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

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research for safer communities

URBAN INSTITUTE
Justice Policy Center

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According to some estimates, only 61 percent of state correctional facilities provide substance abuse treatment. Despite a significant infusion of federal funds to support residential substance abuse treatment in prisons, the percentage of state prisoners participating in such programs declined from 25 percent in 1991 to 10 percent in 1997. The policy shortfall is clear: Inmates with substance abuse problems may not be receiving the treatment that would reduce their drug problems and criminal behavior.

Why they are not getting treatment remains largely unknown. One possibility is simply a lack of political or correctional interest in providing drug treatment. But an equally plausible explanation is a lack of sufficient funding. In addition, there may be conflicting expectations, systems constraints, and philosophies. These and other possible explanations suggest that there are yet-to-be-specified roles that federal agencies might play to assist the integration of treatment into corrections.

This report emerged from a collaboration between the Urban Institute and the National Institute on Drug Abuse (NIDA), the goal of which was to help identify and address the unique circumstances of the criminal justice environment and the challenges posed by the integration of treatment services and a public health orientation into this environment.

To help achieve this goal, the study, funded by NIDA, included three components: (1) a literature review covering a range of issues pertaining to correctional drug treatment; (2) interviews with practitioners, such as directors of state correctional agencies or programming divisions; and (3) a meeting of researchers and practitioners to discuss issues raised from the literature review and interviews. Both the interviews and the meeting were designed to help bridge the gap between researchers and correctional practitioners and to identify key issues and solutions for which practitioners have unique insight.

This report presents results from the interview stage of the study, the main findings of which are summarized below. Twenty inter-

views were conducted with practitioners such as directors of state correctional systems and treatment programming, as well as drug treatment providers and consultants. In all, 13 states were represented. The 13 states were not selected randomly but rather were selected to capture perspectives from different regions and states of different sizes.

Each interview was conducted by telephone and involved a series of questions about a range of issues pertaining to drug treatment in prisons:

- Drug Screening and Assessment
- Treatment Matching and Planning
- Treatment Programming
- Treatment Goals and Expectations
- Generating and Sustaining Support for Treatment
- Transitional Services
- A Research Wish List

The questions focused on the type of treatment provided, how treatment programming decisions are made, and the types of practical research needs practitioners would like to see addressed. The full set of questions that guided the interview process is provided in the appendix.

PRACTITIONER PERSPECTIVES ON KEY ISSUES

Drug Screening and Assessment

Instruments

- Across the 13 state correctional systems in this study, practitioners and researchers reported considerable variation in the instruments used, the quality of the instruments used, and the quality of the screening and assessment process.

- Respondents reported that the screening process typically is cursory, even though it provides the basis for the sorting and classification of offenders. In some systems, the initial drug screening process consists of a recommendation from the

judge or sentencing court that the offender be placed in treatment.

- For a simple screening process, most interviewees in our sample reported using the Texas Christian University Drug Screen (TCUDS), which is touted as being more "realistic" and producing fewer false positives than other screens, as well as the Simple Screening Instrument (SSI). The Michigan Alcoholism Screening Test (MAST) was also mentioned. Other states chose to create their own instrument by modifying existing instruments and then validating their new instrument.

- Assessment instruments used by the state correctional systems we examined include the Level of Supervision Inventory-Revised (LSI-R), Addiction Severity Index (ASI), Adult Substance Use Survey (ASUS), and Substance Use History Matrix (SUHM).

Process

- Respondents stated that in many state correctional systems the screening and assessment process is, in the words of one interviewee, "in dire need of help."

- Within and across state correctional systems, there is reported to be considerable variation in when screening and assessments are conducted, how and by whom they are conducted, the instruments and quality of assessment, and the use to which the results are put.

- Typically, full drug assessments do not take place until inmates enter an assigned, structured program, according to respondents.

- Some, not all, interviewees reported that within the state correctional system, security concerns ultimately override consideration of assessment recommendations. Further, although programs generally are not meant to be mutually exclusive, treatment is generally secondary to other types of programming. In many prisons, the decision to provide drug treatment is an "either/or" one — the offender either receives treatment or is sent to another program or receives nothing at all.

- Most respondents emphasized that the major problem they face with screening and assessment has less to do with selecting an instrument and more to do with the overall screening and assessment process. Two major problems they reported include the lack of transfer of information and the lack of standardized policies for transferring information (e.g., among counties, correctional treatment providers, and parole boards).

- Many respondents reported that their correctional systems lack a centralized, comprehensive, functional, cross-system database. The better systems link data from several sources and across different database systems (e.g., within different parts of the correctional system, between corrections and the courts, between prisons and post-release supervisory agencies), track behavioral and program outcomes over time and across different facilities and programs, and can be easily used to guide placement decisions.

Treatment Matching and Planning

Treatment Matching

- The use of theoretically and empirically guided placement criteria is in the formative stages for some correctional systems.

- Respondents reported that many state correctional systems would like to build consistent criteria into their assessments, particularly criteria for treatment matching and level of care, but many systems cannot afford rigorous implementation of treatment matching.

Drug Treatment Planning

- Respondents emphasized that treatment planning is a central part of drug treatment services, though treatment is often secondary to security considerations.

- Most correctional systems reportedly lack database automation, vary greatly in their processing and treatment orientation, and frequently lack basic information, such as case files or medications, because of poor communication between different departments or divisions.

Treatment Programming

Definitional Issues

- The term "treatment" is widely used throughout jails and state and federal prisons, yet a concise, agreed-upon definition of treatment is rare. The definitional issues concerned many respondents in trying to describe their drug treatment services and to interpret others' services.

- Most respondents did not consider Alcoholics Anonymous or Narcotics Anonymous (AA/NA) and education-type services alone to constitute drug treatment. When asked about the treatment provided in their systems, respondents generally stated that they provided some kind of residential treatment, therapeutic community, or intensive outpatient treatment, and viewed these collectively as "drug treatment."

- Respondents emphasized holistic philosophies about drug treatment, but the range of services varied tremendously, as did the level and types of services at different stages in the criminal justice system. Because there are so many variations of similar programs, program directors and correctional administrators wanted to know more about the *quality* of programs and what factors were most relevant for effectively treating offenders with drug problems.

Cognitive-Behavioral Treatment Approaches

- The cognitive-behavioral approach, regardless of setting, was the dominant approach reported by correctional agency representatives and direct service providers.

- Some agencies have attempted to standardize their alcohol and drug treatment philosophy to reflect cognitive-behavioral orientations. In agencies where there is an entrenched commitment to specific treatment modalities or philosophies, this process has been difficult but not insurmountable.

- Most of the programs reported by our respondents addressed at least some "dynamic"/"criminogenic" needs, particularly

risk and resiliency, procriminal attitudes, and deficits in educational, vocational, and employment skills.

Diversity of Programs and Implementation

- A wide range of drug treatment programs is provided by the prisons in our sample; many do not directly address drug problems yet are viewed as indirectly helping to address such problems. Programs include educational and vocational programs, AA/NA, life skills programs, therapeutic communities, substance abuse facilities for probationers, faith-based residential centers, and separate facilities for offenders with co-occurring disorders.

- Implementation of particular treatment programs, such as therapeutic communities, can vary considerably across correctional systems, according to respondents.

- Few prisons monitor or carefully assess the quality of program implementation, and respondents said they want guidance on what aspects of implementation are most important. They also want more assistance with program design.

- Some respondents felt that much more attention should be given to providing substance abuse treatment in jails, where many offenders have drug problems that may go unidentified and that contribute to subsequent criminal activity.

Maintaining a Drug-Free Environment

- Prison administrators emphasized that a broader reason for maintaining a drug-free environment is that the prevalence of drugs within a facility can undermine correctional agency operations, not just treatment.

- Prison officials reported employing several strategies to create a drug-free environment. These elements include random urine testing; the use of canines; electronic drug interdiction for staff and visitors; machines in the mail room that can identify drug paraphernalia; random searches of staff; use of sanctions (e.g., loss of visiting privileges) for misconduct relating to drug distribution or use; and ensuring that gang members are separated

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from each other to discourage drug access and distribution.

Voluntary and Mandatory Treatment
- Many respondents believe that coerced treatment can be effective, a view supported by recent research.
- "Coerced treatment" is prevalent in most correctional systems in our sample, but treatment is not generally mandatory per se. However, some states employ mandatory treatment in prison or upon release.
- Some respondents hold the belief that for treatment to be effective, offenders must be voluntary and ready for treatment.

Meeting the Need for Drug Treatment
- "I don't think anybody has a handle on demand for services." This view was echoed by several respondents, who emphasized that definitional ambiguity, particularly about the distinction between drug abuse and drug addiction, underlies much research and policy.
- Practitioners warn that using a broad definition of substance abuse problem to allocate treatment beds can help justify funding for drug treatment. However, some also emphasized that it can dramatically overstate the actual extent of need.
- Some respondents suggested that treatment need and supply should be described with respect to specific stages of the criminal justice system as well as to specific stages of an inmate's term of incarceration.

Selection of Specific Treatment Programs
- Respondents in the 13 states in the study reported that the Department of Corrections ultimately makes the decision about the type of treatment programming offered in the system. However, the process of making the decision involves input from a variety of key policy staff.
- According to respondents, some states have created committees consisting of representatives from a range of agencies and backgrounds, while others rely on informal consultation.

- Some correctional agencies rely on single-state agencies, which are responsible for licensing and accrediting all treatment programs, both within and outside of correctional settings. Some respondents report that the involvement of single-state agencies greatly improves correctional drug treatment.

Treatment Goals and Expectations
- Treatment providers and system administrators were asked if recidivism is the "gold standard" for evaluating drug treatment. Respondents stated that recidivism is not the only expected goal, but it is the one in which most legislators and the public are interested. Recidivism is most widely accepted by state legislators, the group that ultimately influences programming via funding.
- Many respondents stressed that recidivism, especially as reflected by reincarceration rates, is misleading. They emphasized that it is more appropriate to talk about incremental, less visible expectations and outcomes related to treatment, such as better management of inmates, reduced medical needs, improved self-esteem, increased compliance with aftercare, greater employability, increased likelihood of family reunification, and either reduced drug use or relapse to less serious drug use.
- Many correctional practitioners focused on goals and outcomes that could be met while an offender is in prison, as opposed to outcomes, such as recidivism, that frequently cannot be directly controlled. Examples including maintaining sobriety while in prison, compliance in treatment, completion of treatment, and an understanding of addiction and its consequences.

Generating and Sustaining Support for Treatment
- Although many studies cite funding and space limitations as key factors limiting drug treatment, correctional practitioners emphasized additional, underlying fac-

tors. Correctional practitioners' responses suggest a model in which the key components to funding drug treatment include social and political support, funding from diverse sources, and implementation of effective drug treatment. Once drug treatment is provided, there is a need to demonstrate benefits and educate policymakers about these benefits.

- Some respondents noted that interest in drug treatment emerged as the result of crises precipitated by lawsuits. In such instances, cases had been filed arguing that offenders' needs had been neglected to the point of criminal or civil liability, leading eventually to significant changes in treatment capacity. As one respondent said, "If [there is a] crisis, you get the political attention [needed to support treatment]."

- Most respondents emphasized that whatever the initial motivation to provide treatment, the failure to actively obtain ongoing social and political support for treatment can result in dwindling funding to the point where treatment programs are closed.

- Although legislatures may fund treatment after being convinced by studies demonstrating the effectiveness of some programs, respondents noted that legislatures frequently then want evidence that the specific programs they fund also are effective. However, the research capacity of many state correctional systems was reported to be quite low.

- Respondents emphasized that some legislators view addiction as a moral deficit and thus are less inclined to fund treatment. One respondent reported that if arguments for drug treatment are grounded in terms of accountability and substance abuse treatment, treatment has a broader appeal. Another stated: "To address the concerns [of those who do not believe in treatment], I emphasize that drug treatment promotes public safety."

- The majority of states reported that legislative support for treatment had declined, but they also indicated that there are many strategies for generating support. Some states build treatment into their formulas for all budget requests involving construction of new facilities. Others actively lobby legislators for funding or propose specific legislation.

Transitional Services

- Every respondent stressed the importance of transitional services to the overall success of treatment and reentry. But this issue reportedly has been neglected during the past decade, with much more attention given to what occurs inside prisons.

- Long-standing, documented obstacles to the continuity of treatment include system segmentation, lack of coordination, lack of structured incentives and sanctions, and lack of services in the community. These issues were mentioned by our respondents as well. The problem cited most often was the lack of systems integration.

- Several respondents talked about the variety of "stressors" present when an inmate returns to the community. These stressors include financial, personal, and medical stress in addition to substance abuse treatment needs. Because of the wide range of needs, providing effective treatment can be a particular challenge.

- Several states reported problems with state funding for aftercare. One state respondent reported their state had undertaken an ambitious pilot program that showed promise but then lost funding before it could become institutionalized.

- According to some respondents, the sheer magnitude of resources for reentry can be overwhelming and thus difficult to efficiently or effectively access, especially in the absence of a centralized basis for coordinating these services.

- Not all correctional systems/agencies reported difficulties with transitional services. Several respondents reported that their state correctional system had adequate transitional services. Some, for example, stated that treatment services were continual and uninterrupted, from prison to placement in a short-term residential

treatment program to treatment on an out-patient basis for three to nine months. One state reported using aftercare contracts, in which all therapeutic communities run by contractors are required to include provisions for aftercare in their contract. Another state has included legislation to update and change the correctional philosophy toward treatment and reintegration.

Research Wish List

Research That Is Accessible

- Many respondents reported that there was little information available that was easily accessed and understood. What they, as correctional practitioners, wanted were succinct reports that stated the core findings and policy implications directly.

Focused Research

- Respondents also spoke about the need for "practical" research. By this, they generally meant research on such issues as "how to fund programs" and "how to form and enhance partnerships with other agencies."

- Respondents spoke about the need for focused research in under-developed areas, such as the needs of black males and Hispanics, women with children, offenders with co-occurring disorders, etc. Respondents felt such research was needed to determine appropriate types of treatment. For example, are there specific factors that differentially influence the recovery of specific groups?

- Respondents wanted to know more about program implementation, including specific information about such issues as staff qualifications, the types of staff who work better in certain types of treatment programs, and the best types of training approaches.

- Many respondents reported that they would like to see research that focuses on the "soft outcomes," such as tracking quality of life, education, employment, and treatment patterns. Recidivism was not viewed as the only relevant outcome.

Systems-Level Monitoring and Research

- Several respondents, particularly correctional administrators, reported that they would like to see more statewide, global, systems-level research. They noted that it is relatively easy to find documentation or studies of specific programs or modalities, but, as administrators, they would like to know how their system is doing as a whole.

- Respondents wanted research to focus on all agencies involved with a transition back to the community to pinpoint exactly what went wrong and where.

- Respondents felt that research was needed on resolving continuing tensions regarding "treatment" versus "correctional" orientations to determine the best way to resolve this problem.

Practitioner Views on Drug Treatment in Corrections

1. INTRODUCTION

This report emerged from a collaboration between the Urban Institute and the National Institute on Drug Abuse (NIDA), the goal of which was to help identify and address the unique circumstances of the criminal justice environment and the challenges posed by the integration of treatment services and a public health orientation into this environment.

To help achieve this goal, the study, funded by NIDA, included three components: (1) a literature review covering a range of issues pertaining to correctional drug treatment; (2) interviews with practitioners, such as directors of state correctional agencies or programming divisions; and (3) a meeting of researchers and practitioners to discuss issues raised from the literature review and interviews. Both the interviews and the meeting were designed to help bridge the gap between researchers and correctional practitioners and to identify key issues and solutions for which practitioners have unique insight.

The current report deals with information garnered during the interview phase of the project. Twenty interviews were conducted during July and August 2001. Each interview lasted between one-half hour and one hour and covered a range of issues pertaining to drug treatment in prisons. The interviewees were key correctional drug treatment stakeholders, including treatment (direct service) providers, state-level corrections program administrators, and state drug and alcohol systems managers, as well as private treatment providers and consultants.

Urban Institute staff spoke with representatives from 13 states: California, Colorado, Delaware, Florida, Idaho, Iowa, Missouri, New York, North Carolina, Ohio, Pennsylvania, Texas, and Washington. The states were not selected randomly but rather were selected to capture perspectives from different regions and states of different sizes.

The goal of the interview phase was to collect basic descriptive information and opinions about the provision of drug treatment in correctional systems (see appendix for the interview protocol).

Urban Institute researchers conducted the interviews, transcribed responses and comments after each interview based on written notes, and then examined the entire set of responses for common sets of themes. When certain responses did not fit in with general patterns, they were listed separately. The findings consist of the researchers' analyses of the responses and of patterns and issues suggested by respondents. The specific topical areas covered in this report are:

- Drug Screening and Assessment
- Treatment Matching and Planning
- Treatment Programming
- Treatment Goals and Expectations
- Generating and Sustaining Support for Treatment
- Transitional Services
- A Research Wish List

2. DRUG SCREENING AND ASSESSMENT

The screening and assessment process is crucial for identifying the specific risks and needs of offenders and assisting with classification efforts. Because of the high demand and scarce resources for treatment, and because effective treatment can reduce both drug use/abuse and criminal behavior, it is important to identify and target those people with the greatest need for treatment as well as those who will most benefit from treatment.

Screening and assessment are separate processes to evaluate an offender's risks and treatment needs, and, if appropriate, they begin the treatment plan process. Screening is a short initial determination of whether a potential problem, such as drug abuse, exists and merits further investigation. Assessment follows screening and is an in-depth process, often taking several hours and involving professionals trained in assessing specific issues. Ideally, an inmate is

screened and referred for assessment if deemed necessary. Information from the assessment is ideally placed into a comprehensive treatment plan, which follows the inmate through the system and eventually back into the community. In practice, this process is not always followed, as was evident from our discussions with interviewees about assessment obstacles and achievements.

The most general finding from this part of the interviews was that for many state correctional systems, the screening and assessment process is an area "in dire need of help." More generally, within and across state correctional systems, interviewees reported considerable variation in when screening and assessments are conducted, how and by whom they are conducted, and the quality of assessments.

Instruments

Across the 13 state correctional systems in our study, practitioners and researchers reported considerable variation in the instruments used. They also reported considerable variation in the quality of the instruments used, the quality of the screening and assessment process, and the use of screening and assessment results.

Drug Screening. The screening process itself was reported to be a cursory event in most systems, even though it provides the basis for the sorting and classification of offenders, sometimes referred to as the pyramid or flow chart. Most systems reported a flow model, where an initial screen takes place at a central intake center. Sometimes the screen involves searching for any evidence of substance abuse. Screeners frequently look for disqualifying factors such as disciplinary actions for violent offenses, prison gang membership, foreign/alien status, or mental illness that may preclude placement in treatment. In some systems, there is no initial screening. Rather, the recommendation from the judge or sentencing court determines whether the offender is to be placed in treatment.

For a simple screening process, most states report using the Texas Christian University Drug Screen (TCUDS), which is touted as being more "realistic" and producing fewer false positives than other screens, as well as the Simple Screening Instrument (SSI). Other states chose to create their own instrument by modifying existing

instruments and then validating their new instrument.

One state mentioned the Michigan Alcoholism Screening Test (MAST). Another mentioned using the Multidimensional Addictions and Personality Profile (MAPP) screening test. However, this state was in the process of phasing out the MAPP in favor of a free, public-domain instrument such as the TCUDS.

Drug Assessment. Drug assessment involves a more intensive and comprehensive analysis of whether an offender needs drug treatment. One prominent criterion for assessing treatment need is the severity of a drug user's problem. One basis for identifying the severity of the problem is the *Diagnostic Statistical Manual* (DSM-IV), which distinguishes between drug abuse and drug dependency/addiction. A drug abuse disorder involves a pattern of drug use that causes impairment or distress and any of several attendant problems during a 12-month period, including an inability to fulfill obligations at work or home, disruption of interpersonal relationships, and use of drugs in hazardous situations. By contrast, a drug dependency/addiction disorder involves pronounced physical symptoms (e.g., drug tolerance and/or withdrawal) and severe disruption in personal and professional relationships.

A wide range of instruments, listed briefly below, have been created for assessing drug treatment need, using either the criteria established in the DSM-IV or some other criteria. Unfortunately, some do not consistently differentiate between levels of severity in drug treatment need. Even when they do, the definitions sometimes are not consistent across instruments, and the information is not always used in determining whether drug treatment is needed or appropriate.

The failure to distinguish between levels of need for drug treatment can result in inefficient and ineffective programming. Research indicates that certain types of drug treatment are more effective for low risk versus high risk and low need versus high need offenders. For example, some researchers have found that low-risk offenders, as well as offenders with moderate treatment needs, fare better in treatment than do high-risk or high-need offenders (Gaes et al. 1999). Assessment is important, too, for obtain-

ing accurate estimates of the prevalence of abuse and dependency disorders, which in turn can assist with system planning, including determining the appropriate number of treatment beds, needed treatment facilities, staffing, etc.

Assessment instruments vary considerably across correctional systems. Several interviewees reported that their state correctional systems used the Level of Supervision Inventory-Revised (LSI-R). Some states or programs within states have created their own self-reported history battery, combining biological, psychological, and social items. The Addiction Severity Index (ASI) was also mentioned.

Some systems have created standardized, tested instrument batteries, such as Colorado's Standardized Offender Assessment Battery, mandated by Colorado law. The Colorado assessment battery begins with an SSI screen conducted during intake. For those deemed to have a substance abuse problem, additional assessments are conducted, including:

- LSI to assess criminal risk
- Adult Substance Use Survey (ASUS) to assess alcohol and drug involvement
- Substance Use History Matrix (SUHM) to assess substance abuse severity and history of treatment

During the general intake at the reception diagnostic center, initial screens are provided to determine whether further assessment of mental health, education, or vocation needs is warranted.

Instruments that "work." If the primary goal of screening is to reduce inappropriate referrals to treatment (i.e., "false positives"), then the TCUDS or the ADS/ASI-Drug are the most accurate instruments. If the goal of screening is to identify the largest number of offenders with substance "dependence" disorders, with less concern for inappropriate referrals to treatment, then the SSI is more accurate (Peters et al. 2000).

Timing of Assessments. For many correctional systems, screening and assessment is an area "reported to be in dire need of help." Both within and across state correctional systems, there is considerable variation in when screening and assessments are conducted, how and by whom they are conducted, the instruments and quality of assessment, and the use to which the results are put.

Typically, full assessments do not take place until inmates enter an assigned structured program. That is, results of an initial, cursory assessment are used to assign an inmate a classification level and some type of programming.

Once the inmate is in the program, additional assessments may be conducted to determine whether the placement indeed is appropriate and what kind of specific risks and needs should be addressed. Some states provide comprehensive assessments of multiple areas of need, while others restrict the assessments to those areas flagged by initial screening results.

Hierarchy of Concerns. Some of the correctional systems in the 13 states reported that security concerns ultimately override consideration of assessment recommendations. In come corrections systems, security reasons mandate placing an inmate in a particular prison and that prison does not offer the treatment that person needs, the risk would override treatment and the offender would be placed in the prison with the appropriate security level. Some states, such as Idaho, explicitly state in official publications that offenders are to be assigned to prisons based on risk and *not* on need. Idaho is currently changing that process to include risk/needs/responsivity assessments to enhance the effectiveness of case management, including placement of offenders in prison facilities according to their needs (Idaho Department of Corrections Program Overview, available online at http://www.corr.state.id.us). Some systems reported that programs are not meant to be mutually exclusive, but that system design frequently forces the treatment option to be secondary. In many of the prison systems respondents described, the decision is an "either/or" one — the offender receives either treatment or another program or nothing at all.

Information Exchange. Most respondents emphasized that the major problem they face with screening and assessment has less to do with selecting an instrument and more to do with the overall screening and assessment process. Two major problems are the lack of transfer of information and the lack of standardized policies for

transferring information (e.g., between courts, corrections, treatment providers, and post-release supervisory agencies). When a state department of corrections and the parole system are separate, this issue is especially problematic. In some states, a standardized package of information is supposed to accompany inmates into prison, but the information provided on each offender frequently is inconsistent.

For these reasons, one respondent stated that correctional systems frequently operate like "broken managed care systems." For example, if an offender comes into the prison system with insulin, it may not always be transferred along with the offender to wherever he or she is ultimately placed. This problem extends to transfer of assessment information as well as case files and records. Not surprisingly, several respondents suggested that after inmates enter the system, assessment information and updates should remain with them to reduce duplication of efforts and aid in providing a continuous treatment plan.

Contributing to a lack of information exchange is the absence in most correctional systems of a centralized, comprehensive, functional, cross-system database (i.e., one that can easily link from different parts of the correctional system and/or with other noncorrectional agencies, such as the courts). Among the 13 state systems, Florida's database system seems to be the most advanced for several reasons. First, it connects several different database systems. Second, it documents important assessment and program information such as sentencing court recommendations, types of treatment received, failure and success in treatment, probation and prison history, and urinalysis results. Third, it relies on this information, using weighted scores for different items, to track inmates and place them in the proper treatment settings. Colorado is currently implementing a cross-agency central tracking system, called the Criminal Justice Information System. Washington also has a database, operational since 1993, that tracks and identifies clients and includes over 400 data elements. New York's correctional system is automated, but the parole database system is not.

3. TREATMENT MATCHING AND PLANNING

Treatment Matching

Because of the sheer quantity of people, limited resources, and new and sometimes conflicting research, there has been a movement to institute guidelines for placement and duration in various types of treatment programs. The American Society of Addiction Medicine (ASAM) is one organization developing such criteria (Mee-Lee et al. 2001). The ASAM manual provides guidelines for five levels of service, ranging from early intervention to medically managed intensive inpatient services. Addiction severity and related problems are identified for each level, as are structured guidelines about settings, staff, services, admission, and discharge criteria.

Several respondents mentioned the ASAM criteria. However, the use of theoretically and empirically guided placement criteria is in the formative stages for most systems. In addition, many systems cannot afford rigorous implementation of treatment matching. One agency, for example, reported attempting a "treatment matching" program, but the effort was discontinued for lack of funding.

Yet the consensus appears to be that many state correctional systems would like to build this type of criteria into their assessments, particularly criteria for treatment matching and level of care. Almost every respondent spoke about the need to match inmates with the right treatment "recipe," taking into account treatment, timing, and service variety. Just as often, respondents stated that they would like to see more research about treatment matching. Specifically, what kinds of programs work best for whom? How can we modify existing programs to address different populations and different types of addiction?

Treatment Planning

Treatment plans are a critical part of any attempt to treat drug abuse and addiction. Assessment is important for developing treatment plans, but then these plans must be implemented and monitored. Research indicates that treatment is more effective when there is a continuity of care upon release. Thus, implementation of a case man-

agement plan for post-release supervision and treatment is crucial.

In this study, respondents emphasized that treatment planning was a central part of drug treatment services. However, for most correctional systems, respondents reported that the lack of database automation, along with system differences in processing and orientation, frequently prevents basic information, such as case files or medications, from transferring between systems. The result is that existing problems can be aggravated, and the likelihood of any treatment provision, much less effective treatment, is greatly diminished.

4. TREATMENT PROGRAMMING

Definitional Issues

The term "treatment" is widely used throughout jails and state and federal prisons, yet a concise, agreed-upon definition of treatment is rare. Alcohol/other drug abuse treatment can refer to a wide range of services to help offenders change their behavior and lifestyle and/or medically as-

sist the recovery process to reduce alcohol or drug abuse addiction. Different services are needed depending on the type of alcohol or drug abuse, client attitude and mental state, and prior drug and treatment history. Some researchers distinguish between treatment services, typically intensive services such as residential treatment or counseling, and nontreatment services, typically self-help or education groups. The definitional issues concerned many of the respondents in their attempts to describe their own drug treatment services and to interpret others' services.

Most respondents did not consider Alcoholics Anonymous or Narcotics Anonymous (AA/NA) and education-type services alone to constitute drug treatment. When asked about the treatment provided in their systems, respondents generally stated that they provided some kind of residential treatment, therapeutic community, or intensive outpatient treatment, and viewed these collectively as "drug treatment." They emphasized that within these different treatment modalities, other core issues, such as education, vocation, life skills, and anger management, are addressed.

Effective Treatment Plans: The treatment plan is as important as provision of treatment. Without a plan, treatment can be disjointed, piecemeal, and, ultimately, ineffective. Ideally, treatment plans should be multidisciplinary in delivery, comprehensive in scope, driven by ongoing assessments, and closely monitored (Vigdal, 1995). Treatment plans generally should include a client profile (needs, risk, history, etc.) along with the prescribed treatment plan, including goals and objectives.

Providers from all systems — criminal justice, treatment, mental health, and medical — should be involved in developing and implementing a treatment plan and sharing the information in the plan. To prevent "re-inventing the wheel," the plan should be automated and updated as risks and needs change and as progress is made. The plan is crucial for the period of time when the offender moves from the institution to the community. It is also important to enable representatives from different services to collaborate. Active linkages should be established and maintained between criminal justice representatives and alcohol or drug treatment and mental health providers, among others.

Case management can be an effective way to supervise the treatment plan. It can bridge different and sometimes competing systems. It creates a network of service agencies, both public and private, which in turn, creates a greater pool of resources of treatment options. And case management ensures continuity by providing a single point of contact, a "navigator," throughout the system.

Vigdal (1995) has identified five models of case management delivery:

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

Each type can be effective, so long as each involves strategies for ensuring coordinated, comprehensive, sustained treatment of drug problems.

The range of treatment approaches and settings in correctional facilities varies tremendously. Most respondents said treatment was viewed holistically. As one respondent stated, "There is a big problem with the way people conceptualize treatment. Some [states] consider education treatment. That is not treatment — that is information, awareness, and education — but not treatment. We want to do everything we can to make it clear that treatment is a different beast. It must be intensive, and results are usually gradual."

Representatives of every system with whom we spoke offered many services, provided in different structures and system "impact points" (i.e., pretrial, jail, presentencing, probation, prison, parole). The main services respondents reported providing included:

- residential treatment facilities in the community, typically as alternatives to incarceration or community-based correctional facilities
- in-prison treatment facilities and/or part-day programs, such as therapeutic communities
- pre-release substance abuse treatment/programs
- aftercare or transitional services

In short, respondents emphasized similar holistic philosophies about drug treatment, but the range of services varied tremendously, as did the level and types of services at different stages in the criminal justice system.

Cognitive-Behavioral Treatment Approaches

Cognitive-behavioral therapy approach uses the same "learning processes" that aid in the addiction process to aid in the recovery process as well. Techniques of cognitive-behavioral therapy include recognizing situations associated with drug X, avoiding these situations when appropriate, and coping with a range of problems and problematic behaviors associated with drug abuse. It focuses on the ways people think and the content of their thinking. Counselors try to teach clients how to change their thinking patterns. This type of therapy can take place in individual or group settings.

The cognitive-behavioral approach, regardless of the treatment setting, was the dominant approach reported by agency representatives and direct service providers in our sample of 13 states. Supported by national research, this approach can be adapted to and is a part of most systems' treatment milieus.

Some corrections agencies have attempted to standardize their alcohol and drug treatment philosophy to reflect cognitive-behavioral orientations. The standardization involves introducing or identifying cognitive-behavioral underpinnings of different treatment modalities or ensuring that a cognitive-behavioral component is a part of all treatment. In agencies where there was an entrenched commitment to specific treatment modalities or philosophies that are not consonant with a cognitive-behavioral orientation, the process of standardizing treatment has been difficult, though some progress was reported.

Research increasingly shows that the most effective programs are those targeting so-called "dynamic" or "criminogenic" needs — that is, factors that both can be changed and have been linked to criminal behavior. Most of the programs reported by our respondents addressed some of these issues, particularly risk and resiliency, pro-criminal attitudes, and deficits in educational, vocational, and employment skills. Some examples of cognitive-behavioral types of programs reported include a focus on breaking down barriers to personal growth and openness to treatment; studying the connection among thinking, feeling, and behavior; moving toward a pro-social lifestyle; and changing dysfunctional belief systems. In addition to these types of topical areas, many programs incorporate life skills and/or social skills programs, like parenting, relationships, goal setting, and time management.

Diversity of Programs and Implementation

Other programs and program combinations vary greatly among systems. Many correctional systems offer what they call a "continuum of services," from education to AA/NA to residential programs. Colorado has "levels of programs," while Idaho distinguishes between "core" and "ancillary" programs.

Among the wide range of drug treatment programs provided by prisons, many do not directly address drug problems but nonetheless are viewed as indirectly helping to address such problems. Some of the types of general and/or drug treatment programs include:

- six-month 1/2-day programs
- full therapeutic communities or other residential programs, 9-12 months
- pretreatment programs for wait-listed people
- work-release centers
- substance abuse facilities for people on probation (in lieu of prison)
- community-based correctional facilities
- sex offender treatment centers
- faith-based residential communities
- programs based on the Minnesota model of chemical dependency
- outpatient treatment
- separate facilities for inmates with co-occurring disorders
- alumni programs for people who have completed treatment and are still in prison
- relapse prevention programs
- AA/NA (as supplemental to treatment)
- education (as supplemental to treatment, mandatory for all inmates in one state)
- life and social skills programs.

Across similar programs, structures can vary considerably. For example, many correctional systems report relying on therapeutic communities. Indeed, almost every respondent referred to New York's Stay 'N Out therapeutic community as the model program. Yet, specific agency approaches to these communities can be quite different. Structurally, they can be similar, but frequently there are differences along dimensions such as how clients are involved in the treatment process.

In part because there are so many variations of similar programs, program directors and correctional administrators wanted to know more about the *quality* of programs and what factors were most relevant for effectively treating offenders with drug problems.

Several correctional administrators and substance abuse administrators stated that they would like to see more work in the area of program design. One director of programming, who has a background in psychology, stated:

> I think that there can be a real disconnect between what people say they are doing and what they [actually] are doing. For example, some counselors say that they are using the "here and now" approach in their therapeutic community. [But] I've seen them in practice,

and they are not really doing this. They are dealing with past behavior.

Another respondent said, "I don't think anybody knows what is going on in treatment programs."

These statements are supported by some qualitative research, particularly case studies. A General Accounting Office study notes that drug treatment research rarely accounts "for the tremendous variation in program operations, such as differences in standards of treatment, staff level and expertise, and level of coordination with other services" (U.S. General Accounting Office [GAO] 1998, 19). The lack of these types of process measures makes it difficult to know whether an absence of positive outcomes results from an ineffective treatment or from ineffective implementation.

Finally, when asked about treatment programming, many respondents emphasized that there is "limited" to "nonexistent" treatment in jails. Frequently, jails are unable to offer the full spectrum of services that longer-term, larger prison facilities offer. They have been described as a less than ideal place for treatment because of the frequent turnover and short stays. Yet many respondents viewed the people who circulate in and out of jail systems as an important group who need substance abuse treatment but generally do not receive it. Thus, for many respondents, jails provide a unique but underutilized opportunity for identifying and addressing substance abuse problems.

Maintaining a Drug-Free Environment

Maintaining a drug-free environment in correctional settings can set the stage for expectations of drug use (zero tolerance) and behavior in prison, yet only 29 percent of state and federal prisons are drug-free (Vaughn and del Carmen 1993). Many prisons provide free cigarettes to some offenders (Vaughn and del Carmen 1993). More important is the illicit drug trade reputed to be widely prevalent in prisons (Inciardi, Lockwood, and Quinlan 1993). Journalists and reporters frequently write about this issue, but from an evaluation perspective, few researchers have documented the actual prevalence of drug use in prisons, in part because of the extremely sensitive nature of the topic.

Several respondents spoke at length about the importance of maintaining a drug-free environment and the role that their extensive drug testing plays in maintaining this environment. One official noted:

> In January 1995, there was extensive drug use by inmates in the corrections department. There was a de facto ignoring of the problem for a variety of reasons. We made up our minds to take the prison back. In our mind, programming without abstinence is futile.

From this point onward, the prison system focused on maintaining a drug-free environment and prioritizing the notion that sobriety and drug treatment should be critical elements of corrections.

Prison administrators in this study emphasized that a broader reason for maintaining a drug-free environment is that the prevalence of drugs within a facility can undermine correctional agency operations, not just treatment. For that reason, some respondents indicated that it is important to encourage not only inmates but guards as well to maintain the "culture of sobriety." For example, guards should not talk about "getting high," and probation officers should not allow recovering addicts to drink alcohol. Failure to follow such steps results in double messages. According to one representative, "We can't afford to send these double messages. We need to break through the ambivalence."

Prison officials reported employing several strategies to create a drug-free environment. One popular approach is random urine testing of inmates for drugs. Drug testing actually can serve several purposes. It targets particular people for help. It can identify offender populations or sections of the prison system where there may be problems. Drug testing can provide incentives

for the inmate as he or she progresses through the gradual steps to recovery.

Other strategies are more directly focused on creating a drug-free environment. These include:

- the use of canines
- electronic drug interdiction for staff and visitors
- machines in the mail room that can identify drug paraphernalia
- random searches of staff
- use of sanctions (e.g., loss of visiting privileges) for misconduct relating to drug distribution or use
- ensuring that gang members are separated from one another to discourage drug access and distribution.

Voluntary and Mandatory Treatment

Conventional wisdom suggests that treatment must be voluntary to be effective. However, research shows that coerced treatment in fact can be effective (NIDA 1999). It can even be more effective than voluntary treatment (Leukefeld and Tims 1988), partly because the traits of addiction often include denial and an inability to recognize a problem; without recognition there can be no "readiness." Thus, those who lack recognition may be particularly appropriate for intervention (Inciardi 1993).

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

Most of the respondents reported that their

Characteristics of High-Quality Programs: The quality of treatment can have a pronounced effect on treatment success. According to several sources (Field 1998; Gaes et al. 1999), a high-quality program should include:

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

system employed a form of "coerced treatment" without making treatment mandatory per se. For example, if an offender is "recommended" for treatment or a sentencing judge has made an "endorsement" for treatment, then inmates are expected to comply with the treatment suggestion. If they do not, there is the implicit understanding that they may receive a more severe sanction or sentence term. As one treatment director said, "Now, treatment is 'voluntary.' [But in reality], there is a bit of coercion. The inmate won't get rewards from the system if he/she hasn't addressed the addiction problem."

For most systems, it is not the mere presence in treatment but rather the success and effort demonstrated in treatment that will result in rewards. Another director described the situation as follows:

> There is statutory earned time, up to 10 days per month, that can be earned by inmates for [good] behavior and participation in treatment. If they don't progress in treatment, GED, whatever, five days can be withheld. Also, refusal of treatment in a recommended program may result in a higher custody level or adversely affect ability to progress to a lower level. The Parole Board takes progress in treatment into account. So, treatment is not strictly voluntary because there are negative results associated with not taking treatment. It is a form of coerced treatment. We think that this produces the best participation in treatment and helps to keep people in treatment.

Other programs were described as strictly mandatory. One state system recently switched from voluntary to mandatory treatment. One respondent noted:

> Coerced treatment is more successful, especially in the criminal justice setting. Also, most people are in denial. The research says that mandated treatment provides the same if not better positive results. Inmates have too many reasons not to volunteer, so we weren't getting the people most in need of

help prior to this change. The high-risk, high-need offenders didn't want to do it, so it was really a public safety issue.

In other systems, in-prison treatment is mandatory while aftercare treatment is voluntary. One respondent emphasized, though, that aftercare treatment should always be mandatory. In still other systems, treatment is mandatory for certain groups, including offenders mandated to treatment as a condition of their sentence.

Some respondents hold the belief that for treatment to be effective, offenders must be volunteers and must be ready for treatment. As one person noted, "I view resistant clients like antibodies. If you send someone who is not interested to treatment enough times, you just increase his or her resistance." This view is supported in part by research showing that a "readiness" for treatment can yield greater improvements (Peters and Bartoi 1997). Such studies indicate that motivation level is an important predictor of treatment compliance, dropout, and outcome and is useful in making referrals to treatment services and in determining prognosis. They also show that treatment is likely to be ineffective until individuals accept the need for treatment of mental health and substance abuse problems.

Meeting the Need for Drug Treatment

"I don't think anybody has a handle on demand for services." This view was echoed by several respondents. The problem they raised centered on the fact that there is definitional ambiguity associated with both the drug problem and drug treatment that underlies much research and policy. Diagnostically, there is a difference between drug abuse and addiction, yet frequently the two are not differentiated by researchers or policymakers.

Practitioners noted that using a broad definition of substance abuse problem to allocate treatment beds can help justify increased fund-

> **"Seventy-five percent of federal research is flawed because [researchers] don't differentiate between abuse and dependency. No matter how sophisticated the research, if the basic definitions aren't clear, then the research is not clear."**
> — *Respondent*

ing for drug treatment. However, some also emphasized that it can dramatically overstate the actual extent of the need.

Some respondents also stated that one-time snapshots of treatment need and availability obscure the fact that prisons operate as systems with intakes, specific lengths of stay, and releases. They suggested that it is more appropriate to portray treatment need and supply with respect to specific stages of the criminal justice system as well as specific stages of an inmate's term of incarceration.

Selection of Specific Treatment Programs

In almost all states, the Department of Corrections (DOC) ultimately makes the decision about the type of treatment programming offered in the system. However, the process of making the decision involves input from a variety of key policy staff.

Some states have created committees consisting of representatives from a range of agencies and backgrounds. For example, the Idaho Standards Committee includes representation from all correctional institutions, the Bureau of Prisons, and the Bureau of Education, among others. Other examples include Missouri's Substance Abuse Planning Committee, a multidisciplinary committee, and North Carolina's Substance Abuse Advisory Council.

Other states rely on informal committees, composed of key staff, and other agencies. Some states rely heavily on the advice of "single-state agencies." Single-state agencies are responsible for licensing and accrediting all treatment programs, both within and outside of correctional settings. Several states have relationships with local universities, which provide research assistance and advice in determining the best treatment.

Several representatives from single-state agencies reported that their involvement with the state correctional agency has greatly improved treatment programming decisions. Representatives from the state Department of Corrections concurred. According to one representative, "[Our state DOC] no longer operates in a vacuum."

5. TREATMENT GOALS AND EXPECTATIONS

Treatment providers and system administrators were asked if recidivism is the "gold standard" for evaluating drug treatment. Respondents stated that recidivism is not the only expected goal, but it is the one in which most legislators and the public are interested. Recidivism is most widely accepted by state legislators, the group that ultimately influences programming via funding.

Many respondents noted, though, that recidivism, especially as reflected by reincarceration rates, is misleading. They emphasized that it is more appropriate to talk about incremental, less visible expectations and outcomes related to treatment. Program directors focused more on specific program issues and outcomes, while treatment and correctional administrators talked more about global issues. Some of the outcomes they noted include:

- better management of inmate time
- fewer medical needs because of participation in drug treatment, which results in reduced financial burdens on correctional health care systems
- improvement in self-esteem
- compliance with aftercare
- improved job prospects and employability
- greater likelihood of successful reunification with family
- reduced drug use or relapse to less serious drug use

Many correctional practitioners in our study focused on goals and outcomes that can be met while an offender is in prison, as opposed to outcomes, such as recidivism, that frequently cannot be directly controlled. Examples included maintaining sobriety while in prison, compliance in treatment, completion of treatment, and an understanding of addiction and its consequences.

Respondents also emphasized that recovery is rarely a "one-shot deal." They emphasized that treatment requires a continuum of services and a connection of systems to provide uninterrupted support for recovery. But frequently they cannot control whether such services are provided. For this reason, respondents emphasized the need to be evaluated based on their ability to

affect behaviors of offenders while they are in the direct control of the criminal justice system.

Some respondents were proponents of gradual harm reduction as a positive indicator of progress. They noted that the expectation of total abstinence is unrealistic. Others, however, emphasized that total abstinence is essential to treatment effectiveness and should be the gold standard.

6. GENERATING AND SUSTAINING SUPPORT FOR TREATMENT

In a 1996 study of correctional departments, 71 percent cited budgetary constraints and 51 percent cited space limitations as two of the major reasons that state and federal systems do not provide more drug treatment (CASA 1998). According to correctional practitioners and administrators with whom we spoke, there are, however, additional factors that may contribute to a lack of treatment.

Correctional administrators in particular emphasized the critical importance of social and political support for drug treatment, which they view as essential not only to obtaining funding but also to sustaining financial support over the long term. In turn, this financial support enables correctional agencies to provide drug treatment, among other types of services. But many respondents stated that without ongoing research showing that their own or similar programs are effective, it is difficult to generate this support.
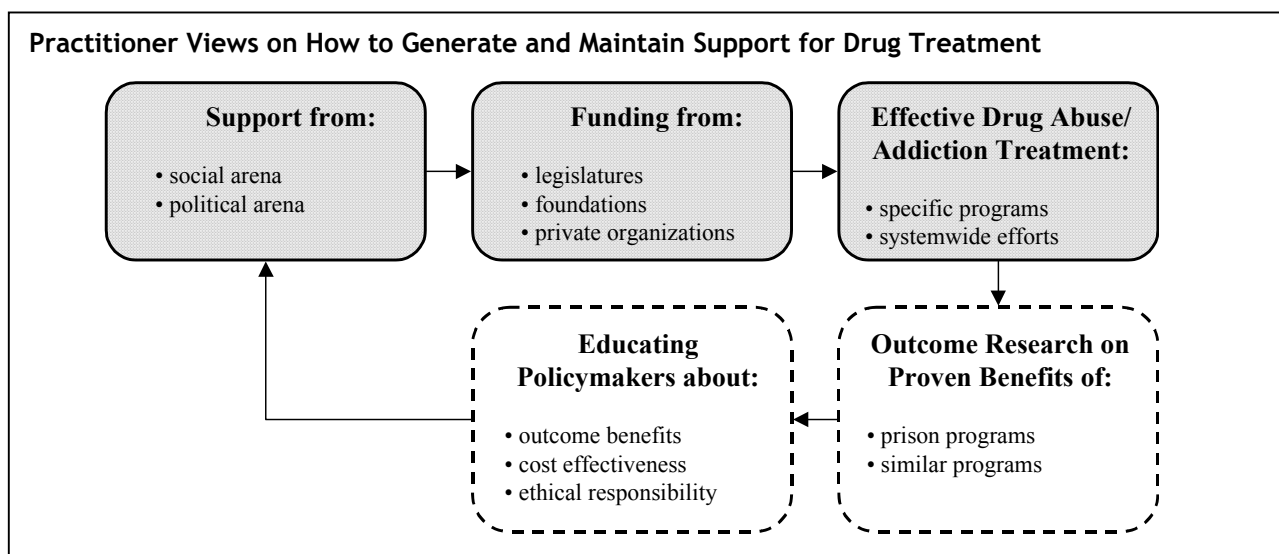
Respondents also noted that even with research showing that treatment can be effective, they have to engage in a constant effort to educate policymakers about the effectiveness of treatment and its benefits. Many respondents remarked that as part of the ongoing education process, they stressed not only practical benefits, such as reduced crime and increased cost-effectiveness, but also ethical issues. The most common example was the idea that offenders with drug treatment needs should be treated, even if treatment is costly and even if it does not directly contribute to reduced criminal behavior.

The responses given by these correctional practitioners suggests a model in which the key components to funding drug treatment include social and political support, funding from diverse sources, and implementation of effective drug treatment. Once drug treatment is provided, there is a need to demonstrate benefits and then educate policymakers about these benefits. Together, these components form a model, depicted in the figure below.

Social and Political Support

Respondents emphasized that social and political arenas are where the fundamental decisions are made about correctional drug treatment. Without support from these areas, initial or sustained drug treatment funding is reported to be unlikely.

Practitioner Views on How to Generate and Maintain Support for Drug Treatment

Support from:
- social arena
- political arena

Funding from:
- legislatures
- foundations
- private organizations

Effective Drug Abuse/ Addiction Treatment:
- specific programs
- systemwide efforts

Educating Policymakers about:
- outcome benefits
- cost effectiveness
- ethical responsibility

Outcome Research on Proven Benefits of:
- prison programs
- similar programs

Some respondents noted that interest in drug treatment emerged as the result of crises precipitated by lawsuits. In such instances, cases had been filed arguing that offenders' needs had been neglected to the point of criminal or civil liability, leading eventually to significant changes in treatment capacity. As one respondent said, "If [there is] a crisis, you get the political attention [needed to support treatment]."

Respondents emphasized, though, that whatever the initial motivation to provide treatment, the failure to actively obtain ongoing social and political support for treatment would result in dwindling funding to the point where treatment programs would be or had been closed.

This issue is particularly acute in times when state funds are limited or reduced. One respondent from a southern state described this situation and its consequences:

> Everyone is competing. Legislatures are looking for the most bang for the buck . . . and quickly. If they have to choose between funding a short-term parole violation program versus making minor improvements to an existing program that will yield incremental results, they will go for the new short-term program. They will ask, "How much will [the program] affect recidivism?" and "How effective is it related to cost?"

In another state, dual-diagnosis residential community beds have not been funded. The reason, according to the respondent, is that "realistically, we need to use money where we will get the biggest bang for the buck, and, frankly, it isn't there for [dual-diagnosis residential community beds]." Sometimes the reason is that other competing needs "win the day." For example, if education becomes a central policy concern, as it did in one state, financial cutbacks in other areas, such as corrections, likely will take place.

Funding

Respondents almost uniformly stated that the lack of sufficient treatment programming is not as simple as a lack of money. They emphasized that the underlying issue is maintaining support for drug treatment. Most respondents stated that the process of generating both initial and ongoing support requires considerable and ongoing effort, particularly in educating policymakers about the effectiveness of programs. Some also stressed that there are ethical obligations to provide treatment. From this perspective, it is inappropriate to incarcerate offenders without addressing their needs, even if there is no direct crime-reduction benefit.

One reason for showing benefits is to retain program funding. Unless the benefits are demonstrated, legislators are more likely to view a program as untested or ineffective and thus not an appropriate target for scarce resources.

Even with support and funding for treatment, there are critical challenges that, if unmet, can undermine long-term funding. For example, program administrators must decide between maintaining, expanding, or improving existing services. One respondent noted that when one drug treatment facility opened during a boom of support and funding, the facility plan was "too ambitious." The administrators were feeling pressured to do too much too fast, which undermined the program integrity and, in turn, the probability of showing positive impact.

Research and Education as Key Ingredients to Generating Support

Although legislatures may fund treatment after being convinced by studies showing the effectiveness of treatment programs, they frequently then want evidence that the specific programs they fund also are effective. However, the research capacity of many state correctional systems in our sample was reported to be quite low. As a result, correctional systems often have no

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Public Opinion about Drug Abuse: Public concern about drug abuse peaked during the late 1980s and then subsequently and dramatically declined. In 1989, 38 percent of the American public viewed drug abuse as the single most important problem facing the country. A decade later, only 5 percent of the public expressed this view. During the 1990s, system-wide drug treatment programming began in many state systems, sparked in part by public support for treatment. In recent years, however, public support has declined and may in turn contribute to pressure on legislatures to focus on other priorities (Pastore and Maguire 1999).

empirical basis to justify current or expanded programming. Some states are able to work closely with universities, but even in these cases the research takes time and may not directly address the needs of the correctional agencies. Other states have single-state agencies that draw on research to advocate drug treatment on behalf of correctional systems.

Even with research that demonstrates the effectiveness of a program, education of policymakers remains a key challenge. One advocate from a single-state agency said, "Getting money for treatment depends a lot on my selling job. Right now, we have new members in the legislature and I need to educate them about this [treatment] one at a time. Sometimes we ask members to visit the programs directly." An important part of this education process, as many administrators reported, is conveying that drug addiction is a disease that requires long-term treatment. A program director reported:

> We know that facilities with programs are safer. We know that certain programs work. We need to sell these concepts to the legislatures . . . and it must be in the form of substantive benefits about drug treatment. I think that there is an image problem between what [legislators] think that we do and what we actually do. Decisionmakers must be armed with information. It doesn't hurt to have connections and advocates going for us as well.

Respondents emphasized that many legislators view addiction as a moral deficit and thus are less inclined to fund treatment. They noted, too, that the general public and political climate create particular challenges for generating support for drug treatment. One respondent noted:

> Although we get good support to provide treatment in prisons, during the past two decades, a punitive philosophy [emerged] nationwide. . . . The war on drugs, which was really the war on addicts, created a stigma for people with addiction. . . . welfare reform, the banning of federal scholarships for drug users, etc. We exacerbated problems for predominately poor drug users. A small-time dealer is imprisoned. . . . He/she gets out and can't get federal grants, can't get into federally subsidized housing, colleges won't take them, and they can't get basic housing. It is a vicious circle.

One respondent reported that if arguments for drug treatment are grounded in terms of accountability and substance abuse treatment, treatment has a broader appeal. Another stated: "To address the concerns [of those who do not believe in treatment], I emphasize that drug treatment promotes public safety."

The majority of states in our sample reported that legislative support for treatment had declined, but they also indicated that there are many strategies for generating support. Some states build treatment into their formulas for all budget requests involving construction of new facilities. Others actively lobby legislators for funding or propose specific legislation.

7. TRANSITIONAL SERVICES

Post-release supervision and reentry services to ex-offenders constitute key mechanisms by which to prevent relapse and recidivism. Some research indicates that re-arrest rates can be lowered within the first year of release by as much as 50 percent for offenders who complete aftercare programs in the community. The critical role of reentry for preventing relapse and recidivism has led correctional institutions to focus increasingly on providing a continuum of treatment and services from incarceration to the community. However, many criminal justice systems still are in the early stages of developing this continuum, and the effectiveness of many programs remains largely unknown. Recent research by Lipton et al. (1998) offers some of the first aftercare guidelines. Many respondents said they support transitional services because they have seen the benefits of these types of services.

Assisting with Reentry

Correctional systems can employ several different strategies for assisting with the reentry process. According to *RSAT Links* (2000), there are several types of successful addiction-related transition models, including:

- outreach programs — corrections staff work with community treatment programs and community supervision agencies
- reach-in programs — community services "reach-in" to the prison walls, and services from the community begin while the inmate is still in prison

- third-party continuity — an independent agency takes responsibility for ensuring continuity of service
- mixtures of the above-mentioned models

Every respondent stressed the importance of transitional services to the overall success of treatment and reentry; however, respondents also reported that this research area is new and under-developed. It was reported to have been largely neglected during the past decade, with much more attention being paid to what occurs inside prisons.

Respondents reported providing a combination of "hand-off" services — the passing of a person from one "system" to another — both outreach and reach-in, with varying success. The majority of agencies reported that this area was in greatest need for improvement, while a few agencies were satisfied that their continuum plans worked quite well.

A majority of correctional systems in our sample described their current reentry process as a "hand-off" or "hook-up" with another system and treatment in the community. For many systems, once the inmate leaves prison, continuum of care is at the discretion of the parole and probation officers and resources. Several states have reported in official documents that this approach to providing reentry services is incomplete and ineffective.

One of the biggest areas of need cited by respondents was for *formal* information exchange among various systems and well-designed plans for each inmate. (Exactly *what* will happen when the inmate arrives in the community? *Where* will the inmate go? *How* will he or she get there?)

Lack of Coordinated Services and Information Exchange

Long-standing documented obstacles to the continuity of treatment include system segmentation, lack of coordination, a loss of the "structure" that includes incentives and sanctions, and a lack of services in the community (Field 1998). Our respondents also mentioned these issues. The problem cited most often was the lack of systems integration. Under most correctional structures, or through practices that have developed over time, different parts of the criminal justice system were reported to rarely coordinate

or cooperate in ensuring continuity of treatment. A respondent noted:

> The criminal justice system is so compartmentalized. We need mechanisms to help people with the transition, to help them break ties in the old communities, get new housing, get a good job, etc. I also think that people should be able to float back and forth into treatment. It shouldn't be such a process.

These problems reportedly are compounded when there are problems at specific stages of processing. For example, many recovering drug addicts do not meet with their parole officers for many weeks or even months after they have been released from prison.

Addressing Multiple Needs

Several respondents talked about the variety of "stressors" present when an inmate returns to the community. These stressors include financial, personal, and medical stress, in addition to the substance abuse treatment need. Because of the wide range of needs, providing effective treatment can be a particular challenge. One respondent stated:

> The problem is that there are many diverse problems: medical and dental needs, health needs, mental health needs, treatment needs in the community, education and job needs, and housing. In fact, people with mental health service needs get very little public health services. Most services are linked to mental illness, not mental health. This same division applies to alcohol and drug treatment. The treatment is there for those who are chemically dependent but not those who are substance abusers. You don't have a chance if you have both an alcohol or drug abuse problem and a mental health problem.

To offset some of the post-release medical pressures, one state is proposing an initiative that arranges preparation of Medicaid applications for eligible offenders. The goal is to speed up the process of accessing Medicaid payments for such drug treatment programs and to ensure that offenders begin receiving treatment and supervision as soon as possible. Without the help of such programs, access to Medicaid can be a particular challenge because, as one respondent noted, "[Medicaid], along with other federal rules, makes reentry more difficult than it al-

ready is. Particularly during the critical first six months of release, this primary potential source of funding for treatment is not available."

Funding and Coordinating Aftercare Services

Funding issues arose as a barrier to good transitional services and programs. Several states have reported problems with state funding for aftercare. One state reported undertaking an ambitious pilot program that showed promise, but then losing funding before the program could become institutionalized.

But funding for services is not the only problem reported by correctional practitioners. One respondent emphasized that the sheer magnitude of resources was overwhelming, especially in the absence of a centralized basis for accessing and coordinating these services.

Promising Transitional Ideas and Practice

Not all systems/agencies in our survey of 13 states reported difficulties with transitional services. Several states reported satisfaction with their transitional services. Some, for example, stated that treatment services were continual and uninterrupted, from prison to placement in a short-term residential treatment program to placement in an outpatient program for three to nine months.

One state reported using aftercare contracts, in which all therapeutic communities run by contractors are required to include provisions for aftercare in their contracts. The idea behind such provisions is to purchase a type of insurance, so that the initial investment of treatment is safeguarded.

Another state has included legislation to update and change its correctional philosophy toward treatment and reintegration: The Office of Program Services became the Office of Programs, Transition and Post-Release. This change not only shifted the correctional philosophy but also shifted money toward the focus on transition. Among other things, this legislation allowed for 50 new post-release positions, the establishment of 400 faith-based post-release beds, and creation of a transition plan requiring all inmates to be linked to community services. Because there is no parole in this state, an "addiction release supervision" status was created. This is a new form of early release for nonviolent of-

fenders with alcohol and drug abuse problems. In essence, it is close supervision with aftercare, as the offender can serve a period of his or her time in the community under addiction release supervision.

One private treatment agency piloted a behavioral program to help clients with the transition to aftercare. In addition to aftercare case management, they are trying "behavioral rehearsals," which involve showing an offender a calendar and demonstrating how to write down appointments, arrange for travel, and, in general, solve problems.

One state mentioned using a mentoring program. This pilot program focuses on minority males and links a minority male inmate with a mentor in the area of release. The program is not exclusively treatment-oriented, but if treatment is needed, the inmate will get it. In this state, the program is a joint effort with the single-state agency.

Some states use "alumni associations" to facilitate reentry. These are usually informal programs with no funding. One agency representative called this type of association the "most successful program that I have seen." The idea is for correctional treatment program graduates to maintain contact with the program through letters, cards, and ongoing interaction (e.g., visiting the program). Once a person leaves the program, he or she is linked to someone in the association. Chapters meet for support and resource sharing (picnics, meetings, etc.).

8. RESEARCH WISH LIST

Research That Is Accessible

Many respondents reported that there was little information that was easily accessed and understood. Frequently, respondents stated that research reports were written for researchers who have the ability and time to understand the material. What they, as correctional practitioners, wanted, however, were succinct reports that stated the core findings and policy implications directly. This format is most effective when addressing legislators, for example. As one respondent said: "[We need] information that can be presented in sound bites. . . . Many of my staff complain that most research is written for

researchers. . . . In the trenches, that presentation of material does not work."

Focused Research

Address Practical Needs. Respondents also spoke about the need for "practical" research. By this, they generally meant research on such issues as "how to fund programs" and "how to form and enhance partnerships with other agencies."

Specific Populations and Programs. Respondents spoke about the need for focused research in under-developed areas, such as the needs of black males and Hispanics, women with children, and offenders with co-occurring disorders. Respondents felt such research was needed to determine appropriate types of treatment. For example, are there specific factors that influence the recovery of specific groups differentially?

Program Quality. Respondents wanted to know more about program implementation, including specific information about the following types of issues/questions:

- What are the staff qualifications?
- What type of staff is better for treatment settings?
- What is the program design and curriculum (details)?
- What is the best training battery for new staff ?
- Does the quality of treatment have impact on outcomes?

Soft Outcomes. Many respondents reported that they would like to see research that focuses on the "soft outcomes," such as tracking quality of life, education, employment, or treatment patterns. Recidivism was not viewed as the only relevant outcome. A frequently expressed view was that if we want to understand what "works," we need to focus on positive indicators and incremental quality of life variables and not just negative indicators such as recidivism.

Systems-Focused Monitoring and Research

Global Understanding. Several respondents, particularly correctional administrators, reported that they would like to see more statewide, global, systems-level research. They noted that it is relatively easy to find documentation or studies of specific programs or modalities, but, as administrators, they would like to know how their system is doing as a whole. For example, administrators stated that they would like to see more "real-time" research on who is in the system and what each inmate needs, who has left, what services he or she received, what he or she did not receive, and why. If an inmate did not receive services, was it because of a system problem or an inmate problem? Respondents said this type of monitoring would also help to identify patterns that could then be addressed.

Agency Relationships and Agency Roles. One agency can not be completely responsible for the outcome of a person. In treatment, though, it is common to equate recidivism or relapse to a failure of the drug treatment in prison. Respondents wanted research to focus on all agencies involved with a transition back to the community to pinpoint exactly what went wrong and where.

Treatment versus Corrections Orientations. Several people spoke about the "treatment" versus "corrections" orientations within the criminal justice system. Respondents felt that research could help to determine the best way to resolve this problem.

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APPENDIX: INTERVIEW SCHEDULE

Strong Science for Strong Practice

Interview Schedule

Interviewee:	Interview date:
Position:	Start time:
Contact info:	End time:
General affiliation category:	
State:	Interviewer initials:

Background information about person/organization

Summary impression of interview/caveats about interview

INTERVIEW INSTRUCTIONS

The following are questions to be asked of key correctional drug treatment stakeholders (providers, state-level corrections program administrators, and state drug and alcohol systems managers). *The goal is to collect basic descriptive information about both views of and provision of drug treatment in correctional systems.* This information in turn will be used to inform the development of a meeting of practitioners and policymakers and a report outlining key research recommendations to the National Institute of Drug Abuse. *Ultimately, NIDA will use this information to develop a research agenda for generating useful research to improve drug treatment in the criminal justice system.*

Questions should be asked in the order in which they appear, with additional follow-up questions or probes relevant to the systems level which each type of respondent is best suited to address (e.g., programs, state policy, prisons, or correctional systems). Interviewers should strive to complete all questions, but should be flexible in focusing on fewer questions if appropriate.

[Interviewer instructions and/or clarifications are in CAPS]

QUESTIONS

1. What types of drug treatment are provided to drug-involved offenders in your system?

    Who is eligible for treatment? [ELIGIBILITY REQUIREMENTS FOR TREATMENT IN GENERAL AND/OR FOR SPECIFIC PROGRAMS?]

    How is it determined that an inmate is eligible? [ARE ASSESSMENTS USED?]

2. Who is responsible for deciding the kinds of correctional drug treatment that are provided? [WHAT PERSON/POSITION WITHIN THE ORGANIZATIONAL STRUCTURE?]

3. How is the decision made to provide particular types of drug treatment services? [WHAT IS THE PROCESS?]

   What other types of drug treatment, if any, have been considered?

   Do you prefer a specific treatment program or a specific treatment modality for treating offenders (or does it depend on the particular needs or problems of the offender)?

4. Who provides drug treatment services in your correctional system? [IN-HOUSE? CONTRACT?]

   What types of training background do they have?

5. What do you expect from drug treatment? [PROBE: IS RECIDIVISM THE "GOLD STANDARD"? ARE THERE OTHER EXPECTATIONS? HOW DO YOU PRIORITIZE THEM?]

   What do other people in the system expect? [LEGISLATORS? STAFF? GUARDS?]

6. How do you determine that drug treatment is working — that is, what criteria do you use or believe should be used? [ASSESSMENTS? WHAT KIND? HOW ARE THE RESULTS USED?]

   Is progress in treatment a factor in determining the offender's status (e.g., continuing in treatment, release date)? Is lapse in treatment progress (e.g., dirty urine) or disruptive behavior a factor in determining the offender's status? Is a system of graduated sanctions in place, and is it applied consistently?

7. How are the drug treatment needs of offenders released into the community being addressed? [PROBATION, PROGRAMS, CONTINUUM OF CARE, CASE MANAGEMENT, ETC.? WHAT ABOUT SPECIAL NEEDS POPULATIONS OR SPECIFIC AREAS?]

8. What information do you need or want to better understand drug treatment issues in corrections?

   To facilitate successful reentry of offenders?

9. What are the primary factors that most facilitate getting drug treatment in prisons? [MACRO-FOCUS: PROBE ABOUT BIG PICTURE ISSUES, SUCH AS LEGISLATION, PUBLIC SUPPORT, RESEARCH-PRACTICE GAPS.]

   What stops drug treatment from getting into prisons?