DRUG PROGRAMS IN CORRECTIONAL INSTITUTIONS

National Institute of Law Enforcement and Criminal Justice
Law Enforcement Assistance Administration
United States Department of Justice

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By
ROGER SMITH

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Gerald M. Caplan, *Director*

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FOREWORD

In many correctional institutions today, more than half of the inmates have drug problems. The presence of such large numbers of addicted offenders poses special problems for the correctional administrator.

The long-range aims of correctional drug programs are to reduce drug abuse and related criminal activity — goals that have not generally been achieved. However, as this manual points out, drug treatment programs can contribute to the efficient management of correctional institutions by improving the correctional environment and enhancing the relationship between inmates and staff.

According to the authors, this manual is less than "prescriptive" in some ways, because thinking in this field is in a "constant state of flux and change as new approaches to treatment and rehabilitation are introduced, modified, or abandoned in the light of the realities of the correctional setting." Many innovative programs are now being undertaken, and correctional agencies and institutions should encourage initiative and experimentation in their programs.

This prescriptive package should be useful to correctional administrators as well as those who set policy and direct drug treatment programs at the federal, state, and regional levels.

Gerald M. Caplan
Director
National Institute of Law Enforcement
and Criminal Justice

December 1976

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We'd like to know what you think of this Prescriptive Package.

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PREFACE

Over the last two decades we have witnessed many new and promising developments in the treatment of drug dependence or abuse. In the late 1950's Synanon successfully challenged the notion that drug dependence could be treated only within the confines of a closed institution. In the mid-1960's literally thousands of community-based drug treatment programs developed nationwide, utilizing a diverse array of treatment methods. Widespread use of methadone maintenance and other chemical treatments added yet another dimension to the treatment process.

Correctional programs for drug offenders have likewise undergone many significant changes within recent years. Many of the new treatment methods initiated in community programs have been transplanted into correctional institutions. Correctional efforts have also been greatly aided by the expanding liaison between institutions, parole, and the network of community drug treatment and rehabilitation agencies.

In some ways, it may be premature to become prescriptive with respect to correctional programming for the drug offender. Thinking in the field is in a constant state of flux and change as new approaches to treatment and rehabilitation are introduced, modified, or abandoned in the light of the realities of the correctional setting. There is no consensus regarding the most effective approach to the drug offender; indeed, there are many who argue that corrections cannot provide such services and should abandon their efforts altogether. Conversely, there are others who feel that we can mount effective programs in correctional institutions.

In this prescriptive package we will review several key areas in correctional drug treatment programming. If we are less "prescriptive" than expected, it is because we feel that corrections has not yet reached the stage in program development where emulation is practical or even desirable. Without question there are aspects of individual programs which are worthy of emulation-staffing practices, treatment methods, therapeutic environments, etc. However, there are few programs which we would recommend as models for other settings.

Throughout this manuscript several major themes are emphasized. Most important is the stress on innovation and experimentation in programming, particularly in the institutional setting. Closely related to this is the stress on evaluation which will allow us to understand both the potential and the limitations of drug programming in this setting. Throughout this package, we will stress the goal of involving offenders in community programs upon their release.

Some reviewers of this manuscript felt that we were unduly pessimistic about the value of drug treatment efforts with offenders. We have tried to reflect the viewpoints of many individuals with whom we spoke during the course of this project who urged us to stress the need to be realistic about drug treatment programs. Too often we have set unrealistic goals for social programs and then had to abandon them altogether when they failed to live up to our high expectations. Throughout this prescriptive package we reiterate the fact that drug dependence is a chronic condition which may not be overcome in a matter of a few months or even years. Drug offenders often bring to treatment a host of other social and personal deficiences in addition to their use of drugs which makes treatment difficult.

Many individuals contributed to the preparation of this document. The many inmates and parolees who shared their thoughts and perspectives on drug treatment programs will find their point of view well represented. Staff members of correctional programs also contributed much helpful information and were generally very candid about their experiences. Many valuable insights were contributed by individuals who function as planners or administrators in either corrections or drug abuse.

Drs. John Kramer and Thomas Ungerleiter served as advisors to the project and assisted in

identifying the major areas which needed to be covered in this report. Reuben Stromme brought a wealth of information and experience to us from his former position as a counselor at the NARA program at Terminal Island, California. Theresa Edwards assembled most of the bibliography and contributed much to the organization of the manuscript. Editing and typing was ably done by Averie Cohen.

The chapter on Evaluation of Programs was written by Dr. Dan Glaser of the University of Southern California, who brought a wealth of experience and information to this task. The administration of the project was handled by Raymond S. Olsen of the American Correctional Association, and by Louis Biondi of the National Institute of Law Enforcement and Criminal Justice. Both provided many helpful services and were highly supportive of the work throughout.

Readers will discover that the bulk of this manuscript deals with drug programs within correctional institutions. It became apparent that there was much information to present on institutional programs. Covering aftercare programs in depth would have expanded the prescriptive package to unmanageable size. Special programs in parole is the subject of a future prescriptive package and should satisfy those readers who are primarily interested in the post-institutional period.

CHAPTER I. DRUG ABUSE TREATMENT AND REHABILITATION PROGRAMS IN CORRECTIONS

A. Introduction

Within recent years, the number of drug dependent individuals entering the criminal justice system has increased dramatically, placing an enormous burden on all of the involved agencies. Past experiences with drug abusing offenders have led most agencies to conclude that traditional methods of criminal prosecution, incarceration and rehabilitation have had little impact on subsequent drug-taking and associated criminal behavior.

Courts and criminal prosecutors, particularly, have been overwhelmed by the seemingly unending flow of drug-involved offenders. Their position on the "front end" of the system means they have felt the full impact of the increase in drug related cases. Not surprisingly, a variety of alternative methods has been developed at the prosecutorial level for disposing of these cases. In some jurisdictions, addicted or drug dependent defendants who are unable to raise bail, or who do not qualify for release on recognizance or other bail programs, may be released under supervision and assigned to a treatment program in the community as a condition of release. In areas where drug abuse constitutes a major criminal problem, a variety of pre and post-trial diversion programs are normally available.

As the means of identification and selection of eligible candidates for diversionary programs becomes more sophisticated, centrally located screening and referral agencies have been established, serving as brokers between the courts and community treatment agencies. Some probation departments operate their own treatment programs, including methadone maintenance programs, therapeutic communities, or out-patient counseling centers. Clearly whenever community treatment is consistent with public safety, it is the most desirable option for attempting to interrupt drug abuse before it becomes an established behavior pattern.

Despite the increasing availability of community alternatives to institutionalization, the current reality is that a sizeable percentage of inmates in state correctional systems and on parole supervision have histories of drug abuse. A nationwide drug abuse survey was recently conducted in state correctional facilities.[1] Questionnaires were administered to 10,359 inmates in 190 facilities selected to participate in the survey. The findings were not surprising: 61% of those interviewed indicated that at some point in their lives they had used drugs without a prescription or outside of a treatment program. The drugs used were: heroin (30%), methadone (9%), cocaine (28%), marijuana (56%), amphetamines (29%), barbiturates (28%), and other drugs—hallucinogens, glue, cough syrup, etc. (16%). About one-third of the inmates had a history of daily or almost daily use of drugs; two out of ten used heroin daily, or almost daily prior to imprisonment. One out of every four inmates was under the influence of drugs at the time of the offense(s) causing the present imprisonment.

Despite the large number of inmates who were involved in drug use, only a small percentage (23%) of those who used drugs on a daily basis had been involved in a drug treatment program prior to incarceration; the majority of them (two-thirds) in methadone maintenance programs.

In California, the percentage of inmates classified at intake as having a history of narcotics usage has increased significantly in a little over a decade, despite the widespread use of diversionary programs, community-based correctional programs, improved probationary services, and other state and local strategies for dealing with drug abusers.

In June of 1961, 20 percent of the male inmates and 30 percent of the female inmates in the California system were identified as having a history of narcotics usage. By the end of 1974, that figure

had risen to 37 percent of the males and 41 percent of the females. Similar data are to be found in many other states[2]. What this steady increase suggests is a pressing need for correctional institutions to provide services for those inmates who need and could utilize treatment and rehabilitation programming.

However, there is currently little agreement in the field of corrections regarding the usefulness of drug treatment programs which are operated by the system itself. Indeed, there is growing doubt and confusion regarding the entire range of treatment and rehabilitation programs which have been initiated over the last several decades. Although the "era of rehabilitation" was ushered in with high hopes, the recent findings of Martinson[3] and his colleagues have cast the shadow of doubt over most of those therapeutically-oriented programs initiated since the end of the Second World War. In their review of over 300 therapeutic programs which were operated during the period from 1945 through 1967, Martinson found few that had any significant impact on recidivism rates.

The National Advisory Commission on Criminal Justice Standards and Goals acknowledged in their 1973 report on corrections that there are many difficulties inherent in providing effective services to an inmate population. They concluded, however, that we must continue to make an effort:

> "As long as drug users are sentenced and committed to institutions, correctional agencies and institutions must attempt to devise programs that will deal with the problem and provide the basis for later treatment in a more appropriate community setting. Staff, including ex-offenders, should be especially selected and trained to work in drug programs. Every institutional resource with potential usefulness should be brought to bear. An effort must be made to align drug users with group affiliations that can substitute for the drug subculture. Because no solutions have yet been developed that provide effective treatment for addicts in correctional institutions, the correctional agency and institution should encourage initiative and innovation on the part of persons operating these programs. Research and experimentation should be a fundamental feature of every drug treatment program."[4]

We essentially concur with the Commission's viewpoint. Despite the uncertainty which surrounds correctional programming for drug treatment, we need to continue to experiment with institutional programs, utilizing new staffing patterns, treatment modalities, and aftercare strategies. Corrections also needs to aggressively explore new ways of effecting solid working relationships with more recently established community-based programs so that service delivery becomes unified and continuous.

Community treatment programs, as well as institutional treatment programs, have passed through a euphoric stage. Most programs and approaches have been carefully if not widely evaluated and much has been learned. The unrealistically optimistic goals of a few years ago have, in most instances, given way to a more pragmatic and reality-based notion of what constitutes treatment and rehabilitation and what they can and cannot be expected to accomplish.

B. Focus and Scope of this Prescriptive Package

This prescriptive package is intended to be a practical and useful resource for a variety of actors in the correctional process—corrections and drug abuse planners and administrators, as well as those on the firing line—clinicians, para-professionals, correctional counselors, and custodial personnel.

As we began to collect information, it became apparent that we had to limit this presentation considerably, if we were to present information in any depth. Thus, we devote most of this prescriptive package to institutional programming.

Our primary concern is with adult offenders, both male and female, in correctional institutions and pre-release programs. There is a more limited discussion of parole. Our focus, is in those programs or strategies which are "system" operated or directed. While we recognize the importance of self-help programs such as Narcotics Anonymous, Narcanon, Seven Steps, and ethnic or religious approaches, it is not our intention to suggest ways in which they might modify or improve their operations. We also recognize that it is important that individuals in a correctional setting be given an opportunity to make choices regarding the types of programming they wish to participate in, if indeed they choose to participate at all. Diversity of options is stressed throughout this document.

Self-help programs represent an important alternative to institutionally-operated and staffed programs.

As we began to assemble data for inclusion in this prescriptive package, several general areas of concern emerged which we intend to develop. We began by posing questions which we hoped would become illuminated during the course of our data collection and site visitations. They included:

1. What specific treatment modalities appear to have applicability within a correctional setting? What are the specific techniques utilized, and what are the goals of these specific modalities?

2. Under what environmental or physical conditions is the possibility of treatment enhanced and, conversely, under what conditions is the task of providing treatment services undermined? Can one effectively provide drug abuse services while the client remains within a general inmate population, with all of the negative attitudes and pressures which exist? We began with the assumption that positive change is not possible in an atmosphere of fear and mistrust so intense that personal survival necessarily becomes an inmate's first priority. Is it possible to create a positive environment for treatment within institutions where the prevailing inmate value system is antithetical to that of the treatment program?

3. What are the roles of the major actors in the treatment process, and how do their attitudes, actions and interrelationships influence the dynamics of the treatment process itself? Is it possible to undo the manipulative and suspicious attitudes which inmates almost necessarily hold toward custodial staff, correctional counselors, or treatment personnel? How do attitudes vary between voluntary and involuntary participants and what effect does this ultimately have?

4. Given the fact that custody is the primary function of correctional institutions, can a balance be maintained between an institution's responsibilities for security and the need for effective treatment programming? Is it possible or even desirable to alter some of the basic assumptions about both custody and treatment in order to improve the quality of correctional services?

5. Is there any reality to the phrase "continuity of treatment" — is it really possible to effect any meaningful relationship between institutional programs and their community counterparts? If so, what is the nature of this relationship and how might we improve it?

As we moved from an investigation of program models and problems inherent in providing services within the correctional setting, we became aware of other important considerations. Drug programs cost money. How would they be funded? They required staff: what kind, with what qualifications, and what experience? Could ex-offenders become an integral part of the correctional treatment process? Were there administrative or legal problems with the employment of such individuals?

As we looked at the question of continuity of services, it became apparent that if corrections is to move out of the vacuum within which it has operated for decades, planning efforts at the highest levels must be improved. In particular, we were interested in ways in which the Single State Agency (SSA) for drug abuse and the State Planning Agency (SPA) for criminal justice might integrate their efforts (which often overlap) in order to maximize the resources available to the correctional client.

Finally, in keeping with the recommendations of the Commission, we sought methods which would be helpful to the program administrators, correctional administrators, and others in evaluating the success which programs or particular aspects of programs were achieving.

The questions and the scope proposed by the above represent a monumental task. Thus, we shall attempt to cover a good deal of territory in a brief space. This publication should not be viewed as a "cookbook" which provides step by step instructions on the design and operation of a correctional drug abuse program. Rather, it provides broad guidelines as well as specific examples which may be utilized in conjunction with other resources. To assist those who wish to explore particular issues in more depth, references to the literature are provided at the end of each chapter.

There are many differences of opinion regarding drug abuse programming in the correctional setting. Some of the differences involve basics—definitions of drug abuse, issues of voluntariness and coercion, appropriate goals for institutional and aftercare programs. Some of the program managers interviewed would argue that the notion that there is a condition called drug abuse which can be identified and treated is absurd and that before change can occur, the nature of the change process must be redefined. On some rather important issues we will take no particular position, preferring instead to simply present both sides of

an issue. In those instances where our biases are interjected, we hope to make clear our reasoning.

This prescriptive package will explore many of the innovative approaches to drug abuse which have emerged within recent years, as well as those persistent problems to effective programming in the institutional setting. We have no panacea for treating the drug-abusing offender, nor is one ever likely to exist. Drug dependency comes in a variety of forms and we must recognize and respond sensitively to the differences.

C. Summary of Recommendations

1. Drug treatment programs in a corrections setting must establish and articulate reasonable and attainable goals. There should be a clear distinction between client goals, societal goals, institutional goals, and program goals. No one set of goals is applicable to all populations.
2. Community resources must be fully utilized whenever possible during both institutionalization and after release.
3. There are many natural barriers to establishing a successful program within an institution such as negative inmate values and attitudes, staff/inmate communications problems, staff dissension, and the inherent organizational structure of the institution. Therefore programs must work to change the environment as well as the individual through the use of separate unit programming, establishing functional units, separate facilities etc.
4. The etiology of drug abuse is as diverse as the institutional population. Therefore the content of the program must be considered as carefully as the context.
5. Within the limits inherent in the institutional setting, any treatment program should be voluntary. Clients should be allowed to refuse or terminate treatment without such a decision having impact on expected parole dates.
6. Professional, paraprofessional and custodial staff assigned to any treatment program should be carefully screened and selected. All three types of staff should be molded into a "treatment team" in an effort to provide a reasonable treatment environment. There is a natural antipathy among the three groups of personnel which must be dealt with and minimized.
7. Continuity of service must be established between institutional programs and after-care programs. Without such continuity, the client's chances of continued success upon release will be greatly reduced.
8. It is recommended that each state establish inter-divisional planning and coordination committees involving the Single State Agency, the State Planning Agency and the Department of Corrections.

D. A Note on Data Collection Procedures

The information contained in this prescriptive package was obtained in two distinct ways. First, we began our efforts with a search of the professional literature, utilizing a variety of sources. In addition, a computerized listing of federally funded programs in the correctional area was reviewed.

It quickly became obvious that while there is an overwhelming amount of information and a plethora of articles in the general area of drug abuse and its treatment, there is very little which specifically relates to drug abuse treatment within the correctional context. Much of what does exist is dated, overly optimistic, or highly critical of correctional treatment in general.

Two general surveys of correctional drug abuse were also reviewed. The first, appearing in the 1972 Proceedings of the 102nd Congress of Corrections, was a report on the results of a questionnaire survey conducted by Richard H. Warfel,[5] a Supervisor for the correctional drug abuse programs in Florida. The second survey was conducted by Research Concepts, Inc., for the National Commission on Marihuana and Drug Abuse.[6] They focused their efforts on adult males in correctional programs. They drew their sample from correctional programs in seven states, and included programs conducted by probation, correctional institutions and parole agencies. Although both of these surveys were useful in identifying some of the major issues to be dealt with, they too were found to be somewhat dated. The latter survey also reviewed the professional literature and found it dated and totally unrepresentative of the level of activity in the field. Our experience generally confirms their impressions that there are little data available in the professional literature which describes correctional drug abuse programming.

Thus, in many instances the best sources of information, aside from actual observation, were grant proposals, in-house program descriptions, and evaluation reports for funding agencies.

We sought to locate a number of distinctive models for providing services in the correctional setting. In some instances, highly regarded (and published) programs were found, upon inquiry, to have been radically altered or disbanded entirely. During the course of our site visits, we came to accept as a natural phenomenon the rapid change which seems to characterize correctional drug abuse programming. In the long run, word of mouth proved to be the most effective way of locating correctional programs of promise. Though quite limited, there is an informal communication network among institutions and agencies and between one state system and another. Given the relative sense of isolation that many in this field experience, a more formal network might well prove valuable.

As institutional programs were located, contact was made with administrators and others connected with their operation. Prior to a site visitation, we sought descriptive materials so that we might have a more detailed background on the particular correctional system, the restraints under which it operated, its levels of support, etc. This information was not always available, nor was it always current.

Site visits were normally one day in length, although in some instances we spent several days in one program. Normally we met with superintendents or wardens, sometimes for an honest exchange of opinions and information, sometimes as a mere formality. Interviews, both formal and informal, were conducted with key administrative and clinical staff, as well as program participants. Whenever possible, we attempted to pay particular attention to correctional officers, for their attitudes toward the program were often quite revealing.

Aside from the standard procedures described above, we tried to listen with a "third ear." How did staff really feel about their jobs? Were inmates genuinely involved in the program or were they cynical and manipulative? What was the level of morale? Was drug use a major problem in the institution? In the program itself? Was discipline a major problem within the program? How were disciplinary matters dealt with? These and other less tangible features of a program often tell much more about its operation than can be learned from analyzing flow charts or reviewing statistical data.

In general we were highly gratified by the cooperation and openess which characterized our site visits. We emerged from the experience with a good deal more optimism than we had at the outset, and the conviction that there is much positive and constructive programming going on in correctional institutions around the country which is worthy of a wider audience than it is currently commanding.

Note to Reader: See Appendix B for Recommended Readings relating to this Chapter I.

NOTES

1. Barton, William I. "Drug Histories of Prisoners: Survey of Inmates of State Correctional Facilities," paper presented at the National Drug Abuse Conference, New York, March 1976.

2. "Narcotics Use History," Administrative Information, Information Section, Research Division, State of California Department of Corrections, February 10, 1975.

3. Martinson, Robert. "What Works? Questions and Answers about Prison Reform," *The Public Interest*, Spring 1974.

4. National Advisory Commission on Criminal Justice Standards and Goals, Task Force on Corrections, *Corrections*, Washington, D.C., January 1973, p. 375.

5. Warfel, Richard H. "A Report of Drug Treatment Programs in America's State Prison Systems," in *Proceedings of the One Hundred and Second Annual Congress of Correction of the American Correctional Association*, Pittsburgh, August 1972, p. 42-57.

6. Research Concepts, Inc. "Treatment and Rehabilitation Programs for Drug-Involved Offenders in State Correctional Systems," in Volume III: The Legal System and Drug Control, Appendix to Drug Use in America: Problem in Perspective, National Commission on Marihuana and Drug Abuse, Washington, D.C. 1973, p. 810-852.

CHAPTER II. ESTABLISHING GOALS FOR INSTITUTIONAL DRUG TREATMENT PROGRAMS

The numerous expectations placed upon drug treatment programs in correctional institutions may be defined by legislation, by sentencing courts, or by correctional administrators. This chapter will examine the major goals established by the facilities which were observed. One of the purposes of outlining program objectives is to explore the "real goals" of treatment programs, which are generally recognized only by program administrators or participants. We are presently concerned primarily with organizational goals as they (1) define the broad parameters of treatment programs, (2) establish program guidelines, and (3) legitimize programs to important "outsiders."[1]

A. Goals for Corrections

Traditionally, the field of corrections has concerned itself with two major goals: the protection of society through isolation of offenders, and the rehabilitation of offenders. The focus of drug rehabilitation, though varied to some extent, has almost exclusively centered on individual "pathology," regardless of the environment which generated and sustained the criminal behavior. This "medical model" approach to treatment has fallen into disrepute in many correctional circles.

The National Commission on Criminal Justice Standards and Goals recently emphasized the necessity of community, as well as individual, change as a prerequisite to effective correctional treatment programs:

> ". . . crime and delinquency are symptoms of failure and disorganization in the community as well as in the offender himself. He has too little contact with the positive forces that develop law-abiding conduct—among them good schools, gainful employment, adequate housing, and rewarding leisure-time activities. So a fundamental objective of corrections must be to secure for the offender contacts, experiences, and opportunities that provide a means and a stimulus for pursuing a lawful style of living in the community. Thus, both the offender and the community become the focus of correctional activity. With this thrust, *reintegration of the offender into the community comes to the fore as a major purpose of corrections.*" (Emphasis added)[2]

If reintegration of the drug offender into the community is our primary focus, then the goals of the community must change appropriately. For example, no amount of institutional treatment can overcome the many legal and social obstacles facing a job-seeking ex-offender. Identification and removal of such barriers thus becomes an important goal for correctional planners and administrators.[3]

Correctional treatment begins in the institution, and for most offenders it should continue beyond the period of incarceration, and sometimes beyond aftercare supervision. Therefore the importance of continuity in the delivery of services necessitates the establishment of liaisons between correctional institutions and community resources such as community-based drug treatment and rehabilitation programs of all types, vocational training and counseling agencies, offender employment services, and various other health or counseling agencies.

Establishment of institutional/community liaison will help to alleviate some of the fragmentation of service delivery which has characterized correctional treatment programs in the past. A reciprocal flow of information and ideas, plus access to this information by inmates, reduces the geographical and social isolation which is also typical of most correctional institutions.

B. Real and Ideal Goals for Correctional Drug Treatment Programs

Unequivocally stating goals for drug abuse treatment programs is an elusive task at best. At the most elementary level, definitions of what constitutes individual "success" or "failure" are extremely variable. By some definitions, one who completes a treatment regimen and subsequently consumes any amount of an illicit substance is deemed a failure. According to other definitions, a substantial reduction in drug ingestion, or a switch from one illicit drug to another less dangerous but also illicit substance is considered "success."

A successful program may be defined as one which diminishes the amount of criminal behavior accompanying drug taking. The waters become very murky, however, when we consider the addict who is able to abstain from heroin, but becomes an alcoholic. Certainly, the alcoholic ex-addict has achieved many of the major purposes of treatment, but his overall ability to cope may be significantly impaired by alcohol. Can he be judged a "success"?

While every drug treatment program establishes ideal goals— those broad, long-range outcomes expected by society—most accept a set of secondary aims which are more in tune with a realistic attempt at altering compulsive drug abuse. Dr. Jerome Jaffee, former director of the Special Action Office for Drug Abuse Prevention, contrasts the treatment expectations which are placed on drug abusers with someone suffering a conventional medical condition:

> "Ideally, a treatment program should attempt to help all compulsive narcotic users become emotionally mature, law-abiding, productive members of society who require no drugs or additional medical or social support to maintain this ideal status. But, this is an ideal set of goals, a set that society does not expect any other group to meet. For example, we do not expect people with mild congestive heart failure to become marathon runners; we do not even insist that, after some arbitrary period of treatment, they abstain from digitalis, diuretics, and visits to the doctor. Compulsive drug use should also be thought of as chronic disorder, and many cases require continual or intermittent treatment over a period of years. It follows, then, that, while treatment programs should attempt to help every individual reach all the components of the ideal set of goals, any evaluation of the overall effectiveness of any specific treatment must take into consideration the fact that different programs tend to place their emphasis on different goals."[4]

Dr. Jaffee was referring primarily to treatment programs operating in the community. Correctional drug treatment programs contain all the limitations of their community counterparts plus additional and unique constraints. They operate in an environment where their goals may conflict with those of the institution. Their activities are always limited by the necessity of maintaining the security of the institution. Limitations imposed by the physical plant are often significant. The social and experiential distance between the rural, white, middle-class "treators" and the urban-bred, heavily minority "treated" is often enormous. Inmates bring multiple personal and social problems with them to the treatment setting, in addition to their drug problems. Often their primary motivation for participation is a desire to use the program to obtain early release, a dynamic which results in a "games" atmosphere.

Drug treatment modalities which are effective in a community program may be entirely inappropriate in the correctional setting. Indeed, some programs which are "hybridized" to accommodate the demands of the correctional setting may produce behavior and attitudes which are the opposite of those intended.

The enormous difficulties which attend establishing an effective drug abuse treatment program in the correctional setting cannot be overlooked. Past experiences with such programs have demonstrated that drug abuse is difficult for the individual to overcome under the best of circumstances. It is with this note of caution that we examine both the ideal and the realistic goals for such programs.

C. Treatment Goals for the Individual Offender

In this society, drug abuse is closely linked to criminal activity. Drug abusers almost inevitably come into contact with law enforcement agencies at some time during their careers. This may be the result of such drug-related offenses as possession, sales, or importation, or offenses which

support the drug lifestyle, i.e., larceny, forgery, etc.

Drug treatment programs in corrections might reasonably establish as high priority, long-range treatment objectives such as abstinence from illicit drug use, and elimination of criminal activity associated with drug-taking. These goals are as difficult to achieve as they are desirable. The interruption of an established pattern of existence in a drug-oriented subculture requires the formation of a viable alternative which is acceptable to the individual as well as to corrections or society in general.

In addition to the above mentioned aims, various secondary goals of correctional drug treatment include:

1. *Improved economic status.* Successful renunciation of drug use is closely linked with the issue of employment. Many drug abusers have limited vocational skills, spotty work histories, and no motivation to engage in legitimate work when illicit activities may appear more fruitful. Realistically, many legal and social barriers limit employment possibilities for the ex-offender.

2. *Personal growth.* Drug abusers often have extremely poor self-images. Drugs may be utilized to mask the many personal and social inadequacies they experience. In order to pull away from the drug subculture which provides a degree of support and status, they must develop alternative ways of deriving satisfaction in their social interactions. All treatment programs include such personal growth goals, though approaches to their attainment may vary.

3. *Developing connections with community resources.* In many ways this may be the most important goal for the institutionalized offender, as it allows an individual to choose the kind of assistance necessary for the attainment of his personal goals. Information about existing community resources is insufficient in itself, however. Inmates must feel that the community resources can help them, and they must feel comfortable approaching those agencies. In many cases, personal involvement with community agencies prior to release or as part of a furlough agenda is beneficial. While drug treatment agencies are important as after care resources, a variety of other social, health, or vocational agencies might also provide assistance.

D. Goals for the Institution

Institutional drug abuse treatment programs hold many potential benefits for the institution as well as the program participants. Many of the general goals elaborated on below are "latent" goals, in the sense that they are rarely officially stated. Nonetheless, they are important and achievable.

1. *Improved correctional environment.* The "climate" of an institution is a critically important factor in the therapeutic process.[5] A supportive environment nurtures personal growth and change, whereas a threatening and distrustful environment may in fact promote behavior antithetical to the major goals of the treatment process.

2. *Development of alternative management approaches.* In order to improve service delivery systems within institutions, traditional management concepts often must be supplanted by more innovative approaches. The unit management plan, which radically alters traditional lines of authority through the process of decentralizing administration, is one prominent example of a drug abuse program employing new management ideas.

3. *Improved staffing patterns.* Drug abuse programs may require the employment of individuals with special skills, such as the ex-addict paraprofessional. As new approaches to staffing have been analyzed, it has been found that the addition of such staff can have implications for the entire institution.

4. *Reducing the isolation of the institution from the community.* As mentioned earlier, a major goal of institutional drug abuse programs is establishing relationships with community agencies. This may involve the institution's allowing inmates to initiate contacts with potentially helpful individuals and agencies prior to their release. This in turn could provide the institution with a more open atmosphere.

5. *Improved relationships between inmates and institutional staff.* Mutual distrust and suspicion of each others' motives have traditionally barred effective communication between inmates and staff in most correctional institutions. Improved relationships here can prevent both individual and collective violence, can lead to a safer, more humane institutional environment, and may enhance the quality of therapeutic interactions.

E. Goals for Society

One of society's major problems is drug abuse and the crimes related to it. Therefore society can draw various direct benefits from effective correctional programs: reduced criminal activity, and the enormous costs of dealing with it. Ex-addict offenders who have successfully adjusted to the community become tax-payers and contributing members of society. Thus society has a large stake in the outcome of correctional drug abuse treatment programs.

F. Summary

The long-range aims of diminishing drug abuse and reducing recidivism remain high priorities among correctional drug programs. In view of the many constraints under which such programs operate, however, a number of other, more realistic, goals have been suggested. Many of these secondary drug treatment objectives have importance for the entire institution; i.e., improved correctional environments, new management concepts, improved relationships between inmates and staff, etc. In some ways, drug abuse programs may make major contributions to the management of correctional institutions, despite their relative lack of success to date in achieving their long-range goals.

NOTES

1. Etzioni, Amitai, *Modern Organization* (Englewood Cliffs: Prentice-Hall, 1964), pp. 5-19.

2. National Advisory Commission on Criminal Justice Standards and Goals, *Corrections* (Washington, D.C., 1973), p. 3.

3. Ward, Hugh, *Employment and Addiction: Overview of Issues* (Drug Abuse Council, Inc., 1973). The author summarizes many of the major barriers to employment of the rehabilitated ex-addict. He also discusses job development strategies which programs might adopt to improve the ex-addict's chances of obtaining employment. Also described are some of the more promising approaches to job development in New York City.

4. Jaffee, Jerome, quoted in *Drug Use in America: Problem in Perspective*, Second Report of the National Commission on Marihuana and Drug Abuse (Washington, D.C., 1973), pp. 337-8.

5. Wenk, Ernst A., and Moos, Rudolf H., "Social Climates in Prison: An Attempt to Conceptualize and Measure Environmental Factors in Total Institutions", *Journal of Research in Crime and Delinquency*; July, 1972, pp. 134-148.

CHAPTER III. THE SOCIAL ENVIRONMENT OF INSTITUTIONAL DRUG PROGRAMS

The social environment of a drug treatment program is critically important. Such programs do not operate in a vacuum; rarely are they isolated from "parent" institution activities such as educational or vocational training programs, prison industries, canteen, and recreational facilities.

The National Commission on Criminal Justice Standards and Goals has recommended the following changes for institutions wishing to improve the quality of their environments:

- Promoting inmate-staff communication
- Giving inmates a more active role in the decision-making process
- Gearing correctional staff recruitment and training procedures, program evaluations, public relations, and administrative policy toward specific ends
- Preserving the individual's identity through liberalized dress and hair style codes, and improvement of family visit conditions
- Expanding the inmate's communication with the free world by means of telephone privileges, more home furlough, and unlimited mail privileges
- Encouraging institutional sensitivity to ethnic groups; increasing efforts to recruit minority staff members
- Increasing contact between the institution and the community through joint programming with community groups, educational and work release programs, and visits by representatives of different labor, ethnic, or religious organizations.
- Employing the least restrictive security measures
- Improving disciplinary procedures.[1]

We strongly endorse these recommendations. Treatment programs reflect the institution's basic philosophy. If the latter is seen as being arbitrary or insensitive to inmates' needs, the programs may become ineffective.

Therefore the first third of this chapter will explore known environmental impediments to effective drug abuse treatment. The second third of the chapter will address the efforts by individual programs to overcome some of these problems. The final section will discuss social scientists' recent efforts to quantify the social climate of institutional programs.

A. Barriers to Effective Institutional Drug Abuse Programming

1. *Inmate attitudes and values.* Most of the program directors interviewed agreed that inmates' negative attitude toward "treatment" in general constituted one of the biggest obstacles to program success. Some inmates regarded treatment as a method of social control, an emasculating process which gave them nothing. Many had become cynical after previous bad experiences with community drug abuse programs. And many inmates generalized negative attitudes about counseling or "group therapy" which they had previously experienced in the institution to the drug program.

Negative attitudes toward treatment may be reinforced or engendered by the informal "con code," which puts down inmates who choose to participate in drug abuse programs as well as the programs themselves. Inmates who join the program may be labeled as weak, naive, homosexuals, or "snitches." As several staff members at the Clinical Research Center in Ft. Worth, Texas, concluded:

> ". . . the system of attitudes, system of status and roles, and system of social control maintained by our informal addict patient community were more forceful determinants of attitudes, behavior, and self-concept of individual members than were the formal systems of influence maintained by treatment staff."[2]

Another antitherapeutic influence on the inmate population, pointed out by these same researchers, is the home town clique. Groups of individuals from the same area form natural groups in the institution. This provides access to current news of the neighborhood such as the status of other "partners" and updated information about the drug scene. Stories are exchanged and participation in this sub-culture is generally reinforced. The clique draws enough strength from its membership to protect newcomers from the more criminalized or aggressive prisoners. In group therapy sessions, clique members tend to protect their own from confrontation by other inmates or staff, thereby supporting behavior appropriate to the drug subculture. Personal growth is, of course, seriously undermined.

When modalities such as the therapeutic community are employed, it is essential that group participants learn to confront their fellows' negative attitudes. This type of peer confrontation reduces the opportunity to rationalize self-destructive behavior, at the same time creating a reciprocal process as the confronted becomes the confronter. The danger with this approach lies in the possibility of it becoming a counterproductive "con game" if inmate prohibitions against peer confrontation are not surmounted.

It should also be recognized that there are many realistic reasons for the protective methods of communication which are part of the inmate code. If an inmate "gives up" a peer who is subsequently punished as a result, then this prohibition is reinforced. The point is that the inmate code may offer functional ways of surviving the prison experience in the absence of more productive alternatives. Expecting change in inmate values without concurrent changes in the attitudes and practices of institutional staff is unrealistic.

Inmate participants in treatment programs are often described as highly manipulative. Manipulation or "dissimulation" has been widely analyzed in the correctional literature.[3] Typically, the therapy group is a stage for elaborate games, in which the object is first to approximate whatever "pathology" the therapist appears to favor (a common situation with untrained treatment staff). The "patient" gradually begins to acquire "insight" into his problems, impressing the therapist with his personal growth. The therapeutic "breakthrough" normally coincides with the parole hearing date. If fellow inmates are unwilling or unable to deal with this manipulative behavior, the distorted group process will quickly become out of the therapist's control.

2. *Staff-inmate interactions.* The problems which exist in inmate-staff communications are often related to the vast social and experiential gaps between the two groups, as described in Chapter Two. Inmates often complain that both professional and custodial staff have little understanding of their lifestyles and have unrealistic expectations of them.

Historically, treatment staff members have played dual roles which inmates often perceive as contradictory. On the one hand, the staff member is a therapist, a liaison between inmate and community, and his advocate in front of disciplinary or parole boards. Simultaneously, staff members must fulfill disciplinary or reportorial duties which may ultimately postpone release dates. In the inmate's view, where these duties come into apparent conflicts they are usually resolved in favor of the institution.

Dissension among staff members is highly damaging to an inmate's perception of the treatment process. During our site visits we observed many serious philosophical disputes between treatment and custodial staff. The latter, particularly those who were assigned to the treatment program rather than volunteering, often downgraded the value of treatment by ridiculing inmates for participating or chiding them about "running numbers on the shrinks."

Dissension is not limited to conflicts between the treatment and custodial force, however. In many cases, staff will actively seek inmate support in their disputes with other staff. Inmates have been known to divide into "camps" and waste much time and energy on petty arguments about staff personality conflicts.

A dangerous person to have in an institutional setting is the professional who identifies with the inmates and openly criticizes the institution's policies or correctional officers in their presence. This is apparently done at least partially to gain the inmates' liking.

It appears that therapeutic communities, because of their emotionally-charged nature, must periodically be overhauled, both in organizational structure and staff. The latter often become "burned out" and cynical about the ultimate value of their program, which inevitably affects the inmate-participants. Several staff members who had experienced these periods of reorganization

remarked that they seem to occur predictably every 18 to 24 months, and are generally followed by a period of renewed energy and high optimism on the parts of both staff and inmates.

3. *Organizational structure.* According to criminologist Donald Cressey, many of the personal traits exhibited by an institution's inmates and staff are merely a reflection of the organization.[4] Inmates' and staff's definition of their respective roles, as well as their communication patterns, are influenced by organizational style. The extent of staff's flexibility in allocating decision-making responsibility to inmates is also determined by administrative policy. If staff members are inflexible and authoritarian, potential innovativeness will give way to the previously established "maintenance of institution" routine. However, from what we have observed, it is possible for a high security institution to grant program administrators the power to make decisions which appear to be in the inmates' best interests.

4. *Conditions for program participants.* We favor voluntary participation in treatment programs; as one director put it. "You shouldn't crowd your program with people who don't want to be there." (The issue of voluntary vs. coerced participation will be elaborated on in Chapter Five.)

An important issue is the incentives which are offered to potential program participants. While incentives reinforce positive behavior inmates may join the program solely because of the promise of (for example) an early release. The therapeutic value of the program will be radically diminished for inmates with an "incentive orientation."

B. Creating Environments Conducive to Drug Treatment Programs

In several of the institutions we observed, the models on which drug abuse programs were based were so successful that they were adapted to accommodate other inmate sub-groups. Drug programs improved personal relationships between inmates, as well as between inmates and staff. On several occasions we observed correctional officers interacting with inmates in highly charged confrontation groups, discussing their feelings about the program, the staff, or the inmates, as peers and co-participants, without concern that their custodial responsibilities might be threatened.

We also visited programs in which inmates were genuinely enthusiastic and sometimes protective of "their program." Racial, ethnic or home-town cliques which were common in the general inmate population appeared to be unnecessary in those settings which encouraged honest communication across traditional role barriers.

We share the enthusiasm of those administrators and program staff members who recognize the potential value of the models developed for drug offenders to the larger institution. At a time when many correctional institutions are experiencing growing tension and violence, new approaches are certainly needed. The long-range gains of these programs remain to be seen. Meanwhile, they have had the short-term effects or reducing institutional violence, improving communications between inmates and staff, and minimizing the negative impact of the inmate code.

This section describes the social environments of three types of institutional drug abuse programs. We are concerned here with the *context* of treatment rather than the specific modality employed.

1. *Separate or functional unit programming.* Several drug abuse programs we observed were located in separate dormitories, cell blocks, or houses. The degree to which this housing is isolated from the larger institution depends on the therapeutic approach used, the internal resources available, and the program's autonomy.

The functional unit concept was developed by the Federal Bureau of Prisons and is used widely in both state and federal penitentiaries. A functional unit is a "small, self-contained institution operating in a semiautonomous fashion within the confines of a larger facility," having the following features: "(a) a relatively small number of offenders (50-100); (b) who are housed together (generally throughout the length of their institutional stay or as they near completion—12 to 18 months—of a long term; (c) and who work in a close, intensive treatment relationship with a multidisciplinary, relatively permanently assigned team of staff members whose offices are located on the Unit; (d) with this latter group having decision-making authority in all within-institution aspects of programming and institutional living; (e) and the assignment of an offender to a particular Unit being contingent upon his need for the specific type of treatment program offered."[5]

Functional units decentralize and institution's organizational structure, placing most responsibili-

ty for decision-making on those who work daily in programs, those who are most in touch with inmate needs. Functional units also reduce the fragmentation of services which frequently occurs in conventionally run institutions, improves inmate-staff relations, and promote group cohesiveness and high staff morale. They permit the "differential allocation of resources"; that is, resources such as educational, vocational, mental health, alcohol or drug specialists can be concentrated where they will be most useful.

The establishment of functional units necessitates a revamping of the lines of authority. For example, correctional officers are responsible to a unit manager rather than to an Associate Warden for Custody. This restructuring of the correctional hierarchy may cause transitional difficulties. New responsibilities for management personnel must be spelled out as supervisory functions become subordinate to the "overseer" role. The development of close knit, multi-disciplinary units teams which share including treatment, secretarial, custodial, educational, and other functions may be threatening to those who prefer rigidly delineated roles.

At the institutions we visited where only one or two functional units existed, they presented a strikingly different social environment from that of the general population. Inmates felt free to criticize openly or support the program with which they were involved. Their relationship with staff, including custodial staff, appeared relatively open and sometimes highly animated. In some programs, alternative disciplinary procedures used reduced the level of distrust and manipulation between correctional officers and inmates. Inmate prohibitions against "snitching" were broken down in the interests of promoting the goals of the treatment program.

The functional unit is not a modality, but a context for treatment. A recent article in *Federal Probation* described three dimensions around which a functional unit might be organized: (1) problem areas such as drugs, alcohol, mental health, etc.; (2) personality types, including I-level subtypes, Quay's Behavior Categories, etc.; and (3) work/training in which offenders who are involved in special academic or work programs live together.[6]

Separate unit programming permits varying degrees of isolation from the larger institution. For example, functional units were difficult to differentiate from traditional housing in several of the programs visited.

a. *Drug abuse program - Lompoc, California.* Inmates in the Drug Abuse Program (DAP) unit at the Federal Correctional Institution at Lompoc, California, were highly integrated into the general population. They ate, worked, or attended classes with other inmates. The therapeutic modalities offered included body movement, biofeedback, and various learning opportunities. The staff felt neither that the institutional setting was conducive to traditional drug abuse treatment, nor that it was their role to "treat"—rather it was to make resources available, to assist inmates in properly utilizing them, and to place the ultimate responsibility for personal change on the inmate himself. Given the program's basic philosophy and its individual rather than group focus, daily interaction of participants with others in the general population was not regarded as a threat to the therapeutic process. The functional unit, housing program staff and facilities (library, biofeedback equipment, tape library, etc.) provided a comfortable setting for exploring the various therapeutic opportunities offered, while allowing for full participation in other institutional programs or activities.

b. *Drug offender rehabilitation program - Memphis, Tenn.* The Drug Offender Rehabilitation Program located at the Shelby County Penal Farm in Memphis contrasts sharply with the Lompoc program. The program is housed in a building which is inside the prison walls but physically separate from the general population. Proponents of this program assert that the use of daily individual or group therapy sessions over a period of months is ineffective, as it tries to undo years of learned behavior in relatively few hours. They feel that the possibility of changing behavior is much greater if the inmate's entire waking life is a corrective learning experience designed to replace dysfunctional with functional behavior, an approach known as environmental contingency management.

The program has developed into a self-contained therapeutic community, free from outside influences, within which both positive and negative reinforcement are applied in response to the smallest element of the individual's behavior. One of the program's primary objectives is to teach positive methods for dealing with stress. This is accomplished by subjecting inmates to gradually increasing pressures within the environment, and by insisting on strict adherence to seemingly insignificant rules (i.e., do not have work gloves in your coat pocket except on work call; after washing clothes, dry the bucket off before securing it;

when looking at the bulletin board, do not block the aisles, etc.).

The Drug Offender Rehabilitation Program operates on a modified functional unit concept, and is isolated to the extent that it provides its own food services, recreation, work details, and security. Participants in the program have no contact with the correctional officers serving the main population. The use of positive social reinforcers such as field trips, private phone calls, civilian clothes, and salaried positions within the program are possible because of the latitude permitted by the organizational arrangements and physical setting.

The enforcement of the hundreds of seemingly petty rules, along with the constant observation and confrontation over misbehavior, impressed us as being overbearing and unattractive to the inmate who simply wanted to do his time and get out. However, we were struck by the inmates' positive attitudes toward their program. Most that we interviewed regarded the DOR as a situation more desirable than being in the general population. They felt that there was much they could learn, that the program was effective, and that the sense of support and kinship they felt with staff and peers made it all worthwhile. The delegation of authority to peers added genuineness to the treatment process and reduced the "us-them" separation between staff and inmates. There was general agreement about the social and personal goals which the program sought to develop, an important element in their attainment. In short, the social environment which had been created in this setting was very responsive to the particular modality employed, and generally supportive of many of the institutional and individual goals as well.

In general, we were impressed with the potential which the functional unit offers institutional programs, regardless of the degree of isolation from the general population which is sought. This approach, which integrates staff, provides autonomy and flexibility in programming, and allows for an altering of staff-inmate interaction, seems to us to merit increased attention. The functional unit concept can be adapted to a variety of institutional settings, and has applicability far beyond drug abuse programs.

2. *Conducting programs with inmates in the general population.* Not all treatment techniques require the development of specialized units within a correctional institution. The programs described in this section are conducted with offenders who live in the general inmate population. They attend separately scheduled drug program activities, but participate in the other institutional activities as well.

Our experience with such programs has been mixed. In general, we found that program goals had to be limited somewhat because of the environmental pressures which exist in the general population.

a. *Chemical abusers program - Texas Department of Corrections.* The Texas Department of Corrections is currently in the process of developing a five stage, multi-modality Chemical Abusers Program (CAP) which will draw participants, both male and female, from several institutions within the Texas Department of Corrections. The activities during Stage I will consist primarily of orientation, instructive courses on drug and alcohol abuse, and a communication skills course. Additionally, inmates complete a behavior contract with TDC staff, specifying what they intend to accomplish during the period they are in the CAP, and what they may expect in return.

Stage II, the "intensive phase" of the program, lasts three to six weeks and takes place in one of two institutions. Here inmates are given extensive educational and vocational skills tests, and are exposed to various therapeutic techniques, including biofeedback, group and individual therapy, desensitization techniques, and a limited amount of aversive conditioning. The final three stages, which involve group meetings, developing contacts with community service agencies, and reviewing the interpersonal skills learned during the first two phases, are conducted while the inmate is involved in the normal routine of the institution to which he or she is assigned.

Again, the emphasis in the TDC program is on the development of specific skills which will aid the individual upon release. Secondary emphasis is given to group interactions.

b. *Chemical dependency program - Lincoln, Nebraska.* The Chemical Dependency Program, located at the Nebraska Penal and Correctional Complex in Lincoln, is currently implementing a pilot program for drug offenders. This three stage program is planned to last 15 weeks, with meetings twice weekly for a total of 30 educational or therapy sessions. The first phase involves six instructive presentations on the physical and psychological effects of drugs. The second phase, lasting 12 sessions, is devoted to small group

counseling, while the final 12 sessions are used for more intensive group and individual counseling. Attempts are made during the final phase to connect those inmates about to leave the institution to community agencies.

This program operates in an institutional setting with few other resources. Its goals are certainly limited and, in the absence of other institutional resources, the counselors assigned to the program will undoubtedly fulfill additional functions for inmates. It is interesting to note that the program has recently employed an ex-convict counselor, which represents a significant breakthrough for this institution. This program may make important contributions to the institution's policies in ways which are only indirectly related to drug abuse.

c. *Gaudenzia House, Inc. - Philadelphia, Pa.* Gaudenzia House, Inc., a Philadelphia-based therapeutic community providing drug treatment services to several institutions, is a relevant example of the problems which may develop when inmates from the general population are placed in treatment programs. Mr. Howard Berne, presently an area director for Gaudenzia, began volunteering at the Gratersford prison in 1971. The staff's primary objective was to involve inmates in groups, with the expectation that some might subsequently participate in Gaudenzia's residential programs upon release. Also, they hoped to provide treatment services to inmates where none existed.

The Gaudenzia staff were primarily ex-addicts. Some, who had previously been incarcerated, experienced intense anxiety about working in this setting. Numerous obstacles were placed in their way. For example, correctional officers would often "forget" to unlock doors to group rooms, causing group sessions to be canceled. On several occasions, according to Mr. Berne, staff were kept waiting to get into the institution, and sometimes were refused admittance altogether.

Many of the inmates joined the program hoping to manipulate Gaudenzia House staff members into writing favorable reports to the paroling authorities. Oftentimes inmates would promise to enroll in Gaudenzia House upon release, with no intention of doing so.

Initially, confrontation groups were the standard technique used by the Gaudenzia staff. However, this approach was altered because of the inmates' inability to handle the pressure they were subjected to in the group. Nothing in their environment had prepared them to deal with the confrontation techniques, and there was no assurance that what was said in groups would remain confidential. The confrontation group gradually became modified to a "rap group."

Relationships between Gaudenzia House personnel and institutional counseling staff varied from one institution to another. In one there was opposition to their presence, whereas in another they were welcomed, and formal inter-staff meetings were established to share information and facilitate the group work.

A crucial point to be made here is that the confrontation group was not appropriate to this setting. Efforts by Gaudenzia staff to establish a separate unit for a therapeutic community eventually failed, leaving the program with little to contribute to the institution or the inmates.

Private agencies such as Gaudenzia have much to contribute to institutional programming. They cannot operate in an environment which is hostile or unsupportive, however. If private agencies are to make meaningful contributions in this setting, they must receive the full support of the administration and key staff persons. Their role should be made clear to correctional officers in particular. Expectations should be clearly spelled out, so that they are not exploited by inmates or used inappropriately by other staff members.

3. *Conducting programs in separate facilities.* Many state correctional systems have established drug abuse (as well as other) programs in untraditional rural camps. Normally, participants are carefully screened to meet basic program qualifications such as age, security needs, psychiatric background, and time before release.

a. *Wharton Tract Narcotic Treatment Unit - New Jersey.* The rurally-located Wharton Tract Narcotic Treatment Unit in New Jersey is fairly typical of most forestry or work camps. It is a minimum security facility with very restrictive conditions of acceptance. The residents are primarily youthful first offenders with less than five years narcotics history, who volunteer to participate. The emphasis at this residential therapeutic community is on gaining personal insights, improving appropriate social skills, handling stress situations, and developing positive work habits. The many treatment methods employed include guided group interaction, community meetings, and family counseling. Inmates live in a dormitory and are responsible for food service, laundry, facility maintenance, etc. They hold a variety of daily jobs, including grounds maintenance in parks bordering the camp.

The treatment regimen here is not that different from that found in any institutional program. The major difference lies in the staff's unanimous perception of the program's purpose. All agree that their primary job is to assist inmates in developing the skills and insights necessary for them to readjust successfully to the outside community. While custody is an important concern, it is secondary to treatment. Thus, the conflicts between treatment and custody found in larger institutions are minimized.

The setting can be effective, according to the program director and several staff members, *only* if there is a core group of enthusiastic inmates who are able to transmit their commitment to the program to newcomers. The program director and staff personally interview candidates from the "parent" institutions. Participants are slowly brought into the program (two or three at a time) and exposed to members of the core group. The director pointed out that without the authority to accept or reject candidates, or stagger their admittance to the program, they might easily be overwhelmed and the core group's influence diminished. Their goal is to sustain a "culture" which is more attractive and beneficial to the inmates than the convict culture. The staff's involvement in the selection process may be a key to maintaining this social environment.

C. Attempts to Define and Measure Institutional Environments

To support their assertion that the interaction between person and environment is the primary determinant of behavior, researchers have conducted studies in psychiatric hospitals, schools, military training camps, and recently, correctional institutions, both juvenile and adult. They have sought to relate specific environmental factors to certain kinds of behavior:

> "That a prison is a complex social system is often overlooked. People of various psychological make-ups and social and cultural backgrounds interact with each other in fulfilling their respective roles within the boundaries of a highly confined space: the prison environment. Life in these total institutions, including the behavior shown by inmates and staff, is, as elsewhere, a joint function of both personality factors of the individuals and their interactions with the environment. The quality of this institutional life is determined by both the attributes of the people and the attributes of the environment and the resulting interactions."[7]

In an institution which heavily emphasizes security measures, attitudes of both inmates and staff will differ significantly from those manifested in an institution with a more therapeutic orientation. One researcher describes the impact of an institution's orientation on communication patterns between inmates and staff, certainly an important factor in the treatment process:

> "Patterns of authority, communication and decision-making are based on management policy. Authority in punitive-custodial prisons is based on rank and incumbency. In treatment institutions authority is presumably based on technical competencies. Communication in punitive-custodial prisons is downward but not upward; decisions are made at the top whenever possible. Treatment-oriented facilities maximize the autonomy of staff members and encourage extensive communication among staff members to facilitate treatment of inmates."[8]

Researchers in recent years have been developing measures for quantifying environmental variables in order to relate them to institutional and post-institutional adjustment.[9] One scale which has been extensively tested within the last several years is the Correctional Institutions Environmental Scale (CIES), developed by Dr. Rudolph Moos at the Social Ecology Laboratory at Stanford University. The scale's 86 items attempt to measure three major environmental dimensions, which he labels (1) relationship, (2) treatment programs, and (3) system maintenance. Table 1 summarizes the nine subscales which measure these three dimensions. The involvement, support, and expressiveness subscales are part of the relationship dimension, and measure the quality of interaction between staff and inmates, the extent to which spontaneous expression of feeling is encouraged, and the "spirit" of program participants.

The autonomy, practical orientation, and personal problem orientation subscales are part of the treatment program dimension. The autonomy subscale measures the extent to which participants take leadership roles in the program. The practical and personal problem subscales reflect the major orientation of the program; whether it emphasizes the acquisition of practical "survival"

TABLE 1[1]

CIES Subscale Descriptions

	Relationship Dimensions
1. Involvement	*measures how active and energetic residents are in the day-to-day functioning of the program, i.e., interacting socially with other residents, doing things on their own initiative, and developing pride and group spirit in the program.*
2. Support	*measures the extent to which residents are encouraged to be helpful and supportive towards other residents, and how supportive the staff is towards residents.*
3. Expressiveness	*measures the extent to which the program encourages the open expression of feelings (including angry feelings) by residents and staff.*
	Treatment Program Dimensions
4. Autonomy	*assesses the extent to which residents are encouraged to take initiative in planning activities and take leadership in the unit.*
5. Practical Orientation	*assesses the extent to which the resident's environment orients him towards preparing himself for release from the program. Such things as training for new kinds of jobs, looking to the future, and setting and working towards goals are considered.*
6. Personal Problem Orientation	*measures the extent to which residents are encouraged to be concerned with their personal problems and feelings and to seek to understand them.*
	System Maintenance Dimensions
7. Order and Organization	*measures how important order and organization is in the program, in terms of residents (how they look), staff (what they do to encourage order) and the facility itself (how well it is kept).*
8. Clarity	*measures the extent to which the resident knows what to expect in the day-to-day routine of his program and how explicit the program rules and procedures are.*
9. Staff Control	*assesses the extent to which the staff use measures to keep residents under necessary controls, i.e., in the formulation of rules, the scheduling of activities, and in the relationships between residents and staff.*

[1]Reproduced by special permission from the *Manual of the Correctional Institutions Environment Scale* by Rudolf H. Moos, PhD., copyright 1974, published by Consulting Psychologists Press.

skills or whether the emphasis is on the development of insight into one's behavior. Both goals may, of course, be emphasized simultaneously in varying degrees.

The final three subscales, order and organization, clarity, and staff control, primarily reflect organization or system maintenance dimensions. Of interest in this section are such factors as institutional housekeeping standards, general rules concerning dress codes and daily procedures, and formal patterns of staff-inmate interaction.[10]

Moos and Wenk suggest that measures of environmental variables will have significance for correctional program planning, for placing inmates in environments which reinforce positive behavior, and for assisting clinicians in improving treatment environments.[11] According to them such measures may aid in distinguishing the relationship between the individual's treatment environment and his subsequent behavior, although they concede that there are many difficulties here because of our inability to control many significant variables.

Note to Reader: See Appendix B for Recommended Readings relating to this Chapter III.

NOTES

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7. Wenk, Ernst A., Moos, Rudolf H., "Social Climates in Prison: An Attempt to Conceptualize and Measure Environmental Factors in Total Institutions", *Journal of Research in Crime and Delinquency*, July, 1972, p. 134.

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CHAPTER IV. APPROACHES TO INSTITUTIONAL DRUG TREATMENT

A. Background

"The history of the treatment and rehabilitation of drug-dependent persons has been and continues to be a series of largely unsuccessful efforts to separate opiate-dependent persons from their opium, morphine and more recently, heroin. For at least 200 years, society's attitude toward such dependent persons has oscillated between the belief that their dependence is simply an example of willful self-indulgence deserving contempt and sanction, and the concept that it is a pathologic condition meriting compassion and treatment."[1]

The treatment of drug abuse in the United States reflects the widespread confusion and debate about its basic cause, and therefore, what constitutes an appropriate response to it. Is addiction primarily a physical condition? If so, then the methods of traditional medicine should be capable of providing us with a solution. However, experience over the last century has repeatedly demonstrated that withdrawing an individual physically from a drug dependence does not necessarily, or even normally, lead to continued abstinence. Relapse is the rule, not the exception.

Are the causes primarily psychological? Again, there is little evidence which supports this position, and very little reason for optimism given the limited results obtained with traditional psychiatric methods.

The National Commission on Marihuana and Drug Abuse suggests that, in large measure, the diversity in treatment methodologies is related both to our uncertainty about the cause and nature of drug dependency, and confusion over the objectives of treatment. We are treating an "illness" which may or may not exist, which we do not fully understand, which varies from one person to the next, and which employs methods which are highly limited and have questionable goals in any case. The Commission continues:

"The confusion which still characterizes contemporary treatment of drug dependence raises a central question which cannot be avoided simply by labelling the condition an illness. Perhaps medical science has been unable to explain the condition or to develop a substantially effective response to it because drug dependence is not really an 'illness,' but only a pattern of human behavior particularly resistant to the usual forms of social control. In less prosaic terms, drug dependence may be primarily an illness of the spirit whose 'cure' is beyond the powers of medicine."[2]

The treatment methodologies which we employ are also reflective of our view of who drug abusers are. For example, most therapeutic communities assume that they are dealing with a character disorder. Methadone programs stress the physiological aspects of heroin addiction, religious programs stress the individual's spiritual deficits, and so on. Perhaps the best we can do at this point is concede that there are many different types of drug abusers, with varying reasons for their involvement in drug abuse and, therefore, with varying treatment needs.

Until approximately 1960, drug abuse treatment was offered almost exclusively within institutions such as Lexington and Fort Worth, and the approach was what might generally be labeled as "medical." Since then, however, several significant events have revolutionized drug treatment methods. The first was Synanon's immensely attractive concept[3] that addiction can be overcome by a total restructuring of the personality through intense communal experiences with others who have been addicts. Verbal confrontation and a complex punishment and reward system were the basic tools of Synanon and the many variations which subsequently developed.

Another major breakthrough was Nyswander and Dole's utilization of methadone as a substitute for heroin.[4] The initial success of their work

promised a quick and easy solution to the problems of heroin addiction. Moreover, it could be done on an out-patient basis, obviating the need for the outrageously expensive residential facilities of the past.

Since the mid-1960's, drug abuse treatment programs have proliferated by leaps and bounds. They have taken numerous forms: residential and out-patient, professional and peer-oriented, drug-free or chemical, etc. As the multiplicity of social types involved in the drug scene has become obvious, the multi-modality program, offering a variety of services under one roof, has come into vogue. Often, methadone maintenance and drug-free modalities exist side by side in the same program, a dilution of approach that therapeutic community "faithfuls" often find totally unacceptable.

With the rapid expansion of community programming has come evaluation, and with evaluation, a more realistic view of what treatment can accomplish. As each approach has fallen short of its initial great promise, new approaches have been tried. Innovation has become the key word in drug treatment today, as we continue to search for methods to replace those of the past.

B. Approaches to Drug Treatment in the Correctional Institution

It is not surprising that the approaches employed by drug abuse programs in correctional institutions vary so widely. Like their community counterparts, institutional programs continue to search for methods which have more relevance to inmates than those traditionally employed: group counseling, psychiatric treatment, reality therapy, etc. Institutional programs are obviously restricted in the methodologies which they can employ: methadone or narcotic antagonists are, of course, not appropriate to this setting. Likewise, the use of certain practices which are standard in therapeutic communities might be legally questionable (or forbidden) in a correctional setting.

This chapter will present some of the more promising treatment modalities currently being employed. Our intent is not to describe specific modalities in detail, but to briefly present an overview of their theoretical bases, their applications to corrections, and the methods which are used in each modality. In some instances, we will present examples of programs in which specific modalities are used. A list of references will be attached to each description.

In the last chapter we discussed the importance of establishing a social environment in the institution which is conducive to treatment efforts. We referred to this as the "context of treatment." In this chapter, we focus on the *content* of treatment. Again, we reiterate the importance of the physical, management, and relational conditions of treatment—for if the conditions under which treatment services are offered are not supportive, then the content of treatment is essentially irrelevant.

1. *Biofeedback.* Biofeedback involves the use of instruments which monitor certain physiological states and provide information about changes in those states. As one experiences changes in what are essentially involuntary bodily responses, one develops the ability to alter or control them in a desired direction. Physiologic states are related to what we are experiencing mentally or emotionally.

> "Every change in the physiological state is accompanied by an appropriate change in the mental-emotional state, conscious or unconscious, and conversely, every change in the mental-emotional state, conscious or unconscious, is accompanied by an appropriate change in the physiological state."[5]

Using a variety of instruments which measure and feed back information on physiological states, individuals can reduce their levels of anxiety, redirect moods and thoughts, and relax in situations which are normally highly stressful. The following is a description of the use of a device which measures skin temperature (as an indicator of the level of stress the person is experiencing) on inmates of the Kansas Reception and Diagnostic Center:

> "Following the introduction and initial testing, the first eight sessions are spent in biofeedback training. I use only temperature control training for this. It is one of the easiest physiological processes to get hold of, so virtually everyone experiences some degree of success. By the end of eight sessions, most of the men can raise the temperature of their hands ten degrees or more in five minutes or less. The physical correlates of increased circulation in the extremities are deep relaxation and a sense of well being. As they gain some competency in relaxing, subjects are encouraged to experiment internally with their feelings by recalling incidents which have produced anxiety, anger,

embarrassment for them in the past, while watching the temperature meter dial and maintaining a relaxed state. Emphasis is placed on being aware, 'owning' one's feelings rather than trying to deny or repress feelings, in order to have control. Subjects have been successful in learning this skill in a short period of time. Being able to relax is of benefit in itself, but in addition the experience is usually accompanied by a greatly increased sense of self-mastery."[6]

As one learns to tune in to and alter his own physiological states, with resultant changes in feelings and moods, one discovers that many aspects of the self which were previously thought to be controlled by external forces can be internally controlled.

Many drug abusers (and others) feel that they have little control over what happens to them in life; the pressures which shape their behavior are regarded as being external. In a sense, they view themselves as victims. One psychologist describes many offenders as behaving in a self-defeating or "counter-phobic" fashion; that is, they are aware of their desire to be free from institutionalization, but they behave in such a way as to insure that they are institutionalized. Without adequate internal ways of coping with uncomfortable feelings, they often act out in such a way as to precipitate an external crisis which completely commands their attention; in the process, they are relieved of the necessity of dealing with disturbing internal experiences. As the individual begins to learn how to control these internal experiences, the necessity for creating an external "diversionary action" diminishes, and with it, the self-defeating behavior. The individual has learned self-control.

Dr. Colin Frank, a pioneer in the use of biofeedback with inmates, describes several advantages to using biofeedback with this population:

- First, biofeedback teaches individuals self-control in a direct way by making them aware of internal states and teaching them methods for dealing with these states.
- Biofeedback, as well as meditation (a practice closely related to biofeedback) can be done alone, without disrupting institutional procedures.
- It obviates the need for sick call by some persons who constantly seek medication for tension.
- Confinement can be redefined by the person through inner exploration.
- Biofeedback is successful with those people who do not wish to participate in verbal psychotherapy.[7]

An interesting biofeedback program has been established at the Drug Abuse Treatment Center of the Federal Correctional Institution in Lompoc, California. Reasoning that interest in meditation, self-awareness, and inner states is keen in the drug subculture, they have sought ways to relate biofeedback to these concerns. Two analogies between drugs and biofeedback have been drawn: drugs modify moods in a rapid but uncontrollable way, while biofeedback suggests that the mood states can be controlled; drugs produce the illusion of insight and self-awareness, whereas biofeedback promises real insight and self-awareness. They are also aware that drug use involves a good deal of ritual behavior. Thus, they have designed the program in such a way as to include ceremony and ritual.

Often, inmates are advised to "cool off," or relax. Efforts to do so in a highly motivated, intentional and stressful fashion often produce opposite results—one cannot try hard to relax, one must try less hard. Thus, they have coined two terms to describe human skills: active volitional skills, and passive volitional skills. Active volitional skills are abilities developed through the expenditure of energy—trying hard to accomplish something. Passive volitional skills are just the opposite—refraining from certain behavior in order to achieve certain desired states. Stated in another way, some things are made to happen, while others allowed to happen.

How can one change a self-image using these techniques? Can one force oneself to change?

"What if changing the self-image was more like relaxing? You couldn't make yourself relax. The higher your motivation the more tense you would become, but you could learn how to systematically allow yourself to relax. If changing the self-image was dependent upon self-observation in any way, then, perhaps, such observation demanded passivity. After all, could you really defend and observe the self simultaneously?

What if most people just naturally refused to accept responsibility for things they honestly feel they have no control over? You couldn't be responsible for how you might feel if you knew you couldn't control how you felt. Were we reinforcing the idea that people couldn't

control what they did, even though what they were doing was assumed to be, in part, a consequence of how they felt? What would happen if we created and maintained an environment that consistently emphasized and reinforced the idea that people could help how they feel?"[8]

An area was set aside within the institution for biofeedback equipment which monitored brain rhythms (EEG), muscle tension (EMG), and skin resistance (GSR), and an instrument to measure skin temperature.

Staff then selected seven aphorisms ("The mind cannot be stilled by force," "I'm not my name," "This too shall pass," etc.), which they considered to be related to passive volitional skills. The program consisted of 25 45-minute sessions, each using a separate symbolic object which would assist the individuals in visualization, concentration, and contemplation. Rituals which would associate the aphorisms with the notion of passive volitional skills were designed for each session. Subjects were asked to listen quietly to the ritual instructions, neither accepting nor rejecting anything.

A number of biofeedback techniques, which are beyond the scope of this chapter, have been developed at Lompoc and elsewhere. What has been learned in correctional institutions where biofeedback is utilized is that it has enormous potential for helping inmates gain control over their own feelings and, therefore, their behavior. It does not involve any of the traditional psychotherapeutic techniques, such as group therapy or individual counseling, in which control is divided between the individual and the therapist. In this approach, the total responsibility for "treatment" rests with the individual. Skills which are learned in this setting have application in the "real world" as well as in the institution.

At Lompoc, as at other institutions where biofeedback is being utilized, the techniques are constantly changing as more effective ways of using this technology emerge. Biofeedback may be used as a single modality, or it may be one of many, as is the case, for example, at the Texas Department of Corrections.

We expressed concern to staff members at Lompoc over the acceptability of this modality to inmates, given the elaborate instruments which are used, and the appearance of a "mind control" laboratory which they give at first glance. At both Lompoc and in Texas, however, we found inmate acceptance high. Many found that the use of biofeedback made them feel "mellow," more relaxed, and better able to cope with stress or the pressures of confinement.

According to Byron Allen, a staff member of the Lompoc program, the basic biofeedback equipment needed for an institutional program can be purchased for approximately $1500, although costs can go much higher. This figure includes a combination EEG and EMG ($650), a differential thermometer ($650), and a combination GSR and basal skin resistance meter ($200). He wisely suggests limiting the use of the more sophisticated and highly expensive biofeedback equipment.

2. *Behavioral techniques.* There are many programs based on learning theory currently operating in correctional institutions. These programs, generally labeled "behavior modification" or "behavioral analysis," focus on modifying specific behaviors. Briefly, behavioral theory is based on the notion that behavior is either maintained or modified by its consequences. Consequences which increase the likelihood that behavior will be repeated in the future are labeled either positive or negative "reinforcers." Punishment, or aversive conditioning, may also be used to modify or extinguish certain forms of behavior.

Behavioral therapy is distinguished from other forms of therapy by its emphasis on:

a. specifying problems and goals in concrete, behavioral terms;

b. using principles of learning and conditioning to facilitate behavioral change; and

c. measuring change in behavior from the problematic to the desirable.[9]

A recent review of behavioral approaches to drug abuse pointed out numerous methods which might be helpful in extinguishing the individual's desire for drugs. Viewing drug abuse as a behavioral excess, it discusses methods for reducing it directly—through punishment, aversion conditioning or extinction; or indirectly—by removing causal factors through, for example, systematic desensitization. Programs might provide alternative responses through the use of assertion training, token economies, or contingency contracting.[10]

Many early attempt at using behavioral techniques in correctional settings have resulted in abuses, particularly with respect to aversive conditioning techniques. In some instances, token economies in institutions have been adjudged unconstitutional. It is thus important to involve the inmate in the setting of treatment goals.

Some of the techniques which are based on behavioral analysis may be useful, in conjunction

with other forms of treatment, in reducing an individual's desire to return to drug use. One technique is called "covert sensitization," and involves the pairing of a description of undesirable behavior (i.e., shooting heroin) with a noxious consequence of that behavior. The previously mentioned review of behavioral techniques includes the following description of a covert sensitization session:

> "Imagine that you are in your room and you decide that you want to fix. You get up from the chair you are sitting in to get the syringe. Just as you get it, a wasp flies into the room and starts buzzing. You get a little fearful as an ugly brown wasp flies in front of you. As you get the syringe and get the fix ready, you see more wasps flying around the room. They are getting louder. You think how nice it will be once you shoot up and try to forget the wasps flying all around you. Just as you put the syringe into your arm, a whole mass of wasps attack your body. They are clinging to your face and your arms. You can feel them sting your whole body. Their high buzzing pierces yours; they get into your clothes. You decide it's not worth it. You throw down the syringe and start to leave the room. As you are leaving the room, the wasps start flying away; the farther you go, the fewer wasps there are. You feel much better, everying is quiet, and you feel good now that you resisted the fix."[11]

Behaviorally-oriented programs are normally very intense experiences for participants. The Drug Offender Rehabilitation program at the Shelby County Penal Farm in Memphis is one example of a well-conceived and tightly operated behavioral program. In a carefully controlled environment, inmates are subjected to a process which examines even the most inconsequential behavior occurring during all waking hours. Each program participant is required to abide by an incredibly long and complex set of rules and regulations, and failure to do so has immediate negative consequences. As the individual moves through a series of stress-producing situations in this controlled environment, functional behavior is reinforced while dysfunctional behavior is extinguished.

The inmate clearly understands the process he is going through, the methods that are utilized, and the goals sought. One vehicle for doing this is the "feedback group," in which progress is evaluated and the methods to be used subsequently are elaborated on. The client may add his own evaluation of treatment efforts and may make whatever comments he feels are appropriate.

The DOR utilizes five distinct groups in "Reconation Therapy:"

- *Commencement groups* are primarily concerned with organizational matters, i.e., cleaning up, work assignments, etc. They also establish goals, levels of reinforcement for various individuals, etc.
- *Orientation groups* are used simply to allow each program participant to describe his own personal history to other members of the program, so as to allow others to better understand him and to realize that they are not unique.
- *Conation groups* are used to help the individual develop his own system of self-reinforcement and motivation.
- *Confrontation groups* allow the individual his only opportunity to express anger, which can only occur after a lengthy procedure for initiating confrontation has occurred. This procedure stresses the development of impulse controls, improved ways of dealing with stress, and appropriate ways to express aggressiveness.
- *Static groups* are similar to many group techniques which seek to explore the background of behavior through discussion of the situations which contribute to drug-taking or criminal behavior. Because topics include such areas as homosexuality, incestuous relations, etc., these groups are closed and confidential.

In each of these groups the expectations are clearly stated, and appropriate behavior can be rapidly established and supported.

Different reinforcement schedules are applied at different stages of the DOR treatment program. During the early stages, when the individual is responding to the confusing array of rules and regulations, continuous positive reinforcement is provided for functional behavior, and continuous negative sanctions for dysfunctional behavior. During the middle stages of treatment, as more functional behavior is elicited, the schedule becomes more variable. In the final stages, an anomalous reinforcement contingency schedule is adopted, in which correct behavior may receive either a positive verbal reinforcement or a negative sanction. The reasoning is that this more nearly approximates the "real world" in which "correct" behavior is not always followed by

rewards, and may, in fact, sometimes elicit negative sanctions.

The rewards that constitute reinforcements range from promotion within the hierarchy of the program to a staff position, to phone calls home, small amounts of money to purchase soft drinks, or trips outside the institution.

Although the pressures which are exerted on program participants are often severe, the program fosters a community feeling. Participants, who are known as "brothers," tend to be extremely supportive of others as they begin the struggle to deal with their attitudes and behavior.

The DOR program is unique in many ways. It must operate within a closed environment, and yet must have a relatively free hand in designing and operating the program, conditions which are too often infeasible in the correctional setting. Nonetheless, it is possible to operate behavioral programs of various types in correctional settings without the elaborate environmental controls which are present in the DOR program.[12]

Behavioral concepts have also been used successfully in conjunction with other treatment procedures. For example, at the Federal Correctional Institution in Terminal Island, staff developed a technique known as "COM-MAND," which they applied to a traditional group therapy approach. Staff observe the group from behind a one-way mirror and issue instructions to group participants, who are equipped with ear plug receivers. Participants may be given verbal "prompts" to say something, do something physical, respond in a certain way to another person, or stop what they are doing. Some communication may simply be reinforcement. Through the use of these techniques, the individual is taught to observe his behavior, its consequences, and its effects on others, and reinforcement is provided when appropriate.[13]

3. *Therapeutic communities.* Synanon, the first therapeutic community (TC), was founded in 1958 by Chuck Diedrick, an ex-alcoholic. The early TC's, having borrowed many of their basic principles from Alcoholics Anonymous, were based on abstinence models. The original TC model basically sought to radically alter an individual's self-image through group pressure. The process of change began with a period of self-examination and "confession" which was achieved by several methods, including extremely brutal group confrontations or games which sought to force an individual into admitting that his or her destructive behavior was caused by his/her stupidity and irresponsibility. David Deitch, former director of Daytop, a New York TC, has summarized the change process:

> "To effect the change, the subject's self-image must be altered. Group pressure provides the influencing force and extracts the behavioral change in two ways: first the individual is encountered, reacts and gets feedback from the group relevant to his reaction. The feedback information informs him how he is perceived by the group. The group is his mirror reflecting an image of his behavioral reaction pattern. Secondly, the group provides a role model. The group, during encounter sessions, provides the individual with the model of honest concern for one another and brutal disapproval for manipulation by the neophyte. Daily, as the therapeutic community members perform their job tasks, the individual sees concrete manifestations of his assumption of responsibility and improved self-image."[14]

Corrections soon began to emulate some of the techniques which had been pioneered in the therapeutic community, including the peer-directed confrontation groups or games. The notion that a group of persons with similar social and personal problems could promote radical attitudinal and behavioral change was very appealing to corrections, in view of the inability of most professionals to affect this population. Thus, therapeutic communities have become common in correctional institutions nationwide. Currently, they operate in most adult and juvenile correctional systems.

Because therapeutic communities are not new programs within corrections, we will not attempt to describe their operation in any detail. They assume myriad forms, and the specific treatment techniques which are utilized within each vary widely. In fact, it might be asserted that the term "therapeutic community" has lost its specific connotations, and is currently synonymous with any residential program which employs group techniques and attempts to change behavior through peer pressures.

One basic ingredient of a successful TC in an institutional setting is the participants' belief in its efficacy. We observed several TC's in which the sheer exuberance of the "faithful" overwhelmed the newcomer, forcing him to buy into the values which the program sought to promote. However,

we also visited three TC's in which admission policies were not carefully controlled and the program therefore lost its selectivity, resulting in a larger number of "nonbelievers" than "believers." The faithful were overwhelmed and program morale was destroyed.

A therapeutic community normally has distinctive phases through which participants must pass. They enter at the lowest level, are assigned to the most menial tasks, and are heavily confronted about their attitudes and behavior. As they progress through various stages, many attain quasi-staff positions. In the final re-entry phase, efforts are made to help the person begin the process of reintegration, through the use of work furlough, family counseling, and various other activities.

However, a major remaining problem for most TC's in correctional settings is the lack of follow-up upon release. Few inmates we spoke with indicated an intention to continue their involvement with a therapeutic community after release. The time commitments required were regarded as too demanding, or the atmosphere "too much like jail."

Many of the problems associated with the operation of therapeutic communities in the correctional setting have less to do with the specific techniques which they employ, than such factors as their social environments, how they relate to correctional officers, administration, and other programs within the institution; and how inmates are selected, how the program is staffed, and what types of incentives are offered to participants. These problems are explored in depth in Chapters III, V and VI.

One criticism which is often made of the TC approach as it operates within a correctional setting is that the attack groups catalyze violent reactions in some inmates. This has appeared to be particularly true in programs where there is a lack of group solidarity, where attack therapy is regarded as a "free for all" outlet for aggression. It also may be destructive for individuals who are essentially non-verbal, or those who come from cultural backgrounds which discourage aggressive forms of verbal communication.

Where they do exist, well-run, cohesive correctional TC's have great potential for making the institution more liveable for both inmates and staff. Decision-making can be made more democratic in these settings. The anger and conflict which frequently build up among inmates or between inmates and staff in closed institutions can be exposed and dealt with in a setting which permits the expression of these feelings without the fear of reprisal. When properly run, TC's can decrease racial tensions. They can offer inmates the opportunity to feel pride and ownership in their program, and to experience a sense of accomplishment as they advance through the status hierarchy. In short, the existence of therapeutic communities is justified not only by their possible impact on drug users, but also by their potentially humanizing effect on institutions.

4. *Other approaches to drug treatment.* Regardless of the specific modality which a program utilizes, a variety of other techniques may be simultaneously applied. Often, new techniques are introduced by staff members who are personally involved in them—activities such as sensory awareness, body movement, meditation, Gestalt or Transactional Analysis groups, or other approaches. In some instances, inmates promote the introduction of activities which personally interest them.

Because these activities are too numerous to go into in this publication, we include a list of recommended readings which describe some of these approaches. Hopefully, they will stimulate interest in exploring other innovative methods which might be of value in this setting.

Note to Reader: See Appendix B for Recommended Readings relating to this Chapter IV.

NOTES

1. Second Report of the National Commission on Marihuana and Drug Abuse, *Drug Use in America: Problem in Perspective*. (Washington, D.C.: U.S. Government Printing Office, 1973), p. 301.

2. *Ibid.*, p. 305

3. Lewis Yablonsky, *Synanon: The Tunnel Back* (Baltimore: Pelican Books, 1965)

4. Vincent P. Dole and Marie E. Nyswander, "Narcotic Blockade—A Medical Technique for Stopping Heroin Use by Addicts," *Transactions of Association of American Physicians*, 79 (1966): 132.

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9. Edward J. Callahan and Robert Paul Liberman, "Behavioral Analysis and Therapy in Drug Abuse Treatment," in *A Survey of New Techniques for the Treatment of Drug Abusers,* prepared for NIMH by Metcor, Inc., 1:8 (Washington, D. C.: January 1975):4.

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12. Robert Wood and Richard Sweet, *Comprehensive Report on the Drug Offender Rehabilitation Program.* Shelby County Penal Farm, Memphis, Tennessee, 1974. A report prepared by the authors for LEAA.

13. James T. Freeman and Reuben E. Stromme, *Com-mand System: A New Technique for Group Therapy*, paper presented to the Western Psychological Association, Sheraton Palace Hotel (San Francisco, California: April 28, 1974).

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CHAPTER V. SCREENING AND SELECTION OF DRUG PROGRAM PARTICIPANTS

An institutional drug program's manner of selecting its participants is a critical factor in maintaining its integrity. Although objective criteria may be used to eliminate such unsuitable candidates for treatment as psychotics or the mentally retarded, screening is basically a subjective process.

This chapter is concerned with the selection of participants for "voluntary" programs, i.e., those which inmates must make an independent decision to join after finding out about them either through official channels or through the "grapevine." The decision whether or not to seek admission to such a program is made on the basis of an inmate's perception of a program's usefulness and advantages to himself, and the relative attractiveness of the program compared to other institutional options.

The existence of true "voluntariness" in prisons has always been debatable. There are, however, circumstances which can allow the inmate a greater degree of self-determination in choosing a program to join. As mentioned previously, inmates should be provided with a diversity of institutional programs from which to choose. They may feel particularly encouraged to volunteer if there are inmate-run, self-help programs available. Such programs provide a valid alternative for many individuals. It is essential that the prison administration support these options by providing necessary space, resources, and access to community agencies.

Screening and selection is a two-way street. Once an inmate has made the decision to participate in a program, he must choose the option which seems most suited to his needs. By the same token, the program staff may choose the applicants whom they feel will benefit most from what they offer and who will not disturb the previously established environment.

Coercing inmates into "volunteering" for a program is a counter-productive practice, since it denies the individual the responsibility for his own decisions and destroys the internal integrity of the program. A convict whose sentence stipulates that he participate in a drug treatment program is actually being coerced into joining. Coercion may also take the form of a "Hobsons Choice"— that is, if the inmate doesn't "voluntarily" enter a program, he may end up serving a significantly longer sentence in the general inmate population.

Few individuals can be forced to change their behavior or attitudes. People are helped in this context primarily because they want to be helped. Despite the fact that a majority of many inmate populations have histories of drug abuse, only a small percentage may desire, need, or effectively utilize formal treatment programs, whether they are sponsored by the institution or are self-help in nature.

The National Commission on Criminal Justice Standards and Goals has taken a strong stand on this question: "No offender should be required or coerced to participate in programs of rehabilitation or treatment nor should the failure or refusal to participate be used to penalize an inmate in any way in the institution." Dr. George Steinfeld, of the Federal Correctional Institution in Danbury, told us, "People have the right to refuse treatment. Then, it becomes our responsibility to influence him—try to get him to be aware of the personal consequences of not being involved in the program."

This view essentially defines the relationship between treatment programs and the inmate population. A program which is regarded by inmates as irrelevant to their needs will simply not be utilized. Treatment goals which programs establish for themselves must closely resemble the goals which inmates set for themselves. This does not mean that institutional counselors and others should avoid "selling" the merits of the various institutional programs in an attempt to recruit

inmates who might profitable utilize programs. It does imply, however, that programs must be made increasingly responsive to the needs of the inmates themselves.

A. The Screening and Selection Process

1. *"Advertising" institutional programs.* Inmates are made aware of the availability of drug abuse programs in various formal and informal ways. The Texas Department of Corrections, for example, merely posts a notice on the bulletin board. Most institutions inform new arrivals of the range of program alternatives available during the course of a formal orientation session. In other instances, case managers or correctional counselors will suggest that inmates with histories of drug abuse should consider participation.

Most inmates we interviewed suggested that they learned through the "grapevine" which programs were legitimate and which were "jive." One of the most frequently mentioned reasons for entering a program was the possibility that it would be "easier time" or that participation would be looked upon favorably by paroling authorities. The question of incentives for program participation will be more fully discussed in the latter portion of this chapter.

2. *Establishing criteria for admission.* The degree of restrictiveness of a program's eligibility criteria is often related to its particular focus. Those programs which require a significant commitment of time and energy from an inmate generally establish rigorous admission criteria, and ultimately eliminate applicants who fail to meet the gross standards. These criteria include age, length and type of drug use, previous criminal involvements, propensity toward violence, sexual orientation, length of sentence, time remaining on sentence, and presence of criminal detainers. Other factors include the level of educational or intellectual functioning, mental stability, and any physical handicaps which might limit one's ability to participate fully in a particular program. For example, it would be inappropriate to accept into a highly confrontative therapeutic community program an inmate who is disabled by intense anxiety, or who is unable to control feelings of frustration and rage.

Most eligibility criteria straightforwardly define the kind of clientele a program can best serve. Three issues relating to criteria deserve further discussion, however. The first is related to the inclusion or exclusion of applicants for treatment on the basis of either the length of their drug use history or the type of drug used. For example, the Wharton Tract program specifies its length requirements precisely: "A minimum of six months use of heroin, but no more than five years dependency." Drug abuse histories are difficult to document, even if an individual has an arrest history which is directly related to drug possession or sales. Many inmates are not "tagged" as drug abusers at intake because court records, probationary reports, or other institutional data do not mention it, and the inmate himself may feel that this label will hamper his chances of early release. Further, styles of drug use are extremely difficult to differentiate, as drugs play different roles in different styles of use. While heroin addiction represents a serious personal and social problem for most individuals, the same could be said for other forms of drug abuse—psychedelics, barbiturates, stimulants, and various drug combinations, including alcohol. The fact that an individual perceives his drug taking pattern as a serious problem requiring outside assistance, should qualify him as a candidate for institutional programming. In general, we found little justification for excluding individuals on the basis of length or type of drug use alone. Even assuming that one could thoroughly document such factors, they appear to be relatively insignificant.

A related issue is the individual's previous history of arrest. In many statutory programs (NARA, for example) individuals with prior felonies are considered ineligible for treatment. Other states exclude those with histories of drug sales or violence. An extensive criminal history may or may not be a good indicator of an individual's readiness or motivation to fully participate in a treatment program; it must be balanced against other factors.

Finally, many programs exclude individuals with histories of homosexual behavior, reasoning that their presence will prove threatening to others and ultimately disruptive to the program's environment. We found little agreement among either program staff or participants on this question. Homosexual behavior is certainly a fact of life in institutions. The ability of program staff and clientele to cope with homosexual behavior varies greatly, however. In one program, homosexuals were scapegoated by their heterosexual

peers, and the issue of sexuality was totally avoided in groups and community meetings. In another program, homosexuals were routinely included in the program, and their behavior and others' reactions to it was "fair game" for group discussions. Again, we found little evidence to support the contention that homosexuals should be arbitrarily excluded from institutional programs.

3. *Providing medical diagnosis and treatment for program participants.* It is important that inmates with extensive histories of drug abuse be examined by a physician and specific medical and laboratory testing be conducted during the early phases of incarceration. Normally, acute medical problems such as withdrawal from a drug dependency, toxic reactions to drugs, etc., have been dealt with prior to the inmate's arrival at the institution. However, many individuals involved in drug use have chronic medical conditions which require diagnosis and treatment.

LEAA has issued guidelines for states which spell out the minimum levels of care which should be provided to inmates identified as drug abusers in the correctional system—institutional and community-based. (See Appendix A.) Institutional programs should require such medical and laboratory examinations as a matter of course, given the high probability that the inmate has not attended to health matters while an active drug abuser in the community.

4. *The orientation period: A mutual screening process.* Programs which demand more of participants, including a change in institutional lifestyle, normally require a pre-acceptance orientation period. During this period, the program's staff and participants are introduced to the inmate, its philosophy and goals are described, and the inmate's needs and expectations are shared. In most of the programs we visited, the final acceptance of a participant was left to the program director, though other staff might have helped in the decision making process. Following the orientation period, the inmates were generally given the opportunity to accept or reject a program, without fear that a negative decision would adversely affect future institutional placements or parole decisions.

The Drug Alternative Program at the Youth Correctional Institution, Bordentown, New Jersey, utilizes this orientation process in the selection of candidates. Their first phase is described as follows:

> "Phase I consists primarily of orientation to the entire DAP concept. Group therapy sessions in this phase are directed toward making participants aware of their problems and assuring them that such problems are shared by others. It is through Group Encounter that the concept of confrontation, challenge, and change is introduced. The participants in this phase are taken from the general population in the institution. They are usually given work assignments, such as, the laundry detail, which makes them available for this therapy, by consolidating people in one area for easy access. Those who are willing to accept the challenge may wish to participate in a more intensive program which is offered in Phase II. At this point, they are fully apprized that a commitment to Phase II also includes a commitment to Phase III."

The Therapeutic Community or "B Ward" program at Camp Hill, Pennsylvania, requires a similar period of "mutual sizing up" prior to acceptance. All inmates who request consideration for entrance into the program through their correctional counselor are interviewed by both program staff and inmates. If the individual meets the basic eligibility requirements, he may be "provisionally" accepted for a trial period of two to four weeks. During this time, an experienced participant is assigned to acquaint him with the program and its procedures. The inmate is then given extensive tests and is asked to sign a contract agreeing to abide by basic program rules, i.e., no violence, no chemicals, etc. At the end of this period, the decision to accept or reject the applicant is made jointly by inmates and staff.

5. *The role of inmates in the selection process.* The involvement of participants in the selection process has greatly influenced the success of those programs which are attempting to establish cohesive "communities" or "families." Responsibility for selecting those who will participate in the program implies some ownership of the program. Participants in the Shelby County Penal Farm Drug Offender Rehabilitation Program (DOR) wrote the following description of the selection process and their role in it:

> "When a man arrives at the Shelby County Penal Farm (with 90 days or more), he spends his first five days at the Psychodiagnostic Center, where he takes a battery of twelve psychometric tests which evaluate him thoroughly. This classification indicates which program or

job is best suited to the individual. The tests also determine whether the man has any sort of brain damage or mental disorder. The California Achievement Test is used to determine his educational level. After testing, the individual joins the main population and is assigned to a job.

Candidates are referred to the Drug Abuse Program by the Diagnostic Center, the Courts, past associations, or word of mouth. Since it is a volunteer program, these are the only means it has of getting applicants. Once word is received that a man wants to join the program, his psychodiagnostic tests are reviewed by professional staff; if qualified, he is scheduled for an orientation interview. During the orientation the candidate is given a brief rundown of the program and told what is expected of him.

After the initial orientation the entire Family will meet and evaluate the candidate, asking questions pertaining to his sentence, his family, etc. After the interview the applicant steps out of the room and a vote is taken. If the majority vote for acceptance, the candidate, in most cases, will join the program at a later date. The orientation is important because, (1) it lets the candidate know the situation he is placing himself in is a demanding one; (2) it prepares him for a complete change of environment and atmosphere; (3) it familiarizes the program participants with the man so they can better evaluate change in his behavior and attitude; (4) it provides each member of the Therapeutic Community with a voice and vote in deciding who joins the Family."

At the correctional institution at Leesburg, New Jersey, participants in the Alpha-Meta therapeutic community produce a pamphlet for distribution to other inmates, describing their program's basic approaches and philosophy. Screening for this program may begin before an individual is physically located in the program, as well as during an in-house orientation phase:

"*Step I*

A man is first a prospect if he has a history of drug abuse or drug related problems. He is interviewed by the Orientation Department. In this interview he is screened and tested for his sincerity in resolving his drug problems; also through this interview it is determined whether he is receptive to our type of treatment that is dispensed throughout our program. Upon the result of this interview, if he is accepted, he is recommended to the Institutional Classification Committee as a member of Alpha-Meta.

Step II

The prospect is assigned a "Big Brother" who teaches him the basic rules and regulations of the program. The "Big Brother" is responsible for all "Little Brothers" actions for a period of two (2) weeks.

Step III

The prospect is then placed on a probationary period to which he is responsible for all of his actions and behavior. At the completion of that period the residential staff members and a member of the treatment team evaluates the prospect's behavior in the program.

Men on the waiting list to enter Alpha Meta Therapeutic Community must participate in two hours of group therapy sessions once a week and exhibit a genuine interest in the groups prior to his admission."

Participation in pre-admission groups serves the additional purpose of weeding out those who are not motivated enough to make the effort required to participate in these groups.

B. Conditions of Program Participation

Participation in drug programs often represents a major commitment on the part of the inmate. His lifestyle within the institution is radically altered, the expectations placed on him increase dramatically, and his participation often causes unanticipated legal consequences. While the orientation phase described above normally is used to inform inmates of the terms of program participation, we suggest that staff pay particular attention to clarifying the following points:

- What consequences, if any, are there to an inmate's decision to leave the program after a period of participation?
- What consequences are there, if any, to expulsion from the program for failure to adjust or for rule violation? This is a particularly important consideration when the inmate is subjected to offensive or demeaning practices (i.e., wearing signs, losing privileges, etc.).
- Does participation in the in-house phase of the program carry with it an obligation to participate in pre-release or aftercare programming?

- How is confidential information handled in the program? Is any information made available to paroling authorities without the consent of the inmate? Are participants required to sign waivers releasing protected information?
- What specific privileges are related to participation?
- What is the relationship between participation and release date?

Several programs we visited have both inmates and staff sign a contract in which both agree to abide by the stipulated condition. These contracts may also spell out specific personal changes the inmate intends to accomplish during his or her stay in the program. These contracts are helpful to inmates in clarifying what is expected of them by the program and what they can reasonably expect from the staff. Violation of the terms of these contracts may lead to expulsion from the program, while achievement of specified goals might support a claim of parole readiness.

The contract described above is normally between the inmate and the drug program, and is not considered binding in the legal sense. Recently, however, several states have begun using contracts which are regarded as legally binding on the inmate, institution and parole board. This procedure, known as Mutual Agreement Programming (MAP), basically requires inmates to establish concrete goals which will be achieved during a specific period of time. These goals may include obtaining a GED, completing a particular vocational training course, attending counseling sessions and avoiding major disciplinary infractions. The institution agrees to provide these programs or resources, and the parole board commits itself to a specific parole date if the agreed upon goals are achieved. Normally, MAP agreements can be re-negotiated during the course of the inmate's period of incarceration.

While we did not visit a drug program in which MAP was utilized (Wisconsin currently is developing plans for a drug program which may include a MAP contract), this procedure appears to have promise as one way of minimizing inmate manipulation of treatment programs, making institutions more responsive to inmate needs, and reducing the often arbitrary parole decision-making process.

The American Correctional Association carried out the initial MAP projects, with funding from the U.S. Department of Labor, and they continue to collect and analyze data on its effectiveness. (See recommended readings at the end of the text.)

C. Incentives for Program Participation

Why does a prison inmate choose to participate in a drug treatment program? Assessing motivation for treatment is a complex undertaking, for the inmate may not be fully aware of his own reasons for seeking admission. Also, the incentives which are offered for participation may be differently interpreted by applicants. For the most part, we must simply rely upon verbal assurances that the individual believes he will benefit from the program. His subsequent behavior is then the best yardstick of "motivation."

We queried numerous inmates and staff about their opinions on why an inmate would seek treatment. Most often, dealing with one's "drug problem" was not the prime incentive. For some, drug programs simply offered more creature comforts than were available to the general population. Living quarters were more comfortable and cheerful, food was more carefully prepared, and the atmosphere was more relaxed. In some programs, guards interacted with inmates on a first name basis, and their disciplinary functions were played down.

Many programs have the reputation of making more privileges available to inmates, a distinct advantage over the general population. These would include the use of the telephones, trips to recreational or cultural events, liberalized visitation policies, or more involvement in work furlough or work release programs.

The incentive which generated the most interest in the programs we visited had to do with the relationship between participation in the program and release date. Nearly all of the programs provided information to parole authorities and, in some instances, assumed an advocacy role for the inmate, a role which most staff members enjoyed as they felt it enhanced their esteem in the eyes of the inmates.

Most programs offer the possibility of a time reduction as a reward for achievement. However, a significantly large time reduction will radically affect reasons for participation. Release from the

institution is the primary concern of most inmates, and to expect otherwise is to invite deception. In general, linking program participation to significant reduction in sentences reduces the degree to which a program can be seen as truly voluntary.

Note to Reader: See Appendix B for Recommended Readings relating to this Chapter V.

CHAPTER VI. STAFFING INSTITUTIONAL PROGRAMS

Experimentation with various aspects of institutional drug abuse treatment has produced radical innovations in staffing. Staff roles and responsibilities have been considerably modified by the development of decentralized units, plus the increased use of multi-disciplinary teams. In many programs the line correctional officer has assumed a therapeutic role, a rarity only a few years ago. Some programs using a peer confrontation model have incorporated ex-addict paraprofessionals, many of whom have been incarcerated, into their staff. Their presence often effects dramatic changes within an institution.

The selection, training, and appropriate utilization of staff is a critical problem for correctional drug abuse programs, as it is for corrections in general. This chapter discusses some of the issues related to staffing programs, focusing heavily on the ex-addict paraprofessional and the line correctional officer.

A. The Paraprofessional in the Institutional Program

With the rapid expansion of drug abuse treatment services at the community level during the 1960's and early 1970's, ex-addict paraprofessionals found themselves in positions of responsibility in a diversity of drug treatment modalities. The claims of success emanating from the early self-help programs such as Synanon, Daytop Village, Phoenix, Odyssey, and Gaudenzia House paved the way for paraprofessional involvement in a variety of clinical and administrative roles in different settings.

The entrance of the ex-addict into the drug abuse treatment field was welcomed by most professionals, who often utilized them to facilitate honest communication between patients and program staff.

The ex-addict staff member may make valuable contributions to a treatment team in the form of his personal experiences and insights, which enable him to recognize manipulative and self-destructive behavior in other addicts. However, ex-addicts, like others assuming therapeutic roles, must have other qualifying skills. Additionally, they must have the support of those with whom they work. Some community and institutional programs, recognizing the pressures that are placed on these paraprofessionals, have initiated training programs which sometimes lead to formal accreditation. This type of exposure to a variety of therapeutic techniques forces the paraprofessional to break out of a narrow view of the therapeutic process ("what works for me") and to deal with the multiple roots of addiction and drug abuse. Conversely, exposure of professionals to ex-addict trainees may lead their views away from the "medical" model of drug abuse treatment.

In the course of our site visits, we observed ex-addicts functioning in several distinct roles, with varying degrees of involvement and responsibility. They are briefly summarized below:

1. *The paraprofessional as a consultant in the institution.* At the NARA unit at the Federal Correctional Institution in Danbury, Connecticut, ex-addicts who had been rehabilitated in the community through the Daytop program were brought into the institution to help organize a therapeutic community. The Daytop consultants taught staff and inmates the basic philosophy and procedures of a therapeutic community, and when the program went into operation, they assumed advisory roles. They participated in group therapy sessions, confronted individual inmates about their behavior or attitudes, and worked with both inmates and staff in making program decisions. The presence of these ex-addicts bridged the social and experiential gap between professional staff—social workers and psychologists—and the

inmate population. It particularly helped in breaking down inmates' inhibitions against participating in group therapy. Lying, evasion, and manipulating "straights" were devices well-known to the Daytop consultants, and they were able to confront inmates with this behavior where professional staff often could not.

In this type of situation, the ex-addict paraprofessional is a respected member of the treatment program, valued for his professional expertise as well as his personal qualities and life experiences. His qualifications are his demonstrated skills with Daytop, not the mere fact that he was once a heroin addict. His role is thus very similar to that of any consultant which a correctional institution might employ.

2. *The ex-addict as staff member.* We visited numerous programs in which ex-addicts (some of whom were also ex-inmates) held staff positions in institutional programs. For example, the drug abuse program at the women's institution in Clinton, New Jersey, is operated by a husband-wife team, both of whom are graduates of a therapeutic community. This program, located in a cottage separate from other living areas, is structured along the same lines as the therapeutic community which they experienced, although they have made programmatic accommodations to the correctional setting. They direct the activities of other treatment and custodial staff, and are fully responsible for the operation of the drug program.

In other programs, ex-addicts held staff positions equal to other staff with professional training. On several occasions we found that the ex-addict staff members were graduates of the program who had returned to work in the institution after completing the aftercare phase of the program. This arrangement has several positive aspects. It provides a real model for other inmates who may have little faith in the availability of legitimate options or in the prospect of remaining drug free upon release. One who has had the experience of participating in a program understands its inherent pressures and can assist others in dealing with them. He can also effectively spot the games and manipulative behavior typical of addicts in treatment.

The Shelby County Penal Farms Drug Offender Rehabilitation program (DOR) has a hierarchy of positions for participants, including several paid positions for graduates of the program. These so-called Addiction Specialists work with the courts, help graduates and work release candidates find job placements, investigate educational and vocational training opportunities in the community, and supervise work release and aftercare activities.

Addiction Specialists work with institutional and aftercare groups, and do individual counseling as well. They have a basic grasp of the behavior modification techniques employed by this program, and they enjoy a good rapport with the professional staff members who are available to them for support and consultation.

A word of caution regarding paraprofessionals in this setting is warranted. The paraprofessional undoubtedly has much to offer in a correctional setting. However, there is nothing inherent in the experience of being an addict that qualifies one to be a counselor or therapist. Quite the contrary, many former addicts have a very narrow personal view of the addiction process and will tolerate no deviation from their point of view. Although many addicts have achieved life changes primarily through adopting the belief systems of the therapeutic community, these beliefs may not be appropriate for all drug abusers.

Ex-addict paraprofessionals may encounter the problem of justifying their new role and responsibilities to program clients who are also their friends or acquaintances. Clients often attempt to manipulate the paraprofessional by appealing to their common bonds of experience. If the paraprofessional is not a fully integrated member of a treatment team, he may find himself in a totally untenable position, unable to relate to his former peers and regarded with condescension by the professional staff.[1]

In short, it is as dangerous to assume that drug abstinence correlates with good counseling skills, as it is to assume that academic degrees assure clinical competence.

3. *The client as counselor.* In most peer-oriented treatment programs, participants are, by definition, involved in the process of helping one another. In some programs, however, outstanding participants may become quasi-staff members, with responsibilities for decisions which may directly affect other inmates.

We observed client-therapists operating quite successfully in the DOR program at the Shelby County Penal Farm. Individuals who progress through the hierarchy receive increasing responsibility for program operation, from scheduling and conducting group sessions to ensuring that work operations are done properly or the living area is

properly maintained. They participate in individual counseling and consult frequently with professional staff members. Participants are given motivation to seek these positions by incentives such as a small salary, use of the telephone, and private living quarters. The behavior of each individual, at whatever level, is carefully monitored by others, so that the potential for the abuse of privileges is minimized. Program participants respect those who have advanced to high status positions, and new members are encouraged to emulate them.

Natural leaders emerge in most group situations, and institutional drug abuse programs are no exception. Without a system of checks and balances, abuses of power can and have occurred. For example, the Federal Bureau of Prisons experimented with the use of inmate-therapists, called "linkers," who were supposed to serve as a bridge between the staff (mainly professionals) and the inmate-participants. They received intensive training in treatment and counseling techniques, and assisted the staff in evaluating other inmates' progress—a responsibility which had a direct connection to parole date, thereby placing linkers in a very powerful position. Thus, inmates began to defer to linkers and sought to curry their favor. This power to influence parole dates proved too seductive for many, and was abused in several institutions. This problem is exacerbated in a situation in which professional staff heavily depend on selected clients for most of their data on other inmates, rather than personally obtaining the necessary information.[2]

In summary, client inmates play an important but limited role as therapists within institutional programs. If they are given too much responsibility in a setting where professionals are not always present, much damage may be done to the program and to inmates who happen to incur the disfavor of their more powerful peers.

4. *The ex-addict as an independent therapist.* We mentioned previously the experiences of the Gaudenzia House staff in several Pennsylvania institutions. Staff members from Gaudenzia traveled to institutions periodically to conduct group sessions, do individual counseling, and assist inmates in the preparation of release plans. They operated with few supports from case managers and other professional staff members. For the most part, their efforts were not well received by the inmates, who attempted to use them primarily for references to the parole board. We do not wish to imply that ex-addicts have no role to play in institutional drug abuse programs. The point we wish to stress, however, is that they cannot be expected to perform well in an environment which is unsupportive of them, if not overtly hostile to their efforts. In this situation, no amount of training or expertise would compensate.

Their experiences clearly indicate that without professional support, ex-addicts will probably not be able to sustain a therapeutic relationship with inmates.

B. The Correctional Officer as a Member of the Treatment Team

Correctional officers play a key role in institutional drug abuse programs. They can contribute greatly to the growth of a program by understanding and promoting its goals, supporting the inmates, and actively participating in the treatment process. On the other hand, they can effectively undermine a program by taking no interest in it, doubting the efficacy of the methods employed, or viewing inmates as being basically manipulative.

An important consideration for treatment programs is the method by which correctional officers are selected. In some institutions, they are rotated through programs periodically, and are given no special training or orientation beyond what program staff provide. Their responsibilities are limited to traditional custodial duties similar to those which they perform in the general population.

In other instances, correctional officers who volunteer or are specially selected, are oriented to the program's goals and methods before they begin work. We interviewed several officers at the drug unit at Bordentown, New Jersey. One officer who was particularly impressive, had a college degree and continued to attend college classes in counseling during his off-hours. After volunteering for the program, he spent two weeks living in a nearby therapeutic community, learning the various status levels and confrontation group methods. (His leave was paid for by the institution.) Upon his return, he became a participating member of groups with no holds barred. This officer had a good sense of himself, and did not feel that allowing inmates to scream at him or call him names was personally or professionally threatening.

We observed correctional officers functioning in similar roles, though not always as successfully,

in several other institutions. In one therapeutic community operating in a women's institution, a female correctional officer expressed concern over her participation in the therapeutic process. She was untrained in the methods used by therapeutic communities, and felt personally threatened when inmates challenged her. She saw this type of behavior as being disrespectful to her and no value to inmates, and felt that other staff members who allowed themselves to be confronted by inmates, lost respect and made discipline and control more difficult. This case illustrates the necessity of providing adequate training for staff members who participate in therapeutic groups, and allowing those who are uncomfortable with confrontations to transfer out of the program.

Several correctional officers we interviewed stated that they were willing to participate in training activities offered by the treatment staff or by outside agencies in order to improve their work with the program. However, they asserted that treatment staff,, particularly those with psychology or social work backgrounds, rarely participated in in-house programs designed to improve the custodial functions. Several correctional officers felt that threatment staff could better understand the context within which they were working by becoming familiar with the intricacies of custody. We support the concept of familiarizing treatment staff with custodial procedures in order to reduce the inevitable friction between the treatment and custodial staffs.

C. The Professional Staff Member

Professional staff members are normally selected through examination and enter the institution presumably with a basic grasp of the theory and practice of treatment techniques. It is important that they also have at least a rudimentary knowledge of the many social and individual needs of drug abusers. Like the paraprofessionals previously discussed, they must gain the support and cooperation of the rest of the institutional staff, as well as the inmates, if they are to succeed. As they probably have never experienced the addict lifestyle, they are more likely to have difficulty in differentiating inmates' genuine interest in treatment from manipulation.

D. Staff Training

We observed a variety of approaches to upgrading the knowledge and skills of staff members in institutional drug programs, though the most immediate teacher is the inmate who, in the course of his interaction with staff, provides insight into the dynamics of drug abuse.

Numerous methods of training correctional staff members have been developed within recent years.[3] At the same time, formal training opportunities for workers in the field of drug abuse have also increased with the development of the network of community-based drug treatment agencies during the last decade. Regional Support Centers (RSC), developed by the National Institute of Mental Health, provide resources for training those involved with drug abuse prevention, education, and treatment. Universities, colleges, and junior colleges have developed specialized curriculums dealing with drug abuse, including courses designed to accredit paraprofessional workers in the field. Many public and private groups have developed staff training programs to aid institutions and agencies which are isolated from other educational resources.

E. A Word About Recruitment of Staff

The literature of corrections frequently bemoans the fact that quality personnel are difficult to recruit.[4] This is particularly acute in those institutions which are located in isolated rural areas. Although we have no reason to challenge this pessimistic view, we have been impressed with the quality of staffing in the programs we visited, several of which were in isolated settings. Several factors seemed to account for the general availability of quality drug abuse staff. First, a large pool of trained drug abuse workers, both professional and paraprofessional, has been developed. They come from a variety of community and institutional programs, and a diversity of treatment philosophies and modalities. For many, relocation in a rural area is viewed as a positive aspect of institutional work. They often view involvement in an institutional drug abuse program as a viable way of gaining entrance into correctional work, or broadening their personal and professional experience.

Note to Reader: See Appendix B for Recommended Readings relating to this Chapter VI.

NOTES

1. Joint Commission on Correctional Manpower and Training, *Offenders as a Correctional Manpower Resource*, a report

of a seminar convened by the Joint Commission in Washington, D.C., March 1968. Available through the American Correctional Association. 4321 Hartwick Rd., Suite 1-208, College Park, MD 20740.

2. *Federal Drug Abuse Programs.* A Report Prepared by the Task Force on Federal Heroin Addiction Programs, and submitted to the Criminal Law Section of the American Bar Association and the Drug Abuse Council, Washington, D.C., 1972. Pages 399-402.

3. Korim, Andrew S., *Improving Corrections Personnel Through Community Colleges*, Commission on Correctional Facilities and Services, American Bar Association. Washington, D.C., 1973.

4. Joint Commission on Correctional Manpower and Training, staff report, *Perspectives on Correctional Manpower and Training*, Washington, D.C., 1970.

VII. INSTITUTIONAL RELATIONSHIPS

Being part of a larger institution, drug abuse treatment programs pursue the same ends, and are governed by the same administrative rules, as the general inmate population. It is important to build a good reciprocal relationship between a drug treatment program and other institutional activities, as a successfully functioning drug program can benefit the institution as a whole. If an atmosphere of mutual cooperation in working toward common goals is established between inmates and staff, disciplinary incidents may be drastically reduced.

This chapter will examine the relationships between program staff and correctional personnel and between program staff and inmates, and the perennial problem of drug use by inmates.

A. The Relationship Between the Drug Abuse Program and the Correctional Staff

We have stressed throughout this prescriptive package how important it is for drug abuse staff to be sensitive to the problems related to institutional security; administrators and custodial staff must not neglect their duty to insure the safety of both inmates and personnel, as well as the community. The superintendent of the Bordentown Reformatory (a Ph.D. psychologist with a treatment orientation) related an incident which illustrates this point. A local hairdresser volunteered to cut and style the inmates' hair and to teach them hair styling. This program was welcomed by correctional personnel and inmates alike. However, after several sessions, several barber scissors' were stolen, necessitating a general shakedown. The barber, oblivious to the possible consequences of his carelessness, refused to take precautions to insure the return of his scissors after each session. As a result, inmates were unable to attend his classes, as correctional officers claimed that "scheduling problems" made it impossible for them to accompany the inmates to the sessions. The barber's class was deserted, and he soon left the institution.

The perceptions which correctional staff have of a drug abuse program may have important implications for its success. For example, a line correctional officer who is suspicious of therapeutically oriented programs, may deter a potential candidate from the general population by "putting down" the program. A thorough orientation of all correctional personnel to program goals, methods, and staff minimizes inaccurate projections about the program, and may significantly improve its image with the inmates and correctional staff alike.

Supervisory personnel—Captains and Lieutenants particularly—tend to be supportive of drug abuse programs which appear to contribute to the safe maintenance of the institution. If a program creates a reduction in disciplinary incidents, it would be in their best interests to support it. In our experience, programs which make an honest effort to cooperate with custodial supervisors on security matters, rarely have difficulties working with such personnel.

Drug abuse staff must also interact with staff from the vocational training, education, religion, and prison industry departments. Through the identification of mutual interests and goals, these groups may develop solid professional and personal relationships. The establishment of professional ties, strengthened by common goals, can prevent the open conflict between departments which exists in many institutions.

The institutional administration—wardens or superintendents, and associate wardens—has a large stake in the success of drug abuse programs. An active, vibrant program reflects positively on the warden, who must justify the administration's activities to many agencies, elected officials, and correctional officials, as well as to the general public.

B. Institutional Relations with Inmates

"Institutions must be opened up, and fresh points of view obtained in the decisionmaking process. Policies affecting the entire inmate body should be developed in consultation with representatives of that body. Decisions involving an individual should be made with his participation. Employees should also have a voice, and a participative management policy should be adopted. An independent check on policies, practices, and procedures suggests the establishment of an ombudsman office serving both inmates and employees. Open discussion should be encouraged in inmate newspapers and magazines."[1]

Correctional officials are becoming increasingly aware of the need to give inmates an opportunity to help make the decisions which will directly affect them. A recent survey of 209 prisoners found that inmate grievances were usually dealt with by a formal grievance procedure followed by legal services programs, inmate councils, and ombudsmen. Forty-four institutions reported some attempts to start a prisoners union.[2]

In the course of our site visits, we found that most administrators and staff of drug abuse programs concurred with this new view of inmate participation in decision-making. In our view, the decision to participate in a drug program rests entirely with the inmate, who should be given the maximum amount of responsibility for life decisions. Most of the programs we visited had staff-inmate committees which dealt with conflicts or made decisions about day to day problems, i.e., recreational activity schedules, canteen privileges, dress styles, the behavior of a particular staff member or inmate, etc.

Meaningful participation in the life of a program gives the inmate an investment in maintaining and improving it. The absence of this sentiment is felt strongly in programs which insist on an inmate's passive acceptance program procedures. In such situations the inmate becomes a powerless "victim" whose lifestyle bears no similarity to the outside world he or she must eventually return to.

The degree or form of inmate participation in decision-making may depend upon such factors as the security level of the institution. In general, institutions' efforts to give inmates more control over their own lives should be supported and expanded.

C. Drug Use in the Institution

"When I was in Sing Sing and Greenhaven, any chance I got I got high—every possible opportunity I got I would get stoned. I even used drugs that I'd never used on the streets before because I wanted to get so bent out of shape that everything that was happening was blocked out. You know—what can you expect? When I came in I was a drug addict; when I left I was a drug addict. They didn't really expect me to change."

This view, expressed by a former addict now employed as a counselor in a community program, is fairly typical of the attitudes expressed by many addicts in prison. Drugs are used whenever they are available, in whatever quantities can be obtained, and often without the degree of discrimination a user might exercise on the streets. Drug use is a constant source of conflict and violence in correctional institutions. Having access to a source of supply elevates an inmate considerably in the eyes of his peers, and is a highly profitable enterprise.

Elaborate schemes for smuggling drugs into the institution are devised. Inmates may bring them back from the community after a furlough; or a visitor's kiss may pass to an inmate's mouth a balloon of heroin, which is swallowed and later retrieved from his feces. In other instances, drops may be made by outsiders at specified locations around the institution grounds. Correctional officers have become involved in smuggling in drugs for inmates, an all too frequent occurrence which would cause havoc in an institution if publicized. The lure of easy profit has corrupted many underpaid correctional employees over the years, and continues to constitute a major problem for corrections.

While heroin constitutes the major drug problem in most institutions, a variety of other drugs are also utilized frequently, including stimulants such as amphetamines and cocaine, barbiturates and tranquilizers (often obtained in the institutional pharmacy), and marijuana. Additionally, many volatile hydrocarbons such as cleaning fluids, lighter fluids, and other similar substances are used, sometimes with lethal results.

Our experience suggests that drugs will be found even in those institutions which take precautions against the possibility of smuggling. Though the type and quantity available may vary,

drugs are a fact of life for most correctional institutions.

While the extent of drug use among inmate populations is not known, it must be assumed that it is substantial. Several aftercare agencies we interviewed during this project recalled clients who were addicted to heroin upon their release from an institution, and in need of detoxification before normal aftercare could proceed.

There is a good deal of disagreement among correctional officials on how drug abuse programs should respond to the presence of drugs among participants. There is, however, no disagreement about the negative impact which widespread use has on both program participants and staff.

In some programs, staff members are required to collect urine specimens from participants on either a surprise or a regular basis. The consequences of a positive urine vary in different programs from immediate expulsion to a loss of status or the denial of earned privileges. In still other programs, a positive urinalysis is used only to indicate that the individual needs to be confronted with his or her behavior in a therapeutic context.

It is our personal opinion that the administration of a correctional institution has the obligation to take every precaution necessary to minimize the availability of drugs because of their potential for corrupting staff, triggering conflict and violence in the inmate population, and causing physical harm to inmates through overdose or impure substances. Administration's usual responses to the suspicion of drug use include shakedowns of living areas, body searches and urinalyses. However, we believe that conducting urinalyses for the purpose of uncovering drug users and distributors is not an appropriate role for treatment staff. If a program is functioning to any degree, drug taking will be quickly apparent to both staff and clients. One can hardly ignore an individual who nods out in the middle of a group session, or engages in non-stop talking or hand-wringing. In programs we have seen where urinalysis is mandatory, the staff's preoccupation with ferreting out drug stashes or catching users easily becomes reduced to a staff versus inmates game.

Our view regarding urinalysis in an institutional drug treatment program is countered by some who argue that periodic unscheduled urine collections may be beneficial both to the program and to participants. Doing periodic urinalysis lends credibility to a program in the eyes of participants and those outside the program. Staff members can use a dirty urine to confront an inmate about his behavior and attitudes in a helpful rather than punitive manner. While we do not doubt that urinalysis is used by some treatment staff in a therapeutic way, there is, in our opinion, the danger that this practice will negatively affect the relationship between program staff and participants.

High levels of drug use by participants in drug abuse programs implies a staff-inmate or inmate-inmate communication breakdown, a rejection of the program's values, and the inmates' lack of feeling of program ownership and responsibility.

Again, in our view, the widespread use of drugs should be interpreted as an indication that the program has become dysfunctional and must be carefully evaluated, by staff and inmates alike, to determine the underlying problems. In some instances, the solution may be the removal of key individuals. For example, in one program we visited, several inmates had been elevated into responsible quasi-staff positions, with considerable power over other inmates. Left alone by staff who felt inadequate in dealing with addicts, they established a drug distribution ring for the institution, operating from the drug program, and blackmailed other program participants into complicity by threatening them with negative evaluations.

Drug use among inmates involved in a program may also reflect dissension among staff members. We witnessed a program in which staff had caused much anxiety and disorganization among the participants by dividing into opposing camps and attempting to enlist inmate support for their differing sides. In this atmosphere, drug use flourished and program objectives were abandoned.

In summary, drug use among program participants must be anticipated and dealt with as it arises. If it becomes widespread, it may be symptomatic of problems within the program itself—a signal that the program needs to examine its own internal needs, and not become preoccupied with launching surprise shakedowns, body searches, or urinalyses.

Note to Reader: See Appendix B for Recommended Readings relating to this Chapter VII.

NOTES

1. National Advisory Commission on Criminal Justice Standards and Goals, *Corrections*, Washington, D.C., 1973, p. 364.

2. McArthur, Virginia, "Inmate Grievance Mechanisms: A Survey of 209 American Prisons," *Federal Probation*, December 1974, pp. 41-47.

CHAPTER VIII. MAKING THE TRANSITION TO THE COMMUNITY

As the time for release from custody approaches, inmates face many difficult tasks. They are suddenly expected to make all their own decisions, to compete with others more qualified than they in a tight job market, and to re-establish relationships with spouses, parents, children, lovers, and friends. Rudely thrust into an alien environment, they must find social alternatives to criminal or drug subcultures. And they are expected to cope with these pressures without returning to drug use.

Few inmates we interviewed in institutional programs faced the future feeling confident about their ability to adjust to the community. Many feared rejection by potential employers or social acquaintances resulting from their status as ex-cons. And many were afraid of drifting back to old friends in the drug subculture, the only place where they had ever achieved any status.

Drug abuse treatment programs in the community have long recognized the necessity of preparing an individual to live drug free after the termination of drug treatment services. The transition from drug dependent to drug free is a difficult one, even under the best of circumstances. Readjustment to the community is further complicated because institution life bears little relationship to the demands of the free world.

Nearly all of the programs we visited attempted to help the inmate make this transition by providing job counseling or placement, initiating contacts with community-based social services agencies, including drug treatment programs, and encouraging inmates to use community resources if necessary.

Several programs developed what might be called a "rite of passage," a formal program element which signaled the end of the intensive, in-house treatment phase, and the beginning of the transitional phase. These programs typically dealt with the newly released inmate's practical problems relating to jobs, money, housing, family relationships, pressure from drug-using former peers, or relationships with parole agents. Many programs simultaneously loosened custodial controls and gave individuals freedom to exercise personal responsibility by participating in work release or work furlough programs, educational release, family visits, or weekend passes to community programs such as halfway houses, etc.

The purpose of a transitional program is to give the individual an opportunity to "decompress" after the institutional experience, to rationally contemplate the problems he formerly had in the community, and to plan ways of making a successful readjustment upon release. To further these ends, some transitional programs were removed from the institution and housed in minimum security facilities, halfway houses, or as in one instance, a separate facility run by a mental health department.

The pre-release phase of institutional programming is crucial, because at this time inmates must make contact with aftercare services which can continue helping them to adjust after they are released. Individuals must also learn to identify their "real" problems and devise methods of dealing with them in the community.

Several inmates with whom we spoke felt that, though their experiences in the institutional drug program were helpful, they were not always applicable to the real world. There, exaggerated responses to seemingly trivial misbehavior did not occur, nor were people rewarded for conformity to rules. One former participant put it like this:

> "One of the things I've noticed is that there is a very high failure rate among those cons who were high status dudes in the joint program. So—when they hit the streets, they ain't the Chief BooHoo of the Beaver tribe, they're just some run of the mill, scumbag, ex-dope fiend just out of the slammer. It's a terrible let-down—lots of them just fall apart."

Although drug treatment programs are helpful to many individuals, they often have relatively limited goals which are appropriate only within specifically defined social environments. Thus, inmates must have a chance to "wind down" from the intensity of the institution before entering the community.

Unfortunately, the bureaucracy of corrections makes the continuity of services to inmates almost impossible. The Drug Offender Rehabilitation Program at the Shelby County Penal Farm is the only facility we observed which allows the continued participation of individuals after their release from the institution. Being a regional facility drawing clients primarily from the Memphis area, it is better able to provide direct supervision (by staff and peers) from the moment of an inmate's admission up to the time of his discharge from parole. The norm, though, is for various agencies and individuals to provide different aspects of aftercare service, often in an uncoordinated manner. This area of the transitional phase of treatment needs to be developed further.

There are as many strategies for helping inmates make the transition to the community as there are correctional institutions. The following section describes some of the variations which we have observed.

A. Programming in a Non-Correctional Setting: Western State Hospital

Because both correctional and mental health administrations in the state of Washington fall under the umbrella of the Department of Social and Health Services, it has been relatively easy to develop a correctional program at Western State Hospital, a mental health facility which contains a ward for the Drug Offenders Treatment Program. This co-correctional program, based on a therapeutic community model, is comprised of 30 offenders who are between eight and 15 months of their parole dates. Potential participants are screened by mental health workers and selected by drug program staff and correctional officials.

Following a two-week observation period during which movement is tightly restricted, participants are permitted increased freedom. They then take part in an intensive in-house treatment phase (approximately six months), after which parole is granted on the condition that they continue to reside in the facility until the staff feel they have successfully completed the program (normally three to six months more).

It is during this last phase of the program that the individual must come to grips with the demands of living in the community. Weekend home furloughs and other privileges are restricted until the person has secured a job or is attending school, as staff have found these types of activities to be crucial to success during this period. If work or school is going well, and the person has had no difficulty in the community, overnight and weekend passes are extended until more time is spent away from the institution than in residence.

Thus, the individual begins to assume the normal responsibilities of living in the community, working, and relating to family, etc., while maintaining a relationship with program staff. Problems which might create stress can be dealt with before they trigger destructive behavior, and controls imposed if it appears that the individual is behaving irresponsibly. At the end of this period, the individual graduates to the out-patient followup phase of the program, living in the community but maintaining contact with program staff.

B. Reducing Custodial Controls: Leesburg State Prison, New Jersey

The Alpha Beta Community program at Leesburg prepares inmates for release by reducing their level of custody prior to parole, and giving them increased access to work release or community service projects. At Leesburg, the minimum security farm facility housing the transitional program is located adjacent to the prison, which increases interaction between residents of the two facilities. Those in the minimum custody phase, in addition to participating in normal Alpha Meta activities, also take part in a variety of other activities designed to ease the transition into the community and strengthen their commitment to drug abstinence. They have established relationships with several community drug abuse programs and school districts, and inmates are routinely released to either attend or give lectures about their program. At the same time, the program participant has the opportunity to deal with those immediate problems which will face him upon release, including readjusting to the family setting. At this stage, families are frequently involved in counseling groups.

Similar approaches to "decompression" are employed by other programs we have visited. At the Shelby County Penal Farm, while the individual is still in the program, he is submitted to looser controls while encouraged to make a concrete decision to either work or attend school in the community. This program has had a close working relationship with the nearby State Technical Institute at Memphis, a technical training college. Program participants are routinely referred to the school's vocational or educational programs. To assist them in gaining employment, Addiction Specialists, most of whom are program graduates, spend most of their time researching employment possibilities in the area.

C. Use of Community-Based Re-Entry Facilities: Camp Hill, Pennsylvania

The staff of the B Ward program at the State Correctional Institution, Camp Hill, Pennsylvania, recognized the critical need for a re-entry facility for their program graduates. Despite the fact that Pennsylvania has established Community Service Centers, or halfway houses for inmates leaving the institutions, a facility which emphasized treatment much more than the CSC's was designed exclusively for individuals who had participated in the B Ward program.

A resident is considered technically under sentence while in the halfway house, which is located near the institution, in Harrisburg. The B Ward staff recommends a transfer, which is sent to the sentencing judges for approval after being reviewed by appropriate institutional officials. The individual then spends from two to 12 months in the halfway house, with the option of being returned to the institution at any time for disciplinary reasons.

Initially, the individual is confined to the halfway house, where he attends groups and receives individual counseling. Major emphasis is placed on obtaining employment, vocational training, education or a combination of these. At this time, families are encouraged to visit the facility, meet with the inmate and staff, and, if desired, enter into family counseling sessions with staff or an outside agency.

After a period of tight supervision, privileges such as late hours and home furloughs are granted. During the latter phases of the program, residents may be allowed to drink alcohol. Urine testing is done periodically; daily, if necessary.

Camp Hill's population is currently restricted to those from eight contiguous counties, which allows easy access to families. Administratively, the facility is operated by a community drug treatment program which subcontracts through the B Ward grant. Correctional officers, along with staff recruited and trained by the subcontractor, are assigned to work in the facility.

This facility is located in an area of Harrisburg which might be labeled "transitional" in that it is going through urban renewal. It is also an area of high crime rates, drug use, and prostitution. Many programs have experienced difficulties in becoming established in "desirable" locations, meeting resistance from local residents who fear that program residents would threaten their safety. While many would debate the wisdom of locating a treatment program for addicts in an area of high drug abuse, the fact is that most of the residents of the re-entry facility in Harrisburg come from just such a neighborhood. The advantage of locating here is that during this period, a resident can deal with the many pressures which he must face upon release, but with the support of peers and staff members.

This facility has effectively integrated local resources into its program. For example, they have established a relationship with a nearby Police Athletic League (PAL), whose recreational facilities they use. An adult education center staffed by instructors from the institutional program is also used by residents. Other available services include a drivers' training course (few of the residents hold valid drivers' licenses) and a free medical clinic.

D. Summary

In many ways, the transitional period is the most difficult phase of the correctional drug treatment program. It is at this time that the offender begins to grapple with the realities of making an adjustment in the community. He must re-establish relationships with family, find new friends, and establish new patterns of social interaction. Most important, he must find a legitimate means of supporting himself.

The issue of employment appears critical, according to most of the followup studies done on institutional programs. It has been found that a transitional program which stresses finding suitable employment and allows contact between the program participant and the potential employer will be more helpful than a job plan developed while the individual is restricted to the institution.

CHAPTER IX. AFTERCARE

The major emphasis in institutional programs for drug users should be the eventual involvement of the users in community drug treatment programs upon their parole release.[1]

The above goal, stated by the National Advisory Commission on Criminal Justice Standards and Goals, has to a large extent become a reality. Correctional programs routinely refer their clients to the drug treatment programs which have developed in communities over the last decade. However, questions still remain regarding the best way to utilize these resources.

This chapter examines some of the approaches to aftercare which we have observed, and poses questions asked us by the major actors in the aftercare process—parole agents, community program staff, and parolees. It must be pointed out that although our major focus in this chapter is on the relationship between community drug treatment programs and the correctional system, we do not wish to underemphasize the importance of other community resources, i.e., vocational training programs, supported work programs, family service or counseling agencies, etc. Given the limitations of this prescriptive package, however, we assume that the need to establish links to these resources, as well as drug treatment programs, is well recognized.

It is important to establish realistic goals for the aftercare phase of treatment. Too often, drug offenders are expected to be "cured" by a short involvement in an institutional program. We wish to reiterate the obvious: drug dependency may be a long-term, chronic condition, characterized by periodic relapses. Drug taking is also only one aspect of the individual's past record, which may also include a background of serious criminal involvement, a spotty work history, disruptive family relationships, etc. Many offenders have had previous unsuccessful experiences in drug programs in the community, and may resist referral if they are forced into treatment.

How do we define success or failure in aftercare? The standards vary greatly enough to make comparison of different programs impossible. A recent study on the outcome of treatment in the NARA II program delineated the criteria for success which were established in various programs.[2] At one end of the spectrum, drug use of any kind is considered failure and grounds for parole revocation. At the other extreme is the definition which condones anyone who is not convicted of a new crime, or does not abscond from parole supervision, become insane, or die during the parole period, regardless of drug usage. In between are many complex, sliding scales for judging the degree of drug use. In short, the definition of "success" is arbitrary.

A. Approaches to the Provision of Aftercare Services

There are numerous ways of insuring that a drug offender receives appropriate drug treatment or other related services as he or she moves from the institution back to the community. In each case, one agency or individual in the community assumes a lead role in the provision or coordination of services. It is important that the offender be sure just who has this responsibility, so as to minimize confusion as well as to prevent manipulation.

In earlier chapters we expressed the view that participation in treatment programs in the institution should be entirely voluntary—a position which we also advocate with respect to participation in community treatment. We found that most program personnel who had worked with parolees who were forced into involvement in treatment, agreed that one shouldn't clutter a program with people who don't want to be there. If an individual does not see his drug use as a problem, he will regard treatment as an unwarranted intrusion, and he will either passively or aggressively try to undermine the program.

Are there conditions under which a parolee might be mandatorily placed in a treatment program? Many parole agents assert that mandatory detoxification or residential care is the only option which they have when a parolee resumes drug use and goes into a "downward spiral"—becoming readdicted, ignoring legal commitments, and becoming involved in street hustling. At this point, the parole agent must bear in mind his responsibility to protect the community from criminal activity. In the past, parole agents often resorted to temporarily jailing parolees who appeared to be in a downward spiral. Because parole revocation is increasingly being discouraged, given burgeoning prison populations, the parole agent must often resort to the enforcement of short-term treatment. The exercise of authority for therapeutic purposes in this instance appears to be both justifiable and necessary for the well-being of the client as well as the community.

Often, involvement in a treatment program in the community is conditional to parole release. In their haste to be released, many inmates agree to participate in programs with which they are not familiar and which may turn out to be inappropriate for them. Given the wide range of philosophies and approaches being utilized in community programs, one should accept the possibility that treatment failure, rather than patient failure, may occur. For example, the literature of drug abuse treatment has for years discussed the inability of Mexican-Americans to adjust to a heavily confrontative therapeutic community environment, because of cultural proscriptions against certain styles of public behavior.

1. *Aftercare as an extension of institutional programming.* The Drug Offender Rehabilitation (DOR) program at the Shelby County Penal Farm (Memphis) has a unique aftercare component in the community which is directly tied to the institutional program. This is feasible because the institution is regional and the program thus has continuing access to participants after their release. DOR requires that inmates who volunteer for the in-house program commit themselves to participation in the aftercare phase as well; failure to do so can result in parole revocation.

DOR employs several peer counselors who are trained to work in the community. They conduct urine screens twice weekly, lead group counseling sessions, and make themselves available to others who need special assistance. The counseling sessions are conducted in a local hospital, although the parolee may occasionally return to the institution for group meetings.

Prior to release, staff members help the program participant arrange either job placement or enrollment in school. According to Dr. Richard Sweet, DOR director, the content of counseling groups in the aftercare phase becomes very practical and directed toward everyday problems of readjustment to the community, jobs, and school.

After a man graduates from DOR, he is assigned to a parole officer who is familiar with the program's methods and goals. The parole standards for DOR graduates are higher than those applied to other parolees from the penal farm, and these conditions are strictly adhered to in order to discourage the tendency of some to test limits. According to one program graduate, a strict enforcement of parole conditions discourages the fantasy that one can resume drug use on an experimental or social basis without resuming the previous destructive pattern of use. Resumption of drug use normally results in revocation of parole, a procedure which may be initiated by DOR, but is the legal responsibility of the parole agent.

This arrangement has two advantages. First, a consistent set of standards, expectations, and procedures is applied to the individual as he moves through the treatment process. Second, close monitoring of graduates' behavior by both parole agents and program staff who are familiar with him allows immediate intervention if behavior begins to deteriorate significantly.

A follow-up of the first 91 graduates of the program indicates that 67% completed the aftercare phase successfully—that is, without drug use or a criminal conviction. It is significant to note that some individuals who participated in aftercare were not legally required to do so, because their sentences had expired. This reflects the level of motivation which the program instills in its graduates, as well as the attractiveness of the services which are offered in aftercare.

2. *The role of drug screening and referral agencies in aftercare.* In many correctional institutions, public and private drug abuse agencies are given access to inmates for the purpose of developing pre-release plans or encouraging participation in community treatment.

An increasing number of centralized diagnostic and referral mechanisms for drug abusers has been developed within recent years, to facilitate

the matching of a client with an appropriate program. The mechanism may be initiated at the state level, as in New Jersey, where a joint Health Department and Department of Institutions and Agencies program, known as Community Treatment Services (CTS), has begun providing diagnostic and referral services to inmates. CTS field representatives interview selected inmates, assess their specific needs, and then make a referral to one of the regional intake centers currently operating in New Jersey. The goal of this pilot program, now receiving approximately 50 referrals per month, is to develop an appropriate community release plan which is also acceptable to the parole board.

Diversion programs for drug offenders have been established in most urban areas. These agencies have the capacity and experience necessary to provide correctional programs with diagnosis and referal, urine screening, patient monitoring, and other necessary services.

We interviewed staff from the federally sponsored TASC (Treatment Alternatives to Street Crime) programs who were involved with corrections, Robert L. Woodall, the director of the Cleveland TASC program, told us that they began developing release plans at the request of inmates in several Ohio institutions. TASC also established liaisons with two self-help programs in Ohio institutions, training them in treatment techniques and conducting groups, until funding cutbacks forced them to curtail these activities. They have worked with the local parole department, training officers to deal with addicts, and assisting them in locating and utilizing community resources. TASC also encouraged the development of a specialized addict caseload within parole.

Currently, TASC does urine testing at the parole agent's request. They may also refer parolees to programs which are operated by TASC (two outpatient, multi-modality programs), or to other community programs which meet TASC minimum standards. One problem which the Cleveland TASC program has had with parolees, according to Mr. Woodall, is that, of those who are interviewed in the institution and who develop parole plans, only a small percentage actually report to TASC upon release for placement. Mr. Woodall estimated this percentage at 23%, which would suggest that the project is manipulated by inmates in order to obtain release. The large percentage of failures to report upon release makes this a less than cost effective use of TASC personnel, and strongly militates for more active participation in placement planning by the parole agent, who has legal responsibility for the offender's performance in the community.

The Pima County (Arizona) TASC program in Tucson has begun to formalize a promising relationship with corrections. TASC staff began visiting correctional institutions on an informal basis, assisting inmates in developing release plans. Their value was recognized by both corrections and the parole authorities, as a result of which a more formal arrangement has been developed. Under their current agreement, according to Ms. Patricia Mehrhoff, TASC supervisor, TASC regularly receives a list of inmates with histories of drug abuse who are due to be paroled within three months. These individuals, along with others who may request TASC assistance, are interviewed at the Institution. Their needs upon release are discussed, and TASC attempts to determine what problems they anticipate upon return to the community. A community study is undertaken, including an investigation of the inmate's family situation. If a spouse is addicted, for example, TASC will attempt to involve both in treatment, because an inmate's chances of success are undermined considerably by an addicted family member.

When a release plan is developed, and agreed upon by the inmate, a contract is signed by TASC, the inmate, and the parole agent. This contract may include such conditions as working or attending school. Though participation in treatment is a condition of the contract, a particular treatment program is not specified. The rationale for this, according to Ms. Mehrhoff, is that inability to adjust to a particular treatment modality may not indicate client failure—it may simply be an inappropriate placement. Other conditions which may be imposed include urine testing, regular attendance at treatment programs, and movement toward achieving the goals specified in the contract.

Although TASC has no legal authority in this relationship, a violation of the conditions of the contract may result in their "blowing the whistle" to the parole agent. Given their relationship with parole, this is tantamount to a violation. Thus, according to Ms. Mehrhoff, parolees regard the TASC staff as having "clout" enough to back up their demands.

In comparing the experiences of the above TASC programs as they relate to the correctional client, it becomes clear that their role must be

clearly defined and understood by clients and parole agents. As shown by the Tucson TASC program, contracts are useful in clarifying responsibilities. TASC and other drug diversion programs are uniquely situated between criminal justice and community treatment agencies, acting as brokers between the two. Their involvement with correctional aftercare programs can only serve to strengthen and clarify the links between corrections and community programs. They may also possess skills and experience in dealing with drug offenders which can assist the parole agent in the management of his caseload. At a time when funding for drug abuse services is diminishing, the increased utilization of such agencies as TASC can reduce costs related to duplication of services.

In those communities where specialized drug abuse caseloads are not developed in parole departments, diversion agencies may be called upon to provide the necessary expertise, and the parole agent may play only a minimal supervisory role, or he may spend more time providing ancillary services which do not require a special background in drug abuse.

3. *The parole agent as provider or broker of services.* Although specialized agencies are playing an increasingly important role in providing aftercare services for drug offenders, the parole officer remains the key to aftercare services. In most states, parole agents are responsible for developing an inmate's release plans. They must also develop community resources and establish working relationships with them, and understand the modalities which each employs and what types of clients are appropriate to each.

Drug offenders may be supervised in either an integrated or a specialized drug caseload. In many rural areas, specialized caseloads are not practical because of the small numbers of drug offenders or the limited community resources which are utilized. However, in most areas with large numbers of parolees with drug histories, specialized drug caseloads have become common.

The specialized caseload is generally staffed by parole agents with special interests or backgrounds in drug abuse. Some agents volunteer for drug units because, as they say, "junkies are a real challenge to me." Many parole agents receive academic training in counseling techniques, drug abuse, or other subjects which aid them in working with drug offenders.

Numerous studies on parole outcome with addicts point to the importance of the individual officer's personality and orientation. If a parole agent sees surveillance and control as his major responsibilities, revocations will probably occur frequently. However, a parole agent who is flexible and willing to try alternatives with unresponsive clients, will have a lower rate of revocation. This fact is clearly demonstrated in recent aftercare studies in California, where significant differences were found in revocation rates among individual officers.[3]

Numerous parole officers indicate that their objectives in dealing with drug offenders have changed radically over the last several years. The optimism which accompanied the development of elaborate correctional treatment programs at both the federal and state levels has been tempered recently by the realization that individual change does not come easily. Performance standards in many systems have been liberalized, and the mechanistic approach to addict-parolees replaced with a more realistic and flexible approach.

With the development of a network of private and public community drug programs, those operated by the parole department have assumed less importance. In general, given the widespread availability of suitable community-based programs, there appears to be little justification for funding programs which duplicate existing services. The possible exception to this might be residential facilities which allow an agent to temporarily house a parolee whose behavior is deteriorating.

In this section, we describe three different approaches to providing aftercare services. In the first, the institution itself remains a major force during aftercare, involving only those individuals who have graduated from the institutional program. In the next two examples, the potential population includes both those who participated in institutional programs and those who did not. The second model involves community agencies, both public and private, in the recruitment, screening, referral, and/or monitoring of persons in aftercare status. Their role in aftercare is a primary one, despite the fact that they have no legal authority. The final approach, perhaps the most common, involves the parole agent as a facilitator or mediator between the client and the resources of the community.

B. Establishing Working Relationships with Community Drug Programs

The parole agent is the key individual in establishing and maintaining links between the correctional client and community drug abuse programs.

As every parole agent who has worked with drug programs knows, programs vary widely, not only in their basic approaches to treatment, but in their stability as organizations and in their receptivity to correctional clients. It is important that the parole agent be aware of the current status of each program, as these programs often deteriorate rapidly because of staff dissension, funding difficulties, or disruptive behavior by clients. In order to facilitate the relationship between the correctional client and the drug treatment agency, we have prepared a "checklist" for parole agents, representing a summary of suggestions and practices of numerous parole officers whom we interviewed.

- Visit the program personally, interview both staff and clients, and observe the physical facilities and the treatment modalities employed. While this suggestion is perhaps obvious, we have found that many parole agents simply refer on the basis of a program description, without having any first-hand knowledge about it. A contact inside a program can be a valuable source of information about changes that are occurring. Oftentimes, the most important insights into a program can be obtained simply by observing the way in which patients and staff relate to one another. Generally speaking, it is the quality of these relationships which hold clients in drug abuse programs. This is particularly important with the correctional client, inasmuch as he or she has come from an environment in which trust was difficult to establish.
- Learn about the various treatment methodologies employed by the program. Drug abusers, like many other people, often have gross misconceptions about the nature of drug treatment and what it can or cannot accomplish. If a parolee enters a program with unrealistic expectations, he or she might quickly fail. One of the major responsibilities of the parole officer, in acting as a broker between his clients and treatment programs, is to interpret and clarify program goals and methods. He or she must have a basic understanding of the client's needs, and must attempt to match those needs with the appropriate services.
- A thorough understanding of single modality programs is particularly important. A parolee who is considering enrolling in a methadone maintenance program, for example, must have a thorough understanding of what this implies—the possible side effects of the drug, the length of treatment, regulations governing dispensing methadone, and withdrawal procedures. Similarly, if a therapeutic community (TC) is suggested, it would be important that the person understand the total commitment which is demanded of TC participants, as well as the activities which are typical of the TC approach, which some might regard as degrading.
- Determine what entrance requirements are for each program, and what charges, if any, there are for services. In many programs, admission is open to anyone who wishes to participate, while in other programs, highly selective criteria are applied. For example, an individual who wishes to enroll in a methadone maintenance program must meet minimum FDA standards for admission, which include at least a two year history of opiate addiction and two unsuccessful attempts at detoxification.
- Determine the capacity of the drug program to provide ancillary services. Many drug programs define their mission strictly in terms of a "drug problem"—and their services are narrowly focused on this issue. Other programs provide a variety of other important services, either directly or through referral. It is important to know whether the following services are available through the program: emergency medical or psychiatric services, including overdose treatment; crisis intervention counseling, detoxification services, outreach, housing, vocational testing, training, or referral, family counseling, recreational or social activities, educational testing or referral, medical services, and legal assistance.
- Assess the attitudes and practices of program staff toward correctional clients and correctional personnel. Although most programs now readily accept clients referred by corrections, many do so under conditions which may or may not be acceptable to the

parole agent. One must establish the "ground rules" at the outset, so that the responsibilities and obligations of each party—the program and the parole officer—are clearly understood. Treatment programs must abide by federal confidentiality guidelines, and cannot, by law, provide parole officers with information about a client, except when authorized by the client's written waiver. We have encountered programs, for example, that refuse to tell a parole agent whether an individual has stopped attending this program, information which is not covered by the confidentiality regulations.

- Monitor the morale of the program. In community programs, as in institutional programs, staff and client dissension can be disastrous. There are normally some obvious indicators of internal dissension. Staff and clients form into cliques, and an "us against them" feeling pervades the program. Drug taking or dealing in and around the program may become a problem. Incidence of violence or theft may increase. Drug abuse agencies have tended, historically, to be extremely volatile organizations, for many reasons. When they do blow up, it is wise for the parole agent to carefully monitor the situation, and, if necessary, withdraw or transfer the parolee in order to protect his or her interests.
- Be flexible about a parolee's progress in treatment. Too often, we have found, the inability of an individual to successfully complete a treatment regimen is interpreted as client failure. It must be recognized that while this may be true, it is also possible that the treatment program selected was simply not appropriate to the individual's needs. Often, environmental pressures trigger behavior which cannot be dealt with in a particular treatment setting. For example, out-patient group counseling may sufficiently meet the needs of an individual for a period of time when things are going well. However, assume that he or she loses a job, is separated from a loved one, or experiences some other personal trauma which triggers a run of drug use. At that point, the only alternative may be a residential program—a hospital-based detoxification program, a halfway house, or a therapeutic community setting. In short, one needs to recognize that as situations change, needs change.

The director of a large aftercare program in Los Angeles told us that the majority of their work with parolees involves intervention in crises—legal hassles, resumption of drug sprees, fights with parents, spouses, or common-law partners, arrests for public drunkenness, petty theft, etc. Keeping parolees functioning in the community requires that the program respond to these crises, support any possible progress, and continue to maintain contact until the crisis has been resolved and the parolee is able to resume participation in a normal fashion.

In summary, drug treatment programs in the community are an important resource for the correctional client. However, if they are to be properly utilized, a solid working relationship must be established between the program and the parole agent. The parole agent must be knowledgeable about program philosophies, modalities, procedures, and selection methods. He must keep in constant contact to insure that the program is fulfilling its responsibilities. And finally, the parole agent must recognize that "success" is rare when dealing with drug offenders—progress may be slow, and setbacks frequent. The patience and flexibility of the parole agent thus becomes the critical element in any aftercare program.

Note to Reader: See Appendix B for Recommended Readings relating to this Chapter IX.

NOTES

1. National Advisory Commission on Criminal Justice Standards and Goals, Corrections, Wash. D.C., 1973 Page 273
2. The NARA II Program After Four Years: Some Variables Related to Outcome, a research report prepared by the Federal Bureau of Prisons, Washington, D.C., 1972
3. Narcotic Treatment Control Program, Phase III, Research Report Number 25, prepared by the Research Division, Department of Corrections, State of California, June 1968, Page 39

CHAPTER X. EVALUATION OF PROGRAMS

The task of evaluation is to estimate the extent to which a program—such as therapeutic community, biofeedback or methadone maintenance—is achieving its goals. Many parties have a strong interest in how this task is performed and what it yields—the public that suffers from crime committed to support a drug habit and pays for correctional programs, the elected officials who are held responsible for making expenditures wisely, the employees who earn their livelihood from the programs, and the drug abusers who are the subjects and objects of the programs. Frequently such diverse parties have different and even conflicting concerns that may impede evaluation efforts. These and other problems can be illuminated by trying to answer four broad questions.

A. By What Societal Goals Should a Program be Evaluated?

A common presumption is that the prime objective of a treatment program for drug abusers is to achieve abstinence from non-medical drug use and, of corrections, to eliminate recidivism by the offenders it releases. Certainly the attainment of these objectives is desirable and should be measured in any evaluative effort. Nevertheless, as Chapter 2 emphasizes, experience has shown these targets to be elusive, so programs must often be assessed not just by whether they "hit the bullseye," but by how close they come. More practical goals include: (a) reducing clients' drug use; (b) diminishing the volume and seriousness of their crimes; (c) increasing their employment; (d) integrating them into drug free relationships in the community. This list stresses objectives of importance to society as a whole, but is far from exhaustive of these, and it omits additional concerns of administrators, which will be discussed later.

B. What Comparisons Indicate Societal Goal Achievement?

The goals specified above are comparative, in that they refer to reducing some variables (drug abuse and crime) or increasing others (employment and social integration). To measure any such reduction or increase one must compare two or more observations made at different times. Four main types of comparison will be considered here, each with certain advantages and with definite limitations.

1. *"One-shot" postrelease observations of program clients.* Presumably all clients discussed here were convicted of a crime and found to be drug abusers, so evaluation begins with these facts, to which any subsequently procured information can be compared. Therefore, program results may be indicated if knowledge is collected on the clients' subsequent crime or drug use, for example, by new "rap sheets" on their criminal records or by the results of urine tests. This kind of evaluation can be summarized as the percent of clients not now using drugs or with no new criminal record, as of a given period after release into the community. One can also record the percentage working or attending school, or the percentage of married subjects living with non-addict spouses. With appropriate reservations, these can all be called "success" rates of the treatment.

One limitation in these gross success rates has already been indicated; they may not reveal some degree of change in those who are not complete successes, such as their less continuous involvement in crime or drug abuse now than formerly. Of course, one can judge whether any new crimes with which they are charged are as serious as those for which they were sent to the correctional program, and one can also report changes from "hard" to "soft" drugs, or the reverse. In addition, one can make repeated or "multi-shot" postrelease observations of the same clients at regular intervals to note trends in their conduct.

The most important reservation on conclusions from "one-shot" or "multi-shot" postrelease observations of a program's clients, however, is that the information thus procured does not permit comparison of the program with other treatment alternatives or with no treatment at all. Some changes in crime, drug use, employment or other variables of interest occur in people from maturation alone; therefore, it is difficult to know whether a program has altered its clients' behavior unless their changes in conduct can be compared to those of similar persons not in the program.

2. *Pre-post comparisons of program clients.* The degree of change achieved by a drug abuse treatment program in a correctional agency can be inferred best by a series of observations on clients over an extended period of time, before and after they entered the program. For example, the employment record or school attendance of clients or their earnings or grades in their last year in the community before entering a treatment program, can be compared with their employment, attendance, earnings or grades in their first year in the community after treatment. Similarly, the clients' days of incarceration in any type of juvenile or adult correctional facility during the five years preceding and five years after involvement in a drug treatment program can be tabulated, and is a sensitive index to changes in the frequency and severity of law violations. Some researchers have even constructed from interviews and records a narcotics use history of the entire lifetime of each client, and thus made pre-post comparisons for those in civil commitment programs. Many programs reveal appreciable success rates if comparisons are made between the postrelease conduct trends of the clients and their behavior records long before treatment; such success may not be evident if one just compares their condition when admitted to their postrelease record.

All the above, and other types of pre- and post-treatment data, will indicate percentage increases or reductions of various types, but they may merely be describing maturation effects. Thus pre-post comparisons of a single program's clients retain the defect of "one-shot" observations, that they do not indicate how the success or failure rates observed compare with those of similar persons in different programs or in no program at all.

3. *Controlled experiments.* Theoretically, the optimum method for comparing the effects of a treatment program with other programs or with no treatment at all is by the classic controlled experiment that has advanced knowledge in medicine and in many other fields of inquiry. Applied to assessing a treatment program for drug abusers in a correctional agency, controlled experimentation requires recruiting appreciably more applicants for the program than the number to whom it will be made available, then using purely random methods to select those who are admitted to the program and those who are denied it. People in the program are the treatment (or "experimental") group and the others are the control group. One can, of course, test several program alternatives at once by randomly assigning people to different experimental groups, each receiving a somewhat different treatment. A comparison of "one-shot," "multi-shot" or pre-post data on all cases later will indicate whether there is any percentage of change in an experimental group different from that found in those receiving no treatment—the control group—or in groups with alternative treatments.

While this method of evaluation is theoretically optimum, there often are practical difficulties in applying it in corrections. The reason for randomly dividing applicants into treatment and control groups is to avoid the possibility that the success or failure rates of the various groups are due to the types of person selected for them, rather than to the treatments they receive. Randomization maximizes the probability that a group of persons assigned to a treatment and the control group denied it are statistically identical in their mixture of traits, but this probability only is high if both groups are large. With small groups there is a great chance of the treatment and control groups being different in important respects, such as prior criminal or drug abuse records, or age. This can be prevented or reduced to some extent by "stratified random" selection, in which applicants are divided into categories similar in presumed relevant characteristics and then the treatment and control groups are randomly selected in equal proportions from each category.

Some people object on alleged civil rights grounds to the whole idea of controlled experiments with people, even with randomly selected volunteers, preferring that we remain ignorant of the effectiveness of treatment programs (discussed in Rivlin and Timpane, 1975). But even when the division into treatment and control groups is endorsed by officials and is adequate from the stand-

point of research procedures, the experiment can be "contaminated" in many respects after it is begun.

Persons thinking an experimental treatment is desirable before it is evaluated, often surreptitiously transfer people from the control to the treatment group, or make the treatment available to members of the control group. Frequently, the treatment staff have a vested interest in their program and try to remove the worst risk cases, so that their results will be favorable or their task will be easier. Sometimes clients assigned to the treatment group change their minds about participating in it. Occasionally staff who have faith in a program even before it is tested will want to send only the worst cases to it.

There is also the so-called "Hawthorne Effect," whereby people in a special program, whether clients or staff, have unusually high morale because of the attention they receive or the fact that they are pioneers, and this spirit—the fact that they "try harder"—is responsible for whatever unusual success they have rather than the treatment methods they are evaluating; if this is the case, the results of the experiment may not apply to future more routine applications of the treatment method. Finally, there is the fact that staff or clients often resist having assignments made to one group or another by random methods because they think that they know best who is most in need of or most deserving of a program even before it is evaluated, or because they have friends who want to be in the treatment rather than the control group, or vice-versa. Sometimes they find it inconvenient to maintain the initial assignments and they transfer people about despite the experimental design.

All of the above problems impeded the progress of knowledge in experimental medicine and other fields of inquiry, and they often make even the suggestion of an experimental design in corrections objectionable to many people. Because of these problems, the carrying out of an experimental design, including what happens to both the treatment and the control cases, must be closely monitored to assure that these two or more groups differ only in the treatment they receive, and that this treatment is accurately described. Sometimes impediments to conducting rigorous experiments can be corrected after they arise, or can be taken into account in assessing the findings. More often, at present, the controlled experiment is just an abstract ideal in evaluation, either never attempted or severely obstructed after it is begun, so alternative methods that approximate it are used instead.

4. *Quasi-experiments.* In a quasi-experiment the results achieved in a treatment group, as revealed by "one-shot" or "multi-shot" or pre-post observations, are compared with those achieved by a comparison group. The comparison group is not selected randomly, as a control group would be, but is instead any group that can be studied and is presumed to be highly similar to the treatment group in every respect, but was not in the program to be evaluated. Sometimes the comparison group consists of clients in the agency before a treatment method to be evaluated was introduced, or persons in other facilities or jurisdictions where the treatment method has not yet been introduced, or just clients of the same agency who did not receive the treatment, for whatever reasons.

The obvious pitfall in quasi-experiments, as compared with rigorously controlled experiments, is the probability that comparison and treatment groups differ in features that affect their subsequent behavior apart from the treatment itself. Thus a group released earlier or in another city may have been exposed to different economic conditions than existed when the treatment group was released, or may be different in average age, prior criminality, prior drug experience, or any other important variable. The latter type of problem can be partially overcome by matching the comparison group to the treatment group through randomly removing from a list of those studied for comparison the people who comprise a higher percentage in some category than is found in the treatment group. Thus, if the comparison group has more people over 30 than the treatment group, enough in this age bracket can be removed randomly from the comparison group to make the proportions of each range identical in the two groups.

No findings from evaluation can be considered absolutely conclusive and infallible, but when controlled experiments or quasi-experiments are repeated in many different settings and yield similar results, we are more assured of their validity. The more scientifically rigorous the evaluations are in design and execution, the greater can be our degree of confidence in them. Especially useful is evidence from evaluative research which tests explanations as to why a particular treatment method should be effective, if these explanations

are deduced from general theoretical principles that apply and have been found valid in a large variety of behavior (see Glaser, 1975).

C. Who Should Evaluate Whom?

Although administrators may seek to achieve societal goals, such as reducing drug abuse and recidivism, they also have other objectives that concern them more immediately and directly. These administrator goals include: (a) keeping clients contented; (b) maintaining staff morale; (c) procuring public support and funding for their operations; (d) reducing stress and insecurity in their jobs. From the standpoint of the general public and of elected officials responsible to the public, it is desirable to attain both societal goals and administrator goals, but societal goals are most important. Whether or not correctional officials agree with this ranking in the abstract, in practice they tend to give first priority to the above four types of administrator goal. This is particularly true at the lower levels of authority, but it is frequent at every echelon. If these priorities impede attainment of societal goals, or could be adversely affected by a valid evaluation of how well societal goals are attained, many administrators tend to resist such evaluation.

The extent to which administrator goals are attained often is assessed by program supervisors only through their personal impressions, but they sometimes err due to poor communication with their subordinates or because of a lack of objectivity. They can then benefit from evaluative research on the attainment of the administrator goals, for example, having an outside survey research organization poll clients, staff or the public systematically.

To assure concern with both societal and administrator goals, resources and responsibility for evaluation should be placed in a research office reporting directly to someone above the level of operations administrator. Thus researchers may be under the director of a state department of corrections, perhaps as part of a planning unit, or may be employed by an agency of the federal government monitoring state and local programs that it subsidizes, or by a state planning and grant coordinating agency in the criminal justice or drug abuse field. The need to procure followup information on releasees from agencies other than the correctional system from which they were released also justifies having the research office identified with a high level in the government hierarchy. Nevertheless, effective evaluation requires backing and assistance at every level of administration involved in the program to be evaluated.

Researchers require access to any records pertinent to their task, and must be able to interview any clients or staff, or former clients or former staff, who can supply information relevant to the questions being investigated. Ideally they should have multiple sources of information, so that each can be used to check on the validity of others. For the most rigorous type of research, controlled experiments, and even for quasi-experiments, they must have cooperation from treatment and administrative staff in following the research design. They should be able to monitor treatment operations to ascertain that an experimental program is being followed, and to describe the services provided for treatment and control groups, and client response to the services.

There is no simple formula to assure such extensive cooperation in evaluation, to maximize its precision and objectivity. Perhaps the best guarantee is to have a long tradition of rigorous research, with the results always fully reported to the public regardless of whether findings are favorable or unfavorable to existing practices. Such a tradition is evident in the California Youth Authority and the California Department of Corrections, and is growing in some other agencies. It was furthered in California by a legislative budget committee's initiative during the 1950s, proposing that approximately one percent of the correctional budget be devoted to research, primarily oriented to evaluation. In other states and some federal agencies similar allocations for research have not been as persistently maintained, research positions have been filled with persons lacking appropriate training and experience, and research staff have been diverted from evaluation, or have had their evaluative reports highly restricted in dissemination or suppressed.

For many types of evaluation it is preferable to contract for research by a university group or a research firm, rather than having it done by a correctional agency's own research staff. What is optimum depends mainly on the research personnel available at a particular time and place for the project that is to be undertaken. Relevant considerations include not only the competence of researchers (best demonstrated by work completed in the past rather than by academic degrees), but

also, the detachment and objectivity of the research organization of which they are a part. Sometimes an outside firm or a university professor is recruited for a specific evaluation, rather than having it done by an "in-house" research organization, in order to obtain fresh perspective, freedom from past ties to program personnel, or lack of any vested interest in a particular evaluation outcome.

Ideally, evaluation should not be undertaken on a piecemeal basis, as a series of scattered and uncoordinated studies, but should be a routine function of correctional treatment, as are bookkeeping and accounting in most businesses or quality control in manufacturing. This routinization leads to the integration of operational and research records so that they best fit needs of both program personnel and evaluators; designing and testing record forms to accomplish this objective, and monitoring their use, then becomes a research office responsibility (for fuller discussion, see Glaser, 1973: Chapter 8). With modern computerized record-keeping, this integration can lead not only to more efficient population and operation accounting systems, but to prompter and fuller feedback of evaluative information than has heretofore been possible, if postrelease data on clients are routinely added to the information collected on them while they are in a treatment program.

Mutual benefits accrue from close interaction between research and operations staff at every level, both in the field and the central office. Researchers can then more readily provide operations staff with evaluative statistics on attainment of both administrator and societal goals; operations staff can contribute to research a sensitivity to issues and problems in treatment, and an awareness of differences between "how things really are" and how they are reported. That can greatly improve the validity and utility of evaluation.

D. How Can Evaluations be Expressed as Monetary Benefits in Relation to Costs?

Ultimately the public, in its private contributions and in the government policies that it supports, deals with monetary questions on how it wishes to cope with each social problem. Should more be spent in combating cancer, and if so, should it be taken from expenditures to cope with drug abuse? Of investments in dealing with the drug problem, how much should be spent in anti-drug abuse education and how much on treating drug abusers in correctional custody or supervision? In treatment within correctional systems, how much should be allocated to methadone maintenance and how much to biofeedback training or therapeutic communities? Furthermore, a societal goal is always to avoid any fruitless costs in treatment programs.

Each type of expenditure on drug abuse treatment in corrections presumably yields different returns of drug abuse or crime reduction per dollar. If we knew exactly what these yields were, or even approximately, our money could be spent more wisely. Currently government support is not concentrated on any single treatment modality because: (a) we presume that each type of treatment has a different contribution to make that complements the others, and that each is of most help to a different type of client; (b) we assume (though we lack the knowledge to apply precisely) an economic law that after the minimum investment necessary is made for each type of treatment, a point of diminishing returns per additional dollar eventually is reached, so that rationality dictates distributing funds among alternative treatments to equalize marginal benefits, that is, to produce the same additional benefit from the last dollar spent on each program (a point presumably reached with quite different expenditures for each); (c) we cannot measure precisely either the benefits or the costs of our diverse programs, so we hedge our investments by giving some funds to all that impress us favorably.

Increasingly, the advancement of the social sciences and their application in government, creates demands for more precise justifications when giving public funds to programs for coping with social problems. This trend was manifest during the 1960s in the pressure for "program performance budgeting" and in the 1970s for conversion of evaluation data into cost-benefit analyses. Such conversions require estimation of the per-client costs of each alternative treatment modality, and assignment of a reasonable monetary value to benefits the treatments produce in crime and drug abuse reduction. Also tabulated as benefits are earnings and taxes paid by employed ex-offenders, as compared with the costs of criminal justice processing and incarceration for recidivists, and even the welfare costs of supporting the dependents of recidivists. These cost and benefit analyses can be made in a very complex manner, but

it usually is preferable to begin with simple calculations (for illustrations, see Glaser, 1973: Chapter 4). When monetary benefits can be demonstrated as the basis for requesting budget support for treatment programs, legislatures are likely to be favorably impressed. This should be a strong motivation for program directors to encourage evaluation research and the conversion of its findings to benefit and cost estimations.

Note to Reader: See Appendix B for Recommended Readings relating to this Chapter X.

CHAPTER XI. PLANNING, COORDINATION, AND FUNDING CONSIDERATIONS

This chapter reviews some of the ways in which planning and coordination of correctional drug abuse programs can be improved, giving examples from those states in which we investigated planning and funding mechanisms. A complete breakdown of the planning process in this area is beyond the scope of this prescriptive package; but additional references are provided at the conclusion of the chapter.

A. Planning for Correctional Treatment Programs

The impetus for initiating an institutional drug abuse treatment program may come from a variety of internal and external sources. Oftentimes, correctional systems respond to legislative or media pressures to provide treatment for offenders with drug histories. On the other hand, pressures may originate from the inmate population itself, as was recently the case in the state of Washington. Regardless of the source, the planning process remains the same.

The first step in any planning effort is a determination of the need for services. One source of rough data is provided by the annual statistical compilations on the institutional population, normally collected at the time of an inmate's admission. These statistics roughly indicate the percentage of the inmate population who have had drug offenses, though it may not identify drug abusers who have been convicted of non-drug offenses.

A recent study of a cross-section of the inmate population in the Oregon correctional system provides a good example of how the inmates' perspective can be used to help assess needs. In this study, interviewers elicited pertinent information by asking the following:

- Questions dealing with personal background, history of drug and alcohol abuse, and criminality. These questions were intended to shed light on inmates' perceptions of the problems that led to their incarceration.
- Questions dealing with the kinds of problems inmates (and parolees) experience. These questions were intended to identify emotional and other pressures, specific crises, and environmental circumstances which inmates related to their difficulties.
- Questions dealing with prison experiences. These questions were intended to assess inmates' attitudes toward rehabilitation, and to determine the nature and extent of their efforts to deal with their problems while incarcerated.
- Questions dealing with treatment and rehabilitation programs. These questions were intended to assess inmates' attitudes toward treatment, etc., to assess their knowledge of available services, and to specify which services they thought were necessary.[1]

We found the Oregon approach of determining inmates' perceptions of their needs to be a particularly important step in planning. Often, treatment programs are designed and implemented by persons removed from the reality of the prison world. While inmates may have a limited capacity to diagnose their own problems or to suggest appropriate therapeutic solutions, they can provide important input into the planning process, while acting as a reality check for concerned but naive professional planners.

Planning involves locating services that cannot be provided by correctional or parole officials, and negotiating working arrangements so that a comprehensive range of services can be provided without unnecessary expense or duplication of efforts. These resources should include technical or trade schools, vocational training programs, employment services, health and welfare facilities, mental health and family counseling services, legal aide programs, and drug abuse treatment programs.

As a final consideration, it is necessary to review proposed program procedures to determine whether they conflict with existing legislation or with administrative and/or institutional policy. Planners may wish to suggest revision of particular procedures which will facilitate program operations. For example, programs might want to establish specific parole dates prior to an inmate's entrance into the program, which would permit predictable progress from institutional to non-institutional or parole status. Administrative policy may also have to be revised in order to create a particular institutional environment. For example, the development of a functional unit necessitates negotiations with administrators who might feel threatened or inconvenienced by the planned changes in management styles and roles.

Many areas which concern institutional programs are beyond their control. Selection of program participants, a program's flexibility in transitional programming, and even the quality of the aftercare programming are somewhat dependent on parole policies. Other areas of concern, which demand coordination at various levels, might include parole agents' role with offenders, or their utilization of community resources. A parole agent who defines his role as being primarily surveillance or control, will ultimately downgrade the value of treatment. If the drug offender is to fully utilize aftercare services, it is important that the parole officer be supportive of the philosophy of treatment.

Much of the responsibility for coordinating the planning services rests at the regional and state level. Institutional representatives should have access to these planning groups so that their concerns are adequately represented.

B. Planning and Coordination at the State Level

Two state agencies have the responsibility for providing services to the drug offender: the Single State Agency (SSA), which administers NIDA funds (as well as other federal and state monies) for drug abuse prevention, education, and treatment; and the State Planning Agency (SPA), a Law Enforcement Assistance Administration (LEAA)-related agency which is responsible for administering federal and state anti-crime monies. Both were created by federal legislation, and the directors of both agencies serve at the bidding of the governor of their state.

1. *Single state agencies.* The Single State Agencies were created by federal legislation in 1972 (P.L. 92-255). Their major responsibility is to develop a statewide plan for drug abuse prevention, education, and treatment, and to allocate funds to the regional and local communities. The statewide plan, submitted to NIDA annually, receives input from a variety of sources, and includes representatives from criminal justice agencies, including corrections.

The SSA's other responsibilities include such diverse activities as training and developing manpower, establishing and enforcing minimum standards for treatment programs, accrediting community programs, credentialing drug abuse workers, and providing technical assistance to community programs, public information, evaluation and research, and in some states, direct services.

SSA's have traditionally focused their attention on the development of community-based drug treatment programs, rather than institutional programs, although there are exceptions in several states. New Jersey and Puerto Rico, for instance, have both initiated programs in correctional institutions.

2. *State planning agencies.* The State Planning Agency was created in 1969 by federal legislation (P. L. 93-83, the Omnibus Crime Control and Safe Streets Act). SPA's are responsible for administering LEAA block grants and other federal and state criminal justice funds. Their responsibilities are quite broad, ranging from supporting the acquisition of police hardware to establishing pretrial diversion programs. The major responsibility for supporting institutional drug abuse programs rests with the SPA's. Like the SSA's, the SPA's are required to develop an annual comprehensive state plan for submission to the LEAA. They are assisted in this task by regional and local criminal justice planning groups, as well as individual criminal justice agencies. Drug abuse programming for correctional clients comprises one component of that state plan.

3. *SSA-SPA coordination.* Because both SSA's and SPA's are concerned with providing services for the drug offender, it is necessary to integrate their planning activities as fully as possible. In some smaller states, the directors of the two agencies have direct communication and easy access to other key individuals or agencies in state government. In larger states, however, infor-

mal arrangements are normally not feasible, so a formal procedure for improving information sharing must be devised. Before this can be done, inter-departmental differences which impede cooperative planning must be resolved. Such "protection of turf" squabbles often stem from philosophical differences about the nature of, and appropriate responses to, drug abuse.

The development of a correctional drug abuse program also necessitates extensive coordination between the institution and the community. In order to provide comprehensive services to offenders, many agencies, including health, welfare, educational, vocational, and legal, must be involved in the planning process at the state level.

To facilitate communications between these various agencies, several states have established inter-divisional planning/coordinating committees. Representatives from the concerned agencies designate a liaison person to provide the group with information about the needs and activities of each agency, as well as to coordinate their activities with other agencies. New Jersey was one of the first states to inaugurate such a group, as a result of a governor's message in 1973 deploring the problems of drug abuse in prisons. Labeled the Inter-Divisional Program Committee, it consists of representatives from the SSA, the SPA, corrections, and mental health. The participants are in positions which allow them to communicate directly with their respective agencies or department directors on matters which call for their contribution.

4. *Federal regulations affecting SSA-SPA interactions.* Because of the increasingly complex interrelationship between criminal justice and drug abuse treatment agencies at all levels, both NIDA and the LEAA have developed guidelines which mandate coordination between the SSA and SPA in the development of the state plan. The LEAA Drug Abuse guidelines require consultation with the SSA prior to submission of the state criminal justice plan. Additionally, these guidelines establish minimum standards for treatment programs in accordance with federal funding criteria.

In April, 1976, a nationwide symposium on the drug abusing criminal offender was held in Reston, Virginia. The conference explored ways to improve working relationships between the two systems. After enumerating obstacles to interfacing these two essentially different systems, several possible ways of improving coordination emerged. Several participants suggested that the SSA's take the lead in developing the mechanism for exchanging information and planning joint activities related to the drug offender. Joint initiates were also suggested in the areas of research, training, planning, and funding.

It is one thing to legislatively mandate cooperation, but it is quite another to achieve it, particularly if the agencies involved are as disparate as the SSA and the SPA. The relationship between criminal justice and health care systems is of recent origin, and is still somewhat tenuous. Many practical as well as philosophical differences need to be resolved if corrections is ever to develop a comprehensive range of quality services, both in the institution and the community.

C. Funding

During the course of our site visits, we encountered much uncertainty about future funding prospects, due to a reduction in federal monies for treatment efforts. Lack of funding resulted in the closing down of one major correctional program in South Carolina, and is threatening many others.

Decreasing funding levels necessitate increased planning and coordination efforts, in order to avoid duplications of services, and to obtain the maximum use of existing resources.

The LEAA presently provides the bulk of federal support for institutional drug abuse programs through the SPA. These funds are supplemented by state monies, and in some instances, by other federally-funded programs. For example, in those programs which have a manpower component, the Comprehensive Employment Training Act (CETA) may pay the salaries of paraprofessionals. Normally, this requires an arrangement between the drug program and CETA's prime sponsor, which may be an existing agency such as a city personnel board, or an agency created especially to administer these funds. The Work Incentive Program (WIN) offers another possible source of support for selected offenders who are on welfare and who meet other eligibility criteria.

Community-based drug treatment programs are the responsibility of the SSA, and are supported primarily by NIDA funds coupled with state and local matching monies. The mandate of the SSA to underwrite the costs of institution-based programs is limited, although, as we have mentioned, in at least two states SSA's provide direct services to inmates within institutions.

Funding considerations obviously influence the development of programs within corrections. In-house programs are, generally speaking, considerably more expensive to operate than community-based programs, because of the custodial responsibilities involved. Obviously, the most cost-effective approach to treatment would be to limit programs to out-patient community-based programs, an approach which several states have taken.

Correctional planners in most states must make tough decisions regarding the allocation of limited resources. In some areas, drug abuse does not constitute the major problem for corrections. In several midwestern and southern states, for example, the establishment of services for alcoholics takes precedence over addicts.

However, the recent upswing in the rate of heroin addiction in the United States, coupled with the increasing relationship between drug treatment and the criminal justice system, may give Congress reason to revise funding levels upward. Without additional federal monies, many state programs will be reduced or eliminated altogether.

Note to Reader: See Appendix B for Recommended Reading relating to this Chapter XI.

APPENDIX A
LEAA PART E GUIDELINES ON NARCOTICS AND ALCOHOLISM TREATMENT

NARCOTIC AND ALCOHOLISM TREATMENT[1]

(a) *Plan Requirement.* According to Section 453(9) of the Crime Control Act, Part E programming must describe how the State is conducting a concerted effort to provide voluntary drug and alcoholism detoxification and treatment programs for drug addicts, drug abusers, alcoholics, and alcohol abusers who are either within correctional institutions or facilities or who are on probation or other supervisory release programs.

(b) *Method.*

1 States must have initiated programs to identify drug and alcohol abusers in the correctional system. The identification programs should be able to indicate the overall magnitude of the drug and alcohol abuse problems and permit early identification of all offenders voluntarily admitting to such abuse.

(c) *Treatment Requirements.* States must provide such treatment as is necessary for incarcerated and convicted persons with a drug or alcohol problem. The following must be established or provided:

1 Criteria for patient admissions and terminations.
2 Adequate facilities, maintained in clean, safe, and attractive conditions.
3 Intake units, providing physical and laboratory examinations as well as a full personal medical and drug history.
4 Educational or job training programs.
5 Regularly scheduled individual or group counseling and medical treatment for all program participants conducted by qualified trained personnel.
6 Program participation on a voluntary basis only.

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[1]SOURCE: Conditions for Participation in Funding Under the Special Corrections Program (Part E) of the Crime Control Act. *Guideline Manual M 4100.IF: State Planning Agency Grants*, Chapter 3, paragraph 53.c. (7), page 68; Law Enforcement Assistance Administration, January 1977.

APPENDIX B
RECOMMENDED READINGS*

*Listed by Chapters

CHAPTER I—RECOMMENDED READINGS

Articles

Federal Drug Abuse Programs, a report prepared by the Task Force on Federal Heroin Addiction Programs, submitted to the Criminal Law Section of the American Bar Association and the Drug Abuse Council. Published by the Drug Abuse Council. Washington, D.C.: 1972.

This is a comprehensive survey of the activities of several agencies concerned with enforcement, research, planning, coordination, and treatment of drug abuse. Although certain sections relating to federal activities are somewhat dated, there are excellent descriptions of the NARA program, treatment approaches in both state and federal correctional institutions, and aftercare approaches.

Martinson, Robert. "What Works? — Questions and Answers about Prison Reform." *Public Interest* 3 (Spring 1974): 22-54.

Reports the results of several studies of the effectiveness of correctional programs. Discusses the issue of punishment vs. rehabilitation and comes to the conclusion that focusing on punishing and equal sentences for all would do more than past efforts at "rehabilitation."

Newman, Charles L., and Price, Barbara. "National Jail Resources Study," prepared under Grant Number 75-N1-99-622, L.E.A.A., August 18, 1975.

This study conducted a survey of drug treatment resources for inmates in a sample of county and city jails throughout the fifty states. The primary objective was to determine the types of services and alternative delivery models which are available to inmates. The study was also concerned with the jail's utilization of community-based treatment agencies and diversionary programs.

Research Concepts, Inc. "Treatment and Rehabilitation Programs for Drug-Involved Offenders in State Correctional Systems," in Volume III; "The Legal Systems and Drug Control," an appendix to *Drug Use in America: Problem in Perspective*, National Commission on Marihuana and Drug Abuse (March 1973): 810-852.

Warfel, Richard. "A Report of Treatment Programs in America's State Prisons," in the *Proceedings of the One Hundred and Second Annual Congress of Corrections of the American Correctional Association.* Pittsburgh, Penn.: August 20-26, 1972. 42-57.

Presents results of a questionnaire survey mailed to 50 states (with an 80% return rate). Data presented includes: (1) the degree of cooperation between the state drug abuse agency and department of corrections in providing services; (2) the specific modalities employed in each state; (3) the frequency with which services are provided; (4) the availability of alternatives to institutionalization; and (5) the state of program development in 35 states.

The author suggests that many, perhaps most, programs offered within the correctional setting lack the three elements which he considers essen-

tial to successful treatment: comprehensiveness, coordination, and professionalism. He stresses the need for the continuation of services from pre- to post-institutionalization.

Books

Brill, Leon, and Harms, Ernest. *The Yearbook of Drug Abuse.* New York: Behavioral Publications, 1973.

Conrad, John P. *Crime and Its Correction: An International Survey of Attitudes and Practices.* Berkeley: University of California Press, 1970.

Based on interviews and observations throughout the United States, Canada and Europe, this book provides a realistic account of correctional programs throughout the world. The emphasis is on the importance of developing a more humane program for all facets of corrections.

Glascote, Raymond N., et al. *The Treatment of Drug Abuse: Programs, Problems, Prospects.* Washington: Joint Information Service of the American Psychiatric Association and the National Association for Mental Health, 1972.

Reports a field study that consisted of visits to nine programs operating more than forty facilities. The authors concluded that no single one of the presently available approaches can be expected to be successful with more than a small percentage of users. Rather than take a position for or against any particular treatment approach, the authors discuss the positive and negative features of each.

Glath, M. M. (Editor, *British Journal of Addictions). A Guide to Addiction and Its Treatment.* New York: John Wiley & Sons, Inc., 1974.

The addictive personality, etc., discussed. Major sections are allocated to the different types of addictive substances, their uses, their effects and results. Emphasis on the need for interdisciplinary approaches to addiction.

Peterson, D., and Thomas, C. *Corrections: Problems and Prospects.* New Jersey: Prentice Hall, 1975.

Series of articles on failure of corrections, a critique of several new treatment approaches employed by the FBOP's, including drug Rx.

Szasz, Thomas. *Ceremonial Chemistry: The Ritual Persecution of Drugs, Addicts and Pushers.* Garden City: Andersen Press, 1974.

The author feels that the religious and political significance of drug abuse has been overlooked. The actual occurrences which constitute our so-called drug problem consist of the regulation (by law, custom, and all other means of social control) of certain kinds of ceremonial behavior. The author states that the answer to our drug problem lies in demythologizing and deceremonializing our use and avoidance of drugs.

CHAPTER III—RECOMMENDED READINGS

Articles

Hughes, Patrick H.; Floyd, Charles; Norris, Gertrude; and Silva, George. "Organizing the Therapeutic Potential of an Addict Prisoner Community." *The International Journal of the Addictions* 5:2 (June 1970): 205-223.

The resistance of narcotic addict prisoners to traditional psychotherapy is viewed by the authors as a product of the group dynamics of the prisoners social organization. The authors attempted to bring about more therapeutic patterns of interaction within their addict prisoner social organization that, in itself, was the major vehicle for therapeutic change in attitudes, behavior and self-concept.

Levinson, R., and Gerard R. "Functional Units: A Different Correctional Approach." *Federal Probation* (December 1973): 8-16.

Describes an approach to decentralizations of institutions into functional units. Describes both advantages and disadvantages of approach, including re-shuffling of managerial roles and responsibilities. Also discusses relationship to institution-wide functions; i.e., industries.

O' Connor, Gerland. "Structural Impediments in Rehabilitation Programs for Durg Addicts." *Journal of Drug Issues*. 4:2 (1974): 99-106.

Suggests that rehabilitation programs for drug abusers have been notoriously unsuccessful because such programs are social control oriented. Their focus is exclusively upon changing and controlling addicts. Argues that rehabilitation efforts should also be addressed toward fostering reciprocal and complementary changes in addicts' social milieu.

Scott, Joseph W., and Hissong, Jerry B. "An Effective Structure and Program for Institutional Change." *Federal Probation* (September 1973)

An organizational structure which can serve as an effective vehicle for implementing the treatment is as important and as critical to success as the treatment prescriptions themselves because of the peculiar nature of residential institutions and the demands which emerge from them. Includes recommendations for converting a traditional institutional program into a treatment program.

Thomas, Charles W. "The Correctional Institution as an Enemy of Correction." *Federal Probation* (March 1973).

Focuses on the history of correctional failures and the need to recognize this reality. The author claims that the organizational structures of many correctional institutions are the major enemy of effective correctional programs. He states that it is the enemy because of its direct relationship with the type of inmate society which emerges within these institutions, and because the attitudes, values, and norms which are transmitted during each inmate's socialization in prison can make or break any prison program.

Wenk, Ernst A., and Moos, Rudolf H. "Prison Environments: The Social Ecology of Correctional Institutions." *Crime and Delinquency Literature* (December 1972): 591-621.

Reports a new way of systematically assessing institutions or parts of institutions based on the assumption that environment influences the way people behave. The authors describe the development of the Correctional Institutional Environment Scale (CIES), an instrument designed to assess environmental dimensions systematically.

Wenk, Ernst A., and Moos, Rudolf H. "Social Climates in Prison: An Attempt to Conceptualize and Measure Environmental Factors in Total Institutions." *Journal of Research in Crime and Delinquency* (July 1972); 134-148.

Describes the nine scales of the Correctional Institutions Environment Scale in detail. Norms of a national reference group are presented and four unit profiles are shown as examples. Various possible uses of the CIES are discussed with special attention to the potential utility of the instrument for the institutional administrator.

Wenk, Ernst A., and Halatyn, Thomas. "The Assessment of Correctional Climates." Final Report submitted to Center for Studies of Crime and Delinquency of the National Institute of Mental Health, Research Grant MH 16461, Research Center, *National Council on Crime and Delinquency.* Davis, California: June 1973.

A summary of the procedures, findings, and conclusions regarding "The Assessment of Correctional Climates" MH (16461), a research grant proposed primarily to complete the development and standardization of the Social Climate Scale (SCS). The major rationale of the study was the practical and theoretical importance of developing techniques for the systematic assessment of special environments in order to measure more effectively the behavioral and psychological effects of different types of milieus.

Books

Moos, Rudolf H. *Evaluating Correctional and Community Settings.* New York: John Wiley and Sons, 1975.

This book discusses the development and use of new methods for evaluating the social environments of institutional and community-based correctional programs.

Moos, Rudolf H. *Evaluating Treatment Environments.* New York: John Wiley and Sons, 1974.

This book discusses the development and utility of new methods for evaluating the social milieus of hospital-based and community-based treatment programs in the context of two new broad conceptual overviews that identify underlying theories and patterns of human environments.

CHAPTER IV—BIOFEEDBACK RECOMMENDED READINGS

Bibliographies

Biofeedback Research Society
Dept. of Psychiatry, C 268
University of Colorado Medical Center
4200 East 9th Avenue
Denver, Colorado 80220

This organization publishes a cumulative bibliography on biofeedback which is available for a small fee.

Annuals

Kamiya, J.; Barber, T.; Dicaru, L.; Miller, N.; Shapiro, D.; and Stoyva, J., eds. *Biofeedback and Self-Control.* Chicago: Aldine Publishing Company.

The first edition of *Biofeedback and Self-Control* contains a collection of works in biofeedback prior to 1971. An annual publication has been printed each year thereafter, containing significant original papers published the previous year.

Books

Brown, Barbara. *New Mind, New Body.* New York: Harper and Row, 1974.

Presents a layman's overview of many biofeedback techniques and possibilities.

Warner Paperback Library. *Biofeedback: Turning on the Power of Your Mind.* New York: Warner Paperback Library, 1973.

Summaries

Kamiya, Joe. "Biofeedback Training as a Modality in the Treatment of Drug Abuse." in *A Survey of New Techniques for the Treatment of Drug Abusers* 1: prepared for NIMH by Metcor, Inc., 2000 P Street N. W., Washington, D.C. 20037.

This is an excellent summarization of what is currently known about the use of biofeedback techniques with drug abusers. It contains a comprehensive bibliography, as well as a list of individuals and programs doing work in this area. This publication may be available through NIMH in the future.

CHAPTER IV—BEHAVIOR TECHNIQUES RECOMMENDED READINGS

Cautela, Joseph R., and Rosensteel, Anne K. "The Use of Covert Conditioning in the Treatment of Drug Abuse." *The International Journal of the Addictions* 10:2 (1975): 277-303.

Reviews behavioral approaches to drug abuse and claims that behavioral techniques show some promise in treating drug abuse. Good overview of behavior techniques in drug treatment.

Droppa, David C. "Behavioral Treatment of Drug Addiction: A Review and Analysis." *The International Journal of the Addictions* 8:1 (1973): 143-161.

Reports studies of various kinds of behavior treatment with drug addicts. Types of treatment studied include: Aversive Conditioning, Aversive Counterconditioning, Instrumental Extinction, Positive Counterconditioning, and other Stimulus-Related Procedures; Development of Alternative Behaviors, and Multiform Treatment of Drug Addiction. Includes Relaxation Training, Desensitization, Assertive Training and Token Economies.

National Institute on Drug Abuse. "A Survey of New Techniques for the Treatment of Drug Abusers" 1 (January 1975): Chapter 8. Final report prepared by Metcor, Inc., under contract no. ADM-45-74.

CHAPTER IV—THERAPEUTIC COMMUNITIES RECOMMENDED READING

Articles

Brook, Ed D., and Whitehead, Paul C. "Colloquialisms of the Therapeutic Community, Treatment of the Adolescent Drug User." *Federal Probation* (March 1973).

Describes and explains the therapeutic principles of a therapeutic community at the Addiction Research Foundation of London, Ontario, Canada. The authors explain that the basic principles take the form of "colloquialisms" or cryptic comments and the article discusses how these have become part of the program.

Deitch, David A. "Treatment of Drug Abuse in the Therapeutic Community: Historical Influences, Current Considerations and Future Outlook," in *Treatment and Rehabilitation, an Appendix to Drug Use in America: Problem in Perspective,* the National Commission on Marihuana and Drug Abuse 1.

The major focus of this paper is on the psychotherapeutic community as an approach to the treatment of drug addicts; its genesis and historical perspective; its methodology; its efficacy and shortcomings; and its outlook for the future. The author points out that any psychotherapeutic approach must be viewed in the context of the society in which it exists. Consequently, this paper also deals with the historical dimension of the drug problem in the U.S., the range of various approaches developed in the way of an attempted solution; and the historic influences of these other approaches on the therapeutic community.

Densen-Gerber, Judianne, and Drassner, David. "Odyssey House: A Structural Model for the Successful Employment and Re-entry of the Ex-drug Abuser." *Journal of Drug Issues* 4:4 (1974): 414-427.

Describes the program at Odyssey House, a drug-free psychiatrically oriented residential therapeutic community which claims it has developed a program which has successfully graduated its residents into the economic mainstream of society. Odyssey stresses the fact that re-entry is a process that must begin from the first day of treatment.

Freudenberger, Herbert. "How We Can Right What's Wrong with out Therapeutic Communities." *Journal of Drug Issues* (Fall 1974).

Basically, an overview of therapeutic communities and drug treatment. Covers the early beinnings of the addict resident therapeutic community to the point today where the typical therapeutic community is a highly structured environment.

Rachman, Arnold W., and Heller, Margaret E. "Anti-Therapeutic Factors in Therapeutic Communities for Drug Rehabilitation." *Journal of Drug Issues* (Fall 1974).

Good overview of the therapeutic community. Begins with a history of the development of therapeutic communities and covers the philosophy, goals and daily practice of TC's.

Books

Densen-Gerber, J. *We Mainline Dreams—The Odyssey House Story.* Garden City, N.Y.: Doubleday & Co., Inc., 1972.

Sugarman, Barry. *Daytop Village: A Therapeutic Community.* New York: Holt, Rinehart & Winston, Inc., 1974.

A detailed history, description and anthropological analysis of what is noted as "the most successful approach to the problems of rehabilitating drug addicts."

Yablonsky, L. *The Tunnel Back: Synanon.* New York: Pelican Press, 1964.

CHAPTER IV—SELF-HELP PROGRAMS RECOMMENDED READINGS

Burdman, Milton. "Ethnic Self-Help Groups in Prison and on Parole." *Crime and Delinquency* 20:2 (April 1974): 107-118.

The author sees value in encouraging the development of self-help groups in institutions. He acknowledges the problems attendant to their formation relating to racism, in and out of prison. He sees self-help groups as potentially helpful in gaining new identity, working for positive institutional change and pragmatically findings jobs, housing, etc., upon release.

Kaufman, E. "A Psychiatrist Views an Addict Self-Help Program." *American Journal of Psychiatry* 128:7 (January 1972).

The author describes the program and methods used in Reality House, a day care treatment center for the rehabilitation of narcotic addicts. Members of the program move up through five levels of treatment which consist mainly of group psychotherapy and vocational training. He then describes two major differences in technique or approach between the program at Reality House and other treatment approaches to the problem of the hard-core addict.

CHAPTER IV—TRANSCENDENTAL MEDITATION RECOMMENDED READINGS

Hearings Before the Select Committee on Crime, House of Representatives. *Narcotics Research, Rehabilitation and Treatment.* Washington, D.C.: June 1971.

Covers the effects of transcendental meditation as a treatment for drug abuse. Describes a study which reports that individuals who regularly practiced T.M. 1) decreased or stopped abusing drugs, 2) decreased or stopped engaging in drug selling activity, and 3) changed their attitudes in the direction of discouraging others from abusing drugs. The unique element of using T.M. in this capacity is that since it is offered as a program for personal development and is not specifically intended to be a treatment for drug abuse, the alleviation of the problem of drug abuse is merely a side effect of the practice. Thus, it may not threaten those beliefs of the committed user who condones the use of drugs.

Kentucky Law Journal. "Transcendental Meditation and the Criminal Justice System." 60 (1972-72)

Discusses the use of T.M. with individuals convicted of crime, including drug users. Reports a program at the Federal Narcotic Hospital in Lexington, Kentucky, utilizing T.M. with inmates there.

Sykes, David. "Transcendental Meditation as Applied to Criminal Justice Reform, Drug Rehabilitation and Society in General." *Maryland Law Forum* 3:2 (Winter 1973).

Overview of the technique of T.M. The author points out that the investigations presented on the technique of T. M. strongly suggest incorporating T. M. into Drug Treatment Programs.

CHAPTER IV—REALITY THERAPY RECOMMENDED READINGS

Bassin, Alexander. "Reality Therapy at Daytop Village." *Journal of Drug Issues* (Fall 1974): 404-413.

Glasser, William, *Reality Therapy, A New Approach to Psychiatry,* New York, Harper and Row, 1965

CHAPTER IV—GENERAL RECOMMENDED READINGS

Articles

Mandel, Arnold J. "The Sociology of a Multimodality Strategy in the Treatment of Narcotic Addicts." *Journal of Psychedelic Drugs* 4:2.

The author makes a case for the development of a multimodality treatment system within a single administrative structure. His general statement is that in order to stimulate, develop, integrate, obtain and maintain support for narcotics treatment programs it is essential to develop a multimodality treatment system.

Moffett, Arthur; Bruce, James; and Horvitz, Diann. "New Ways of Treating Addicts." *Social Work* (July 1974): 389-396.

Survey of Rx methods in drug programs in Pennsylvania. Focus on what doesn't work, i.e., traditional treatment. Suggests increased use of ex-ad-

dicts and describes the gaps between professional therapists and addicts. Emphasizes the fact that in working with the addict, limited goals seem to be the only feasible ones. A first step may be to relinquish the notion that rehabilitation is synonymous with total abstinence from drugs and that the reliance on a chemical is incompatible with progress.

Peck, Michael L., and Klugman, David J. "Rehabilitation of Drug Dependent Offenders: An Alternative Approach." *Federal Probation* (September 1973).

This article covers the program in L.A. with offenders from Terminal Island, California, in the Federal Correctional Institution there.

Books

Brill, Leon, and Lieberman, Louis, eds. *Major Modalities in the Treatment of Drug Abuse.* New York: Behavioral Publications, 1972.

Presents descriptions of the major modalities currently employed in the treatment and rehabilitation of narcotic addicts and other drug users. Discusses the state of the art today and suggests kinds of additional efforts required to help eliminate drug addiction. Under a multi-modality rationale, the editors are not commited to any one approach as the exclusive method for treatment.

DeLong, James V. "Treatment and Rehabilitation" in *Dealing with Drug Abuse.* A Report to the Ford Foundation, New York: Praeger Publishers, 1972.

This chapter provides a comprehensive overview of the myriad approaches to treatment and rehabilitation of both opiate and non-opiate drug abuse, including drug-free programs, therapeutic communities, multimodality programs, narcotic antagonists, and other more esoteric approaches. The author concludes that despite the rapid expansion of treatment approaches within the last decade, we have little hard data about the efficacy of different approaches. The basic problem, as he views it, is our lack of understanding of the nature and causes of addition. Lacking such information, we have no choice but no proceed empirically.

Wicks, Robert J. *Correctional Psychology.* San Francisco Press, 1974.

A comprehensive presentation of the psychological approaches to treatment of the criminal offender. Topics include classification, current therapies, behavior modification, the use of non-professionals, prison violence, unusual problems in corrections, rehabilitation programs, community-based corrections, and the future of correctional psychology.

CHAPTER V—RECOMMENDED READINGS

Bernstein, Blanche, and Shkula, Anne N. "The Drug User: Attitudes and Obstacles to Treatment." *New School for Social Research, Center for New York City Affairs*. New York: 1975

Interviews over 400 drug users on Riker's Island about their experiences and attitudes toward drug treatment programs. Describes their attitudes concerning therapeutic communities, drug-free day care, and methadone maintenance which reveal certain obstacles to treatment. Concludes that the most important single treatment factor is attitude (the user must view his drug use as a problem).

Bogan, Joseph. "Client Dissimulation: A Key Problem in Correctional Treatment." *Federal Probation* (March 1975): 20-23.

States that client dissimulation is an inherent characteristic of correctional treatment and must be dealt with directly. This article focuses on ways of coping with client dissimulation and stresses that its resolution is a key to successful treatment.

Kozel, Nicholas J.; DuPont, Robert; and Brown, Barry. "Narcotics and Crime: A Study of Narcotics Involvement in an Offender Population." *The International Journal of the Addictions* 7:3 (1972): 443-450.

This article compares addicts and non-addict offenders in terms of background characteristics and current functioning, and then discusses the extent to which addiction and criminal activity are linked. One of the most striking findings of this study is the widespread use of heroin among persons entering the D.C. jails (almost one out of every two offenders entering the D.C. jail are heroin addicts). The authors then emphasize the obvious relationship between an effective treatment program for addict-clients and an effective program of crime prevention for the larger community.

Mutual Agreement Programming: An Overview. Parole-Corrections Project, American Correctional Association, 4321 Hartwick Road, Suite L-208, College Park Md. 20740, 1974.

This pamphlet summarizes the basic goals and procedures involved in MAP, describes the experiences of Arizona, Wisconsin and California with different MAP models, and provides sample MAP contracts from those 3 states. This pamphlet gives a good overview of MAP and some of the issues related to its use.

The Parole-Corrections Project has published a series of monographs related to MAP which may be of interest. They include:

The Mutual Agreement Project: A Planned Change in Correctional Service Delivery, Leon Leiberg and William Parker, American Correctional Association, 1973.

MAP Markers: Research and Evaluation of the Mutual Agreement Program, by James O. Robison, American Correctional Association, April 1975.

An Evaluative Summary of Research: MAP Program Outcomes in the Initial Demonstration States, by Anne Rosenfeld, American Correctional Association, July 1975.

The Legal Aspects of Contract Parole, U.C.L.A. Law School, American Correctional Association, 1976.

MAP with Vouchers: An Alternative for Institutionalized Female Offenders, by Leon Leiberg and William Parker, American Journal of Corrections, 1975.

Manual: The Planned Implementation of Mutual Agreement Programming in a Correctional System, by Stephen D. Minnich, American Correctional Association, 1976.

CHAPTER VI—RECOMMENDED READINGS

"A Time to ACT." Final Report of the Joint Commission on Correctional Manpower and Training. October 1969.

Reports the findings and recommendations based on the Joint Commission's three years of intensive research and study of correctional employees.

Deitch, David. "Evolution of Treatment Roles in More Recent Response to Addiction Problems." *Journal of Drug Issues* (April 1971): 132-140.

Reviews the recent drug treatment history, the role of the ex-addict and the professional. Focuses on the use and misuse of the ex-addict and the professional in treatment settings. Concludes that perhaps the greatest importance is the future structuring of programs that will allow for horizontal, diagonal, and vertical mobility for the ex-addict.

Korim, Andrew S. "Improving Corrections Personnel through Community Colleges." A final report under L.E.A.A. grant No. 71-DF-1096. August 1973.

Discusses the idea of improving personnel for line functions in corrections through programs in community and junior colleges. To insure that such educational programs are of the highest quality, reflect the needs of corrections, and have maximum impact upon the field of corrections, a number of standards are suggested.

"Offenders as a Correctional Manpower Resource." *Joint Commission on Correctional Manpower and Training,* American Correctional Association. October 1970.

Reproduction of the papers presented at a seminar convened by the Joint Commission on Correctional Manpower and Training. Includes the results of a survey of institutions made by the Joint Commission in 1967 which revealed that both adult and juvenile facilities are now using offenders, ex-offenders, and persons on parole or probation in numerous capacities.

"Perspectives on Correctional Manpower and Training." Staff Report of the Joint Commission on Correctional Manpower and Training. Washington, D.C.: January 1970.

Presents an overview of the manpower problems of contemporary corrections. The major objective of this report is to design strategies for the best utilization of correctional manpower.

"The Involvement of Offenders in the Prevention and Correction of Criminal Behavior." *Correctional Treatment.* Massachusetts Correctional Association, Bulletin #20. October 1970.

Focuses on the potential role of the offender in the prevention and correction of criminal behavior. This issue documents this trend and examines both its potential and limitations.

Wheeler, Charles E., and Jones, Lawrence K. "Training Former Incorrigible Inmates for New Careers as Correctional Counselors: An Evaluation." Paper presented to the Annual Meeting of the American Society of Criminology. November 1973.

Reports a treatment program in North Carolina using inmates formerly labeled as incorrigibles who had been trained as counselors, to work with other inmates in a therapeutic community yet to be developed.

CHAPTER VII—RECOMMENDED READINGS

"Bargaining in Correctional Institutions: Restructuring the Relation Between the Inmate and the Prison Authority." *The Yale Law Journal* 81 (1972): 727-757.

Attempts to develop a framework for understanding a system of control within prisons, and suggests a means of using that system of control to achieve more effectively the subtle and often incompatible goals of rehabilitation, institutional order, and protection from arbitrary punishment.

Ohlin, Lloyd E., and Lawrence, William. "Social Interaction Among Clients as a Treatment Problem." *Social Work* 4 (April 1959).

"Walpole, Prisoners' Statements." Walpole, Mass: November 1974. A statement put together by inmates at Walpole which discusses the nature, cause and cure of crime. Suggests that the creation of a prisoner-community program to cure crime in the community is the first step. Includes figures concerning the price of punishment.

CHAPTER IX—RECOMMENDED READINGS

Articles

Gottfredson, Don M.; Wilkins, Leslie T.; Hoffman, Peter B.; and Singer, Susan M. "The Utilization of Experience in Parole Decision Making." U.S. Department of Justice, L.E.A.A. Grant Number NI-72-0170-6. (November 1974).

Summary report of the Parole Decision Making Project. The aim of this project was the development and demonstration of model programs to provide information to paroling authorities for improving parole decisions by an increased utilization of experience in these decisions.

Moseley, William H., and Gerould, Margaret H. "Sex and Parole: A Comparison of Male and Female Parolees." *Journal of Criminal Justice* 3:1 (1975): 47-58.

Male and female parolees released in 1970 with a two-year follow-up were compared on three basic factors: personal attributes, time served, and parole outcome. The two sexes were substantially different in five commitment offenses, prior prison sentences, age at admission to confinement from which paroled, and alcohol and drug involvement. They were relatively similar in the proportion of prior non-prison sentences. Women, on the average, serve less time in prison before parole than men. The proportion successfully continued on parole is the same for both sexes.

Norton, Eleanor Holmes, Chair, New York City Commission on Human Rights. "Employment and the Rehabilitated Addict: Employment Experience and Recent Research Findings." Drug Abuse Council, Inc. (January 1973.)

This report was based on hearings held by the New York City Commission on Human Rights. This report focuses on the hearings designed to probe the employment problems of those who have a history of drug use. Emphasizes the need for such a special focus since drug offenders who have been "rehabilitated" all too often find it impossible to get a job.

Parker, William. "Parole." *Parole Corrections Project, Resource Document #1,* American Correctional Association. (May 1975.)

This report presents a summarization of the parole statutes in all fifty states, the Women's Board of Terms and Parole, the District of Columbia and Canada. The purpose of this document is to provide an information source concerning the parole process and its interrelationship with other agencies in the system, current practices and parole rules, statutes and regulations.

Smith, Robert R.; Wood, Larry F.; and Milan, Michael A. "Ex-Offender Employment Policies: A Survey of American Correctional Agencies." *Criminal Justice and Behavior* (1974): 234-246.

Reports that an April 1972 survey of 50 state correctional systems, the District of Columbia Department of Corrections, and the Federal Bureau of Prisons, indicated that 44 of the 52 agencies have dropped whatever prohibitions they may have had against the employment of ex-offenders.

Of these 44 agencies, 38 employed a total of 280 ex-offenders at the time of the survey. The most frequently stated point was the ex-offenders' familiarity with inmates and the criminal justice system and their resulting ability to communicate more effectively with inmates than with their non-offender counterparts.

Taggart, Robert. "The Prison of Unemployment: Manpower Programs for Offenders." 1972.

Books

Irwin, John. *The Felon.* Englewood Cliffs, New Jersey: Prentice-Hall, 1970

Written by an ex-con sociologist, this book traces the career of the felon from early environment to crime, to prison and parole, from the point of view of the felon himself. Concentrating on the obstacle course confronting the felon in his attempts to re-enter society, *The Felon* attests to the importance of the parolee-parole agent relationship and integrating treatment with aftercare in the community.

Pearl, Arthur, and Reismann, Frank. *New Careers for the Poor.* New York: The Free Press, 1965.

CHAPTER X—RECOMMENDED READINGS

Articles

Campbell, Donald T. "Reforms as Experiments." *American Psychologist* 24 (April 1969): 409-428. A widely cited and reprinted article on the need for controlled and quasi-experiments for evaluation when we try new methods of dealing with social problems. It includes descriptions of major types of design and statistical analysis in such evaluation.

Glaser, Daniel. *"Achieving Better Questions: A Half Century's Progress in Correction Research." Federal Probation* 39 (September 1975): 3-9. An article on the occasion of the 50th anniversary of the federal probation service that sets forth as the major lesson from reviewing correctional evaluation research in this period, that the most useful and cumulative knowledge will come from research designed to test explanatory theory on *why* a particular treatment should work best with a specific type of client.

Books

Adams, Stuart. *Evaluative Research in Corrections.* LEAA Prescriptive Package series. U.S. Government Printing Office, 1975. A general work on evaluation in all branches of corrections, with special focus on research administration strategies and tactics, and the author's impressions of their impact.

Caro, Francis G., Editor. *Readings in Evaluation Research.* N.Y.: Russell Sage Foundation, 1971. A good collection of articles on many aspects of evaluation research, but with most examples from outside the criminal justice system.

Glaser, Daniel. *Routinizing Evaluation: Getting Feedback on Effectiveness of Crime and Delinquency Programs.* NIMH Crime and Delinquency Issues Monograph Series. DHEW Publication No. (HSM) 73-9123. U.S. Government Printing Office, 1973. A "how to" manual focusing on making evaluation a routine part of correctional programs, and on integrating research with operations for benefit to both.

Rivlin, Alice M., and P. Michael Timpane, editors. *Ethical and Legal Issues of Social Experimentation.* Washington, D.C.: The Brookings Institution, 1975. An excellent collection of essays on the moral and legal problems that may develop in experimenting with humans, and on how to design and administer experiments so that these problems are avoided.

United Nations Social Defence Research Institute. *Evaluation Research in Criminal Justice.* Published by the Institute, at Via Guiluis 52, 00186 Rome, Italy, in January 1976. Proceedings of a conference on this subject with interesting contributions by people from many different countries.

Weiss, Carol H. *Evaluation Research.* Englewood Cliffs, N.J.: Prentice-Hall, Inc., 1972. A very concise and readable text discussing a large variety of issues, though with few of its illustrations from the criminal justice field.

CHAPTER XI—RECOMMENDED READINGS

"Federal Drug Abuse Programs." A report prepared by the *Task Force on Federal Heroin Addiction Programs,* Drug Abuse Council, Washington, D.C.: 1972.

Chapter five describes LEAA's method of operation and assesses its goals, programs, and administration of grants. Chapter six examines the processes and mechanisms which direct monies into all federal agencies involved in the drug abuse problem.

"Federal Strategy for Drug Abuse and Drug Traffic Prevention," Prepared for the President by the Strategy Council pursuant to the Drug Abuse Office and Treatment Act of 1972.

This report is the response to the Drug Abuse and Treatment Act of 1972 which directed the development of a long-term federal strategy for all drug abuse activities sponsored by the federal government. Pages 87 and 88 explain that whenever possible, programmatic decision-making and allocation of resources should be delegated to the state and local level. Federal strategy has facilitated this policy by asking the governor of each state to designate a Single State Agency to be responsible for coordinating all state drug abuse prevention efforts. The Single State Agency's responsibilities include the coordination of the overall drug abuse prevention effort among the various involved state agencies.

Glaser, Daniel. "Strategic Criminal Justice Planning." *Crime and Delinquency Issues,* National Institute of Mental Health, Center for Studies of Crime and Delinquency. Rockville, Maryland: 1975.

In this monograph Dr. Glaser explains that the primary sources of literature for most current training on criminal justice planning are public administration and business writings on the planning process. This creates a problem since this literature seldom gets to specifics when exhorting planners to think imaginatively. This monograph provides a supplement for such training literature by showing criminal justice officials more specifically what they can learn for policy-making and strategic planning from the social and behavioral sciences, especially sociology and psychology.

Warfel, Richard. "A Report of Treatment Programs in America's State Prisons." *Proceedings of the One Hundred and Second Annual Congress of Corrections of the American Correctional Association,* Pittsburgh, Pennsylvania: August, 1972, 42-57.

This article describes the importance of coordination between the correctional agency and the drug abuse agency on the state level. The author states that only when both groups are committed to the task of successful treatment in an organized and meaningful fashion can programs meeting the cliens' needs be developed. He presents the results of a questionnaire suvey mailed to 50 states. The data presented includes the degree of cooperation between the state drug abuse agency and department of corrections in providing services.

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PRESCRIPTIVE PACKAGE: "DRUG PROGRAMS IN CORRECTIONAL INSTITUTIONS"

To help LEAA better evaluate the usefulness of Prescriptive Packages, the reader is requested to answer and return the following questions.

1. What is your general reaction to this Prescriptive Package?
   [ ] Excellent [ ] Above Average [ ] Average [ ] Poor [ ] Useless

2. Does this package represent best available knowledge and experience?
   [ ] No better single document available
   [ ] Excellent, but some changes required (please comment)
   [ ] Satisfactory, but changes required (please comment)
   [ ] Does not represent best knowledge or experience (please comment)

3. To what extent do you see the package as being useful in terms of: (check one box on each line)

	Highly Useful	Of Some Use	Not Useful
Modifying existing projects	[ ]	[ ]	[ ]
Training personnel	[ ]	[ ]	[ ]
Adminstering on-going projects	[ ]	[ ]	[ ]
Providing new or important information	[ ]	[ ]	[ ]
Developing or implementing new projects	[ ]	[ ]	[ ]

4. To what specific use, if any, have you put or do you plan to put this particular package?
   [ ] Modifying existing projects
   [ ] Administering on-going projects
   [ ] Others:
   [ ] Training personnel
   [ ] Developing or implementing new projects

5. In what ways, if any, could the package be improved: (please specify), e.g. structure/organization; content/coverage; objectivity; writing style; other)

6. Do you feel that further training or technical assistance is needed and desired on this topic? If so, please specify needs.

7. In what other specific areas of the criminal justice system do you think a Prescriptive Package is most needed?

8. How did this package come to your attention? (check one or more)
   [ ] LEAA mailing of package
   [ ] Contact with LEAA staff
   [ ] LEAA Newsletter
   [ ] Other (please specify)
   [ ] Your organization's library
   [ ] National Criminal Justice Reference Service

(CUT ALONG THIS LINE)

9. Check ONE item below which best describes your affiliation with law enforcement or criminal justice. If the item checked has an asterisk (*), please also check the related level, i.e.

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[ ] LEAA Regional Office		[ ] Court *	
[ ] State Planning Agency		[ ] Correctional Agency *	
[ ] Regional SPA Office		[ ] Legislative Body *	
[ ] College/University		[ ] Other Government Agency *	
[ ] Commercial/Industrial Firm		[ ] Professional Association *	
[ ] Citizen Group		[ ] Crime Prevention Group *	

10. Your Name_____
Your Position_____
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