reflect the agency's needs and pertinent local issues. Additional training opportunities should be offered to others in the treatment/criminal justice continuum. This might include judicial briefings on the effects of sentencing on jail-based treatment programs, or parole and community corrections briefings on strategies for drug treatment intervention and coordination in the criminal justice system and the community.

At minimum, training within the institution should include the following personnel:

- Treatment staff
- Correctional officers
- Correctional treatment officers
- Supervisory personnel (treatment and correctional)

Training prior to the start-up of the program is called transition training and involves the learning and practicing of all institutional and treatment-related tasks required in operating the institutional program. As this phase of training is complex, many jails request professional training assistance.

Ongoing or in-service staff training can take many forms. Most often it involves improving the skills and knowledge required to perform one's job safely, effectively, and efficiently. Staff participation in this kind of training should be an institutional priority. In addition to in-service training, sufficient funding should be allowed in the training budget for staff to continue professional development or meet certification requirements off site.

1. Cross-Training

A part of general staff training that is critical to a drug treatment program's success is cross-training. Cross-training is the training of treatment staff about corrections issues and training corrections staff about treatment issues. Cross-training promotes teamwork and leads to more successful issue resolution while promoting better understanding of roles and stereotyping. Cross-training should be conducted several months before the onset of programming, a few weeks or days before program commencement, and at regularly scheduled in-service training sessions.

Suggested cross-training topics include:

- Basic addictions curriculum
- Program philosophy
- Treatment methodology
- Inmate management style
- Life/safety procedures
- Disciplinary procedures
- Report writing
- Team building
- Legal issues/inmate rights
- Policy and procedures
- Communication skills
- Cultural diversity

A cross-training curriculum for probation/parole officers and drug treatment personnel has been developed jointly by NASADAD and APPA. Efforts are under way by Corrections

Research Institute to develop a cross-training curriculum for corrections and drug treatment personnel.

2. Cultural Competency

It is important that program staff deal effectively with cultural and regional diversity among participants and staff. Staff should be specifically trained to recognize, respect, and understand culturally sensitive issues that may influence program effectiveness. Certain aspects of a program may be offensive to, or not well received or understood by, participants. Staff should be competent to initiate appropriate discussion of cultural differences and the impact these differences may have on the therapeutic community and program goals.

E. Participant Selection

1. General Considerations

Preparatory to the implementation of any jail-based drug treatment program, it is essential that the program designers meet with corrections personnel (and perhaps others in the criminal justice system, such as work release and community corrections personnel to reach agreement on client selection and release-eligibility criteria. Each agency must assess its resources and mission statement. For example, some programs deliver services to just-sentenced offenders, or to pre-trial detainees; others may target individuals diagnosed as mentally ill and as substance abusers (dual diagnosis or MICA). Coordination and compromise may be necessary to allow "work-release" inmates to participate in treatment programming. When weighing options, consideration should be given to the resources and housing available, program goals, as well as what will ultimately be most beneficial to inmates, the institution, and society.

The criteria for selection of program participants should be relatively broad to provide maximum flexibility. The inmate's institutional record, history of violence, and desire to address his/her addictive behavior should be considered.

Security and treatment staff together should conduct the interviews of prospective participants and should be equally involved in the decision to grant or deny admission to the program. In the Amity/Pima County model, both co-coordinators engage in this activity. Implementing the process in this manner emphasizes teamwork and solidarity between corrections and treatment staff. Inmates see that there is little chance of pitting staff against one another.

2. Length of Program Participation

The length of participation in a treatment program is directly correlated with success in overcoming drug abuse. Participants need an uninterrupted minimum of 45 days in a jail-based treatment program. This allows treatment staff to deal with denial and other issues related to addictive behavior. It is best to design programs of a minimum of six weeks and a maximum of six months' duration. The best programs are long enough to effect an impact on the offender but short enough to allow significant numbers of inmates to complete it prior to being released.

Consequently, an effective selection policy would be to exclusively admit inmates for who it is expected will be detained for at least 45 days subsequent to entering the program. This would hold true for unsentenced as well as sentenced offenders. Because of the length of time that some offenders remain in jail unsentenced, unsentenced inmates are also appropriate candidates for inclusion. In fact, the majority of detainees' stays in jail are as unsentenced offenders. Many detainees are ultimately sentenced to time they have already served.

3. Gatekeeping Functions

Problems have arisen in some jurisdictions because judges have sentenced offenders directly to treatment programs without the approval of program staff. This arrangement has proven unsatisfactory because these unwilling, unmotivated, and inappropriate participants have undermined program goals and objectives. To avoid this outcome, it has generally been determined that program representatives are the most appropriate to maintain the integrity of the treatment program, and this must include the screening of participants.

"Gatekeeping," then, is the process in which the control and authority for participant admittance to the program are maintained internally by program staff, not by the external criminal justice system. Only designated program staff (possibly co-coordinators) have the authority to admit potential entrants to the program.

To facilitate coordination and understanding between program and criminal justice representatives, program directors should meet regularly with judges and probation officers to discuss program goals and objectives as well as the criteria for admission and discharge. Program representatives should discourage the use of court orders and other directives. Training suggestions for the judiciary are further discussed in the section "Staff Training."

4. Co-Ed Programming

The courts have mandated the provision of equal programming opportunity to male and female inmates. Co-ed programming need not be disruptive if planned properly. Clear policies and procedures, as well as guidelines regarding participant behavior, should be established. Inmates should understand that there will be no tolerance of -- and immediate consequences for -- inappropriate behavior. The guidelines should be explained in detail to staff and participants, with ample opportunity provided for them to ask questions.

F. Treatment Issues

1. Confidentiality

There should be a clear understanding between staff and inmates regarding confidentiality. Inmates' expectations of confidentiality should be limited to treatment-related issues, victimization, and other participant issues. Program participants should be advised of this during program recruitment and orientation.

Communication of confidential information should be handled discreetly among staff. Issues that fall into "gray" areas should be discussed by corrections and treatment staff. Given the sensitivity of this issue, violations can seriously hamper program operations and cause distrust among staff.

The issue of confidentiality should be addressed in the staff training program at the beginning of the program. It should also be included in the policy and procedures manual and in the orientation of new staff members and participants.

2. Buddy System

Many successful jail-based programs employ a variation of the "buddy system," in which seasoned participants are paired with new recruits to explain program procedures and to answer questions. The buddy system has shown merit in many settings, but especially following confrontational therapy sessions, when buddies can help newer participants "cool down."

The Amity/Pima County program reports an incident that led to the adoption of a buddy system. Following a particularly confrontational group counseling session, the program participants had returned to their rooms for the night. A new participant, who had not "cooled down" completely, kept thinking about issues that had surfaced during the group

session. He felt humiliated, convinced he had lost face, and attempted suicide in his closed room. Two improvements came from that situation. The buddy system was initiated to attempt to prevent such incidents. In addition, participants were allowed to keep the doors to their room unlatched at night so that they could leave their rooms to talk with an officer if they needed to.

3. Rule Infractions

It is important to handle rule infractions within the program. A program that is not secure is not effective. However, rule infractions should be handled with flexibility, using techniques such as "time outs" or a "sitting pew." Other methods of graduated sanctions could require the offender to compose essays or carry a sign drawing attention to the new behavior being implemented. No infractions involving acts of violence or drug use should be tolerated, however. The rules and consequences of their infraction should be spelled out and clearly understood by staff. Legal reviews as needed should confirm the appropriateness of sanctions.

G. Urinalysis

Most jail-based treatment programs require the offenders to undergo urinalysis testing at some point in their incarceration. Urinalysis is useful in supplementing initial drug-use assessments: inmates are more likely to discuss their drug use when faced with irrefutable evidence of it.

Another point in favor of urinalysis is that it maintains program integrity. Inmates know that random and with-cause testing will reveal their drug-using behavior. Test results must be returned within a day or two for random testing to be effective. Longer waits reduce the immediacy of sanctions and the program's integrity. Regular urine testing of all program participants during the in-jail phase of treatment, however, does not seem warranted.

Urinalysis should be a component of work-release options and should be continued on a regular and/or random basis following release to probation. There is sufficient evidence that urinalysis coupled with post-release treatment increases positive treatment outcomes.

V. Program Evaluation

A. Overview

The need for in-jail drug treatment services has become increasingly apparent in the past several years as a growing number of drug-involved individuals are arrested and placed in jail to await trial or to serve a sentence. A large proportion of recent jail admissions are repeat felony offenders, and, if untreated, are likely to return to a pattern of drug abuse and crime. As drug treatment programs are developed in jails, there is a corresponding need to evaluate the effectiveness and impact of jail interventions, particularly with respect to reductions in further drug use and criminal behavior. Little is known, for example, about which drug treatment modalities are most effective for use with jail inmates, and the optimal length of treatment in this setting.

Evaluation activities are also useful in ensuring accountability of the program to jail administrators, county officials, and others who are interested in the effective use of jail resources. The importance of evaluation activities is magnified by the prevalent belief that jail inmates are incorrigible, resistant to treatment, and that resources should not be spent on treatment due to high rates of recidivism traditionally associated with drug abusers, in particular, or with correctional populations, in general. A comprehensive evaluation program will help describe the usefulness of an in-jail drug treatment program in preventing subsequent drug use and crime, and will contribute significantly to an understanding of the cost effectiveness of allocating scarce resources towards treatment in a jail setting. This chapter will address several key issues in the development of such an evaluation program.

B. Defining Evaluation Goals

Evaluation is sometimes thought of as an isolated activity that ultimately has little bearing on the daily operation of a successful treatment program. Many programs developed in jails, prisons, and in other criminal justice settings have not involved evaluation activities. As a result, our knowledge of the effectiveness of correctional drug treatment is not as extensive as it might be.

This chapter will discuss the potential uses of evaluation. Evaluation can serve as an administrative tool to gather information regarding client/inmate needs and to assess difficulties arising in the early stages of treatment program development. It can also serve

as an important research tool to examine inmate progress achieved during the course of treatment, and outcomes for inmates released from treatment.

A major consideration in determining what type of evaluation program to develop in a jail setting is the intended audience. Taking the broadest perspective, there have been few systematic studies of drug treatment programs in jails; thus, there is considerable national interest in the impact of such treatment on the growing drug-involved inmate population. However, for many program administrators, the most important consumer of evaluation information will be supervisors within the jail, city, county, or state funding agency. A critical challenge in developing evaluation efforts is to assess the short- and long-term needs for information among these constituents, to prioritize these needs, and to then determine appropriate methods of data collection and dissemination of findings.

Once the target audience is defined, the next step is to determine specific evaluation questions. For many program administrators there will be a primary need to gather program data concerning patterns of inmate admission to, and participation in, the program. In addition, most programs will be asked to provide some measurement of success in treatment and of community adjustment following release from the program (e.g., involvement in treatment, drug use, rearrest). Two common areas of evaluation involve data collected during the treatment program (in-treatment) and data collected after release from the program (post-treatment or follow-up). In-treatment measures are somewhat easier to obtain and include information collected at the time of intake (including jail records, pre-sentence reports, or materials received from non-criminal justice agencies), at predetermined markers during treatment, and at the conclusion of treatment. Post-treatment measures require additional contact with program participants or collaterals, probation officers, community treatment staff, or examination of criminal justice databases.

Several critical questions may be addressed in the course of in-jail drug treatment evaluation activities:

1. What are the characteristics of the treatment program? Basic statistics regarding program census, length of stay, frequency of successful discharges and of unsuccessful terminations, characteristics of unsuccessful terminations, cost of the treatment program, the proportion of unsentenced and sentenced inmates, and the number of staff are essential in describing program operations. This information is crucial in examining how the program fits within the larger jail organizational context

and in providing an accurate picture of facility size, costs, and staff and administrative needs for individuals not familiar with the program.

2. What type of treatment is being provided? Although this question appears to be superficial, it is not uncommon to read or hear descriptions of drug treatment programs in correctional settings without fully understanding the intensity or the type of treatment that is actually provided. Surveys conducted by the National Institute of Justice and the American Jail Association have found that many "programs" consist of no more than self-help groups provided by community affiliates of Alcoholics Anonymous or Narcotics Anonymous. Accurate description of what is provided in treatment requires periodic monitoring of group treatment sessions, individual counseling sessions and adjunctive activities. This information enables administrators to fully define the length and content of the treatment intervention and to assert with more confidence that changes observed in inmate behavior over the course of treatment are associated with a specific intervention.

A related evaluation question is whether the treatment provided in the jail program is consistent with the treatment that is intended. In other words, "Do the treatment sessions presented to inmates reflect goals and principles established by the program administrator/clinical director?" Again, this information is useful in order to insure that in-treatment and post-treatment findings are attributable to a specific and definable in-jail treatment intervention. Accurate presentation of an intended treatment intervention is enhanced through use of standardized materials, such as treatment curriculum manuals, that assist counselors in organizing and presenting materials.

3. How has the treatment intervention changed over time? Often, a drug treatment program undergoes substantial changes during the first few years of operation as a result of adding new types of treatment groups or interventions, expanding the length of treatment, changes in the philosophy of the program, staff turnover, and changes in the inmate population. Without monitoring these changes, results may be tainted by combining (for evaluation purposes) several diverse types of inmates or by combining several diverse treatment interventions. If these changes to the program are not examined, outcome evaluation results may be misinterpreted.
4. What are the characteristics of inmates in the program? This area of inquiry is important in understanding specific treatment needs of the referred inmate population and in establishing a baseline of pre-treatment behaviors and psychosocial functioning

related to drug abuse, criminal offenses, prior incarceration, employment, and marital/family relationships. Several important measures of treatment success rely on examination of pre-treatment behavior and functioning to determine changes over time that may be attributable to the treatment program. In addition, compilation of participant characteristics is useful in developing profiles of inmates who are successful (or unsuccessful) in completing the treatment program, and of inmates who experience successful adjustment to the community.

5. To what extent have inmates made progress toward treatment goals during participation in the program? In the absence of follow-up data that have often required a substantial amount of time to accumulate, it is useful to survey evidence of inmate progress during in-jail treatment. Although not describing outcomes following release from jail, in-treatment evaluation measures examining motivation, knowledge of drug coping skills, and abilities to apply coping skills in high risk situations provide important evidence regarding the impact of the treatment intervention on program participants. Other in-treatment evaluation measures need to be adapted to address specific treatment program objectives. These objectives may include reduction of behavioral incidents within the treatment unit, successful completion of the in-jail treatment program for a specific number of inmates, within a specific period of time, or inmate or staff satisfaction with the treatment program.
6. Does the treatment program have the intended impact following the inmate's release from jail? Probably the most requested information about any drug treatment program (and the most difficult to obtain) is "Does it work?" Are the program participants successful after leaving jail? Some program administrators have chosen to examine incomplete sources of data to provide answers to this question. As an example, one method of outcome evaluation that tends to inflate the program success rate is to sample only program participants who are released to residential treatment centers. Follow-up treatment in a residential setting is often as restrictive as in-jail treatment and does not provide a realistic gauge of recidivism or relapse. Measurement of follow-up evaluation outcomes (e.g. arrest, substance abuse) for these individuals should begin after release from residential treatment. Another potentially misleading outcome evaluation strategy is to define "success" as completion of the required number of in-jail treatment sessions without addressing follow-up measures. As a result of nonstandardization of outcome evaluation strategies and techniques, it is quite difficult to accurately assess and to compare outcomes for many drug treatment programs. In reality, it is possible to sample only a few of the many outcomes that are associated

with in-jail drug treatment. However, careful measurement of selected post-treatment variables such as arrest/incarceration, drug use, and employment provide an extremely useful means of assessing the long-term impact and cost effectiveness of an in-jail treatment program.

C. Methods of Evaluating In-Jail Drug Treatment Programs

The following section is a review of evaluation strategies designed to address each of the questions raised above. Of course there are many evaluation approaches and techniques that may provide useful information for program administrators. These approaches are necessarily developed according to the program goals, resources, and staff expertise. It is also expected that just as treatment programs evolve over time, evaluation strategies will also change to accommodate new sources of data and to meet additional needs for information.

1. In-Treatment Evaluation

In-treatment evaluation is conducted at the time of intake to the treatment program, during the course of treatment, and at the conclusion of the program. Key content areas to be addressed at intake include:

- sociodemographic characteristics
- education
- vocational training
- employment history
- previous and current living arrangements
- AIDS knowledge and behavior
- patterns of substance abuse
- problems related to substance abuse
- history of involvement with juvenile and adult criminal justice system
- current probation and parole status
- history of behavioral incidents within the jail setting
- substance abuse treatment history
- clinical assessment of alcohol and drug dependency
- psychiatric impairment or disorder and mental health treatment history
- health status
- family relationships

- social and cognitive functioning
- motivation to participate in treatment
- self-esteem

Within the area of substance abuse it is useful to obtain information regarding the following:

- lifetime drug use
- patterns of abuse in the period preceding arrest (e.g., past 30 days)
- preferred route of administration, including I.V. use
- age at first use and at first regular use
- history of drug use episodes, particularly in the several years preceding the last arrest
- the current drug of choice
- history of criminal activity and arrest associated with drug use
- periods of successful abstention from drug or alcohol use
- impairment in psychosocial functioning related to drug use
- family history of drug abuse
- coping skills to manage high-risk situations for drug relapse
- recent relapse experiences, including behavioral antecedents to relapse

Due to the incidence of cocaine use among inmates admitted to jail in the past few years, it is important to obtain specific information regarding the following:

- history of cocaine use and dependence, including binge behavior
- current route of administration
- sexual behavior associated with cocaine use
- severity of cocaine addiction

a. Instruments

A range of standard evaluation instruments may be employed to evaluate characteristics of program participants and progress during treatment. Comprehensive intake evaluation instruments for psychosocial and drug history information include the Addiction Severity Index (ASI; McLellan, Luborsky, Woody, and O'Brien, 1980), the Treatment Outcome Prospective Study (TOPS) Intake Form (Craddock, Bray, and Hubbard, 1985), the intake assessment battery developed for the Drug Abuse Treatment Outcome Study (DATOS; Research Triangle Institute, 1989), or the UCLA Natural History Interview Form. Another

recently developed instrument with potential use for in-jail treatment programs is the Individual Assessment Profile (IAP; U.S. Department of Health and Human Services, 1991). The IAP was designed by the Research Triangle Institute as an intake assessment for use in projects funded through the National Institute on Drug Abuse and the Office for Treatment Improvement. A supplement to the IAP is being developed to survey additional information relevant to criminal justice populations.

There are several clinical intake assessment instruments that provide a useful adjunct to psychosocial surveys. Clinical evaluation instruments to assess psychopathology and emotional functioning include the Hopkins Symptom Checklist/SCL-90, the Referral Decision Scale (RDS), the Minnesota Multiphasic Personality Inventory (MMPI-II), and the Millon Clinical Multiaxial Inventory-II. The first two instruments provide a brief but useful psychodiagnostic screening; the latter two instruments are more comprehensive but require more than an hour to complete. The Shipley Institute of Living Scale or the Revised Beta test provide a brief measure of cognitive and intellectual functioning. Other clinical instruments such as the Cocaine Abuse Assessment Profile (CAAP; Washton, Stone, and Hendrickson, 1988) or the Michigan Alcoholism Screening Test (MAST; Selzer, 1971) examine the extent of cocaine or alcohol dependency.

Several instruments have been developed to identify high-risk situations for drug relapse, and to evaluate coping skills used in high risk situations, and self-confidence in managing high risk situations. The Inventory of Drinking Situations (IDS; Annis and Davis, 1988) and the Inventory of Drug Taking Situations (IDT; Addiction Research Foundation, 1990) are useful in examining past situations that have led to substance abuse. The companion instrument to the IDS, the Situational Confidence Questionnaire (SCQ) evaluates the individual's perceived ability to resist alcohol use in these same high-risk situations. A similar measure of self-efficacy in managing high-risk situations for drug abuse is currently being developed by the Addiction Research Foundation in Canada. Situational competence tests such as the Problem Situation Inventory (PSI) are used to identify important areas of skills deficits in coping with high risk situations for substance abuse relapse. Other instruments, such as the Substance Abuse Relapse Assessment (SARA; Schonfeld, Peters, and Dolente, 1991) provide information regarding precursors of relapse, and current skills available to help prevent relapse.

Several in-treatment evaluation measures may be administered on a repeated basis over the course of treatment to gauge inmate progress. Key areas in which observed changes over time may be expected include the following:

- motivation for treatment
- knowledge of concepts provided within the treatment curriculum (e.g., knowledge of AIDS prevention techniques or of the relapse prevention model)
- behavioral skills rehearsed in treatment (e.g., coping skills, interpersonal skills)
- confidence in abilities to handle high-risk situations for drug relapse
- indices of emotional functioning (e.g., depression, anxiety)
- self-esteem

Several of the clinical instruments described previously, including measures of psychological functioning and situational competence tests, may be re-administered during treatment to assess changes in inmate functioning. The Situational Confidence Questionnaire is useful as a repeated measure during in-jail treatment to assess changes in self confidence in managing high-risk situations for drug relapse. Additional repeated measures have been developed for assessment of changes in motivation and commitment to treatment and of knowledge of key areas of the treatment curriculum. Changes over time in self-esteem are often measured by the Tennessee Self-Concept Scale.

In-jail program staff may also wish to adapt instruments to evaluate treatment integrity. This evaluation activity will help determine the extent to which drug treatment conforms to established treatment goals or to an established treatment curriculum. Evaluation of treatment integrity allows for periodic review of the content of treatment sessions and of counselor performance, and serves as a vehicle for identifying in-service training needs, particularly during the early stages of the treatment program. Treatment integrity rating scales have been developed (Laws, 1988) to address the comprehensiveness of coverage of treatment materials, use of handouts and exercises, the counselor's understanding of the treatment material, effectiveness of the counselor in communicating treatment concepts, and overall quality of the treatment session.

Other evaluation measures administered at the conclusion of in-jail treatment are useful to assess participant's response to the program, including general satisfaction with the curriculum, degree of rapport with staff, and suggested changes in the content or format of treatment. These instruments (Research Triangle Institute, 1981; Dolente and Peters,

1989) may be self-administered or administered by a counselor, usually at the time of the final in-jail treatment session. Key areas of information obtained include the degree to which the treatment program is perceived as meeting the inmate's treatment needs, as enhancing the inmate's understanding of drug dependency, and as useful in assisting the inmate to prevent subsequent drug relapse. In addition, participants may be asked to assess the quality of counselors, the treatment curriculum, and the length of the treatment program, and to identify the most useful (or least useful) aspects of the program.

b. Procedures

Development, implementation, training, and oversight of a comprehensive evaluation program and dissemination of evaluation results require at least part-time commitment of a designated treatment program staff member. Evaluation duties should be clearly described within the employee's job description and should be approved by the jail administration. Clerical assistance is also required in order to input data and to analyze results. A personal computer with word processing and statistical capabilities is also recommended. In some cases, the services of nearby universities or community colleges may be enlisted to assist in designing the evaluation program, implementing the evaluation, and analyzing data. Faculty or staff from statistical consulting centers at major universities or faculty members in departments of criminology, psychology, sociology, and rehabilitation sciences may be willing to assist in evaluating programs or in developing statistical programs for data analysis.

Inmates should receive a full explanation of all pertinent aspects of the evaluation assessment and give their informed consent prior to participating in the assessment. This procedure should be effected by a treatment counselor in the presence of another staff member. It should include a description of any potential risks and benefits associated with participation in the evaluation assessment, with consequences for refusal to participate. Each inmate should be informed of the limits of confidentiality that apply to the evaluation assessment. In most cases this information is included in the treatment record and will be reviewed by treatment and evaluation staff, as needed. Barring disclosure of intentions to escape, imminent threats to harm self or others, or acts of child abuse perpetrated by the inmate prior to incarceration, the confidentiality of evaluation information will ordinarily be assured. All treatment counselors should receive an orientation to evaluation strategies and on-site training and supervision in methods to obtain informed consent, use of evaluation instruments, and data collection procedures

prior to involvement in intake assessment. Correctional officers involved in evaluation efforts should receive similar training.

Evaluation assessment at intake to the treatment program should be conducted individually in a private interview area. Consideration should be given to allow sufficient time to answer questions that may arise (e.g., whether information will be used by the prosecutor in court or by probation officers), and to take occasional breaks. Use of a battery of psychosocial, clinical, and other in-treatment evaluation instruments does not involve collection of significantly more information than would ordinarily be obtained through a comprehensive intake assessment to a drug treatment program.

In-treatment evaluation measures are ordinarily administered within group treatment sessions. Whenever possible, time should be provided within the treatment session for interpretation and discussion of these measures. The clinical supervisor should monitor treatment integrity by periodically observing group sessions. Following observation of the session, the supervisor may wish to complete a structured treatment integrity rating scale and to meet with the treatment counselor to discuss observations. Serious performance deficits revealed through treatment integrity evaluation should be corrected through retraining prior to the counselor's resuming treatment responsibilities.

In-jail drug treatment evaluation efforts are enhanced by development of procedures to ensure accurate and efficient coordination of data. These may include occasional checks on the reliability of data collection, coding, scoring of test instruments, and data input. Intake and other in-treatment data should be added to the database as collected. A single data file should be established for each inmate at the conclusion of intake. Additional data may be added to the file as follow-up measures (e.g., rearrest, employment information) are obtained. Quantitative measures for analysis of evaluation data include a variety of descriptive statistics and multivariate analysis to assess changes over time in relevant skills and levels of psychosocial functioning.

Program evaluation staff may wish to identify a sample of untreated inmates to provide a comparison to the treated inmate sample on important demographic characteristics and other in-treatment variables, such as psychological functioning or self-esteem. It may be particularly useful to identify key demographic characteristics (e.g., age, race, sex, education) of the general inmate population to determine whether inmates referred for drug treatment are representative of the entire jail population. If staff resources are available, it may also be useful to assess (using measures of emotional/psychological

functioning, for example) a small sample of untreated inmates to determine whether changes over time in selected evaluation measures are attributable to the treatment intervention.

2. Post-Treatment Evaluation

A critical evaluation question is the extent to which treatment enhances the adjustment of inmates released to the community, as measured by the following:

- reduction in criminal recidivism,
- favorable outcomes on probation/parole,
- prevention or delay of relapse to drug use,
- retention in drug treatment,
- utilization of other social services, and
- positive outcomes related to employment and social and emotional functioning.

The post-treatment evaluation may assess the degree of change in baseline measures of psychosocial functioning (taken at the time of intake to in-jail treatment) and may provide additional information regarding the impact of factors such as duration in treatment, progress achieved in treatment, and inmate characteristics on treatment outcome.

A critical post-treatment evaluation activity is to determine patterns of criminal recidivism among offenders completing the in-jail program. This activity will often require development of staff contacts and access to data outside the immediate drug treatment program. Use of a comparison group of untreated offenders should also be considered, enabling more accurate assessment of reductions in recidivism attributable to the specific treatment intervention, and cost effectiveness of the in-jail program.

In-jail drug treatment programs can be expected to evolve and change considerably during the first several years of implementation. As a result, post-treatment outcome data such as criminal recidivism may not initially reflect the full impact of the intended treatment program. A common evaluation strategy employed in these circumstances is to begin tracking and follow-up activities during the second year of program implementation (or at the point that the treatment curriculum has been established and the program is perceived as reasonably stable). At this later stage of program implementation, treatment interventions will have matured due to staff training, quality assurance activities, and

greater consistency in application of program policies and procedures. Delay in implementing this component of the evaluation is designed to enhance the validity and generalizability of post-treatment evaluation findings.

a. Instruments

A preliminary source of data on criminal recidivism among offenders treated in the jail drug treatment program is arrest information obtained from the county sheriff's office. This source of information is supplemented through review of state and national criminal justice databases (e.g., NCIC) as regulated by state departments of law enforcement and the Federal Bureau of Investigation. Although additional work is required to access state and national databases, this effort is worthwhile to ensure that comprehensive arrest information is compiled, particularly for offenders who may eventually travel out of state after a brief period on probation or parole. A complete "rap" sheet should be obtained for all offenders who are released from the program and who are tracked in the community. This will provide information regarding arrest, conviction, and incarceration, and will also provide a valuable mechanism to assess the reliability of offender self-report.

Post-treatment information regarding drug use may be obtained through interview of probation officers, examination of probation records or community drug treatment records, or through interview of the offender or significant collaterals (e.g., spouse, family members). The offender should provide a full informed consent to these post-treatment evaluation activities at intake to the treatment program, and should sign a release of information specifying the probation officer, treatment staff, or other relevant sources who are authorized to provide data to evaluation staff.

Psychosocial survey instruments such as the Addiction Severity Index and the Treatment Outcome Prospective Study follow-up interview instrument may be re-administered to gather self-report data regarding drug use, employment status, and social and emotional functioning. In some cases it is possible to administer these instruments over the phone. Critical areas to be examined include drug and alcohol use, criminal activity, employment, psychiatric status, health status, social functioning, social support, use of community resources, and retention in community treatment. Face-to-face interviews conducted with offenders may also include re-administration of in-treatment evaluation measures.

Analysis of cost effectiveness should be based on:

1. Costs per inmate for participating in the in-jail program, over and above the ordinary costs of incarceration.
2. Marginal reductions observed in arrests, convictions, and incarceration that are attributable to the in-jail program. This is determined by evaluating differences in baseline levels of criminal activity and in post-treatment criminal activity and by contrasting these differences with those obtained from an untreated comparison sample of jail inmates.
3. Costs of crimes committed, court proceedings, and incarcerations prevented as a result of marginal reductions in criminal activity among the treated inmate sample.

b. Procedures

Information regarding the inmate's booking number, jail identification number, and other vital statistics and demographic information (birthdate, race, sex, height, hair color), should be recorded at intake to the drug treatment program, in order to match with state and national criminal justice data examined during follow-up. In addition, a locator form should be completed at intake that describes contact persons in the community, including friends and relatives, the expected place of residence and work addresses, and phone numbers. All locator information should be verified at the time of release to the community.

Tracking of inmates released from the in-jail program should include all individuals who have been admitted to the program, including inmates who have been unsuccessfully terminated, inmates who have been discharged prematurely (due to release on recognizance or on bond), and inmates who have successfully completed the program. Inclusion of all inmates in the post-treatment evaluation sample will assist in determining the effects of treatment length and type of discharge on post-treatment outcome. There is no absolute minimum number of individuals required for an effective post-treatment evaluation. However, samples larger than 50 are recommended in order to maximize opportunities to accurately assess differences between treated and untreated samples. Post-treatment follow-up on measures of criminal recidivism, drug use, employment, and other significant variables should include information from at least one year after release

from the in-jail program. This period provides sufficient time to record drug relapses and drug-related arrests that occur well after the completion of treatment.

Whenever possible, evaluation staff should select a random sample of untreated jail inmates in order to provide a post-treatment comparison on measures of criminal recidivism and other significant variables. This comparison group may be obtained by examining booking or classification records to identify inmates who 1) have a substance abuse problem, 2) are willing to participate in treatment, and 3) have not been placed in treatment either due to lack of available program slots or due to release from jail. This untreated sample should resemble the group of treated inmates on important variables such as offense type (at intake to the program) and demographics. Untreated inmates should also be matched to treated inmates according to the date of admission to the jail so that the follow-up period in the community will be roughly equivalent between the two groups.

Trained evaluation staff should conduct post-treatment interviews. In addition to information from the locator form completed at intake, interviewers will occasionally need to contact probation officers to obtain an offender's phone number or address. An interviewer manual may need to be developed that describes procedures for maintaining confidentiality and specific interview techniques. Careful effort should be made to record the quality of responses to self-report interview data (e.g., number of nonrespondents) and to verify information obtained through probation records.

VI. Points of Linkage Between Treatment and Criminal Justice

A. Overview

In consideration of linkages between the substance abuse treatment programming system and the criminal justice system, the following four questions will be addressed:

1. Why link treatment to the criminal justice system?
2. Where to link treatment with the criminal justice system?
3. How to link treatment with the criminal justice system?
4. What is the role of treatment in linkage with the criminal justice system?

Chapter II of this Monograph, "Partnerships Between Treatment and Corrections: A Rationale," deals extensively with the question 1 above. The succeeding questions -- "where," "how," and "what" -- will be the purview of this chapter.

B. Background

The adjudication process can be divided (somewhat conveniently, it is admitted) into four stages of involvement:

1. information gathering (investigations, hearings, conferences, testimony),
2. consideration of disposition options (pretrial conferences, plea bargaining, pre-sentencing hearings),
3. decision making or determining a disposition (diversions, sentencing, sentence modifications, early release/alternatives to custody), and
4. carrying out and enforcement of the disposition (incarceration, supervision).

In reaching dispositions on cases, judges are not only the system's decision makers. Considerable decision making authority rests with the arresting officer, district attorney, defense attorney, probation department and officers, county parole board and agents, and various alternative-to-custody/early-release programs.

Though there appears to be wide latitude in decision making, decision makers often are limited by statute and by not knowing or having available the full range of disposition options for a specific offender. This is particularly true in cases involving substance

abuse. County-supported programs market themselves poorly, and application procedures, waiting lists, and costs make accessing programs complicated.

Too often pressure from court backlogs and overcrowded jails results in insufficient time for probation personnel and defense attorneys to research the best option for each case. Therefore, decision makers quite often appreciate help in the form of additional input and disposition options from other credible sources. This opens the door for treatment personnel to establish their own credibility, earn the opportunity to expand the decision maker's knowledge of treatment alternatives, and provide consultation that helps the decision-making process take advantage of realistic treatment plans.

C. Where and How to Link Treatment Programming with the Criminal Justice System

The questions of where and how to link treatment with the criminal justice system can be answered by referring to a statement in Chapter II regarding the partnership between treatment and corrections: treatment can be linked wherever the two disciplines (treatment and the criminal justice system) share common goals, and, by working together, are better able to reach their own and the other discipline's goals.

Generally speaking, with reference to the four stages of involvement in the adjudication process described in the above overview, treatment best links with criminal justice at the following points:

1. information gathering,
2. when considering disposition options, and
- 4 when carrying out the disposition.

It is recommended that treatment staff not to enter into the area of decision making, but leave that to the bailiwick of the authorities within the criminal justice system. Further discussion of this recommendation is the focus of the last section of this chapter, "What is the role of treatment in linkage with the criminal justice system?"

The criminal justice system provides an opportune time for entry into treatment. It is a catchment area for the substance-abusing offender population and therefore a convenient area into which to bring clients and services. Arrest and incarceration (or the threat thereof) is a natural intervention process, resulting in significant reduction of defense

mechanisms, including denial. For those in custody, jail provides a gathering point for contact when this population is detoxified, rested, well-fed, medically and psychologically attended to, and either genuinely or ambivalently motivated to participate in treatment. Two primary services are possible: assessment and referral, and treatment.

The criminal justice system is extremely complex. Systems vary greatly between jurisdictions. Innumerable points of linkage exist. (Refer to the series of charts "Points of Linkage in the Criminal Justice System.") Three primary points of linkage and common scenarios will be presented. To discuss links, and in an attempt to simplify the system description, generalizations will be made that readers must modify to fit their specific situations.

Points of linkage and scenarios to be presented are:

1. Diversion
2. Pre-sentenced
3. Pre-release/transition planning

1. Diversion

There are two primary types of diversion: informal and formal. Both can provide linkage to treatment. Diversion can be a means for referring individuals who come in contact with the law to appropriate educational and counseling programs, or assessment centers, as an alternative to arrest or prior to the filing of a formal criminal complaint: successful completion of the program or placement in the assessment center keeps the person from entering the criminal justice system, and potential criminal charges are dropped.

a. Informal Diversion

When an officer has initial contact with an offender who appears intoxicated and the offense is minor, he can exercise significant discretion over informal diversion rather than arrest. Common dispositions which link with treatment can include one of the following:

- transporting a public inebriate to a detoxification center,
- transporting a suspected mentally ill chemical abuser or dual diagnosis patient to a psychiatric emergency center for assessment, or

- ensuring the person returns home safely, then counseling the individual and family with a recommendation to treatment.

b. Formal Diversion

Formal diversion takes place after arrest and is usually offered by the judge at arraignment. Often this happens within the first three days if the defendant is in custody. Otherwise, the defendant may be out of custody on bail or released on his/her own recognizance (OR), with a date to return for arraignment. Often, an attorney will discuss diversion with his/her client in preparation for arraignment. Because the main purpose is to divert minor offenders out of the system, diversion takes place as soon as possible after arrest. For this reason, many jurisdictions have formal, established diversion systems wherein offenders who meet simple screening criteria (first-time, minor alcohol or drug offenses) can be referred to identified diversion programs. Diversion programs usually provide education and minimal counseling and are directed at early-stage abusers, for whom this is an effective intervention.

2. Pre-sentenced

a. General Considerations

Prior to sentencing, the criminal justice system is focused on information gathering to assist in determining an appropriate disposition. The court, probation, and defense attorneys are open to input regarding assessment of treatment motivation and amenability, especially treatment plans that specify providers.

For both early-stage substance-abusing offenders and members of the substance-abusing offender social system, the likelihood of being found guilty is usually apparent to the defendants soon after arrest. When defendants expect to be found guilty, an innocent plea quite often is a strategy to create time and bargaining leverage while investigating potential plea-bargaining options. For treatment staff, pre-sentenced defendants in this category should be considered "sentenced but looking for their best deal." For this reason, in-custody programs should include pre-sentenced offenders. Many programs exclude this population, believing that the offenders' preoccupation with the pending case, court dates, and uncertain release date interfere with treatment. The benefits of including this population should be weighed against the drawbacks.

Early-stage substance-abusing offenders, with denial defenses devastated, are highly motivated to participate in treatment and are often good candidates for release on their

Points of Linkage in the Criminal Justice System

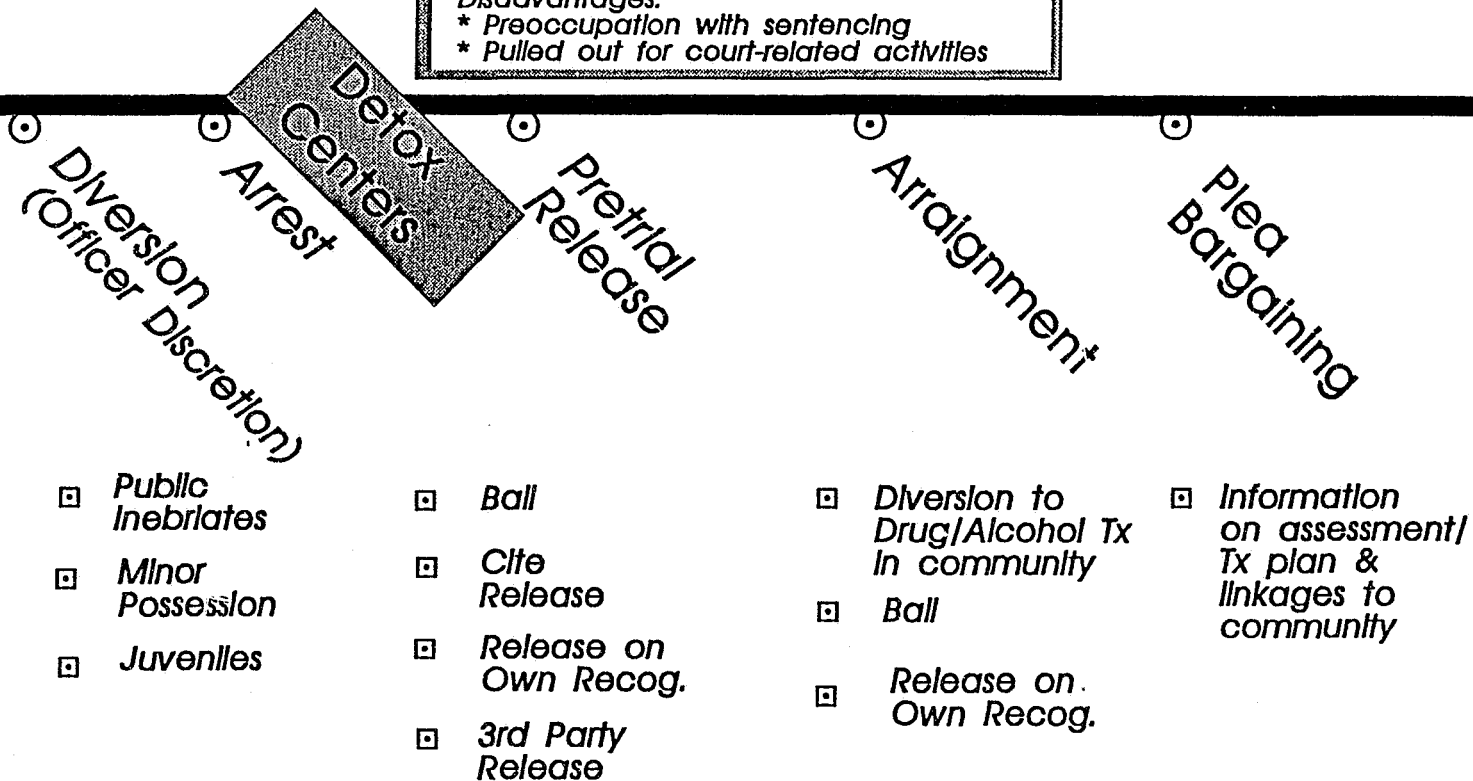
Pre Sentenced

Advantages:

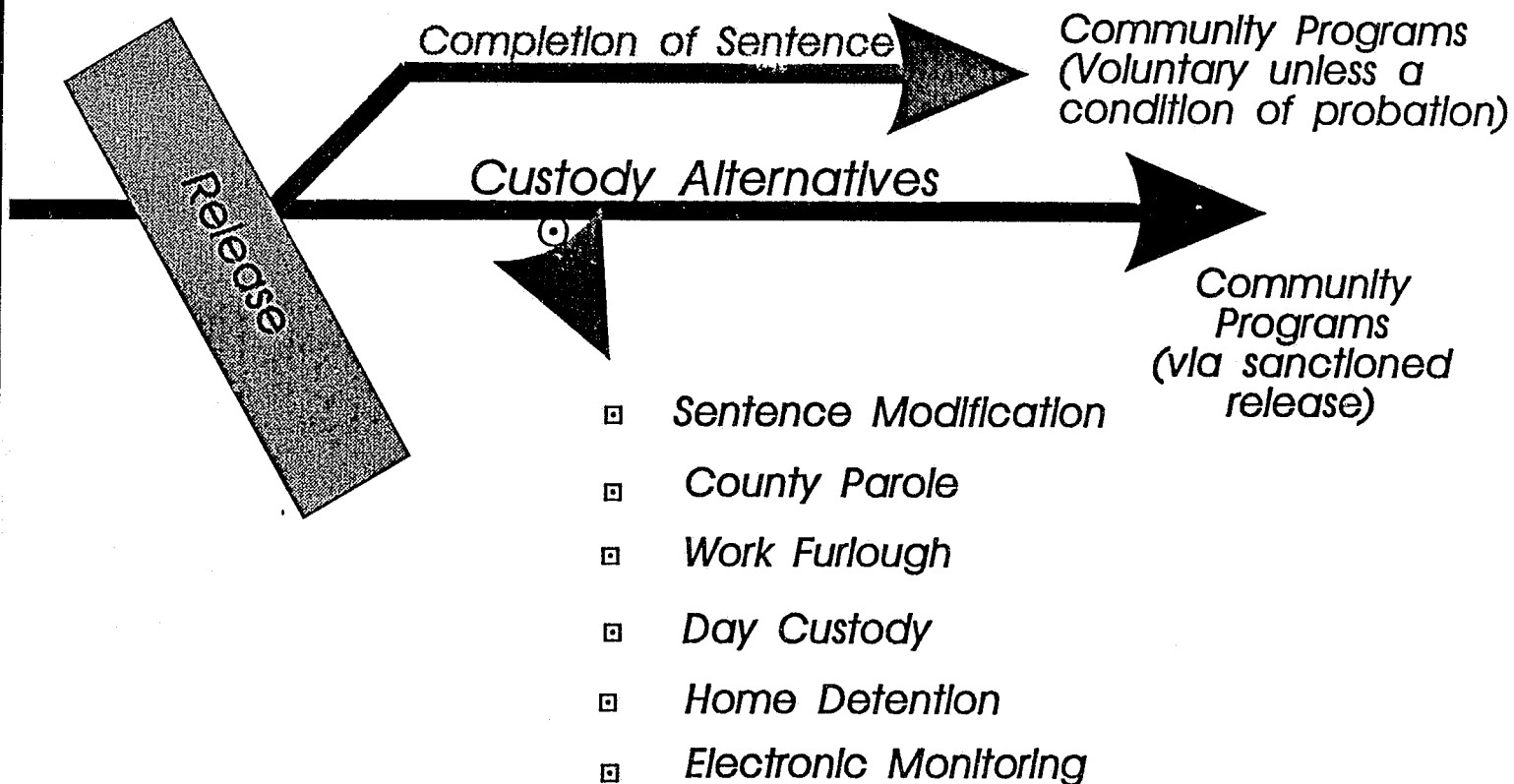
- * Makes use of deadline
- * Reduces overcrowding
- * Denial is lower

Disadvantages:

- * Preoccupation with sentencing
- * Pulled out for court-related activities



Points of Linkage In the Criminal Justice System Release



own recognizance to community treatment pending disposition of their case. Treatment participation while pre-sentenced can provide valuable insight for sentencing decisions. The offender's attitude and quality of participation can aid in determining whether or not to include early release to treatment as part of the original sentencing order.

Unsentenced addict members of the substance-abusing offender social system are open to considering long-term community residential treatment programs (generally the treatment of choice) as part of a plea bargain. This group frequently compares the length of sentence they expect with the length of residency required in the program before making a commitment to placement in residential treatment.

The case management/TASC model is a good means of linking at this point with the criminal justice system. A case manager (or TASC counselor) gathers information for submission either directly to the judge, to an investigating probation officer for inclusion in a court report, or to the defense attorney for submission to the judge. The information gathered can include:

- a formal assessment of the defendant's motivation and amenability to treatment,
- verification of current participation in jail or community treatment programs (depending on whether the defendant is in or out of custody), and
- a proposed treatment plan arrived at in agreement between the case manager and client, to be incorporated into the sentencing orders and to include treatment options in custody (if available) as well as in the community following release.

b. Release of Confidential Client Information

Treatment staff can release this information only when authorized by the voluntary consent of the client. Client authorization requires a properly signed form (often entitled "Consent for the Release of Confidential Information") and is controlled by the federal "Confidentiality of Alcohol and Drug Abuse Patient Records" regulations, 42 CFR Part 2, which implements two federal statutory provisions applicable to alcohol abuse patient records (42 USC 290dd-3) and drug abuse patient records (42 USC 290ee-3).

When judges incorporate treatment plans within their sentencing, orders often include the following points:

- a lengthy sentence in state prison (for felons) or county jail (for misdemeanants) that is usually suspended,
- an order to serve a specified shorter minimum or no sentence in county jail,
- eligibility for release to the community thereafter with conditions that include satisfactory participation in the treatment plan, and
- placement under probation supervision for sufficient time to enforce completion of the treatment plan.

3. Pre-Release/Transition Planning

a. General Considerations

Pre-release/transition planning is critical for the offender who is serving a sentence, participating in some form of in-custody treatment program, and either about to complete his/her sentence or ready for early release to the community. The weakest link overall in treatment programs in correctional settings is effective transition to the community. Offenders who participate in effective in-custody treatment programs experience remarkable attitudinal and behavioral changes along with goal reorientation as a result of successful intervention in their substance-abusing offender lifestyle. Despite these real gains, studies indicate that without a structured plan for continuing recovery in the community, a large percentage of offenders relapse within the first ninety days, and the majority of those remaining relapse within nine months.⁴

b. Constructive Coercion

Constructive coercion is a critical tool with which to combat this devastatingly high relapse rate. Treatment provides the constructive element, while the criminal justice system provides the coercion. The goals of both criminal justice and treatment are enhanced by a close coordination between the two.

With the cooperation of the offender-client, a treatment transition counselor or case manager assesses the client's needs for continued treatment upon return to the community. At a minimum, this often includes an assessment of needs in the areas of:

- substance abuse programming,
- self-help participation (12-step),
- individual or family counseling,
- education,
- job training or employment development, and
- leisure-time activities.

From this assessment, through individual and group task oriented counseling, a re-entry treatment plan is designed. Both the counselor and client must believe that the plan is practical, and that it will create an opportunity for the client to remain clean, sober, and crime free in the community. With this plan, the client is ready to approach the criminal justice system.

c. Early Release

The role of the criminal justice system is to determine whether to release the offender early, under supervision, based on conditions that include the satisfactory participation in voluntary re-entry treatment plan. Additional conditions may be imposed by the releasing authority.

Early release performs several functions:

- it provides incentive and motivation for offenders to participate in in-custody treatment and to commit themselves to continued participation after release,
- by including the treatment plan in the conditions for early release, it creates a mechanism for supervision and enforcement of the treatment plan,
- it helps to relieve jail overcrowding by identifying offenders who are less likely to reoffend by virtue of their personal and voluntary commitment to a well-thought-out plan to accomplish that shared goal, and
- it formally acknowledges the attitudinal, behavioral, and goal-oriented changes that have taken place during in-custody treatment.

Regarding the last point, the judge has already determined an appropriate sentence based upon the information available prior to sentencing. To support an early release, the offender must present new information that justifies reconsidering that decision. The new information can be the positive effect of in-custody treatment, a tangible and voluntary re-entry treatment plan of which the offender has "ownership," and the offender's willingness to cooperate with supervision to ensure his/her plan is carried out. The releasing authority must then determine whether there is less likelihood for reoffense if they enter into this partnership. Agreement to early release is a vote of confidence and an affirmation that the releasing authority is convinced that a change has taken place.

d. Early Release Mechanisms

The following three early-release mechanisms will be addressed:

- original sentencing orders that include conditions for early release,
- sentence modification, and
- alternative-to-custody programs.

1) Original Sentencing Orders: Most commonly, as part of a plea bargain prior to sentencing, a defendant may agree to a longer sentence that can be suspended or modified upon completion of an in-custody treatment program with an acceptable re-entry plan or upon acceptance into a community treatment program. In the former situation, a case manager or TASC counselor will arrange for verification of program completion and submission of the re-entry plan to the court. He/she will also provide linkage with the community treatment provider and supervising authority (most often probation).

2) Sentence Modification: For offenders who complete in-custody treatment programs, or following counseling with a case manager or TASC counselor, a modification of the original sentencing order may seem warranted if it enhances the effectiveness of a re-entry plan as the next step in treatment. Modifications require presenting an argument to the original sentencing judge. This process entails providing information to the judge either directly or, most often, through the original defense attorney or probation officer (if the offender is in probation). The defendant's argument is the same as outlined above in the section on early release functions.

Modifying the treatment plan or imposing intermediate sanctions can be a cumbersome process. It may take days or weeks for the inmate to appear before the bench.

Treatment adaptability and the effectiveness of coercion are reduced because the inmate does not feel the effect of the sanctions immediately.

3) Alternative Custody Programs: Such programs usually operate under the authority of a custodial agency (the sheriff or department of corrections) and/or a board established under legislative authority. As a result, alternative custody programs are often more informal, flexible, and amenable to coordination with treatment than is the court. Examples of such programs are:

- County parole
- Home detention
- Electronic monitoring
- Day custody

These programs share similarities in their ability to link with treatment but have differing means of supervising offenders. Not all alternative custody programs will be described in this monograph. However, attention will be afforded county parole, which has been found to be one of the best release mechanisms.

4) County Parole: County parole usually consists of a board and agents responsible for supervision of parolees and enforcement of the board's orders. Parolees are considered to be in the custody of the board but are allowed to reside in the community under specified conditions. Since the parole board operates under legislative authority, it is an independent body that does not require the approval of sentencing judges. Most often, however, boards seek the concurrence of the sentencing judge prior to paroling offenders. Offenders can apply for early release on county parole if they meet the board's criteria, which usually include a minimum of the following:

- not currently serving mandatory sentences or having completed the mandatory portion of their sentence
- having served the minimum portion of their sentences as specified in that jurisdiction (e.g., must have completed one third of the original sentence), and
- not having been convicted for certain offense categories, such as violence, arson, sexual offenses, escape, or weapons charges.

In addition to the early release incentive and intensive supervision, county parole has several characteristics that facilitate coordination with treatment:

- a closer relationship with a single stable board than with many judges with differing philosophies,
- to meet the client's changing needs in treatment, the treatment plan and conditions of parole can be modified more easily and rapidly through the parole board rather than through the court,
- parole boards are less formal than court, allowing more rapid access to the releasing authority, and
- there are fewer parole officers enforcing the board's orders than there are probation officers enforcing court orders; this allows for better liaison between officers and treatment staff.

Through county parole, factors enhancing the effectiveness of coercion include:

- since the parolee is still in custody but allowed to reside in the community, return to custody can be effected with a much lower level of proof,
- sanctions for transgressions can be imposed immediately, without the delays inherent in returning to court, and
- intermediate sanctions are easily established and modified.

5) Intermediate Sanctions

Intermediate sanctions are less punitive alternatives to returning to custody for offenders who violate conditions of their early release to the community. Sanctions are requirements imposed on offenders by the criminal justice system as conditions for being allowed to remain in the community. Sanctions can also be tools for programs to increase or decrease the intensity of treatment, depending upon the client's need for structure. Examples of intermediate sanctions include the following:

- required urinalysis with increased or decreased frequency

- medication support: Antabuse, Methadone, Naltrexone
- intensity of supervision (regarding both frequency and intrusiveness)
 - intensive supervision (frequency of contact with parole officer),
 - search and seizure
 - electronic monitoring,
 - home detention,
 - day custody
 - work furlough
- intensity of treatment program
 - long/short-term residential treatment,
 - outpatient/intensive outpatient program,
 - self-help programs (12-step),
 - individual and/or family counseling
 - special groups (domestic violence, sexual offender program, etc.)
 - remedial education
 - job training/employment development
 - leisure-time structuring

D. What is the role of treatment in linkage with the criminal justice system?

The role of treatment and treatment staff in the criminal justice system varies from jurisdiction to jurisdiction and from program to program. This often creates controversy and raises considerable debate. A treatise on the professionalism and ethics of treatment providers within criminal justice systems deserves a monograph of its own; it will not be attempted here. This monograph does, however, present the following recommendations.

Treatment staff should take the time to **clearly** define the scope of their role within the criminal justice system. Professional training has not caught up with the burgeoning opportunities for criminal justice treatment positions. As such, few counselors, despite their level of training, are prepared for the unique circumstances that arise in providing treatment within the criminal justice setting.

Treatment staff should define their role along two lines:

- as a proponent of change in both the substance-abusing offender social system and in the individual offender's lifestyle, and
- as a consultant to the criminal justice system, but not part of its decision-making process.

1. Treatment Staff as Proponents of Change, not as Advocates

It is important to distinguish the role of proponent of change from that of client advocate. A proponent of change is a provider of a program or service intended to promote attitudinal change, provide an opportunity to define new goals, and impart knowledge and skills to offenders so that they can achieve their goals. A client advocate, on the other hand, represents and argues in a more impassioned way for the client's best interests. In doing so, the advocate appears to assume a certain level of responsibility for the client's conduct, whether or not that is the intention.

One suggestion is that treatment programs and staff, as proponents of change, be responsible for the organization, professionalism, and effectiveness of the programs and services they provide. Treatment should not assume responsibility for the conduct of any client/offender. That is the offender's own responsibility. Treatment staff who step outside their area of responsibility and, either formally or by assumption, accept responsibility for their clients may jeopardize a program's viability.

2. Treatment Staff as Consultants, Not as Decision Makers

The effectiveness of the treatment programming system and the criminal justice system is enhanced when each system fulfills the roles for which its members have been trained.

Members of the treatment system should accept responsibility for providing an opportunity to promote and facilitate positive change in the substance-abusing offender's lifestyle. If done effectively, this will benefit not only the offender but the jail, the correctional officer, and the community, as well. This alone justifies treatment within correctional settings.

Treatment staff can provide consultation can be provided to decision-makers in the form of a treatment report, including verification of completion of or successful participation in in-custody treatment (or the converse), a post-release treatment plan, and connection with

community treatment providers. This type of consultation is invaluable because a continuum of treatment increases the likelihood for released offenders to remain clean, sober, and crime free in the community. Information of this nature enhances the decision-makers' ability to determine the best disposition option for each individual offender.

Treatment staff should steer clear of decision making, leaving that authority to decision makers within the criminal justice system and thereby avoid the conflict in roles between treatment and enforcement.

Along with decision making comes the burden of authority. This complicates the role of treatment, compromises the fragile trust and rapport necessary between client and counselor, and forces treatment into the role of enforcement. Clientele, staff, and the system benefit greatly from separating treatment's responsibilities from those of criminal justice. Clarity in this area frees treatment staff to focus on fulfilling the roles of confidante and supportive agent of change.

VII. Endnotes

1.The criminal justice system is not a system at all, but a loose knit cluster of independent entities and agencies, each with separate responsibilities regarding justice and handling of offenders (Gerald Vigdal, NIC Monograph 1990, Chapter 3, page 1).

2.DATOS; Research Triangle Institute, 1989.

3.Delancey Street Program, 2563 Divisadero, San Francisco, California 94115, 415/563-5326.

4.This high percentage of relapse does not preclude the fact that the criminal justice system benefits even when a treatment attempt fails. Jail programs alone benefit the facility, correctional staff, and inmates prior to release; and following effective in-custody treatment, recidivists statistically remain crime free longer, commit less serious offenses, and return to custody taking more responsibility for their failure and with a more positive attitude to try again.