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Major Treatment Issues for Offenders Who Use Substances

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This distance learning course was developed for CEUMatrix by Ed Roberts, M.A, LCDC, CCJP. It is based on information found in the Treatment Improvement Protocol (TIP) Series 44 – *Substance Abuse Treatment for Adults in the Criminal Justice System. (*Center for Substance Abuse Treatment. *Substance Abuse Treatment for Adults in the Criminal Justice System.* Treatment Improvement Protocol (TIP) Series 44. DHHS Publication No. (SMA) 05-4056. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2005.)

Copies of this TIP may be obtained free of charge from SAMHSA's National Clearinghouse for Alcohol and Drug Information (NCADI), (800) 729-6686 or 240-221-4017; TDD (for hearing impaired), (800) 487-4889; (877) 767-8432 Hablamos Espanol, or electronically through the following Internet World Wide Web site: http://www.kap.samhsa.gov/ .

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About the Instructor:

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Major Treatment Issues for Offenders Who Use Substances

Introduction

While many similarities exist between substance abuse treatment for those in the criminal justice system and for those in the general population, people in the criminal justice system have added stressors, including but not limited to their precarious legal situation. Criminal justice clients also tend to have characteristics that affect treatment. These include criminal thinking and criminal values along with the more typical resistance and denial issues found in other substance abuse treatment populations.

Many offenders also have a long history of psychosocial problems that have contributed to their substance abuse: interpersonal difficulties with family members, difficulties in sustaining long-term relationships, emotional and psychological problems and disorders, difficulty managing anger and stress, lack of education and vocational skills, and problems finding and maintaining gainful employment (Belenko and Peugh 1998; Peters 1993). These chronic problems often are associated with reduced self-esteem, anxiety, depression, and enhanced expectations about the initial use of substances. Unsuccessful attempts at abstinence also tend to reinforce a negative self-image and increase the likelihood that offenders will use substances when faced with conflict or stress.

Part 1 addresses strategies for modifying substance abuse treatment services for criminal justice clients. Some of these strategies are underlying program components, such as incentives for program participation and emphasis on personal accountability; others are more directly related to clinical issues, such as intervening with criminal thinking and teaching basic problem solving skills.

While the suggestions offered here are applicable to many criminal justice clients, it is important to note that treatment approaches must take into account the unique situation of the offender and his stage in the recovery process. Treatment plans and assessments should be continually revised to reflect changes in the client's situation, such as recent relapses, continued sobriety, and improvements in mental and psychological functioning.

Certain criminal justice system populations may be recognized as having specific needs; it is recommended that whenever possible, treatment be modified to meet those needs. A thorough client assessment will enable treatment providers to determine what modifications to treatment are required. However, in order to

explain different types of treatment modifications and the need for those modifications it is necessary to group clients according to certain socially defined categories that mark their relationship to a dominant identity. Part 2 provides a basic overview of treatment needs of offenders belonging to subpopulations including women; men; violent offenders; gay, lesbian, and bisexual offenders; clients with physical and sensory disabilities; older adults; people with co-occurring mental and substance use disorders; people with infectious diseases; and sex offenders.

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- **Conclusions and Recommendations**

Part 1: Major Treatment Issues and Approaches

Clinical Strategies

Substance abuse counselors working with criminal justice clients are likely to face a host of challenges. Offenders may require help meeting basic life needs, such as finding housing, applying for a job, or cooking a meal. Moreover, counselors generally will have to motivate clients to find new ways to manage their feelings, control impulses, and work toward concrete goals. Confronting manipulation and setting boundaries are constant challenges for many substance abuse counselors who work with criminal justice clients.

This section discusses some of the issues that the counselor is likely to face, along with strategies for meeting those challenges. The second part of this chapter, "Program Components and Strategies" addresses a broader range of strategies.

Addressing Basic Needs

It is difficult to label any particular needs of offenders who abuse substances as more basic than others. Offender needs vary depending on issues such as their legal status, gender, culture, sexual orientation, age, and functional capacities. There are also significant differences in what an individual experiences in different criminal justice settings (i.e., jail, prison, community supervision). Despite these differences, there are commonalities in the treatment needs of offenders. In addition to substance abuse treatment, offenders typically require the following services:

- Detoxification
- Screening and assessment
- Treatment for co-occurring mental disorders
- Treatment for physical health issues
- Family-related services such as visitation, childcare, and reunification
- Case management
- Legal assistance
- Vocational skills development and employment

What varies from offender to offender is the emphasis placed on particular needs and the treatment and related services available to meet those needs. The following highlights some of the more salient issues offenders face—detoxification, homelessness, and life skills.

<u>Detoxification</u>
Even if a counselor does not perform screening and evaluation, he or she should be aware of the signs and symptoms of withdrawal. Sometimes offenders in need

of detoxification are not identified at intake because they lied about the extent of their substance use, there was no reason to suspect substance dependency, or withdrawal symptoms were mistaken for mental illness. Offenders who experience withdrawal without medical attention are at risk for serious health consequences, and withdrawal from some drugs (e.g., alcohol, barbiturates) even carries a risk of death.

Symptoms of withdrawal vary according to the substance abused, but signs that may be noted by the counselor include

- Anxiety, restlessness, irritability, panic attacks, insomnia
- Profuse sweating, muscle jerks, constant blinking
- Yawning, sleepiness, exhaustion, lethargy
- Depression, crying fits, disorientation
- Suicidal thoughts or behavior

For some drugs, symptoms of withdrawal can be prolonged. For example, the insomnia and anxiety common in people with benzodiazepine dependency can continue for months following discontinuation of use (Federal Bureau of Prisons 2000). For offenders undergoing treatment for withdrawal, the counselor should work closely with the medical team to ensure that symptoms are identified and treated.

For more on information on detoxification, see the CEU Matrix course "*Screening and Assessment of Clients in the Criminal Justice System*."

Homelessness

The impact of homelessness on offenders varies depending on the particular setting in which they are being treated. Jails frequently work with homeless offenders; in fact, some people enter jail to get food and housing (and may enter substance abuse treatment programs for the same reasons). Homelessness can be a traumatic experience, and for some clients who have had to live on the streets, jail may be the safest environment in which they have lived for some time. Those used to being homeless may need to relearn how to live their lives in a stable environment.

Some offenders may have become homeless because of their incarceration in jail or prison. Even if homelessness was not an issue when the offender was arrested, it is likely that an offender will be homeless upon release. In some instances, people who have served their full sentence (and therefore are not being released on parole) enter the community without aftercare options or any plan for housing.

Counselors should be aware that a great deal of stigma and shame is attached to homelessness, and many clients are reluctant to discuss it without prompting. One way to obtain this information is to ask offenders where they lived in the month prior to incarceration or arrest and if they anticipate being homeless upon their release. A plan should be in place to provide offenders with housing if they are leaving a prison facility. In all cases, effective counselors have working relationships with personnel in housing services to which to refer offenders in need of housing.

Life skills

Many offenders have hidden deficits in basic life skills; e.g., knowing how to balance a checkbook, prepare a meal, accept feedback from an employer. While these deficits are as individual as the offender, treatment programs with criminal justice clients should address a range of instrumental skills (e.g., meal preparation, money management, laundry, resume writing), as well as some basic social skills, particularly those needed in employment and other interpersonal situations. Counselors should observe offenders to identify problem areas.

Among the skills most underdeveloped in offender-clients are basic problem solving skills. Because of their impulsiveness and difficulty delaying gratification, many offenders are particularly poor at breaking down moderately complex problems into the few basic steps required to get from problem to solution. Practice is needed to learn clear problem identification, generation of options, thinking through likely outcomes, option selection, trying out options, and reviewing outcomes.

Advice to the Counselor: **Homelessness**

- Offenders should be asked where they lived in the month prior to arrest.
- If offenders anticipate being homeless when they leave the prison, a plan to provide offenders with housing should be in place before their release.
- Addressing deficits in basic life skills as well as housing issues can help prevent recidivism.

Addressing Criminality

Antonowicz and Ross (1994) address the need to prioritize treatment according to the criminogenic needs of criminal justice clients, particularly the specific issues that brought the client to the criminal justice system in the first place. These are most often substance abuse and criminal thinking and values. This section describes the components of criminality (i.e., criminal thinking, the criminal code, and manipulation), and suggests programmatic and clinical strategies for addressing criminality in substance abuse treatment for offenders.

Criminal thinking

A range of factors are associated with substance use among offenders, including peer substance abuse, impulse control difficulties, trouble managing negative emotions, poor problem solving and self-management skills, impaired moral reasoning, and cognitive distortions (Wanberg and Milkman 1998). As noted, criminal thinking is especially important to address, as individuals with ingrained criminal lifestyles employ a number of cognitive distortions or "thinking errors" (see Figure 1).

Offenders can learn to recognize thinking errors and to understand how those errors can lead to behavior that gets them into trouble (Wanberg and Milkman 1998). Strategies include

- Involvement in specialized therapeutic community (TC) programs
- Cognitive-behavioral group interventions focused on correcting and eliminating criminal thinking errors
- Self-monitoring exercises through keeping a journal and "thought logs"
- Staff and peer confrontation regarding criminal thinking patterns and related behaviors observed within treatment programs (Field 1986; Wanberg and Milkman 1998)

A number of approaches, drawing largely on cognitive-behavioral methods, have also been developed in recent years to address criminal thinking, the most popular among these being *Thinking for a Change,* issued by the National Institute of Corrections (NIC) (Bush et al. 2000), Gordon Graham and Company's *Framework for Recovery* (Graham 1999), and Wanberg and Milkman's *Criminal Conduct and Substance Abuse Treatment* (Wanberg and Milkman 1998). The core components of *Thinking for a Change* are described below. For more information on *Framework for Recovery*, go to www.ggco.com/. Wanberg and Milkman's module is available as a provider's guide and participant's workbook.

Figure 1 Common Thinking Errors

Power thrust	• Putting people down, dominating
Closed channel	• Seeing things only one way
Victim stance	• Blaming other people
Pride	• Feeling superior to other people
Don't care	• Feeling unconcerned about how other people are affected
Want it now	• Demanding gratification now
Don't need anybody	• Refusing to be dependent on others for anything
Rigid thinking	• Thinking in black and white terms
They deserve it	• Believing that people have it coming
Screwed	• Feeling mistreated

Source: Wanberg and Milkman 1998.

Thinking for a Change

NIC's *Thinking for a Change* helps offenders learn to change criminal behaviors using three basic techniques:

- *Cognitive self-change*. Offenders learn how to examine their thinking, feelings, beliefs, and attitudes in order to understand how these factors contribute to criminal behaviors.
- *Social skills development*. Participants explore alternatives to antisocial and criminal behaviors.
- *Problem solving skills development*. Offenders integrate the skills they learn and use them to work through difficult situations without engaging in criminal behavior.

Thinking for a Change is designed to work in a variety of criminal justice settings, and is ideally implemented in groups of 8 to 12. The curriculum is available online, along with more information (at www.nicic.org/pubs/2001/016672.htm).

Criminal thinking also can be addressed using the same paradigms used in substance abuse relapse prevention. Many of the early warning signs and risk factors for relapse will be the same or very similar to those warning signs and risk factors for the client's criminal thinking. It is important that the focus on addressing criminal thinking not become another way of stigmatizing criminal justice clients. Criminal thinking should be viewed as the outcome of maladaptive coping strategies rather than as a permanent fixture of the offender's personality.

Client manipulativeness

Criminal justice client manipulativeness can be addressed by identifying "criminal thinking errors" or one of the other, similar methods of identifying cognitive distortions (Wanberg and Milkman 1998). For example, a particular client may try to avoid the work of personal change by repetitively demeaning others, including the counselor. Another client may repetitively project an attitude of giving up at every small setback ("zero state"). These maladaptive and manipulative coping strategies readily undermine the treatment process unless they are addressed. Addressing client manipulativeness involves

- Counselor or treatment group identifying the primary thinking errors they observe
- Instructing the client to begin self-monitoring when these occur (journaling)
- Providing regular feedback to the client, usually from peers in a treatment group

Criminal code

Offenders tend to have a shared value system that includes refusal both to cooperate with authority and to confront negative behavior by others. This "criminal code" or "convict code" is another part of criminal thinking that must be addressed in treatment. The criminal code explains why good treatment programs stressing personal accountability, peer support for change, and peer confrontation of negative behavior are so threatening to the offender culture. It also explains why it is often necessary to separate inmates in treatment in correctional institutions from the general inmate population.

Treatment staff needs to pay attention to the extent to which their clients are being stigmatized by other offenders as "snitches" or "weak" because they participate in treatment. It is sometimes necessary to remove clients from a negative situation to give treatment a chance. Sometimes, a newer treatment group might be pressured to revert to the criminal code with antisocial values predominating over prosocial values. These situations require careful confrontation, limit-setting, and clear expectations with consequences by treatment staff.

Advice to the Counselor: Criminal Thinking

- Criminal thinking should be viewed as an outcome of maladaptive coping strategies rather than as a permanent fixture of the offender's personality.
- Criminal thinking can be addressed using the same tools as in substance abuse relapse prevention. This includes identifying offenders' primary thinking errors, instructing clients to self-monitor when these errors occur, and providing regular feedback from peers to prevent reversion to criminal behavior.

Addressing Anger and Hostility

Dealing with anger and hostility with criminal justice clients is much like dealing with anger and hostility with other clients. However, due to their higher incidence of antisocial personality disorder, criminal justice clients are more likely to use anger as a manipulative coping strategy and less likely to be able to separate anger from other feelings.

Clients may be angry for a variety of reasons, including

- Genuine feelings of being treated unfairly
- Limited affect recognition; confusing anger with other feelings
- Using anger to maintain adrenaline

- Goal-directed manipulative coping strategies such as deflecting attention from other issues or to keep others off-balance

Often, problems with expressed anger relate to an inability to express other feelings—a problem with affect. Interventions involve teaching criminal justice clients to recognize their affective states and to understand the difference between feelings and action. Many criminal justice clients (especially men) have limited understanding of and insight into what they are feeling at particular points in time. The counselor's goal, then, is to broaden affect (emotions) identification. For a surprising number of offenders, feeling states initially consist of "angry" and "other." Often, what they first think is anger turns out to be frustration, hurt, loneliness, fear, etc.

Offenders who abuse substances also have a tendency to think that if they feel it, they must act on it. Learning the relationships between behavior, thinking, and feeling, and how each affects the other, is helpful to many criminal justice clients. Learning that feelings do not equal thinking or behavior can be a revelation for many offenders. Counselors should point out that feeling it doesn't make it so, nor does it mean the client has to act on the feeling. As the Alcoholics Anonymous saying states, "Your feelings are not facts."

In summary, interventions addressing emotions should encompass

1. Identifying the feeling(s). Maybe other feelings are involved, such as embarrassment or guilt.

2. Understanding clearly where the feeling is coming from. What is the real source of the anger?

3. Identifying the goals the anger is serving (e.g., deflecting attention).

4. Identifying the goals the anger is undermining (e.g., staying out of jail or keeping a job).

5. Working toward taking the longer view (e.g., beginning to use a prosocial thought process to manage the anger).

Several additional strategies can help clients to recognize their feelings. For example, counselors can set boundaries on how anger and hostility can be expressed and set limits as to reasonable duration of expression of anger and hostility. Once the offender calms down, the counselor can refocus on what the client can learn from the situation and how the client can benefit in the future. Counselors can also use peers in a group setting to explore how the client might use anger and hostility for secondary gain. TC groups have "cardinal rules" that include no violence or threat of violence (justification for program removal if violated) that provide a safe environment for exploring anger issues.

Addressing Identity Issues

As offenders move through the criminal justice system, important elements in their identity can change. In the pretrial stage, their identity as a member of a racial or cultural group, a family member, or employee may be most prominent. In jails there is generally a more immediate crisis, as one grapples with the shame and stigma of being labeled a criminal and the fear of facing extensive incarceration.

Criminal identity

In prison, some people learn a new identity based on the prison culture in which they are involved; some prisoners learn to think of themselves as criminals. In part, this is a result of institutional pressures on them, and partly it is the result of interactions with other inmates who have accepted the persona of criminal. For offenders who enter community supervision programs on release from prison, embedded criminal identities can pose a number of problems.

Regardless of whether the offender is in jail, prison, or under community supervision, the identity of an offender often is an issue that needs to be confronted in treatment. Those who have adopted a criminal identity need to learn new ways of thinking about themselves; those whose identity is shaken by the incarceration will need help coping with their criminal charges. An overall rehabilitation goal is to help offenders develop more prosocial identities consistent with positive social values.

Cultural identity

Race and cultural background can play an important role in the life of offenders, but the dynamics of race and culture are especially pronounced in jails and prisons. In these settings, Caucasians often are in the minority for the first time in their lives. A number of subcultures are found within jails and prisons. Inmates who belong to minority groups may see correctional staff members (including treatment staff) as adversaries. Gangs represent the most significant of these subcultures, at least among male populations. Gang affiliation can influence with whom an offender is able to socialize. Thus, treatment must take into account this aspect of the offender's identity.

Role as a family member and/or parent

Family relationships are often an important part of an offender's life. Family can represent a connection to the outside world and can be a source of stability for offenders as they move through the criminal justice system. Moreover, the quality of the offender's relationship with his or her family can be an important factor in recovery. Slaght (1999) reported that the only independent variable related significantly to relapse at 3 months after release to the community was whether the offender was getting along with family members. Those who were getting along very well with family members were the least likely to use drugs. Based on

this, Slaght recommends more extensive efforts to involve family members in drug treatment.

Just as positive family relationships can foster abstinence, family connections also can be a source of confusion and worry for clients who see their role as a family member in conflict with their role as an inmate and/or criminal. This can be especially true for parents. According to the Bureau of Justice Statistics, in 1999 the majority of State and Federal prisoners reported having at least one child under the age of 18 (Mumola 2000). For many of these offenders, drug or alcohol abuse was a factor in their incarceration. For example, one in three mothers in State prison committed her crime to get money for drugs, and 65 percent reported drug use in the month prior to the offense. For both mothers and fathers, 25 percent met the diagnostic criteria for alcohol abuse (Mumola 2000). In a survey of female inmates, Acoa and Austin (1996) found that nearly 20 percent of mothers were concerned that one or more children may have been exposed to substances in utero.

Confronting the guilt associated with their drug abuse can be important in treating parents involved in the criminal justice system. These individuals often identify themselves as "bad" parents and experience a great deal of shame over how their involvement in the criminal justice system has impacted their children. While this may be especially true for mothers, fathers also have strong feelings about their role as parents and express concern about their children. Jeffries and colleagues (2001) reviewed several parenting programs for male offenders. Descriptions of these programs are available online at www.vera.org/publication_pdf/fathers.pdf .

Treatment that includes other family members can be of use. In some families, more than one family member is incarcerated; treating the family can address a generational cycle of incarceration. Family treatment also can prepare inmates and their families for release. Since family problems can be a relapse trigger, Slaght (1999) recommends that offenders learn how to identify and cope with family conflicts. Substance abuse treatment programs also can use family involvement as a source of motivation. For example, extended parent-child visits can be used as a reward for good behavior.

It is important to note that family involvement in recovery is not always positive. Inmates, especially those with moderate to longer sentences, often can develop a false sense of "healing" of family problems. This results from a number of factors including reduced and controlled contact with family members and the tendency of families to shelter the inmate from problems on the outside. This false sense that family relations have changed becomes a potential stressor on release, when the inmate discovers that the previously existing problems are still present and often worsened. It is also important to note that sometimes offenders use their families to provide them with drugs and to enable their substance abuse. Family members may also be involved in criminal activity and be

expected to carry on criminal activities such as drug dealing while one member is incarcerated.

Role as a person of status

Prisons and jails are hierarchical societies, and men and women can attain status within a prison or jail community often using a different set of skills and behaviors than they would use in the community. This is especially true in prisons where longer stays make status and belonging more important issues. Therefore it is possible that an offender may face a loss of status either by going to prison (and losing a job and a place in the community) or by being released from prison (where the individual may have been a leader). Providers also should be aware that the offender may have had high status and a large income on the "outside" because of criminal activity (e.g., drug dealing) and may need to deal with a loss of status when incarcerated or resist the temptation of returning to a high-paying but illegal occupation on release. In other instances, an inmate may carry status (e.g., as a gang member) into jail or prison, and may resist treatment in order to maintain that status. Regardless of the setting, treatment activities should include opportunities for participants to "earn" status in the program.

Advice to the Counselor: Family Involvement

- Involving the family in an offender's treatment can be a positive source of support. Unfortunately, however, some family members may provide offenders with drugs and be involved in criminal activity. Inmates can develop a false sense of "healing" of family problems from having reduced and controlled contact with family.
- Extended family visitation can be used as a reward for good behavior.
- On release, inmates often find that preexisting family problems are still present and often worse.

Addressing Denial

Criminal justice clients exhibit denial in ways similar to those of other populations. For some offenders, denial is a product of their criminal thinking. The criminal justice system may help reduce denial—it is harder for an offender to deny that drugs are a problem while sitting in a cell. Treatment staff can remind clients of the reality of their legal problems as a way to break through denial.

While substance abuse treatment providers often are trained to view denial as a negative symptom of the offender's addiction, denial may be a necessary strategy to further the offender's legal goals. In some situations, offenders have incentives to admit to a substance use disorder even if they do not have such a

disorder, so that they can avoid prison and enter a treatment program instead. Admitting to substance abuse can have legal consequences for the offender that need to be understood by treatment providers before they ask an offender to self-identify as an "addict" or "alcoholic." It should also be noted that there are offenders who use or sell substances but do not have a substance use disorder.

Denial of criminal activity is a different, but related, issue. People may deny criminal activity even if they have dealt with their substance abuse. Just because an offender is in recovery from substance abuse does not mean he or she has ceased criminal activity. Treatment providers also will find that some offenders do not believe that what they have done is criminal or, at least, do not believe it is immoral. Some (e.g., gang members) perceive their actions as a normal part of daily life in their community and believe that the only problem was that they got caught. They see themselves as victimized by the law, rather than as victimizers. Others admit their substance abuse and even realize that they must cease criminal activity but deny that they have to change their lifestyle (e.g., their associations, the place they live), which can contribute to relapse.

Addressing Resistance

Sending criminal justice clients to treatment under threat of direct consequences with little incentive and loss of freedoms is not effective coercion. However, coercion can be very effective at getting criminal justice clients to treatment and keeping them there (Leukefeld and Tims 1988). This is best done using incentives as well as sanctions and involving some degree of choice by the client, even if leverage is present to encourage the client to make the desired choice.

When dealing one-on-one with the criminal justice client on this issue, the following strategies are suggested:

- Avoid personalizing the situation and focus on the client's role in forcing the consequence. For example, avoid phrasing that sends the message "I'm doing this to you." Say things such as "You sort of forced the judge into giving you this consequence for using again."
- Focus the client on the future and what she can learn from the current situation.
- Be aware of cultural differences. Clients have culturally based attitudes toward authority that can affect how they respond to coercion in treatment. For example, confrontational treatment modalities may not be helpful for American Indians (Vacc et al. 1995).
- Approach clients with sensitivity, understanding, and honesty. This includes paying careful attention to body language, eye contact, and tone of voice.

Guilt and shame may also be a major consideration for some criminal justice clients. Offenders new to the criminal justice system, particularly first-time offenders who have recently lost much of their social standing, may struggle with guilt and shame. In some cases these feelings are realistic and may facilitate treatment, but in other cases they may be exaggerated and interfere with substance abuse treatment until they are adequately processed. As noted above, many offenders experience a significant amount of shame over their actions even if they are not willing to show it. Those who do not may either have an antisocial personality disorder (ASPD) (see below for more information) or come from criminally involved family or social networks where criminal behavior is expected and approved; those clients may still feel shame, but it could be because they "messed up" and got caught.

Shame can be healthy, if it can motivate people to change their lives. Making amends can be a positive way to address guilt and shame and further treatment goals. Talking about feelings of guilt and self-loathing can also help an offender reduce feelings of hostility and anger. Shame and guilt, however, can also fuel denial and can make some individuals more prone to violence in order to cover up their feelings of shame. In general, female offenders face more shame than men or are, at least, more conscious of the shame they feel.

The stigma associated with criminal behavior and substance abuse also can be very powerful but is less useful as motivation for clients. The criminal justice system does much to stigmatize the offenders in the system, and the people involved in that system (whether they be corrections officers or inmates) often reinforce guilt, shame, and stigma. Stigma also comes from outside the criminal justice system (e.g., family, mass media, and society). While it is important for offenders not to forget their past, it is not necessarily helpful that society does not allow people to move on or accept that they have paid their debts. It is also important for offenders to have appropriate role models who have overcome the stigma of a criminal past and a history of substance abuse in order to achieve something in their recovery.

Advice to the Counselor: Addressing the Coerced Client

- Approach coerced clients with understanding and honesty, paying careful attention to body language, eye contact, and tone of voice.
- When dealing one-on-one with the coerced client, focus on the client's role in forcing the consequence, with statements such as "You sort of forced the judge into giving you this consequence for using again."
- Focus the client on the future and the difference treatment can make.

Sealed Records

A criminal record follows offenders long after they serve their time in prison. Many recovering individuals find that, despite their best efforts, the stigma of their criminal records limits their options. A 2001 CSAT initiative, Rehabilitation and Restitution, contains a component to help recovering offenders get their criminal records sealed. Additionally, participating programs may offer

- Comprehensive assessments
- Individualized service plans
- Case management
- Continuum of substance abuse treatment services
- Support in obtaining a GED or other necessary education
- Job training, placement, and retention programs
- Continuum of supervision, aftercare, and continuing care programs

CSAT's cooperative agreement initiative is aimed at improving the likelihood of successful reintegration. Programs funded through the initiative will compare the success rates of those who receive additional assistance with those who receive whatever help is usually offered to recovering offenders.

While there has been some reduction of stigma attached to substance abuse and mental illness in recent years, the stigma associated with arrest, conviction, and incarceration remains very strong. Societal change occurs slowly, but treatment providers can help the situation by not burdening clients with additional stigma because they are involved in the criminal justice system. If crime is part of addictive behavior, then criminal behavior can be seen as another manifestation of a substance use disorder. Treatment providers need not condone an offender's past criminal activity, but they should be able to accept it as part of the client's past and not a permanent character flaw or insurmountable obstacle to recovery.

Establishing Boundaries

Counselors' methods for establishing a relationship with clients vary according to the setting. It is much more difficult to develop a relationship in prisons or jails than in the community because boundaries and rules limit how psychologically close one can get to incarcerated offenders. For example, while eliciting emotional responses is quite useful in psychotherapy, corrections staff generally see this as a problem to be avoided. In these settings there needs to be careful supervision to evaluate how closely counselors and clients are interacting.

Because boundaries between staff and clients have a special significance in criminal justice settings, treatment staff need to be especially vigilant about self-disclosure. The counselor needs to ask him- or herself whether a personal disclosure is going to make a difference for the client and not just for the counselor. For example, using one's personal experience as guiding life lessons can add credibility and be helpful on a more personal level, but recent experiences that may expose too much vulnerability should be avoided. Also, recovering staff in TCs who often share personal experiences have found the practice to be beneficial when balanced with appropriate boundaries. Counselors also should not associate with clients to the detriment of their relationship with corrections and treatment staff; no matter how much empathy they feel toward offenders, counselors need to remember that they represent the criminal justice system. Offenders are often deft at conning a counselor into doing small and seemingly meaningless things for them, but this is often the first step in an unhealthy alliance that can be used against the counselor at a later date. Alternatively, a well-trained counselor can often confront the offender and turn the attempted manipulation into a step in developing a stronger treatment alliance.

Advice to the Counselor: Establishing Boundaries

- No matter how much empathy they feel for offenders, counselors need to remember that they represent the criminal justice system.
- Counselors' self-disclosures can be helpful when balanced by appropriate boundaries.
- Offenders are often deft at conning a counselor into doing small and seemingly meaningless things for them, but this is often a first step in an unhealthy alliance that can be used against the counselor at a later date. A well-trained counselor can confront the offender and turn the attempted manipulation into a step for developing a stronger treatment alliance.

Creating a Therapeutic Alliance

While it is not always easy, given the boundary issues that exist in criminal justice settings, the creation of a therapeutic alliance is very important when working with this population. Of course, the ability to create this alliance and its relative importance varies according to staff ability, experience, and training. In jails, it may be less crucial because clients may remain in treatment only a short time. It may, however, be most critical in community supervision settings if clients are engaged in outpatient treatment. In residential programs, such as therapeutic communities, peers play a larger part in the treatment experience, and the client's relationship with his or her peers is often as important as or more important than the relationship with the counselor.

Relationships with criminal justice staff are often quite important in the therapeutic process. This is especially important for offenders under community supervision, as their alliance with their probation or parole officer is critical. In a prison or jail setting, it also helps to include corrections staff as part of the treatment team, but clients should be told if this is going to be the case. When probation officers or corrections staff members are part of the treatment team, roles need to be very clearly defined. Because they may lack experience in treatment, corrections officers can become too involved in the treatment process and become overly distraught over treatment failures. In order to operate within a prison or jail, corrections staff need to maintain a certain degree of distance from offenders as well as keep their respect. Treatment programs that are going to involve corrections staff or probation officers should provide extensive cross-training between corrections and substance abuse treatment staffs. The legal issues surrounding confidentiality, for example, are a suitable subject for cross-training.

Striving for counselor credibility

Counselors working in any treatment setting need to maintain credibility with their clients.

If offenders believe that treatment staff is competent, they will be more influenced by the treatment and less likely to return to incarceration. Research by Broome and colleagues (1996*a*) showed that high self-esteem and high ratings of counselor competence were associated with a significant reduction in recidivism by probationers ending their treatment. Strauss and Falkin (2000) found similar results with a cohort of female offenders. Their data indicate that clients who successfully completed treatment had more favorable perceptions of staff within the first 2 weeks of treatment than those who did not.

Striving for cultural competence

Cultural competence is an important factor in developing a counselor-client relationship. Programs should have a culturally diverse staff that reflects the diversity of the population they serve; however, that is not always possible. What is possible, is to train the staff to understand cultural issues affecting the populations in the area in which they work. Cultural issues reflect a range of influences and are not just a matter of ethnic or racial identity (e.g., Ohio prisons have a large number of inmates from Appalachia, and staff there need to understand that culture). Special training programs can be developed to help counselors attain cultural competence for the cultures the agency serves.

Advice to the Counselor: Establishing Counselor Credibility

- Avoid making promises that you foresee being unable to keep. If you are unable to keep a promise, be clear as to why you cannot do so and accept the consequences.
- Demonstrate the attitudes and behaviors you are trying to get clients to implement (credible staff are those who do as they say).
- Show a positive attitude toward colleagues, the program, one's family, and so on.
- Work to have the client respect who you are, even if he does not like what you represent.
- Ensure that you maintain the respect of your supervisor and other staff (including corrections officers and probation officers). Credibility with offenders is affected by their observations of the counselors' interactions with other staff, and clients do watch staff closely.
- Clearly articulate roles and boundaries. Inmates often see treatment staff as potential inroads into all areas ranging from personal property issues, to job assignments, to case management concerns. Treatment staff needs to clearly define their role and limits or they quickly find their credibility lost because inmates interpret the staff's inability to correct a nontreatment issue as a lack of concern or caring.

Designing Treatment to Reflect the Stages of Change

Counselors with criminal justice clients often find they spend much of their time working in the precontemplation and contemplation stages. This can be discouraging to some, but the trade-off is that this is important work that reduces both crime and the number of crime victims, in addition to rehabilitating offenders.

Figure 1-2. Strategies for Working with Offenders Based on Their Stage in Recovery

Stage	Description	Strategies
Precontemplation	Unaware of substance abuse problems	Instill discomfort in a supportive manner. Increase the client's ability to recognize problems with current behavior and dissonance with future goals.
Contemplation	Awareness of substance abuse problems	Tip the balance. Elicit from the client the reasons to change, and the risks of not changing. Support prosocial thinking from the client.
Preparation	Decision point	Plan the action. Help the client determine the best course of action. These plans are individualized as they vary considerably from client to client.
Action	Active behavior change	Help the client take steps toward change. Begin shifting from external motivators to internal motivators by supporting the client's self-efficacy for change.
Maintenance	Ongoing preventive behaviors	Relapse prevention focusing on coping mechanisms and avoidance of triggers. Monitoring of attitudes and behaviors that can lead to relapse. Assisting the client in making lifestyle changes and encouraging the client to assist others who are in the recovery process.

Program Components and Strategies

The initial goals of substance abuse treatment are to "get them there" (engagement) and to "keep them there" (retention). This section addresses programmatic strategies to foster both engagement and retention and discusses other program components that promote effective substance abuse treatment for criminal justice clients.

Engagement

Arrest and incarceration can provide an important opportunity to identify substance abuse and other psychosocial problems, to provide stabilization of acute needs (e.g., detoxification from alcohol or opioids, medication for psychotic or depressive symptoms), and to engage offenders in substance abuse treatment services (Peters and Kearns 1992). Jails, prisons, and community diversion or supervision programs often serve as the first point of contact for offenders who have substance abuse problems. Motivation to enter treatment frequently occurs at particularly stressful times such as after being arrested, after one's children have been removed by authorities, or following an overdose or a "bad high." Substance abuse treatment staff needs to watch for these opportune times and respond quickly so that the client can be engaged in treatment while the motivation is still strong. Most of these individuals have not had previous contact with substance abuse treatment agencies, and their first involvement in treatment services is frequently while in jail or prison (Mumola 1999).

Program incentives and sanctions to encourage engagement

In the community, the usual sanction for refusing to participate in treatment is loss of freedom—often incarceration. In jails and prisons it usually involves longer incarceration times. At the point of decision of whether or not to participate in treatment, the offender usually faces more sanctions than incentives to participate, and the sanctions may be severe.

A key point in "getting them there" is to be sure that disincentives to program participation are minimized. For example, if offenders lose freedoms or have worse housing (in institutions) as a result of program participation, many will not give treatment a chance.

Enhancing motivation

While legal pressures may be sufficient to get a client into treatment, engagement is necessary if the client is to become motivated to commit to change and maintain recovery (Hubbard et al. 1988). Therefore, treatment programs need to be aware of the common characteristics of clients who leave treatment early and use this knowledge to develop approaches that motivate these clients to stay in treatment.

In a study of offenders on probation, Broome and colleagues (1996*a*) looked at three client background factors that are associated with treatment outcomes to see if they had an effect on establishing therapeutic relationships. Recognition of the existence of a substance abuse problem was associated with a positive therapeutic relationship and engagement in treatment, while the degree of peer deviance in the client's social network and family dysfunction was not. The fact that recognition of substance abuse problems was a positive indicator for successful engagement in treatment lends support to the use of motivational

approaches that help the client recognize he or she has a problem with substance abuse.

Effective Use of Coercion at the Program Level

"Coercion" means using incentives and sanctions to encourage program participation. In some jurisdictions, coercion may come in the form of legal mandate to treatment. This rarely affects offenders already sentenced to prison, but it often affects clients under community supervision who may need to be involved in treatment as part of their probation or parole. Clients under community supervision also may elect to enter treatment to avoid harsher alternatives (such as involuntary admission into a mental hospital) or negative repercussions (such as losing custody of one's children). Individuals convicted of driving while under the influence may be required to complete a psychoeducational class to retain their driver's license. The California initiative known as Proposition 36 offers a choice between incarceration and probation with substance abuse treatment to first- or second-time offenders convicted of nonviolent drug possession charges. Arizona has enacted a similar law, and other States have them under consideration. Offenders may also receive pressure from other governmental agencies (e.g., child protective services agencies) to enter or continue treatment, as part of community supervision or while in jail or prison. Not all forms of coercion are explicit for clients involved in the criminal justice system; people may receive reduced sentences or avoid incarceration in a higher security facility if they enter treatment.

Does Coerced Treatment Work?

In a review of 11 coerced treatment studies conducted over 20 years, Anglin and colleagues (1998) found that, while coercion was generally effective, the results were far from unequivocal, with five studies reporting that coerced clients did better, four studies reporting no difference, and two studies reporting that the coerced clients did worse. It is important to note, however, that in the 11 coerced treatment studies reviewed, none directly assessed the motivation of the clients (Farabee et al. 1998). In most cases, involuntary or coerced status of clients was inferred from criminal justice status at intake. Many clients whose treatment was coerced say they would have entered treatment without legal pressure to do so (Marlowe et al. 1996). Only about a third of those who entered coerced treatment for cocaine abuse said that legal coercion was a reason for entering treatment. Rather, psychological, financial, social, familial, and medical pressures exerted more influence in the decision to enter treatment (Marlowe et al. 1996).

While some critics have argued that treatment will be ineffective unless a client is motivated to change his or her substance abuse behavior, treatment itself can alter the client's motivation. In fact, an important indicator of an effective program is its ability to engage and retain clients who initially join under coercive

pressures. The major difficulty, then, is often a matter of getting resistant clients to enter treatment, and coercion has been shown to increase the likelihood of an offender's entering treatment (Anglin et al. 1998).

Coercion such as that from the criminal justice system can play an important role in making sure the client enters treatment, but it will be internal motivation that predicts whether the client will stay in treatment and have a positive outcome. Knight and colleagues (2000) showed that external legal pressure and internal motivation are positively and independently related to retention in treatment. The authors recommend targeting those with low internal motivation for an intervention to increase readiness.

Research also suggests that in the absence of leverage imposed by the criminal justice system, offenders have a poor record of retention and graduation from substance abuse treatment programs. Moreover, outcomes for offenders who receive coerced treatment are as good as or better than for other participants in treatment (Hubbard et al. 1988*a*; Miller and Flaherty 2000). Leverage through the criminal justice system also helps retain offenders in treatment over time (Miller and Flaherty 2000), which tends to reduce the rate of criminal recidivism.

Retention in Treatment

Roberts and Nishimoto (1996) studied retention in treatment among a group of women who were cocaine dependent, many of whom were under criminal justice supervision. The type of treatment services provided to the women made the largest difference in retention. The authors concluded that the intensity of the treatment, its structure, and the existence of woman-focused programming engaged the clients. However, greater levels of severity of a substance abuse problem also predicted shorter stays in treatment, and previous substance abuse treatment increased slightly the risk of dropping out.

Other research has shown that early dropout from treatment in criminal justice settings is correlated with having a history of psychiatric treatment, high levels of anxiety and depression, unemployment immediately prior to sentencing, cocaine dependence, lower levels of self-efficacy, and social networks that demonstrate low levels of social conformity (Hiller et al. 1999*b*). These authors found that the strongest predictor of treatment dropout was a high score on a criminality classification system they developed based on the Lifestyle Criminality Screening Form (Walters et al. 1991) that measured aspects of an offender's lifestyle related to criminality (e.g., irresponsibility, self-indulgence, interpersonal intrusiveness, social rule-breaking). Lang and Belenko (2000) found that offenders in a diversionary treatment program for felony drug offenders who completed treatment had higher levels of social conformity and more friends, fewer drug felony convictions, less involvement in psychiatric treatment, less income from drug dealing, less unprotected sex, and fewer injuries from gunshots or stabbings.

While many of the factors that correlate with treatment dropout cannot be altered, some changes to treatment programs can be developed based on these studies. For one, there seems to be general agreement that a client's friends can have a good deal of influence on whether that person will successfully complete treatment. Developing positive peer networks should therefore be a priority for retaining offenders in treatment.

A history of co-occurring mental illness, as demonstrated through a history of mental health system involvement, can have a significant negative effect on treatment retention. High rates of co-occurring mental illness have been documented in the offender population (estimated to be 7.4 percent in Federal prisons, 16.2 percent in State prisons, and 16.3 percent in jails) (Ditton 1999), suggesting a need for treatment programs tailored for offenders with co-occurring disorders in order to reduce dropout rates.

Coerced individuals should be mainstreamed with noncoerced clients where possible—such as in community settings—and should not be separated into different treatment tracks. Coerced treatment is much less likely to work if only similarly coerced individuals participate in the program. Because research showed that coerced treatment can be effective under some circumstances, some criminal justice systems developed new programs for these clients that did not build on existing programs; clients in these programs do not seem to have fared as well because they lacked community support from clients who were committed to treatment. It is not always clear that treatment models are followed accurately (Farabee et al. 1999). Administrators should avoid creating coercive programs with minimal resources.

There is a risk that treatment could become overly coercive and susceptible to charges of cruel and unusual punishment. It is important that participants in treatment be offered the opportunity to leave the program after a minimum time period (e.g., 90 days). The use of experienced outside contractors and recovering staff can help reduce the mistrust.

Incentives and sanctions to improve retention

Once the offender enters treatment, more options usually become available for creative use of incentives and sanctions to keep the offender in treatment. It is important to continue to push for a preponderance of incentives over sanctions to motivate offenders (Gendreau 1995). Because of the manipulative coping strategies and evidence of criminal thinking that bombard treatment staff daily, it is all too easy to focus on the negative behaviors instead of "catching people in the act of doing good work." But positive reinforcement is relatively more powerful than sanctioning in changing behavior as well as other aspects of personal growth.

The types of incentives to use are limited only by creativity. Beyond reduced supervision, other incentives can be greater access to other services (e.g.,

employment training or improved housing), higher status within the treatment group or community, or even variations on a token economy can be considered. The point is to continue to refocus on reinforcing desired behavior, look for additional ways to motivate the clients from a positive perspective, and to remember that most people begin and sustain personal change out of external motivation (the internalized motivation comes later).

The key points in effective use of incentives and sanctions are:

- Emphasize incentives over sanctions. Gendreau (1995) has suggested that 4:1 is optimal.
- Sanctions should be applied as rapidly as possible. The longer the time period between the undesired behavior and the consequences, the less effective the consequences.
- Repetitive use of mild sanctions (implemented quickly) is more effective than repetitive threats of sanctions followed by an intensive sanction (e.g., incarceration).
- Be creative with incentives.
- Treatment staff and criminal justice staff should collaboratively apply incentives and sanctions.

Prosocial Activity

Prosocial activity is any positive activity. In other words, criminal justice clients will do better in treatment when kept busy doing any positive activity. Most criminal justice clients tolerate boredom poorly. This is probably partly due to the high incidence of antisocial personality disorders and attention deficit disorders within this population (Jemelka et al. 1994; Wender et al. 2001). Offenders tend to demonstrate high excitement needs coupled with poor delay of gratification (Field 1986). Without positive activity, criminal justice clients tend to use unstructured time for antisocial thinking and behavior. Therefore, regardless of content, treatment programs need to be heavily structured, particularly for clients who are early in the change process.

Staff Modeling Accountability

Criminal justice clients are particularly sensitive to what staff actually does, in contrast to what staff says. Words about personal accountability with this population will have only modest impact unless staffs are willing to model the behavior and hold themselves to the same standards. The modeling of this behavior, of insisting on demonstrating one's accountability instead of waiting for others to demand it, can be very powerful in helping criminal justice clients' change. This is another point of collaboration between treatment staff and criminal justice staff, as both need to model personal accountability in their behavior.

Peer Support and Feedback

Peers usually have more opportunity than staff to observe each other's behavior. Peers using a group treatment modality have the capacity to give more immediate feedback for positive steps to change and for negative thinking and behavior. Peers can often give feedback in ways that the client can more readily assimilate. Criminal justice clients often quickly and accurately see the relapse signs in others well ahead of the time they are able to see relapse signs in themselves. Using peer support and feedback also serves to prepare incarcerated criminal justice clients for using peer support organizations in the community.

Program Phasing

Many criminal justice clients have little experience with success with prosocial endeavors. Dividing programs into identifiable phases can provide markers of accomplishment and progress and focuses treatment efforts at steps along the way. Typically, residential programs include orientation, treatment, and reentry phases.

Self-Management Skills—Relapse Prevention

Once personal change occurs during treatment, a sustained effort is required to maintain that change, namely relapse prevention and recovery planning. Relapse prevention is "a systematic method of teaching recovering patients to recognize and manage relapse warning signs" (Gorski and Kelley 1996, p. 15).

There are several advantages to using relapse prevention as a general approach throughout criminal justice programs:

- *Relapse prevention is a key issue for community supervision.* Beyond the obvious applicability of self-management training to offenders, this work provides key information to parole and probation officers. If the supervision officer knows that a primary overt relapse sign for a particular offender is isolating in his room, for example, the officer has critical supervision information. Knowing an offender's early warning signs for relapse is probably as important to supervision as employment and living situation.

- *Relapse prevention emphasizes taking responsibility for oneself*. Relapse prevention work makes it difficult for the offender to blame others. Self-management training puts responsibility squarely on the individual. The occurrence of a partial or full relapse is a signal that the individual has more work to do in developing or performing his own relapse prevention and recovery plan. Relapse prevention work, then, can be a primary means of moving from necessary external controls (on the offender) early

in treatment to the needed internal controls (from the offender) later in treatment.

- *Relapse prevention work emphasizes the long-term nature of many disorders.* Many major life problems, such as addictions, are life-long problems, requiring continuing work by the individual. The concept of relapse prevention implicitly communicates this point to criminal justice clients.

- *Relapse prevention work is easy to communicate.* Warning signs in the individual's behavior, and specific actions by the individual in response to those signs are easy to communicate between corrections program staff, offenders, supervision officers, and others in the offender's support network. Relapse prevention plans aid communication from institutional programs to community supervision and to community programs.

- *Relapse prevention is applicable across theoretical perspectives.* Practitioners from the theoretical perspectives of behaviorism and disease concepts are currently using relapse prevention and recovery planning techniques with equal facility. Relapse prevention strategies seem to ring true regardless of beliefs about the etiology of addictions or criminality.

- *Relapse prevention is a unifying concept across programs.* Whether the problem is alcohol abuse, drug abuse, mental illness, sex offending, or criminality generally, the same basic process seems to occur in relapses, and the same basic strategies seem to be needed in recovery. Relapse prevention work therefore offers a unifying concept and means of communication across types of programs and service populations.

Spiritual Approaches

Spiritual approaches have been used in combination with substance abuse treatment services and can provide powerful tools for some to achieve sustained abstinence. There are, however, limitations to what can be done in a public institution such as a jail or prison. While a distinction should be made between "spiritual" and "religious" practices (the former being concerned with one's own identity and a connection to a greater whole, the latter involving the formal practice of a system of beliefs), such a distinction is not always perceived by criminal justice authorities. Because of issues concerning the separation of church and State, it can be difficult for treatment programs to provide any kind of specific religious activities. However, treatment providers can refer clients to the religious leaders of their choice for additional counseling. Treatment programs can also accommodate voluntary 12-Step groups that do not explicitly endorse any one religion.

To provide inmates in jails and prisons with opportunities for spiritual growth, programs can be creative to avoid promoting religion while still facilitating spiritual practices. Some spiritual practices, such as American Indian sweat lodges, have been instituted on the grounds that they are an important cultural activity. Some prison programs use rituals to mark certain events (which provide a way for people to express themselves without using words). Rituals and ceremonies, even if they are as simple as having a meal together, can be very important for these clients because they do not have positive rituals in their lives. The only ceremonies they may have experienced may revolve around gang activity or substance abuse. Other suggestions for promoting spiritual practices include designating an area for meditation and acknowledgements of achievements. Providing a place for such activities is an important step in promoting them. It can also be helpful to schedule times for meditation or silent reflection.

The offender-client should be encouraged to become involved in the spiritual and religious practices with which he or she is most comfortable. Jails and prisons should enable offenders to receive spiritual guidance from religious figures of all persuasions. Clients should be encouraged to connect with the religious or spiritual tradition with which they associate most closely and to think about how that tradition can help them understand their own lives and what may be missing in them.

Interest in faith-based substance abuse treatment programs has opened avenues for treatment improvement that have been less accessible. Many of the "transformational" aspects in religion are similar to effective treatment components, especially relevant in self-help and therapeutic community approaches. Some examples of the common elements include the concept of transformation, credible role models, behavioral rules, the centrality of positive social values, community membership and participation, rituals and celebrations, and stages of change. In addition, consideration of a faith-based perspective offers additional support for treatment that is not usually considered, such as inviting an offender's church of choice to consult and provide resources for the postrelease planning process.

Advice to the Counselor: Spiritual Approaches

- Spiritual approaches can provide powerful tools for some to achieve sustained abstinence. Counselors can refer clients to the religious leaders of their choice for additional counseling, or to voluntary 12-Step groups that do not explicitly endorse any one religion.
- Rituals and ceremonies can be used to mark positive events.

Part 2:
Adapting Offender Treatment for Specific Populations

Treatment Issues Related to Cultural Minorities

There is no denying that the ethnic and cultural composition of offender populations is quite different from that of society as a whole. African Americans are disproportionately represented in jails, prisons, and community supervision programs in comparison with their numbers in the general population. They represented 39.2 percent of the jail population and 44.1 percent of the prison population in 2003, 41 percent of those on parole, and 30 percent of those on probation. According to the 2000 Census, however, those who said they were African American alone or in combination with one or more other races represent only 13 percent of the U.S. population. Hispanics/Latinos, of any race, are also somewhat overrepresented, representing 15.4 percent of the jail population and 19.0 percent of the prison population in 2003, but only 13.3 percent of the U.S. population according to 2002 Census data (Ramirez and de la Cruz 2002). Caucasians are underrepresented at each stage of the criminal justice process, making up only 43.6 percent of the jail population and 35 percent of the prison population in 2003, 40 percent of those on parole, and 56 percent of probationers in 2003, but 77.1 percent of the U.S. population (Glaze and Palla 2004; Harrison and Beck 2004; Harrison and Karberg 2004; U.S. Census Bureau 2001).

McKean (1994) summarizes four somewhat overlapping theoretical perspectives to explain why certain racial or ethnic groups are overrepresented among offenders:

- Social isolation
- Social disintegration
- Resource deprivation
- Violent cultural orientation

These theoretical stances inform substance abuse treatment as well. The social isolation model states that the dominant group will always choose to maintain a social distance between itself and minority groups, and to this end may employ discriminatory laws and policies. Social disintegration models look at how weakened informal and institutional social controls lead to increased crime. The resource deprivation theory emphasizes that economic variables such as unemployment, poverty, and income inequality are associated with crime. The idea of a subculture of violence implies that violent interactions are more accepted among some groups than others, for example in gang culture.

In a study of Alaska Native men, Glass and Bieber (1997) found criminal activity to be related to social disintegration caused by acculturative stress. This stress

develops when members of a minority culture are pressured to adapt to a dominant culture. The bicultural individuals in their study had the highest levels of acculturative stress and violent behavior and seemed more prone to identity issues, unstable interpersonal relationships, and unstable emotions. The authors surmise that these individuals are not accepted in either culture and that their efforts to walk in both worlds contribute to their stress.

CCJP.com will be developing coursework that provides detailed information on adapting treatment to specific cultural populations, and, while it is not oriented toward offenders in criminal justice settings, much of what it has to say will apply here as well. There are not, however, many culturally specific programs operating in the criminal justice system, and there also are limited data concerning the benefits of culturally competent services in these settings. This is certainly an area that requires more research.

Longshore and colleagues (1998) have studied treatment motivation among African-American detainees who used drugs and had never been in substance abuse treatment. Of all the factors they studied, "problem recognition" was most clearly associated with motivation for treatment, and that recognition was strongest among those who more strongly endorsed Afrocentric values such as community, spirituality, collective self-esteem, and conventional family roles. Incorporating these values into treatment may therefore improve treatment outcomes. For example, it could be more beneficial to emphasize the prosocial reasons for stopping substance use than the negative effects of continuing use, to include family counseling in treatment, and to view recovery as benefiting the community, not just the individual. Compared to clients in traditional programs, those in Longshore's culturally congruent treatment were more involved in the experience, were more forthcoming in their self-disclosures, and participated more actively. They also reported more motivation to seek help (Longshore et al. 1998).

It is extremely difficult to create a culturally specific program within a prison or jail given the variety of populations who enter the facility and the need to provide equal levels of treatment for all offenders. Culturally specific programs also require from clients a certain level of commitment to their culture that cannot be assumed for all members of a particular group.

Substance abuse treatment requires two-way communication of vital information including instructions, treatment expectations, personal information, and expressions of emotions. In a criminal justice setting, where the counselor represents the same institutional forces that have convicted and imprisoned the client, the levels of distrust and possibilities for misunderstanding are magnified. While all correctional staff members (including counselors) are seen, to some extent, as representatives of the dominant culture, the possibilities for misunderstanding can increase when client and counselor are from different ethnic or cultural backgrounds. These misunderstandings can jeopardize the

client's chances for success in treatment. It is the counselor's job to be aware of and sensitive to the values, biases, and assumptions that his or her culture has created in matters of communication, therapeutic style, and interpersonal contact and how they affect his or her ability to provide culturally competent services to clients. The most common misunderstandings in counseling originate in culture, socioeconomic class, and language (Sue and Sue 1999).

Advice to the Counselor: Culture and the Counselor

- The most common misunderstandings in counseling originate in culture, socioeconomic class, and language. It is the counselor's job to be aware of and sensitive to the values, biases, and assumptions of his or her own culture and to provide culturally competent services to clients.

Women's Treatment Issues

In 1998, an estimated 950,000 women were under supervision by correctional agencies, with 85 percent on probation or parole in the community. These women were mothers to about 1.3 million children under age 18. Forty-four percent of them, across settings, reported that they had been physically or sexually assaulted at some time during their lives (Greenfeld and Snell 1999).

The percentage of women in the criminal justice system has increased in the past decade—in jails it has risen from 10.2 to 11.9 percent (Harrison and Karberg 2002). The average annual percentage increase in State and Federal prisons for women between 1995 and 2003 was 5.0 percent, compared to 3.3 percent for men. In 2003 more than 100,000 women were in State and Federal prisons, and women represented 11.1 percent of adults on parole under State and Federal jurisdiction in 1997 (Harrison and Beck 2004; Maguire and Pastore 2001).

About 60 percent of women in State prisons used drugs in the month prior to the offense for which they were convicted, and about half of these women admitted to daily drug use. Drug use at the time the crime was committed was higher for female inmates than for males (40 percent compared to 32 percent), but more male inmates than females were under the influence of alcohol at the time the crime was committed (Greenfeld and Snell 1999). Interviews with incarcerated women in California, Connecticut, and Florida State prisons indicated that more than 80 percent had used substances regularly during their lifetimes while 71 percent reported regular substance use during the month prior to their most recent arrest (Acoca and Austin 1996). A study conducted by the Connecticut Department of Corrections indicated that 45 percent of female prisoners

compared to 22 percent of male prisoners were in need of substance abuse treatment (Acoca 1998).

Many of the issues discussed in this section apply to male offenders as well as to females but are discussed here because the issues create greater problems for women offenders.

Compared to their male counterparts, female inmates are more likely to have mental disorders (Ditton 1999), to be HIV positive (Maruschak 2004), to have been physically or sexually abused (Harlow 1999), and to have lived with their children in the month prior to their arrest (Mumola 2000). According to Peters and colleagues' (1997) study of women in a Tampa, Florida, jail treatment program, the most common mental disorders that incarcerated women have are serious depression and anxiety disorders. In another study of women in jail awaiting trial, 60 percent were found to have substance abuse or dependence, 22 percent had posttraumatic stress disorder (PTSD), and nearly 14 percent had at least one major depressive episode in the 6 months before entering jail (Teplin et al. 1996). Varese and colleagues (1998) demonstrated that depression among female inmates is greater among women who have deficits in social skills (e.g., are less assertive and/or are more aggressive), have dysfunctional attitudes, and are less able to provide self-reinforcement. These issues must be dealt with in substance abuse treatment programs for incarcerated women because they are intertwined with substance abuse and criminal behavior (Henderson 1998).

Few substance abuse treatment programs have been developed specifically for female offenders, and many of the programs that do exist for women in jails and prisons are based on treatment models developed for male offenders (Peters et al. 1997). However, available research suggests that treatment tailored for female offenders is effective. For example, an outcome study of Forever Free from Drugs and Crime, a California program created specifically for women offenders, found that the longer an offender remained in Forever Free, the more likely she was to stay out of jail. Women participating in Forever Free come from California State prisons, live in a 240-bed housing unit, and receive treatment four hours per day, five days per week. Counseling addresses issues specific to women, such as dependency, physical and sexual abuse, and parenting. Information on Forever Free is available online at www.drugstrategies.org/ks1998/p_crimin.html or through the California Department of Corrections Office of Substance Abuse Programs at (916) 327-3707.

Women in treatment, particularly those in early recovery, need to feel they are in a safe environment, but many do not feel, and some are not, safe in jail or prison (Covington 1998). To try and make the treatment experience feel safer, the harsh confrontational techniques often used in therapeutic communities (TCs) can be modified for women's programs. Instead, a more supportive approach should be used, emphasizing therapeutic sanctions (e.g., participation in treatment

activities) rather than punitive consequences (e.g., work assignments) for breaking rules. Nearly all women's programs consider the use of harsh language, expressions of hostility, and physical force by staff members as detrimental to their clients' recovery (Welle et al. 1998). Indeed, such staff actions can recreate abusive interpersonal situations experienced by many of the female offenders while they were in the community. Also, rather than needing help in anger management, women are more likely to benefit from learning techniques to reduce "guilt and self-blame, improve self-esteem and self-awareness, and attempt to create an environment of safety and support" (Peugh and Belenko 1999, p. 31). Women are more likely to complete a treatment program designed specifically for women (Roberts and Nishimoto 1996), and clinical experience suggests that women are more likely to disclose personal trauma, such as sexual abuse and domestic violence, in single-sex groups.

Based on their research with women referred to a jail-based substance abuse treatment program, Peters and colleagues (1997) recommended that programs for female offenders adapt treatment approaches developed for clients with co-occurring disorders (COD). In part, this is because COD are so common in this population, but also because this is one area where more sensitive and flexible clinical approaches have been developed. They stress the need to be flexible in terms of the sequence, focus, and intensity of treatment and to adapt treatment to individual needs wherever possible. They also note that time needs to be set aside for the assessment and diagnosis of COD and for teaching a range of skills (i.e., parenting, nutrition and health care, accessing social services and housing) that are generally not considered as important in treatment programs for male offenders.

Advice to the Counselor: Treating Female Offenders

- Nearly all women's programs consider the use of harsh language, expressions of hostility, and physical force by staff as detrimental to client recovery as these actions recreate abusive interpersonal situations experienced by many of the female offenders while they were in the community.

Histories of Physical and Sexual Abuse

Histories of abuse are of particular concern for female offenders and can have a significant impact on treatment. (In the general population, about one third of women and between 3 and 24 percent of men have experienced physical or sexual abuse. Among substance using populations, the figures are higher [Gil-Rivas et al. 1997].) Screening for a history of abuse should be included as part of the intake assessments for women in criminal justice treatment settings; to do this, a psychosocial history should be taken that asks about issues such as

childhood abuse and domestic violence. One difficulty with addressing these issues with women who are incarcerated is that immediate ongoing counseling is not always possible, given that counseling staff may not be available every day. Programs should have aftercare available for clients with histories of abuse. These issues can take a long time to work through and, depending on the setting in which treatment is provided, sufficient time may not be available within the program. Treatment providers should be aware of the range of aftercare options available for clients who are leaving the facility to enter either the community or another facility.

In-depth treatment for the trauma related to a history of abuse should be provided by professionals specifically trained in this area. However, innovative strategies that help women address issues of abuse at a level with which they are comfortable have been developed. For example, the Empowerment through Literacy Project helps women address issues of sexual abuse in a supportive group atmosphere. Women participate in a reading group that facilitates discussions on a number of important issues (e.g., sexual abuse, substance abuse) at the same time it promotes literacy. Readings pertinent to these women's life experiences are selected, including books such as Maya Angelou's *I Know Why the Caged Bird Sings*, Janet Fitch's *White Oleander*, and Elena Diaz Bjorkquist's *Suffer Smoke.*

Under community supervision, an offender's primary goal needs to be to remain drug free and out of trouble, and treatment programs may not have sufficient time or resources to treat all issues that impact their clients. In such cases, however, programs should be prepared to assist clients in finding a suitable treatment program where they can receive treatment for traumatic effects of abuse. Some providers conduct survivors' groups that are geared toward including treatment for trauma issues within substance abuse treatment for women.

In addition to substances, women can also abuse children or even, occasionally, spouses. However, if a cycle of ongoing violence is going to be interrupted, the nature of a woman's crime should not disqualify her for treatment. For example, a woman who is incarcerated for killing an abusive spouse will likely be considered a violent offender and therefore not qualify for treatment.

Low Self-Esteem

Low self-esteem certainly is not just a women's issue. Many offenders, both male and female, experience low self-esteem. Guilt and shame over past actions are often contributing factors to a poor self-image and low self-esteem, but so is a history of discrimination (whether toward the individual or the culture/ethnic group to which he or she belongs) that can produce poor self-esteem when internalized. Low self-esteem often takes years to produce; it can begin early in life and be increased by physical and sexual abuse, substance abuse, and arrest and incarceration. In order to improve a client's self-esteem, programs need to

address this issue continually, affirming at each stage of treatment the client's ability to change and create a positive life.

The strengths-based approach to treatment is widely considered the most effective approach for improving women's self-esteem. Group work should be used with both women and men as a crucial means of building self-esteem. Presenting positive role models to clients also is essential for women (even women who have not gone through the criminal justice system can be role models).

For women, the more time spent in treatment the more likely self-esteem will increase; this increase is most likely if the women are in a residential/inpatient setting. A residential TC helps women build awareness of their strengths and helps them "practice" having higher self-esteem (De Leon and Jainchill 1982). However, if treatment is provided in an outpatient setting, women often return to unhealthy situations (e.g., domestic abuse, a job with low pay and high stress) after their treatment session and their self-esteem will drop again. It takes an extended period of positive reinforcement to raise a client's self-esteem to a level sustainable in the face of oppressive forces. Of course, eventually clients will need to leave a treatment program, but to make that difficult transition as smooth as possible, programs should help the client connect to an appropriate support group.

Parenting and Child Custody

The majority of women imprisoned in jails or prisons are parents and some programs in and out of prison are adding parenting workshops to their agendas (see text box below). In 1999, more than 1.5 million children had a parent in prison (Mumola 2000; Petersilia 2000), and many more children have had a parent incarcerated during a period of their early lives. At least half of the children of imprisoned mothers have not seen or visited their mothers since incarceration began. Under the Adoption and Safe Families Act of 1997, parents of children in foster care for 15 or more of the past 22 months may have their parental rights terminated by the State. Given that the average prison term for incarcerated women is 15 months (Genty 1998), an increasing number of parents are permanently banned from their children's lives—often a devastating blow for mothers and their children.

A Program for Paroled Women and Their Children

Walden House opened a residential treatment facility for paroled women and their children in El Monte, California, in 1999 as part of the Female Offender Treatment and Employment Programs (FOTEP). The program is based on the TC model but includes parenting skills, education and vocational preparation, job readiness, job placement, and intensive case management. FOTEP fosters an environment where clients learn new

ways of meeting their needs without relying on substances. In addition to its emphasis on obtaining employment, the program includes components for children and models parenting behaviors (Smith 2001).

Parenting is not just a women's issue, and, in fact, the vast majority (93 percent) of incarcerated parents are male. However, mothers in State and Federal prisons are often (46 percent and 51 percent of the time, respectively) the sole parent living with their children at the time of their incarceration; 31 percent of mothers in prison were the only adult caring for their children before incarceration. Only 28 percent of the children of women in State prisons reside with their other parent and nearly 10 percent live in foster care or an agency. The majority of incarcerated mothers rely on grandparents or other members of their extended family to care for their children while they are incarcerated (Mumola 2000). If a woman is in prison and has no one else to care for her children, her loss of custody could be permanent. Innovative community reintegration programs for female prisoners may feature eventual reunification with their children as a significant motivator for treatment.

Many incarcerated women feel enormous guilt about being away from their children and worry about maintaining custody of their children (Covington 1998). This guilt may be a motivating force, but it can also overwhelm the client and be a cause for relapse. In some cases, children are used to coerce a parent into treatment; family drug courts, for example, may remove children from a mother's custody if she does not successfully complete treatment. However, the presence of children can be a mother's only link to a stable life, and after losing her children to a Child Protective Services agency or another family member, she sometimes increases her substance abuse.

Research does suggest that it is in the best interest of both mothers and their children to have continued interactions while the woman is incarcerated. Early research by Holt and Miller (1972) found that maintaining family ties and providing parenting training positively affected a parent's success on parole. Stevens and Patton (1998) have found that women in a modified TC that enables them to have their children with them had better treatment outcomes than women who had the same treatment unaccompanied by their children. Jail and prison programs need to allow for more interaction between incarcerated mothers and their children; the 2–4 hours of supervised visitation per week that many institutions allow is not sufficient for mothers or their children. One program that is attempting to increase interactions between incarcerated mothers and their children is located at the Denver Women's Correctional Facility (DWCF) and is described in the box below.

The DWCF Program for Women and Their Children

DWCF opened in early 1999 to serve the needs of 900 female offenders. In addition to providing treatment for substance abuse and mental health problems, DWCF follows recommended treatment principles for incarcerated women by addressing gender-specific treatment issues such as improving the relationships of mothers and their children and increasing contact between them. All mothers in DWCF participate in a 12-week Parenting Skills Seminar as well as a 12-week seminar that focuses on family relationships (the Family Dynamics Seminar). Among other things, these seminars teach mothers about the importance of regular phone contact with their children to discuss things such as homework, report cards, and special school events. Additionally, the facility has placed special emphasis on increasing the frequency of phone contacts and visits between mothers and children. Visits are encouraged and facilitated by the DWCF staff. Special children's visiting areas have been created; these are painted with motifs from children's literature and furnished with colorful children's furniture, games, books, and toys. The environment is attractive and appealing to children and facilitates positive mother-child interactions. The DWCF administration also has established a collaborative relationship with a Quaker volunteer organization, whose members provide weekly transportation for children (and their caretakers) who lack other means of transportation to the facility. Additionally, the facility has developed several apartments within the prison, permitting weekend visits for mothers and their children during the 4 to 6 weeks prior to the mother's release into the community; these visits help to reconnect mothers and their children during the crucial period just prior to discharge or parole. Staff monitors these visits and provides support and assistance for mothers and their children when needed.

Advice to the Counselor: Parent Training

- Discussions of parenting and the welfare of one's children often promote strong emotional explorations and counseling opportunities.
- Offenders are sometimes more receptive to treatment and more willing to accept prosocial values when the appeal is made for the sake of their children.

Job Skills Training

As Peugh and Belenko (1999) note, female inmates with substance use disorders have poorer employment histories than their male counterparts, and

likely have fewer opportunities for employment (especially at jobs that pay more than minimum wage) than do men. Vocational training would reduce the need for women to turn to illegal sources of income to support themselves and their families after release (Peugh and Belenko 1999). Therefore, vocational training should be a priority for female offenders in substance abuse treatment; however, this often is not the case. The vocational options available for female inmates are often extremely limited compared to the options available for male offenders. Male offenders have more opportunities to learn higher-paying job skills (such as carpentry or mechanics) than female offenders, and so women too often return to jobs in the community that pay a low wage, do not enable them to support themselves and their children, and do not raise their self-esteem.

In prisons and jails, substance abuse treatment programs and TCs introduce vocational programs for women and expand the range of vocational skills taught. Programs for offenders under community supervision can obtain access to community vocational programs that will accept their clients. Because so many incarcerated women with substance use disorders have no real employment history or work skills, clients will benefit from learning prevocational skills, earning GEDs, and meeting other educational goals. Counselors can assess both women's vocational interests and their existing work skills. One innovative program that is targeting women with substance use disorders who are serving a prison sentence was developed by the Project for Homemakers in Arizona Seeking Employment (PHASE). A complete description of the program is available online at www.ag.arizona.edu/impacts/2000/ready3.pdf.

Men's Treatment Issues

Because men make up the vast majority of offenders and because gender bias often makes people see men's treatment as the norm, it sometimes is difficult to see how certain issues need to be addressed for men in substance abuse treatment programs. Typically, these are issues that have been thought of as women's issues (e.g., sexual abuse, parenting) but also can include issues that are significant for men in the general population, but often forgotten for offenders (e.g., status). Much of the information presented above also applies to men.

Fathering

Male offenders often are very concerned about the welfare of their children, although socially defined gender roles still put more pressure on women to be good parents. Male offenders may not talk as much about their children or the feelings they have for them, but they often keep pictures of them and, if asked about them, express concern. According to Mumola (2000), 40 percent of fathers in State prison had at least weekly contact with their children.

It is particularly difficult for male offenders to admit that they failed as fathers. Being a good father is not, as some might expect, looked down on in prisons as a sign of "weakness," but rather is generally perceived as an important and valuable activity. However, an individual perhaps feels a conflict between his role as a caring parent and the role of a "hardened criminal" that he presents within the prison.

Many male offenders feel inadequate when dealing with their children and have never had any instruction or assistance in how to be a good father. Their own fathers often were poor role models, and some were (and may still be) incarcerated themselves, even in the same prison. This does not mean, however, that they are bad fathers—just that they are not aware of what they should be doing or how well they are doing in that role. According to Landreth and Lobaugh (1998), at the end of a parent training class a group of incarcerated fathers was more accepting of their children, perceived fewer problems with their children, and had less stress about parenting compared with offenders who did not participate. The children benefited as well from the structured play therapy, as their self-concept scores improved significantly.

Parent training can also serve as a bridge to counseling. Few criminal justice clients want their children to wind up in prison. Discussions of parenting and the welfare of one's children often promote strong emotional explorations and counseling opportunities. Offenders are sometimes more receptive to treatment, and more willing to accept prosocial values, when the appeal is made for the sake of their children.

Developing Relationships

Learning how to relate to people and build relationships (including how to be a friend) takes a lot of work for men. In many cases, this is not a matter of rehabilitation but rather habilitation; some male offenders do not understand how to be a friend, family member, or significant other. They often experience great difficulty even talking about this issue, in spite of the fact that they want to learn these skills. One of the attractions of gang participation is that it gives members a sense of belonging and a certainty about their relationships with one another that they do not have outside the gang. Thus, treatment should encourage men to form relationships based on a shared experience with recovery. Relationship training also is important for job success. Learning how to communicate with peers and supervisors is necessary for maintaining employment and advancement.

Working with Violent Offenders

While substance abuse treatment providers working in any setting may need to discuss violence in a client's past, this issue is especially important when working in the criminal justice system because offenders' violence often has led to their

arrest and conviction. Clinicians also must be aware of the possibility that violence could erupt in the treatment program and should pay careful attention to issues that could trigger violence between offenders.

Relationship Between Substance Abuse and Violence

Literature on the subject generally concludes that substance use often is a cause of or a predisposing factor for violence (Friedman 1998). Alcohol is the most frequently used substance that can precipitate violent crime. According to victim reports, perpetrators were clearly under the influence of alcohol in nearly 35 percent of violent crimes; two-thirds of victims who suffered violence caused by a current or former spouse or partner also reported that alcohol was a factor in the incident (Greenfeld 1998). In a 1997 survey, 41.7 percent of State prison inmates and 24.5 percent of Federal inmates convicted of a violent crime reported that they were under the influence of alcohol at the time they committed the crime for which they were convicted; 29 percent of State and 24.5 percent of Federal inmates reported that they were under the influence of drugs at the time (Mumola 1999).

There is some evidence that cocaine, amphetamines, and possibly other substances also have the potential to stimulate violent acts. The relationship of cocaine to violence is better established for those inner-city residents who predominantly use crack cocaine (Friedman 1998). The possible effect of race, ethnicity, or culture on this relationship has not been studied systematically. Although more research is needed, there is at least some reason to believe that the relationship of drug and alcohol use to violence may be affected by cultural factors as well (Valdez et al. 1997). Earlier substance abuse seems to be associated with subsequent violent behavior for both women and men. The effect of alcohol as a precipitant of violent crime is better established for men than women (Friedman 1998).

The relation between substance use and violence is complicated, and there are many individual and group differences in the way substances are used and how they affect people. Some people may in fact use substances in order to be calmer and less prone to violence; others may use them to forget the guilt associated with past acts of violence, which may then precipitate further acts of violence.

Drugs influence levels of violence in other ways. The business of manufacturing and selling drugs can be very violent, and offenders who have been involved in these activities may have committed violent acts in order to survive and succeed. A study demonstrating that legal prohibitions against the use of alcohol or drugs actually increase the level of violence (and homicide in particular) was published by Miron in 1999.

Managing Violence

Within prison culture, violence is an everyday part of life and inmates may resort to violence in order to protect themselves. The prevalence of violence in the system reduces a client's feeling of safety within the treatment setting. Many offenders react with violence because they have never developed the social and coping skills necessary to react to problems in more positive ways. This lack of skills is even more prevalent in offenders with extensive histories of substance abuse. Interpersonal violence is also associated with methamphetamine abuse (Cohen et al. 2003). The prison culture reinforces violent behavior. Individuals who are incarcerated without a history of violence quickly learn its value in jail or prison. Past violence is an issue particularly for offenders who are making the transition from incarceration to the community because past actions may come back to "haunt" them. It can be difficult to find treatment programs in the community that will accept violent offenders.

A number of programs have been developed to help offenders stop violent behaviors. Many of these programs use variations on cognitive-behavioral therapy (CBT) and ask offenders to look at their "criminal thinking" and the ways in which it leads them to commit violent crimes. Several programs have been developed from the model of the Oakland Men's Project, a community-based violence prevention program for men that began in 1979. This project developed a series of workshops that use role-playing exercises to help men understand how society pressures them to commit (and rewards them for) violent actions.

Programs such as the Violence Interruption Process (VIP) of the Illinois TASC (Treatment Alternatives for Special Clients) and the Ohio Department of Alcohol and Drug Addiction Service's (ODADAS) Ohio Violence Prevention Process (OVPP) were developed from the Oakland Men's Project model. Illinois's VIP works on the assumption that violent behavior is learned and has an institutional as well as a personal dimension. When people become aware of how they have learned violent attitudes and behaviors, they can learn new methods of communication and resolving conflicts (People for Peace 1996). ODADAS provides onsite trainings in OVPP to substance abuse treatment programs, corrections programs, school systems, and other groups; trainings touch on a variety of issues including the connection between substance abuse and violence, the role of racism and sexism in violence, and building multicultural alliances (ODADAS 2000). More information on promising violence prevention and psychoeducational programs in a range of locales can be found on the Partnership Against Violence Network (Pavnet) Web site (www.pavnet.org).

Anger management groups are another useful intervention with this population but it is recommended that these groups be connected with other interventions and not simply provided as a stand-alone treatment for violent offenders. A variety of curricula are available for running anger management groups in jail or community settings. Incentives also are very important when dealing with this

population. These are clients who have not had much positive reinforcement in their lives and have grown accustomed to reacting to negative reinforcement with anger and resentment. Head trauma and related brain injury can be another cause of violent behavior (Diaz 1995; Robinson and Kelley 2000).

In some cases, medication may be called for in order to manage aggressive behaviors (Lavine 1997). When medical, psychiatric, and substance abuse assessments indicate that a client's aggressiveness is not under control, pharmacological treatment sometimes is considered.

Treatment Issues Based on Client's Sexual Orientation

Sexual orientation and sexual behavior are not necessarily congruent, especially within a prison or jail. Many offenders who engage in homosexual activity while in jail or prison do not self-identify as gay, lesbian, or bisexual. Others, who may recognize that they are gay, lesbian, or bisexual, do not openly proclaim that fact (i.e., are not "out") in an incarcerated setting because they fear reprisals. The institutional culture of men's jails and prisons may recognize only the "passive" or receiving sexual partner as gay, which supports a heterosexual self-identification for some men who engage in homosexual activity.

Incarcerated individuals may engage in sexual activity with members of the same gender for many reasons, not all of which reflect their sexual identity. Self-identified heterosexuals may engage in prostitution for money or have sex in order to gain the protection they need to survive within the jail or prison. For such individuals, sexual identity can become an especially important issue upon release as they try to understand their sexual activity and how it relates to their identity and sexual identification. There may be, in fact, men within the prison system who have had more sex with men than women but who still identify as heterosexual. These individuals may face particular difficulties when they return to sex with female partners and may use substances in order to facilitate heterosexual activity.

Reliable data on the prevalence of homosexual behavior in jails and prisons are limited. In one study of a low-medium-security prison, which claimed to underreport some types of sexual behavior, 55 percent of self-identified heterosexuals reported being involved in sexual activity in prison (Donaldson 1990). Despite disciplinary codes in jails and prisons that prohibit all sexual activity, such behavior still occurs. Within men's prisons there is a social hierarchy based on sexual roles. Although middle-aged and older men are most likely to abstain from sexual activity while incarcerated, others engage in sexual behaviors to assert their masculinity, to establish power over others and over their own lives, and, in the case of stable relationships, to provide companionship. Relationships between inmates imply obligations by each partner: the dominant partner to defend his partner physically against

mistreatment by others and the receptive partner to obey the other (Donaldson 1990).

In a study of homosexual behavior in prison, Alarid (2000) surveyed men incarcerated in a county jail who had requested and received protective custody because of their sexual orientation. The gay and bisexual men in the group tended to be older and never married. Nearly half were African American. Slightly more than half of the men in this study self-identified as bisexual, with one third of those preferring female partners (bisexual/heterosexual). Gay and bisexual men were generally satisfied with their sexual orientation. Almost one fourth of the group (a majority of them gay) exchanged sex for money or favors. The bisexual/heterosexual group felt more pressure to have sex and often used it to gain the protection of another inmate. This is perhaps a result of the fact that the group was small in number and that other inmates sought them as sexual partners. Most of the group believed that their fellow jail inmates treated them disrespectfully. Only a few gay inmates and none of the bisexuals felt that jail personnel tolerated gay behavior or gay or bisexual individuals. More than a third of this group feared being raped in prison and believed that having the protection of a heterosexual was the best way to do prison time (Alarid 2000).

In male institutions, individuals who do self-identify as gay are often victims of rape and/or physical violence. They may need to resort to violence to protect themselves or else become a sexual partner of someone who can protect them. However, these are not typically mutual relationships and the gay partner often needs to assume a submissive role that may not be compatible with the sexual role he prefers; gay inmates often wish to distance themselves from these partners upon release.

Many women also face conflicts between sexual orientation and sexual behavior when incarcerated. However, generally, confusion around sexual orientation is not as difficult for women because sexual encounters in prison involve more of a relationship than they do for men; sexual activity is often a part of a nurturing, family relationship (and women often explicitly take on roles as "husbands and wives"). It is assumed that the prevalence of homosexual activity in women's jails and prisons is similar to that in men's. In contrast to relationships among men, women establish partnerships voluntarily and consensually. These partnerships are generally respected by other inmates (Donaldson 1990).

Female offenders also seem more accepting of openly lesbian women than their male counterparts are of openly gay men. Overall, lesbian women have an easier time dealing openly with sexuality while incarcerated than gay men. They may develop very close relationships with other women while incarcerated and express regret that the relationship may end after one partner leaves the institution. Some lesbian offenders say that they enjoy the sexual freedom that a prison environment allows them, and, after release, may express a desire to return to a relationship they had while incarcerated.

Other issues related to sexual orientation, such as conflicts with the family of origin and societal discrimination, can create additional stress that can lead to increased substance abuse.

Treatment Issues Based on the Client's Cognitive/Learning, Physical, and Sensory Disabilities

People with substance use disorders may experience a coexisting cognitive or physical disability. A study by the New York State Office of Alcoholism and Substance Abuse Services found that more than 22 percent of the clients served by licensed treatment facilities had a co-occurring mental or physical disability (CSAT 1998*d*). Self-reports from inmates in 1997 indicate that 31 percent of State prisoners and 23 percent of Federal prisoners had learning or speech disabilities, hearing or vision problems, or mental or physical conditions. This includes 108,000 individuals with learning disabilities, 135,000 with physical impairments, 65,000 with hearing problems, and 94,000 with vision problems (Maruschak and Beck 2001).

Evidence suggests that people with cognitive disabilities are disproportionately involved in the criminal justice system (Cockram et al. 1998). Nearly one third of inmates in State prisons and one quarter of those in Federal prisons report having a physical or cognitive disability. This data, derived from self-reports, is likely to under represent some conditions, including learning disabilities, of which inmates themselves may not be aware. Ten percent of State and 5 percent of Federal prison inmates report a learning disability. Also, data from inmates in State prisons show that they are three times more likely than the general population to have a speech disability and more than twice as likely to have impaired vision. These inmates are, however, slightly less likely to have a hearing impairment, but this can be accounted for by the age and gender differences from the general population (Maruschak and Beck 2001).

People with cognitive disabilities are at a significant disadvantage in their contacts with the criminal justice system. For example, offenders with developmental challenges are disproportionately likely to be arrested and coerced into a confession for a crime they did not commit. They may not understand their Miranda rights and are eager to please, ignorant of the value of remaining silent, susceptible to leading questions, insensitive to nonverbal cues, and desirous of appearing competent (Cockram et al. 1998). They also are easily led into criminal activity by others, and, in their desire to feel like they belong to a group, they may even view arrest and incarceration as successful achievements (Wood and White 1992). Inside jails and prisons, they tend to be victimized by other inmates, and often try to hide the presence of their disability in order to avoid further victimization. According to focus group interviews with family members of people with cognitive disabilities, one way the criminal justice system

could better assist people with cognitive disabilities is to provide qualified staff members to work with them in the early stages of the legal process (Cockram et al. 1998).

Jails and prisons can be difficult places for people with physical disabilities (e.g., there may be no wheelchair access and bathrooms may not be fitted with hand rails). Sometimes clients with disabilities can be moved to other facilities that are not necessarily appropriate for them, given their sentence (e.g., they may be moved to a medium security facility even though their sentence warrants maximum security). In June 1998, the U.S. Supreme Court ruled that State prisons must comply with the provisions of the Americans with Disabilities Act. This means that they must make reasonable accommodations to provide access to basic facilities and services for eligible prisoners with disabilities (American Civil Liberties Union 1998).

Certain physical disabilities require medication, and this can pose particular problems for treatment facilities in jails and prisons. Facilities may need to give offenders medications at specific times that could conflict with other scheduled activities. Clients under community supervision require a support system that can help them manage their medication and oversee compliance.

Clients who have conditions such as diabetes that require the administration of medication by means of a syringe may face daily what could be a significant trigger for substance use. In the community, they will have to contend with the theft or use of their syringes by others. These clients will need assistance in looking at these triggers and developing a relapse prevention plan that addresses them. For example, individuals who need to administer medications using a syringe who are no longer in a residential program could have a friend or relative available to be with them when they give themselves their shots (at least for the first few months after release). Programs can provide these individuals with a small safe where they can keep needles and should advise them to keep syringes in more than one place so that if any are stolen they will still be able to administer their medication. Individuals should always check their syringes to see if others have used them and should keep a supply of bleach available to clean needles if they suspect their needles have been used.

Given the prevalence of disabilities in incarcerated populations, especially among offenders with substance use disorders, treatment providers need to be able to screen for co-existing disabilities and make accommodations for offenders who have them. For example, someone with mental retardation may not be able to participate in a traditional TC and may need to be sent to a modified TC or have another suitable treatment option available.

Treatment Issues for Older Adults

Age is a factor associated with positive treatment outcomes. The older one is the more likely one is to stay in treatment, complete treatment, and have positive outcomes following treatment. For some older clients the negative consequences of a criminal lifestyle accumulate over time, while the body becomes less capable of managing substance abuse and related stressors, leading to a desire for change. Engaging these individuals in treatment may be relatively easy. However, older offenders also have unique issues that counselors need to be prepared to address. For one, this population is more prone to health problems. Visual impairments and hearing loss are factors, along with chronic health problems, senile dementia, and dementia related to long-term substance abuse. Other characteristics typical of this population that complicate treatment include

- A slow response to directions
- Rigid habits
- The likelihood of a physical condition presenting as an emotional problem
- Lifelong patterns of criminal behavior that cannot easily be altered
- A lack of assertiveness, suggesting that younger, more verbal inmates are more likely to get treatment (Chaiklin 1998)

Treatment Issues for Clients from Rural Areas

In the past, alcohol has been the largest substance abuse problem in rural areas, but that is beginning to change. While certain substances of abuse are more available than others, illicit substances are reaching rural communities. There is now no difference in prevalence of illicit drug use between large and small metropolitan areas and rural areas with the exception of marijuana (National Center on Addiction and Substance Abuse [CASA] 2000). In an evaluation of substance abuse in rural Nebraska, marijuana was found to be the most common drug (as it was in urban areas), but methamphetamine abuse was more common than cocaine abuse; those who abused substances tended to be younger than those in urban Nebraska and were more likely to be involved in the selling of drugs (Herz 2000). However, these patterns vary by region; for example, in rural northern Louisiana, cocaine abuse predominates and methamphetamine abuse does not seem to be a significant problem (Monroe 1998). Abuse of OxyContin has been more common in several rural areas, such as the eastern Kentucky and western Virginia areas of Appalachia.

Clients from rural communities have distinct cultures that differ from region to region. Treatment staff working with clients from a particular rural population should seek to understand that culture in the same way they would any other. Increasingly, offenders from urban areas are being sent to prisons located in rural regions and staffed by local residents; here again, a cultural clash can develop, and training can help staff understand the cultural background of offenders coming from urban areas.

Services available in rural areas may also be more limited than those in more densely populated regions. A rural jail, for example, is generally unable to develop a substance abuse treatment program because its resources are limited. Community supervision programs in rural areas also have particular difficulties. Few programs will be available, there is little coordination between programs, privacy and confidentiality may be difficult to maintain, and certain types of substance abuse (e.g., excessive alcohol consumption) may be the norm in the area.

Advice to the Counselor: Rural Clients, Rural Counselors

- Clients from rural communities have distinct cultures that differ from region to region. In addition, more and more offenders from urban areas are being sent to prisons in rural regions with local staff.
- Counselors should seek to understand urban-rural differences in culture as they would any other.

Treatment Issues for People with Co-Occurring Substance Use and Mental Disorders

According to a study conducted in 1998, an estimated 283,800 offenders in jails and prison and another 547,800 on probation reported having a mental disorder and/or had stayed overnight in a mental hospital (Ditton 1999). Reported mental disorder varied across setting, with 16.2 percent of inmates in State prison, more than 7 percent of Federal prison inmates, 16 percent of jail inmates, and 16 percent of probationers reporting mental disorders or a stay in a mental hospital. Rates were substantially higher for women than men and for Caucasians than African Americans or Hispanics/Latinos. Individuals with mental disorders were more likely to have been under the influence of substances at the time of their offense and substantially more likely to report a history of substance abuse than others (Ditton 1999). The National GAINS Center, a Substance Abuse and Mental Health Services Administration (SAMHSA) initiative to study mental health and substance abuse services for people in the criminal justice system, estimates that of jail inmates identified with mental illness, 64.3 percent reported alcohol or drug use at the time of the offense. Among the State prison population the figure is 58.7 percent (National GAINS Center 1997).

Even conservative estimates report high rates of mental disorders. Ditton (1999) reports that three previous studies of inmates in jail or State prison with rigorous sampling methods found rates of mental disorders to be between 8 and 16 percent. A study of incarcerated women awaiting trial in a Chicago jail found significantly higher rates of mental disorders based on offender reports of psychiatric symptoms; 18.5 percent of the women had experienced symptoms of

a severe disorder (i.e., schizophrenia/ schizophreniform, manic episode, major depressive episode) at some point during their lives, 33.5 percent had experienced PTSD, and 70.2 percent had a substance use disorder (Teplin et al. 1996).

Identifying Co-Occurring Disorders

There is a great deal of stigma associated with mental disorders even within the culture of prisons and jails. At the same time, in correctional institutions, substance abuse does not carry the same degree of stigma as it does in the outside community. In some prison settings, procedures such as public medication lines expose the inmate with a mental disorder to public ridicule, adding to the stigma and reinforcing the inmate's reluctance to admit to his or her disorder. Offenders may be willing and able to face talking about their criminal activity or substance abuse but reluctant to discuss their mental disorder. Consequently, actual rates of mental disorders in this population are likely to be higher than self-reported rates.

Because one disorder can mask or imitate the other, accurate diagnosis of COD requires skilled screening and assessment. Assessment should look for both problems at the same time, rather than separating assessments for mental disorders and substance abuse. Regular reassessment is also important. Trained staff should be used to perform such assessments. Most prison programs for inmates with COD do use doctoral-level staff for initial screenings (Edens et al. 1997).

Co-Occurring Disorders Treatment Programs

In order to serve the high number of offenders with mental and substance use disorders, a number of diversionary and corrections-based programs have been developed for offenders with COD.

Diversionary programs for offenders with co-occurring disorders
These programs, generally referred to as Mental Health Courts, currently exist in a handful of municipalities across the country (Broner et al. 2002). SAMHSA has funded jail diversion programs at nine sites for offenders with COD. In the Eugene, Oregon, program, for example, mental health and substance abuse treatment is collaborative; sanctions applied are sensitive to mental health problems and the case manager is a mental health specialist who acts as court liaison (National GAINS Center 1999*b*).

Prison- and jail-based programs for offenders with co-occurring disorders
In addition to diversion programs such as mental health courts, there has been a rapid growth in corrections-based co-occurring programs during recent years, from only 2 State systems that had developed these programs in 1993, to 7 systems with programs in 1997, to 18 systems in 2002 (Edens et al. 1997).

However, few State systems have systematic procedures for identifying and tracking prison inmates with COD. Moreover, little research has yet been done on the effectiveness of these programs. Preliminary outcome data from one study comparing a modified therapeutic community (MTC) program for prison inmates with COD with treatment as usual and with a mental health group showed the MTC group to have fewer new arrests, less use of illicit drugs, and better compliance with treatment regimens (Sacks et al. 2001).

Several features distinguish the programs that treat inmates with COD from other criminal justice substance abuse treatment programs:

An integrated treatment approach is used whenever possible. Mental health treatment staff, substance abuse treatment staff, and criminal justice staff are located in the same program unit, and often share in decision making. In some jurisdictions, both correctional officers and community supervision officers have been successfully involved in treatment team meetings, treatment groups, and other therapeutic activities. A wide range of treatment approaches are implemented, according to the client's stage of treatment. Collaboration and/or consultation may be adequate to serve offenders who have less severe COD.

Both disorders are treated as "primary." Integrated treatment involves simultaneous consideration of both disorders and attention to the interactive nature of these disorders. However, the scope and intensity of treatment activities will vary according to the client's needs and functioning level.

Comprehensive treatment services are flexible and individualized. Treatment should be adapted to address different levels of symptom severity, functioning, and commitment to treatment. Both early intervention and active treatment interventions should be adapted for different diagnostic groups and for offenders with special needs (e.g., those with cognitive impairment, women with trauma and abuse histories).

Treatment approaches that are commonly used in substance abuse treatment settings (e.g., TCs, cognitive-behavioral treatments, relapse prevention, peer and alumni support groups) are adapted to better suit the needs of offenders with COD. Common modifications include smaller caseloads, shorter and simplified meetings, special attention to criminal thinking, education about medication, and minimizing confrontation (Edens et al. 1997; Peters and Hills 1997).

Treatment is provided in graduated "phases" or "stages," using a highly structured psychoeducational treatment approach. Early phases of treatment include a focus on orientation, assessment, development of treatment plans, and engagement and persuasion activities. Didactic approaches are particularly useful in early stages of treatment to help offenders understand the nature of their mental disorders and biological aspects of both disorders. Secondary phases focus more on "active treatment," such as development of coping and life

skills, lifestyle change, and cognitive-behavioral interventions. Later phases may include relapse prevention, peer mentor activities, vocational training, reentry planning, and linkage with community support and treatment programs. Case management and relapse prevention activities often are provided throughout the various phases of treatment, with a particular emphasis during prerelease and reentry phases. In jails, where the relatively brief period of incarceration may prevent the use of a long-term phased treatment approach, services may focus on assessment, brief psychoeducational interventions, community "in-reach" services, and linkage to community services.

The focus of treatment is long term, with an emphasis placed on continuity of treatment in aftercare and postrelease settings. Recovery and stabilization for offenders with COD often occurs over a period of several years and includes multiple treatment episodes. COD treatment programs should provide linkage with other community treatment and ancillary service providers, and should develop detailed aftercare, transition, and postrelease plans to ensure continuity of services. These should include provisions to furnish an adequate supply of psychotropic medications for the offender during transition from institutional to community programs. The offender also should be monitored carefully during transition periods, when stress levels are high and there is increased risk for recurrence of mental health symptoms, substance abuse relapse, and recidivism. Forensic coordinators or other case managers have been used successfully in some jurisdictions to help in community transition.

Staff are trained and experienced in treating both mental disorders and substance abuse. A blend of staff experience is needed, including those trained in working with acute symptoms of mental disorders and those who have worked in specialized substance abuse treatment settings, such as TCs. Cross-training activities are useful to share information from the perspectives of each of the treatment disciplines, and also from the perspective of security/community supervision.

Programs for offenders with co-occurring disorders under community supervision

This group of offenders will have particular difficulties finding aftercare programs to accept them because of the stigma associated with the combined problems of COD and a criminal record. Nor will most traditional community mental health interventions be effective for them, as they typically have complex problems that require specialized treatment (Broner et al. 2002). Community supervision of offenders with COD also requires specialized strategies (Peters and Hills 1997), including

- Recognition of special service needs
- Use of supportive rather than confrontational approaches
- Positive reinforcement for small successes and progress
- Different expectations regarding response to supervision
- Flexible responses to infractions

- Use of concrete directions
- Highly structured activities
- Ongoing monitoring
- Enlistment of support from family members to work with offenders with COD where appropriate
- Close coordination between the community supervision/probation officer and the offender's clinician

Medication Management

Substance abuse treatment providers working with people with COD need to understand and be able to help educate clients about the importance of medication management and compliance. Clients sometimes have trouble distinguishing between "good" and "bad" drugs, particularly at the beginning of treatment. The distinction is made more difficult by the fact that the "good" medications are more expensive and more difficult to obtain than illicit drugs. There still is a myth within the substance abuse treatment field that use of psychotropic medication by individuals with co-occurring mental disorders should be discouraged. Programs in criminal justice settings should update their formulary so that they are using the most up-to-date medications. Offenders entering jails may have particular problems around medications because they may not be able to receive necessary medication while incarcerated or may not be given a supply of medication upon discharge (which they might need until they can get prescriptions filled). It often takes well over a month to be seen by a psychiatrist and to receive a prescription for medication. In addition, certain medications (e.g., antidepressants) take several weeks to build up to effective levels in the bloodstream. Moreover, individuals often do not have enough money to pay for the medication. Programs working with people who are making a transition from institution to community need to ensure that these clients have an adequate supply of psychotropic medications.

On the other hand some inmates can skillfully manipulate signs and symptoms of mental disorders in order to receive medications with sedative properties. Some of these medications (such as benzodiazepines, prior-generation antidepressants, and antipsychotics) can have serious and severe side effects. These medications can be sold to other inmates or exchanged for favors.

Advice to the Counselor: "Good" and "Bad" Drugs

- Clients with COD need help with medication management, especially in distinguishing between substances of abuse and licit medication.
- Counselors must be alert to inmates who skillfully mimic the symptoms of mental disorders in order to receive medications.

Case Management Services

Case management services are useful in providing access to a broad range of mental health and substance abuse services and are complementary to a range of other treatment approaches used with offenders with COD. Research indicates that case management services can lead to improvement in a client's functional status and fewer hospitalizations during an extended follow-up period (Mueser et al. 1997). One model is Intensive Case Management (ICM). ICM is provided by multidisciplinary teams that include mental health treatment staff, substance abuse specialists, housing specialists, and community supervision officers. These teams often share caseloads to provide flexibility in coverage. Participation in treatment is provided through crisis and outreach services, use of specialized engagement and motivational strategies, and culturally relevant programming over an extended period of time.

Services provided by case managers are developed to address the stage of COD treatment (Lurigio 2000*b*). This includes an early emphasis on client engagement and commitment to the recovery process, and is followed by persuasion to consider abstinence and to begin active behavior change. Later stages of treatment include the use of cognitive-behavioral interventions, development of a drug-free social support network, understanding of relapse risks, and use of relapse prevention skills. Another frequently employed case management approach for use with COD is the Assertive Community Treatment model (ACT) (Brown 2003; Stein and Test 1980). Key elements of this approach include crisis intervention, supportive therapy, substance abuse counseling, skills training, medication monitoring, housing support, vocational rehabilitation, specialized dual diagnosis groups, family psychoeducational groups, and family outreach activities.

Special Considerations in Treating Antisocial Personality Disorder (ASPD)

Substance abuse often is associated with criminal or antisocial lifestyle and is highly correlated with ASPD (Knop et al. 1998; Robins and Regier 1991). Someone with ASPD does not accept society's values or norms and acts without guilt; he sees other people as objects to meet his needs. According to the *Diagnostic and Statistical Manual of Mental Disorders,* 4th edition (DSM-IV), ASPD "is a pattern of disregard for, and violation of, the rights of others" (American Psychiatric Association [APA] 1994, p. 645). In order to be diagnosed with ASPD, a person needs to demonstrate, after the age of 15, three or more of the associated traits. (See Figure 1 for list of traits.) Given these criteria it is easy to see why offenders who abuse substances often are diagnosed with ASPD. In a sample of 325 psychiatric patients who had recently been hospitalized, Mueser and colleagues (2000) found that both a history of incarceration and ASPD were predictive of substance use disorders. In another study that looked at clients in substance abuse treatment, Compton and colleagues (2000) found that 44

percent qualified for ASPD at some time during their life. Research from a male prison TC found 52 percent of clients had ASPD (Wexler and Graham 1993).

While it is generally believed that ASPD is more common in men than women, available data are mixed. Researchers studying people in psychiatric hospitals (Grilo et al. 1996), in treatment programs for alcoholism (Cornelius et al. 1995), and in homeless populations (North et al. 2004) have found significantly higher rates of ASPD for men than for women. Galen and colleagues (2000), however, found prevalence rates of 16 percent for men and 22 percent for women in a group of 235 clients at outpatient substance abuse treatment centers. Rates are high for offenders of both genders. A study of women entering prison in North Carolina found that rates of ASPD were significantly higher than for women in the general population (Jordan et al. 1996), and Teplin and colleagues (1996) in their study of women in Cook County, Illinois, jails found that 13.7 percent met DSM-III-R criteria for ASPD within the 6 months prior to their incarceration.

Some people who meet the criteria for ASPD do not really have the disorder—their behaviors are the result of other factors, most notably substance abuse. The behavior of these clients is improved greatly after treatment. It is not easy, though, to determine who really does have ASPD and who does not. There also are people who have ASPD but who lie about behaviors that qualify for this diagnosis.

Psychopathy is a term used to describe a more extreme form of ASPD. In addition to the criminal tendencies apparent in ASPD, people with psychopathy also exhibit affective and interpersonal dysfunction (Hare et al. 1991). Moreover, offenders who score high on the PLC-R (the test for psychopathy) have higher rates of recidivism and are more prone to violence both in and out of criminal institutions (Hare et al. 1991). See Figure 1 for the diagnostic characteristics associated with ASPD.

Figure 1 Traits of ASPD (DSM-IV)

- Deceitfulness, as indicated by repeated lying, use of aliases, or conning others for personal profit or pleasure
- Irritability and aggressiveness, as indicated by repeated physical fights and assaults
- Consistent irresponsibility, as indicated by repeated failure to sustain consistent work behavior or honor financial obligations
- Failure to conform to social norms with respect to lawful behaviors as indicated by repeatedly performing acts that are grounds for arrest
- Impulsivity or failure to plan ahead
- Reckless disregard for safety of self or others
- Lack of remorse, as indicated by being indifferent to or rationalizing having hurt, mistreated, or stolen from another

Source: Hare et al. 1991.

ASPD and psychopathy are difficult to treat and in this regard are addressed somewhat differently from other mental disorders. Approaches used for offenders with ASPD and psychopathy are typically focused on behavior management rather than on counseling or other therapeutic techniques. These approaches involve heightened accountability (i.e., surveillance and monitoring), highly structured programming, and application of carefully crafted sanctions and incentives for targeted behaviors.

People with severe ASPD require intensive, long-term residential treatment for their disorder and for substance abuse; if they interrupt treatment they are likely to return to previous behaviors. It should be noted, however, that about half of all people with ASPD display fewer antisocial behaviors as they grow older, beginning in their 40s or 50s (APA 1994).

Special Considerations in Treating Borderline Personality Disorder (BPD)

According to the DSM-IV, borderline personality disorder is characterized by "a pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity beginning by early adulthood and present in a variety of contexts" (APA 1994, p. 654). It can include recurrent suicidal or self-harming behavior, intense anger or inability to control anger, and stress-related, psychotic-like symptoms (see Figure 2). Women are three times more likely than men to be diagnosed as having BPD (APA 1994).

Figure 2 Borderline Personality Disorder

People diagnosed with BPD must have five or more of the following behaviors:

- Frantic efforts to avoid real or imagined abandonment
- A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation
- Identity disturbance or markedly and persistently unstable self-image or sense of self
- Impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating)
- Recurrent suicidal behavior or gestures, or self-mutilating behavior
- Affective instability due to marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days)
- Chronic feelings of emptiness
- Inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights)
- Transient, stress-related paranoid ideation or severe dissociative symptoms

Source: APA 2000.

Treating offenders with BPD requires great care due to their emotional instability, tendency toward violence, and risk for self-destructive or suicidal behavior. Moreover, because of their tendency to idealize counselors, the therapeutic relationship is likely to be intense, and the offender with BPD is likely to have strong reactions to the counselor. The American Psychiatric Association recommends that treatment for people with BPD take into account these special features:

Co-occurring disorders. In addition to substance use disorders, mood disorders, eating disorders (especially bulimia), PTSD, anxiety disorders, dissociative identity disorder, and attention deficit/hyperactivity disorder are especially common in people with BPD.

Use of alcohol and illicit substances. People with BPD rarely are forthcoming about their use of alcohol and illicit substances. Counselors should inquire specifically about substance use from the beginning, and continue to educate clients about the dangers of substance use.

Violent behavior and antisocial traits. Treatment courses will vary according to the degree of violent or antisocial behavior. In mild cases (e.g., shoplifting),

cognitive therapy is recommended. For more severe cases, residential treatment (e.g., a TC) may be effective. Episodic violence may benefit from the use of mood-stabilizing medication. For severe antisocial features, hospitalization may be required.

Self-destructive behavior. Addressing self-destructive behavior is a primary part of treating BPD. Behaviors such as self-mutilation, suicide attempts, risky sexual behavior, and reckless driving are immediate threats to the individual and should be given treatment priority. Helping clients to think through the consequences of destructive behavior can be of use.

Childhood trauma and PTSD. While not universal, childhood trauma is very common among people with BPD. Treating offenders with BPD will often entail addressing the trauma and symptoms of PTSD.

Dissociative symptoms. Because there often is comorbidity between BPD and dissociative disorders, counselors must also be aware of the likelihood that the offender with BPD experiences transient dissociative symptoms (e.g., depersonalization, derealization, and loss of reality testing), and/or dissociative identity disorder. Counselors can assist by exploring the extent of the dissociative symptoms, the current issues that may lead to dissociative episodes, and the nature of dissociative symptoms. It may also be helpful to teach clients how to control dissociation and to work through posttraumatic symptoms.

Psychosocial stressors. Stress can heighten the symptoms of BPD, trigger relapse, and undermine recovery. Moreover, because of their intense fear of abandonment, many clients with BPD will be sensitive to any perceived rejection within any relationship, including the client-counselor relationship. Counselors should thus be watchful of reactive behavior that often results when the offender feels in danger of being abandoned. (For more information, go to www.psych.org/psych_pract/treatg/pg/borderline_revisebook_index.cfm.)

A general clinical observation is that the TC is an effective treatment for both ASPD and BPD through the emphasis on interventions that facilitate socialization and maturity.

Special Considerations in Treating Depressive and Bipolar Disorders

Treatment strategies for offenders with co-occurring major depressive disorders have focused on modifying thoughts that lead to depression or that are related to substance abuse. Issues surrounding loss and trauma are typically addressed when an offender is able to tolerate uncomfortable mood states without turning to substance abuse. Activities are designed to promote understanding of how trauma and abuse experiences are expressed through emotions, physical reactions, and behaviors, including substance abuse. In addition to the interventions for depressive disorders, treatment for offenders with bipolar

disorders addresses impaired judgment that occurs during manic episodes, and the effects of substance abuse on judgment. Treatment strategies often focus on building an acceptable set of coping responses to manic or hypomanic impulses, as well as medication adherence when warranted.

Special Considerations in Treating Schizophrenia/Psychotic Disorders

Treatment for offenders with co-occurring psychotic disorders is designed to address disorganized thought patterns and communication style. Specialized approaches used in treatment include use of concrete concepts, avoiding harsh confrontation, and greater use of structured exercises and written materials. Offenders who have psychotic disorders often abuse substances for many of the same reasons as other individuals. Key treatment components include education in drug refusal skills, identification of strategies to fight boredom, building supportive social networks, and medication adherence.

Special Considerations in Treating Attention Deficit/Hyperactivity and Other Cognitive Disorders

Interventions for offenders with co-occurring attention deficit/hyperactivity disorder (AD/HD) focus on interpersonal difficulties, social skill deficits, and cognitive skill-building to address impulsiveness and aggression. Information should be conveyed visually as well as orally when possible. Short therapeutic sessions provided in environments that have few distractions are preferable. With this population it is particularly important to repeat important themes and to rehearse key skills in various settings. Those with cognitive disorders need concrete, practical information and skills.

Special Considerations in Treating PTSD, Phobias, and Other Anxiety Disorders

Treatment of co-occurring anxiety disorders focuses on interventions to improve social skills and to modify cognitions associated with difficult interpersonal situations, particularly those that augment anxiety. It is particularly important in treating clients with anxiety disorders for the counselor to be calm and reassuring. Clients with PTSD often make slow progress in achieving the trust necessary in a therapeutic alliance. It is important not to encourage discussion of traumatic events, particularly early in treatment. Those whose trauma-related symptoms are severe can benefit from learning techniques to help them focus on staying in the "here-and-now." Recovery from PTSD often requires long-term treatment from specially trained clinicians. Counselors should be prepared to refer these clients to trauma experts. Clients with phobias can be especially sensitive to social situations and may need help in participating in mutual self-help groups. Specialized approaches, including use of medications, to reduce anxiety-induced insomnia also may be indicated.

People with Infectious Diseases

HIV, AIDS, and tuberculosis are more prevalent among inmates than in the general population. At the end of 2002, 2 percent of all inmates in State and 1.1 percent of all inmates in Federal prisons were known to be infected with the HIV virus. Rates of HIV infection were higher (3 percent) for female inmates of State prisons than for males (1.9 percent) (Maruschak 2004). In 2002 they were also higher for African-American (1.2 percent) and Hispanic/Latino (2.9 percent) jail inmates than for white jail inmates (.8 percent) (Maruschak 2004). More than a quarter of all inmates known to be HIV-positive in 2002 were held in New York State, amounting to 7.5 percent of that State's total prison population (Maruschak 2004). According to 2002 data, 0.50 percent of inmates in State prison had confirmed cases of AIDS, three and one-half times the rate for the general population (Maruschak 2004).

Evidence suggests that sexually transmitted diseases (STDs), hepatitis B and C, and tuberculosis also affect inmates disproportionately (Hammet 1998; Hammet et al. 1999; Varghese and Fields 1999). Routine screening for STDs and hepatitis is not included in many correctional systems, and, although HIV prevention programs are becoming more common, few correctional systems have implemented system wide programs to educate inmates about these diseases or to institute preventive measures. High-risk behaviors for the spread of HIV occur with great frequency in correctional facilities. These include unprotected sexual activity, substance use, and tattooing. The data clearly show that there is transmission of HIV between inmates (Hammett et al. 1999). Curricula for HIV prevention are available in many prisons. However, although female inmates have higher rates of HIV than their male counterparts, few HIV educational programs have been developed for the particular needs of women.

The Federal prison system undertakes random HIV testing of inmates for data collection purposes, and all inmates are tested on release; otherwise inmates are tested only if there is a clinical indication that they may be HIV-positive or if they request testing. States have various procedures for testing the HIV status of inmates. Some States test all inmates who meet the criteria for belonging to a high-risk group, some test everyone entering the facility, and still others test inmates upon discharge from the facility.

Project ARRIVE

Project ARRIVE, a NIDA-funded AIDS prevention training model, was designed specifically for recently released parolees with histories of intravenous drug use—a population particularly vulnerable to resuming high-risk behaviors (Wexler et al. 1994). ARRIVE's assumption was that reinforcing parolees' general social and personal rehabilitation could reduce the risk of contracting AIDS. The

program incorporated the principles and techniques found to be useful for treating those with substance use disorders in other settings.

- *Social learning approach to prevention training*. The training program emphasized learning skills to resist relapse and develop personal and social competencies (Botvin et al. 1984) and included rational decision-making, coping with anxiety, assertiveness, and relaxation skills.
- *A strong self-help orientation*. Participants were encouraged to accept responsibility for their behavior; to develop their capacity to change negative features of their daily lives; and to engender a sense of mutuality, trust, and honesty among participants (Gartner and Riessman 1977).
- *Use of principles effective in TC programs* (De Leon 1999, 2000; DeLeon and Ziegenfuss 1986). Some ARRIVE training staff were themselves in recovery and could function as role models. In addition, the program fostered the development of peer support networks. Graduates were encouraged to continue their association with the program through weekly aftercare groups.
- *Job readiness preparation and placement assistance*.

These elements were combined into a structured 8-week, 24-session AIDS prevention program. Each new class met for 2 hours a night, three times per week over an 8-week period. Participants received $10 per session for a total of up to $240 if they attended all 24 sessions. Trainees also were given two subway tokens per session. ARRIVE participants were offered confidential HIV testing and counseling.

During the NIDA study, a total of 394 eligible parolees were recruited, of whom 241 (61 percent) attended the Training Program, including 164 program completers, for a 68 percent graduation rate. (During the second half of the program, 81 percent graduated.) The outcome evaluation, conducted 1 year after study recruitment, compared program graduates with parolees who never attended, controlling for observed group differences at baseline. ARRIVE participation significantly decreased most sexual and some drug-related risk behaviors and improved parolees' community adjustment during the follow-up period (Wexler et al. 1994).

While HIV/AIDS is widely recognized as a serious and significant problem within prisons, other infectious diseases are not always given the same attention. A vaccine is available for hepatitis B that could control the spread of that disease. However, the prevalence of hepatitis C virus (HCV) is increasing. In California, 41 percent of incoming prisoners were positive for HCV in 1994. Prevalence rates among HIV-positive offenders are higher (Hammett et al. 1999). Because the incubation period is so long (approximately 20 years), many offenders who have the disease will not experience its effects until after they are released.

Consequently, not all prison systems recognize hepatitis C as a problem; nor do they expend costly resources on its treatment. Rates of tuberculosis (TB) have declined since 1991 both in the general population and among incarcerated offenders, although they are still higher among inmates. Not all systems routinely screen for TB and report results. There is a risk to correctional employees of contracting TB due to insufficient control measures (Hammett et al. 1999).

Medical Care

Research indicates that medical care for offenders in the criminal justice system is inadequate and under funded, and the burden is increasing as the inmate population ages. This exacerbates poor health habits and neglect of health care not uncommon among people who come in contact with the criminal justice system. Medical care is extremely important for offenders with substance use disorders, who often have a number of medical problems. While using alcohol and illicit drugs, offenders often ignore their health problems. When they finally enter treatment they could have several problems that have been untreated except for self-medication. If they are in pain they are less able to focus on their substance abuse treatment. As a consequence, substance abuse treatment staff often request that the institution pay greater attention to medical issues and advocate for medical services for their clients.

Substance abuse treatment staff also should stress the importance of good health when working with offenders. Health improvement can be included as a goal for clients and written into their treatment plans.

Prevention and Education

Educational programs about infectious diseases are a useful addition to a treatment program but cannot stand alone without counseling and treatment for those diseases. Simply informing a group of offenders about the dangers of infectious disease without helping them deal with the possibility of infection can actually cause additional problems, such as fights caused by fears of infection. Prevention and testing efforts often work more smoothly if integrated into a substance abuse treatment program, as counseling staff can work with an individual and help him or her deal with concerns and fears. Programs can use peers who are HIV-positive to provide education to other offenders; in addition to providing other offenders with information from a credible source, peer education helps the person who is HIV-positive feel that his or her life has some sense of purpose.

Advice to the Counselor: **Infectious Diseases**

- Education about infectious diseases such as HIV/AIDS and hepatitis C is a useful addition to a treatment program. However, this education must take care not to cause additional problems such as fights over

fear of infection.

- Counseling by peers who are HIV-positive provides information from a credible source.
- Health improvement can be included as a goal for clients and can be written into their treatment plans.

Sex Offenders

Self reports of those incarcerated for rape or sexual assault reveal that 23 percent admitted they were under the influence of alcohol alone when they committed their crime, another 15 percent acknowledged using both alcohol and drugs, and an additional 5 percent reported they had been using drugs alone (CASA 1999). That even these self-report numbers considerably underestimate the pervasiveness of substance abuse among sex offenders is suggested by the fact that 42 percent of those arrested for sex offenses tested positive for drugs at the time of arrest (CASA 1999). Similar evidence for alcohol use is not available but can be presumed to be considerably higher. Among incarcerated sex offenders, two of every three have a history of alcohol or drug use, abuse, or addiction (Peugh and Belenko 2001).

While the high prevalence of substance abuse among sexual offenders is clear, solid information about the relationship between substance abuse and sexual offending is not readily available. While many convicted sex offenders will admit to problems with alcohol or illicit drugs, it is unusual for someone identified with alcohol or drug problems to freely disclose illegal sexual behavior. The negative consequences of such an admission would usually be too great. Consequently, what is known about the co-occurrences of substance use disorders and the commission of sex offenses comes mainly from the personal history and self reports of identified sex offenders within the criminal justice system and their victims.

Sex offenders apprehended and labeled through the criminal justice system are thought to represent a small portion of those who actually commit sexual offenses (Center for Sex Offender Management 2001*a*). Only those individuals actually convicted of sexual offenses are likely to be identified as a sex offender subgroup with COD requiring specialized attention. And for this population, the focus of treatment is likely to be the sexually deviant behavior. Alcohol and drug issues are usually seen as one part of a broad array of problems contributing to the sex offense and specific attention to substance abuse issues may comprise only one of many treatment modules designed to address these underlying problems (Barbaree et al. 1998). Many sex offenders with substance abuse issues are excluded from many substance abuse treatment programs. Analysis of Bureau of Justice Statistics data reveals that 34 percent of sex offenders

receive drug treatment in prison, as opposed to 42 percent of other violent offenders (Peugh and Belenko 2001). Often if they are to get any treatment for their substance abuse problems, it must be in or in conjunction with a sex offender treatment program. Otherwise, to participate in substance abuse treatment, they must conceal their sex offender identities and histories—not a promising foundation for fostering the self-disclosure treatment requires.

The subpopulation of sex offenders among offenders who require interventions for substance abuse issues raises many questions and complications, especially since they also may be concurrently mentally ill, culturally diverse, developmentally disabled, or otherwise high need (Raymond et al. 1999). Sex offenders often stir strong emotions and reactions (Jenkins 1998). The criminal justice system, other offenders, and the community at large typically think of sex offenders, particularly those whose victims are children, as a different class of criminal. Within jails and prisons, if identified, they are at great risk of being victimized by other inmates (and sometimes correctional staff) because of the nature of their crimes. Some States provide sex-offender-specific treatment services for a portion of these inmates, pre- and postrelease, and many counties require treatment as one of the conditions of probation (Burton and Smith-Darden 2001). When released from incarceration, sex offenders are required to register with local authorities, often receive more stringent supervision than other offenders, can be subject to community notification procedures, frequently encounter serious problems finding appropriate housing, and may have their identities and pictures made available on the Internet (Center for Sex Offender Management 2000*a*).

Some Relevant Facts About Sex Offenders

The image of the typical sex offender conjured by lurid newspaper headlines bears only some resemblance to the actual picture. The blanket term "sex offenders" includes a population so heterogeneous that only a few generalizations are not inaccurate and misleading (Center for Sex Offender Management 2000*b*). Although once there were thought to be discrete offender types—rapists, child molesters, incest offenders, exhibitionists—an increasing body of evidence derived from polygraph examinations of convicted offenders demonstrates that there is considerable "crossover" between behaviors once thought to define these subgroups. Thus nearly 9 of 10 offenders originally thought to have only adult victims were found, under polygraph examination, also to have victims under 18. Similarly, 36 percent of those convicted of an incest offense disclosed that they also had victimized adults (English et al. 2000). One important distinction, however, is that sexual offenses committed while intoxicated (e.g., date rape) are unusual occurrences and do not represent habitual behavior. These problems are more about impulse control amplified by alcohol and other substance use and often can be treated in substance abuse programs.

It now is generally accepted that no single causative factor can adequately explain the commission of sexual offenses. Only multifactorial explanations that take into account the presence, to various degrees, of deviant sexual arousal, lack of victim empathy, inadequate social skills, personal trauma history, criminal association, thinking errors, and other elements now appear to provide adequate models for understanding these crimes. The use of alcohol and drugs is seen as contributing to disinhibition but is never thought to be a stand-alone explanation for sexual offending (Laws et al. 2000).

Sex-Offender-Specific Treatment

The emergence, over the past 20 years, of an increasingly solid body of research-based information about sexual offending has led to correspondingly sophisticated treatment models and outcome studies (Marshall et al. 1998). Treatment focus areas are based on an emerging set of "dynamic" (i.e., modifiable) risk variables. One widely used instrument for assessing such factors is the Sex Offender Needs Assessment Rating (SONAR) (Hanson and Harris 2001). Risk factors identified in the SONAR include intimacy deficits, negative social influences, antisocial attitudes, inadequate sexual self-regulation, and general self-regulation. Addressing such factors in non-sex-offender-specific treatment might have some impact on reducing the risk of sexual recidivism. A growing body of solid research provides evidence that, overall, treatment now reduces the reoffense rate between 10 and 17 percent (Center for Sex Offender Management 2001*b*).

SHARPER FUTURE

Awareness of the presence of significant numbers of sex offenders among inmates participating in California's in-prison substance abuse treatment programs—as high as 30 percent—led to the development of a specialized aftercare program specifically tailored to address both substance abuse and sex offense issues concurrently. For many reasons, in-prison programs do not address sex offense issues. SHARPER FUTURE (Social Habilitation and Relapse Prevention - Expert Resources), a private-sector forensic mental health agency, has been operating a program under contract in central Los Angeles since 1999 to meet the needs of parolees who have completed one of the in-prison substance abuse programs but who are screened out of other aftercare programs because of their sex offense histories. (SHARPER FUTURE also has a component to treat offenders with mental disorders.)

- SHARPER FUTURE is staffed by licensed clinicians with expertise in treating both areas concurrently. The existence of many parallels between treatment strategies for substance abuse and for sex offense issues offers a foundation for such an integrated approach. Concepts from relapse prevention apply equally well to both areas of concern.

- Because of restrictions in California codes prohibiting registered sex offenders from sharing a common residence, SHARPER FUTURE is exclusively outpatient. As an outpatient program, SHARPER FUTURE cannot fully continue but does support the therapeutic community philosophy that is the foundation of the prison-based system. Although the program is considered "aftercare" for substance abuse issues, which have been directly addressed previously in the institutional setting, the sex offense issues are addressed directly for the first time only in this outpatient phase. During the 14-month intensive treatment phase of SHARPER FUTURE, participants, all on parole, attend three 2-hour groups per week. A weekly aftercare group can subsequently continue until the end of the parole period or beyond.
- Because personal issues related to substance abuse already have been addressed in prison and because the level of shame related to sex offense behavior generally is much more intense, greater resistance in dealing with the sexual behavior is common. Frequently analogies with substance abuse cycles, behavior chains, thinking errors, low capacity for delayed gratification, and similar themes offer a more acceptable entrance to the sex offense work. Creating a group treatment culture supportive of the work needed to address deviant sexual patterns is essential to treatment success.
- Standards of the Association for the Treatment of Sexual Abusers (ATSA—see www.ATSA.com) require substantial training and experience for staff involved in treating sex offenders and finding such qualified staff, especially individuals who also have expertise in substance abuse treatment, has been a challenge, as has working collaboratively within such a large and complex system as the California Department of Corrections. Future goals include replicating this pilot program in other geographical areas and, ultimately, developing structures to allow the sex offense issues to be addressed from the beginning of treatment in specialized separate tracks of the in-prison substance abuse treatment system. (For more information go to www.thesharpprogram.com/.)

Relapse Prevention: The Common Thread

With some modifications, relapse prevention concepts and formulations borrowed from the substance abuse treatment field have been found to fit sex offender programming needs quite well (Laws 1989; Laws et al. 2000). At present, relapse prevention—or the more broadly designated cognitive-behavioral therapy—has grown to be the dominant model used by most sex offender treatment programs, whether institutional or community-based, so that currently over 80 percent of programs in North America identify "cognitive-behavioral/relapse prevention" as their primary treatment model (Burton and Smith-Darden 2001). Sharing such a common lineage has the benefit of

permitting easy movement in the treatment setting between relapse prevention as applied to substance abuse and relapse prevention as applied to sex offending.

Areas of Divergence

Important differences prevent a simplistic merger of sex offender treatment and substance abuse treatment models. Sex offender treatment usually is provided by specially trained—sometimes specifically credentialed—mental health professionals, and interventions can include medical and behavioral efforts to modify deviant sexual arousal patterns (ATSA 2001). Stakes are higher because any "relapse" involves another traumatized victim and can lead to a long, even lifetime, prison sentence. Since the primary goal is community safety, sex offender treatment usually involves close collaboration with the criminal justice system, represented by probation and parole officers. Great caution is exercised with regard to encouraging mutual support efforts between sex offenders and, consequently, self-help support systems are ordinarily unavailable. Treatment themes seldom are discussed freely with support persons outside of the program since the stigma and other social consequences of being a sex offender are considerably higher than for those in substance abuse recovery.

Conclusions and Recommendations

Part 1:

- Whenever possible, treatment should be modified as needed to meet the individual client's specific needs. A thorough client assessment covering multiple dimensions will enable treatment providers to determine what modifications to treatment are required.

- Individual needs should be considered in adapting the sequence, focus, and intensity of treatment.

- It is important for offenders to have appropriate peer and staff role models who have overcome the stigma of a criminal past and a history of substance abuse. Provisions should be made whenever possible to allow criminal justice programs to hire staff who are ex-offenders and who are in recovery. Treatment programs have found it useful to maintain a blend of recovering and nonrecovering staff.
- While legal pressures may be sufficient to leverage a client into treatment, specific engagement strategies are necessary if the client is to be motivated to commit to change and to maintain recovery.

- Anxiety, guilt, and remorse related to past substance abuse and criminal behavior can be productive in motivating offenders to change their lives.

Making amends to those who have been harmed by past behaviors is one strategy that can be used to positively address these emotions.

- There is a risk that treatment could become overly coercive and susceptible to charges of "cruel and unusual punishment." It is important that participants in treatment be offered the opportunity to leave the program after a minimum period of time (e.g., 90 days).

- Internal motivation for treatment is a better predictor of retention than external motivation. It is recommended that counselors target those with low internal motivation for an intervention to increase readiness.

- Motivation to enter treatment frequently occurs at particularly stressful times such as after being arrested, after one's children have been removed by authorities, or following an overdose or a "bad high." Substance abuse treatment and criminal justice staff should watch for these opportune times and respond quickly so that the client can be engaged in treatment while their motivation is still strong.

- While clients in criminal justice settings are often coerced and resistant to treatment, they can become invested in treatment through the use of motivational interviewing and similar techniques.

- Clients who agree to enter treatment may be seen as "traitors" by other offenders, as the prison culture makes it a point to resist anything that is seen as a further attempt to control the lives of inmates. For this reason, it is useful to provide treatment services in residential areas or separate prisons that are isolated from the general inmate population.

- In jurisdictions that involve probation/parole officers or corrections staff in treatment team activities, roles need to be very clearly defined. Criminal justice staff who do not have treatment-related experience or specialized training can become overly involved in the treatment process and overly invested in treatment issues.

- Criminal justice professionals have been effectively involved in facilitating psychoeducational groups and other treatment activities and are often included in treatment teams and treatment and discharge planning. Criminal justice professionals providing group treatment services should receive specialized training in therapeutic techniques and treatment approaches and should consider obtaining substance abuse certification and licensure.

- Many correctional treatment programs in jails and prisons have found it useful to establish co-coordinators from both treatment and correctional/security systems. These arrangements provide a sense of

joint "ownership" of treatment programs, enhance program credibility among correctional officers, and provide an effective mechanism for addressing critical incidents and solving problems that affect both treatment and corrections staff.

- To operate within a prison or jail and maintain inmates' respect, corrections and treatment staff need to maintain a certain distance from offenders. Cross-training can assist staff in defining appropriate "boundaries" that should be maintained in relationships with inmates, and to identify related situations that can compromise the effectiveness of security/public safety and treatment operations.

- Treatment providers need not condone an offender's past criminal activity, but they should accept it as part of the client's past, and not a permanent character flaw or insurmountable obstacle to recovery.

Part 2:

- Screening and assessment for a history of physical/sexual abuse should be included as part of intake assessments for men and women in criminal justice treatment settings. Referral information should be provided to inmates who report prior abuse and who are interested in receiving services related to this abuse.

- Use of "strengths-based" approaches to substance abuse treatment is highly recommended, particularly for female offenders. These interventions are considered effective in improving self-esteem.

- Substance abuse treatment programs in jails and prisons (including TCs) should include vocational programs for men and women. Offenders under community supervision also should have access to community vocational programs.

- Treatment programs in women's institutions are encouraged to use the segregation of genders within the criminal justice system to the advantage of their clients by developing treatment programs that specifically address women's needs.

- Jail and prison programs need to allow for more interaction between incarcerated mothers and their children; the 2–4 hours of supervised visitation per week that many institutions allow is not sufficient for mothers or their children.

- Given the high rates of co-occurring mental disorders in the offender population, more treatment programs need to be developed for offenders with COD.

- Given the prevalence of cognitive and physical disabilities in incarcerated populations, especially among offenders with substance use disorders, treatment providers need to be able to screen for and to provide accommodations for offenders who have these co-existing disabilities.

- Because mental health and substance use disorders can mask or imitate each other, accurate diagnosis of these disorders requires skilled screening and assessment. Assessment should look for evidence of both disorders, rather than providing separate assessments for the disorders. Regular reassessment for COD also is important, and should be conducted at major transition points in the criminal justice system by staff with specialized training in this area.

- Substance abuse treatment programs for offenders should include staff who reflect the cultural diversity of the population they are treating. Efforts need to be made to adopt treatment to specific cultural populations (e.g., ethnicity, race, age, sexual orientation, rural cultures, socioeconomic class, and language). Counselors need to be aware of different cultural sets of values, biases, and assumptions related to communication, therapeutic style, and interpersonal contact and should be trained in techniques for adapting treatment approaches to reflect these differences, in order to more effectively engage and maintain clients in program services.

- The therapeutic community has been successfully modified to treat specific populations, including female offenders and offenders with COD.

Appendix A: Bibliography

Acoca L. Defusing the time bomb: Understanding and meeting the growing health care needs of incarcerated women in America. Crime and Delinquency 44(1):49-69. 1998.

Acoca, L., and Austin, J. *The Crisis: Women in Prison.* Oakland, CA: National Council on Crime and Delinquency, 1996.

Alarid LF. Sexual orientation perspectives of incarcerated bisexual and gay men: The county jail protective custody experience. Prison Journal 80(1):80-95. 2000.

American Civil Liberties Union. *ACLU Applauds Supreme Court Ruling Protecting Disabled Prisoners.* Press release, June 15, 1998. www.aclu.org/news/n01598b.html [Accessed April 11, 2002].

American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders* . 4th ed. Washington, DC: American Psychiatric Association, 1994.

American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders* . 4th ed. Text Revision. Washington, DC: American Psychiatric Association, 2000.

Anglin, M.D., Prendergast, M., and Farabee, D. "The effectiveness of coerced treatment for drug-abusing offenders." Paper presented at the Office of National Drug Control Policy's Conference of Scholars and Policy Makers, Washington, DC, March 23 –25, 1998.

Antonowicz DH, Ross RR. Essential components of successful rehabilitation programs for offenders. International Journal of Offender Therapy and Comparative Criminology 38(2):97-104. 1994.

Association for the Treatment of Sexual Abusers. *Practice Standards and Guidelines for the Members of the Association for the Treatment of Sexual Abusers* (revised 2001). Beaverton, OR: Association for the Treatment of Sexual Abusers, 2001.

Barbaree, H.E., Peacock, E.J., Cortoni, F., Marshall, W.L., and Seto, M. Ontario penitentiaries program. In: Marshall, W.L., and Fernandez, Y.M., eds. *Sourcebook of Treatment Programs for Sexual Offenders* . New York: Plenum Press, 1998. pp. 59 –77.

Belenko, S., and Peugh, J. *Fighting Crime by Treating Substance Abuse* . Issues in Science and Technology Online. Washington, DC: National Academy Press, 1998. www.nap.edu/issues/15.1/belenk.htm [Accessed March 27, 2002].

Botvin GJ, Baker E, Renick NL, Filazzola AD, Botvin EM. A cognitive-behavioral approach to substance abuse prevention. Addictive Behaviors 9(2):137-147. 1984. (PubMed)

Broner, N., Borum, R., Gawley, K., and Whitmire, L. A review of screening instruments for co-occurring mental illness and substance use in criminal justice programs. In: Landsberg, G., Rock, M., and Berg, L., eds. *Serving Mentally Ill Offenders: Challenges and Opportunities for Mental Health Professionals* . New York: Springer Publishing, 2002 *a* . pp. 289 –337.

Broome KM, Knight K, Hiller ML, Simpson DD. Drug treatment process indicators for probationers and prediction of recidivism. Journal of Substance Abuse Treatment 13(6):487-491. 1996a. (PubMed)

Brown, K.A. *Assertive Community Treatment: A Reentry Model for Seriously Mentally Ill Offenders.* Columbus, OH: The Supreme Court of Ohio, 2003. www.sconet.state.oh.us/ACMIC/resources/assertive.pdf [Accessed March 1, 2005].

Burton, D., and Smith-Darden, J. North American Survey of Sexual Abuser Treatment and Models: Summary Data - 2000. Brandon, VT: The Safer Society Press, 2001.

Bush, J., Glick, B., and Taymans, J. *Thinking for a Change: Integrated Cognitive Behavior Change Program* . Longmont, CO: National Institute of Corrections, 2000. nicic.org/Library/016672 [Accessed March 28, 2005].

Center for Sex Offender Management. *The Collaborative Approach to Sex Offender Management*. Silver Spring, MD: Center for Sex Offender Management, 2000 *a* . www.csom.org/pubs/collaboration.pdf [Accessed April 1, 2002].

Center for Sex Offender Management. *Myths and Facts About Sex Offenders* . Silver Spring, MD: Center for Sex Offender Management, 2000 *b* . www.csom.org/pubs/mythsfacts.html [Accessed April 11, 2002].

Center for Sex Offender Management. *Community Notification and Education* . Silver Spring, MD: Center for Sex Offender Management, 2001 *a* . www.csom.org/pubs/notedu.pdf [Accessed April 1, 2002].

Center for Substance Abuse Treatment. *Substance Use Disorder Treatment for People With Physical and Cognitive Disabilities* . Treatment Improvement Protocol (TIP) Series 29. DHHS Publication No. (SMA) 98-3249. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1998 *d* .

Chaiklin H. The elderly disturbed prisoner. Clinical Gerontologist 20(1):47-62. 1998.

Cockram J, Jackson R, Underwood R. People with an intellectual disability and the criminal justice system: The family perspective. Journal of Intellectual & Developmental Disability 23(1):41-56. 1998.

Cornelius JR, Jarrett PJ, Thase ME, Fabrega H Jr, Haas GL, Jones-Barlock A, Mezzich JE, Ulrich RF. Gender effects on the clinical presentation of alcoholics at a psychiatric hospital. Comprehensive Psychiatry 36(6):435-440. 1995. (PubMed)

Covington SS. Women in prison: Approaches in the treatment of our most invisible population. Women & Therapy 21(1):141-155. 1998.

De Leon, G. Therapeutic communities. In: Galanter, M., and Kleber, H.D., eds. *Textbook of Substance Abuse Treatment* . 2d ed. Washington, DC: American Psychiatric Press, 1999. pp. 447 –462.

De Leon, G. The Therapeutic Community: Theory, Model, and Method. New York: Springer Publishers, 2000.

De Leon G, Jainchill N. Male and female drug abusers: Social and psychological status after treatment in a therapeutic community. American Journal of Drug and Alcohol Abuse 8(4):465-497. 1982.

De Leon, G., and Ziegenfuss, J.T., eds. *Therapeutic Communities for Addictions: Readings in Theory, Research and Practice* . Springfield, IL: Charles C. Thomas, 1986.

Diaz FG. Traumatic brain injury and criminal behaviour. Medicine and Law 14(1–2):131-140. 1995. (PubMed)

Ditton, P.M. *Mental Health and Treatment of Inmates and Probationers* . Washington, DC: Bureau of Justice Statistics, 1999. www.ojp.usdoj.gov/bjs/pub/ascii/mhtip.txt [Accessed June 15, 2001].

Donaldson, S. Prison, jails, and reformatories. In: Dynes, W.R., ed. *Encyclopedia of Homosexuality* . New York: Garland Publications, 1990.

Edens JF, Peters RH, Hills HA. Treating prison inmates with co-occurring disorders: An integrative review of existing programs. Behavioral Sciences and the Law 15(4):439-457. 1997.

English, K., Jones, L., Pasini-Hill, D., Patrick, D., and Cooley-Towell, S. The Value of Polygraph Testing in Sex Offender Management: Research Report Submitted to the National Institute of Justice. Denver, CO: ORS, 2000.

Farabee D, Prendergast M, Anglin . The effectiveness of coerced treatment for drug-abusing offenders. Federal Probation 62(1):3-10. 1998.

Farabee D, Prendergast M, Cartier J, Wexler H, Knight K, Anglin MD. Barriers to implementing effective correctional drug treatment programs. Prison Journal 79(2):150-162. 1999.

Federal Bureau of Prisons. *Federal Bureau of Prisons Clinical Practice Guidelines: Detoxification of Chemically Dependent Inmates, December, 2000* . Washington, DC: U.S. Bureau of Prisons, 2000. www.nicic.org/pubs/2000/016554.pdf [Accessed April 4, 2002].

Field G. Psychological deficits and treatment needs of chronic criminality. Federal Probation 50(4):60-66. 1986.

Friedman AS. Substance use/abuse as a predictor to illegal and violent behavior: A review of the relevant literature. Aggression & Violent Behavior 3(4):339-355. 1998.

Galen LW, Brower KJ, Gillespie BW, Zucker RA. Sociopathy, gender, and treatment outcome among outpatient substance abusers. Drug and Alcohol Dependence 61(1):23-33. 2000. (PubMed)

Gartner, A., and Riessman, F. *Self-Help in the Human Services* . San Francisco: Jossey-Bass, 1977.

Gendreau P. What works in community corrections: Promising approaches in reducing criminal behavior. IARCA Journal on Community Corrections 6:5-12. 1995.

Genty PM. Permanency planning in the context of parental incarceration: Legal issues and recommendations. Child Welfare 77(5):543-559. 1998. (PubMed)

Gil-Rivas V, Fiorentine R, Anglin MD, Taylor E. Sexual and physical abuse: Do they compromise drug treatment outcomes? Journal of Substance Abuse Treatment 14(4):351-358. 1997. (PubMed)

Glass MH, Bieber SL. The effects of acculturative stress on incarcerated Alaska Native and non-Native men. Cultural Diversity and Mental Health 3(3):175-191. 1997. (PubMed)

Glaze, L.E., and Palla, S. *Probation and Parole in the United States, 2003* . NCJ 205336. Washington, DC: Bureau of Justice Statistics, 2004. www.ojp.usdoj.gov/bjs/pub/pdf/ppus03.pdf [Accessed February 10, 2005].

Gorski, T.T., and Kelley, J.M. *Counselor's Manual for Relapse Prevention With Chemically Dependent Criminal Offenders* . Technical Assistance Publication Series 19. DHHS Publication No. (SMA) 96-3115. Rockville, MD: Center for Substance Abuse Treatment, 1996.

Graham, G. *A Framework for Recovery* . Bellevue, WA: Gordon Graham and Company, Inc., 1999. www.ggco.com/recovery.htm [Accessed March 13, 2002].

Greenfeld, L.A. Alcohol and Crime: An Analysis of National Data on the Prevalence of Alcohol Involvement in Crime. Washington, DC: Bureau of Justice Statistics, 1998.

Greenfeld, L.A., and Snell, T.L. *Women Offenders.* NCJ 175688. Washington, DC: Bureau of Justice Statistics, 1999.

Grilo CM, Becker DF, Walker ML, Edell WS, McGlashan TH. Gender differences in personality disorders in psychiatrically hospitalized young adults. Journal of Nervous and Mental Disease 184(12):754-757. 1996.

Hammett, T.M. *Public Health/Corrections Collaborations: Prevention and Treatment of HIV/AIDS, STDs, and TB.* Washington, DC: U.S. Department of Justice, 1998. www.ncjrs.org/pdffiles/169590.pdf [Accessed February 19, 2002].

Hammett, T.M., Harmon, P., and Maruschak, L.M. *HIV/AIDS, STDs, and TB in Correctional Facilities: 1996-1997 Update.* Issues and Practices in Criminal Justice. NCJ 176344. Washington, DC: National Institute of Justice, 1999.

Hanson RK, Harris AJR. A structured approach to evaluating change among sexual offenders. Sexual Abuse: A Journal of Research and Treatment 13(2):105-122. 2001. (PubMed)

Hare RD, Hart S, Harpur T. Psychopathy and the DSM-IV criteria for antisocial personality disorder. Journal of Abnormal Psychology 100(3):391-398. 1991. (PubMed)

Harlow, C.W. *Prior Abuse Reported by Inmates and Probationers* . Bureau of Justice Statistics Selected Findings. Washington, DC: Bureau of Justice Statistics, 1999. www.ojp.usdoj.gov/bjs/pub/pdf/parip.pdf [Accessed April 1, 2002].

Harrison, P.M., and Beck, A.J. *Prisoners in 2003* . Bureau of Justice Statistics Bulletin. NCJ 205335. Washington, DC: Bureau of Justice Statistics, 2004. www.ojp.usdoj.gov/bjs/pub/pdf/p03.pdf [Accessed February 10, 2005].

Harrison, P.M., and Karberg, J.C. *Prison and Jail Inmates at Midyear 2002* . Washington, DC: Bureau of Justice Statistics, 2003. www.ojp.usdoj.gov/bjs/pub/pdf/pjim02.pdf [Accessed July 21, 2003].

Harrison, P.M., and Karberg, J.C. *Prison and Jail Inmates at Midyear 2003* . Bureau of Justice Statistics Bulletin. Washington, DC: Bureau of Justice Statistics, 2004. www.ojp.usdoj.gov/bjs/pub/pdf/pjim03.pdf [Accessed October 21, 2004].

Henderson DJ. Drug abuse and incarcerated women: A research review. Journal of Substance Abuse Treatment 15(6):579-587. 1998. (PubMed)

Herz, D.C. *Drugs in the Heartland: Methamphetamine Use in Rural Nebraska* . National Institute of Justice Research in Brief. Washington, DC: National Institute of Justice, 2000. www.ncjrs.org/pdffiles1/nij/180986.pdf [Accessed April 1, 2002].

Hiller ML, Knight K, Simpson DD. Risk factors that predict dropout from correction-based treatment for drug abuse. Prison Journal 79(4):411-431. 1999b.

Holt, N., and Miller, D. *Exploration in Inmate-Family Relationships.* California Department of Corrections, 1972. www.fcnetwork.org/ [Accessed April 1, 2002].
Hubbard, R.L., Collins, J.J., Rachal, J.V., and Cavanaugh, E.R. The criminal justice client in drug abuse treatment. In: *Compulsory Treatment of Drug Abuse: Research and Clinical Practice* . NIDA Research Monograph 86. Rockville, MD: National Institute on Drug Abuse, 1988. pp. 57 –80.

Hubbard RL, Marsden ME, Cavanaugh E, Rachal JV, Ginzburg HM. Role of drug-abuse treatment in limiting the spread of AIDS. Reviews of Infectious Diseases 10(2):377-384. 1988. (PubMed)

Jeffries, J.M., Menghraj, S., and Hairston, C.F. *Serving Incarcerated and Ex-Offender Fathers and Their Families: A Review of the Field* . New York: Vera Institute of Justice, 2001. www.vera.org/publication_pdf/fathers.PDF [Accessed September 24, 2002].

Jemelka, R.P., Rahman, S., and Trupin, E.W. Prison mental health: An overview. In: Steadman, H.J., and Cocozza, J.J., eds. *Mental Illness in America's Prisons* . Washington, DC: The National Coalition for the Mentally Ill in the Criminal Justice System, 1993.

Jenkins, P. Moral Panic: Changing Concepts of the Child Molester in Modern America. New Haven, CT: Yale University Press, 1998.

Knight K, Hiller ML, Broome KM, Simpson DD. Legal pressure, treatment readiness, and engagement in long-term residential programs. Journal of Offender Rehabilitation 31(1/2):101-115. 2000.

Knop, J., Jensen, P., and Mortensen, E.L. Comorbidity of alcoholism and psychopathy. In: Millon, T., Simonsen, E., and Davis, R., eds. *Psychopathy: Antisocial, Criminal, and Violent Behavior* . New York: The Guilford Press, 1998. pp. 321 –331.

Landreth GL, Lobaugh AF. Filial therapy with incarcerated fathers: Effects on parental acceptance of child, parental stress, and child adjustment. Journal of Counseling & Development 76(2):157-165. 1998.

Lang MA, Belenko S. Predicting retention in a residential drug treatment alternative to prison program. Journal of Substance Abuse Treatment 19(2):145-160. 2000. (PubMed)

Lavine R. Psychopharmacological treatment of aggression and violence in the substance using population. Journal of Psychoactive Drugs 29(4):321-329. 1997. (PubMed)

Laws, D.R. *Relapse Prevention With Sex Offenders* . New York: Guilford Press, 1989.

Laws, D.R., Hudson, S.M., and Ward, T., eds. *Remaking Relapse Prevention With Sex Offenders: A Sourcebook* . Thousand Oaks, CA: Sage Publications, 2000.

Leukefeld, C.G., and Tims, F.M., eds. *Compulsory Treatment of Drug Abuse: Research and Clinical Practice* . NIDA Research Monograph Series No. 86. Rockville, MD: National Institute on Drug Abuse, 1988.

Longshore, D., Urada, D., Evans, E., Hser, Y.-I., Prendergast, M., Hawken, A., Bunch, T., and Ettner, S. *Evaluation of the Substance Abuse and Crime Prevention Act: 2003 Report.* Department of Alcohol and Drug Programs, California Health and Human Services Agency, September 2004. www.uclaisap.org/prop36/reports.htm [Accessed March 8, 2005].

Lurigio AJ. Persons with serious mental illness in the criminal justice system: Background, prevalence, and principles of care. Criminal Justice Policy Review 11(4):312-328. 2000b.

Maguire, K., and Pastore, A.L. *Sourcebook of Criminal Justice Statistics [Online].* Albany, NY: University at Albany, 2001. www.albany.edu/sourcebook/ [Accessed March 15, 2002].

Marlowe DB, Kirby KC, Bonieskie LM, Glass DJ, Doods LD, Husband SD, Platt JJ, Festinger DS. Assessment of coercive and noncoercive pressures to enter drug abuse treatment. Drug and Alcohol Dependence 42(2):77-84. 1996.

Marshall, W., Fernandez, Y., Hudson, S., and Ward, T., eds. *Sourcebook of Treatment Programs for Sexual Offenders* . New York: Plenum Press, 1998.

Maruschak, L.M. *HIV in Prisons and Jails, 2002* . Bureau of Justice Statistics Bulletin. NCJ 205333. Washington, DC: Bureau of Justice Statistics, 2004. www.ojp.usdoj.gov/bjs/pub/pdf/hivpj02.pdf [Accessed February 22, 2004].

Maruschak, L.M., and Beck, A.J. *Medical Problems of Inmates, 1997* . Bureau of Justice Statistics Special Report. Washington, DC: Bureau of Justice Statistics, 2001. www.ojp.usdoj.gov/bjs/pub/pdf/mpi97.pdf [Accessed June 18, 2001].

McKean, J. Race, ethnicity, and criminal justice. In: Hendricks, J.E., ed. *Multicultural Perspectives in Criminal Justice and Criminology* . Springfield, IL: Charles C. Thomas, 1994. pp. 85 –134.

Miron, J.A. *Violence and the U.S. Prohibition of Alcohol and Drugs.* NBER Working Paper No. W6950. Cambridge, MA: National Bureau of Economic Research, 1999.

Monroe, G. *Drug Abuse Patterns and Trends in Monroe/Ouachita Parish* . Baton Rouge, LA: Louisiana Office for Addictive Disorders, 1998. 204.58.127.25/OADA/epidem-report/18-monroe.htm [Accessed June 18, 2001].

Mueser, K.T., Drake, R.E., and Miles, K.M. The course and treatment of substance use disorder in persons with severe mental illness. In: Onken, L.S., Blaine, J.D., Genser, S., and Horton, A.M., eds. *Treatment of Drug-Dependent Individuals With Comorbid Mental Disorders* . NIDA Research Monograph 172. NIH Publication No. 97-4172. Rockville, MD: National Institute on Drug Abuse, 1997. pp. 86 –109.

Mueser KT, Yarnold PR, Rosenberg SD, Swett C Jr, Miles KM, Hill D. Substance use disorder in hospitalized severely mentally ill psychiatric patients: Prevalence, correlates, and subgroups. Schizophrenia Bulletin 26(1):179-192. 2000. (PubMed)

Mumola, C.J. *Substance Abuse and Treatment, State and Federal Prisoners, 1997.* Bureau of Justice Statistics Special Report. Washington, DC: Bureau of Justice Statistics, 1999.

Mumola, C.J. *Incarcerated Parents and Their Children* . Bureau of Justice Statistics Special Report. Washington, DC: Bureau of Justice Statistics, 2000. www.ojp.usdoj.gov/bjs/pub/pdf/iptc.pdf [Accessed June 18, 2001].

National Center on Addiction and Substance Abuse. *Dangerous Liaisons: Substance Abuse and Sex* . New York: National Center on Addiction and Substance Abuse, 1999. www.casacolumbia.org/pdshopprov/files/Dangerous_Liasons_12_7_99.pdf [Accessed March 28, 2005].

National Center on Addiction and Substance Abuse. *No Place to Hide: Substance Abuse in Mid-Size Cities and Rural America* . New York: National Center on Addiction and Substance Abuse, 2000. www.casacolumbia.org/Absolutenm/articlefiles/No_Place_to_Hide_1_28_00.pdf [Accessed March 28, 2005].

National GAINS Center. *Drug Courts as a Partner in Mental Health and Co-Occurring Substance Use Disorder Diversion Programs* . Delmar, NY: The National GAINS Center, 1999 *a* . www.gainsctr.com/pdfs/fact_sheets/Drug_Courts.pdf [Accessed April 2, 2002].

National GAINS Center. *Maintaining Medicaid Benefits for Jail Detainees With Co-Occurring Mental Health and Substance Use Disorders* . Delmar, NY: The National GAINS Center, 1999 *b* . www.gainsctr.com/pdfs/fact_sheets/Maintaining_Medicaid_02.pdf [Accessed March 28, 2005].

Ohio Department of Alcohol and Drug Addiction Services. *OVPP: Safety, Healing, Justice, Liberation.* Columbus, OH: Ohio Department of Alcohol and Drug Addiction Services, 2000.

People for Peace. *The Violence Interruption Process* . Chicago: Center for Violence Interruption, 1996. members.aol.com/pforpeace/vip/violence.htm [Accessed March 29, 2005].

Peters, R.H., and Hills, H.A. Inmates with co-occurring substance abuse and mental health disorders. In: Steadman, H.J., and Cocozza, J.J., eds. *Mental Illness in America's Prisons* . Seattle, WA: National Coalition for the Mentally Ill in the Criminal Justice System, 1993. pp. 159 – 212.

Peters, R.H., and Hills, H.A. *Intervention Strategies for Offenders with Co-Occurring Disorders: What Works?* Delmar, NY: National GAINS Center, 1997. www.gainsctr.com/pdfs/monographs/Intervention_Strat.pdf [Accessed March 29, 2005].

Peters RH, Kearns WD. Drug abuse history and treatment needs of jail inmates. American Journal of Drug and Alcohol Abuse 18(3):355-366. 1992.

Peters RH, Strozier AL, Murrin MR, Kearns WD. Treatment of substance-abusing jail inmates: Examination of gender differences. Journal of Substance Abuse Treatment 14(4):339-349. 1997. (PubMed)

Petersilia, J. When prisoners return to the community: Political, economic, and social consequences. *Sentencing & Corrections: Issues for the 21st Century* (9):1 –8, 2000.

Peugh J, Belenko S. Substance-involved women inmates: Challenges to providing effective treatment. Prison Journal 79(1):23-44. 1999.

Ramirez, R.R., and de la Cruz, G.P. *The Hispanic Population in the United States: March 2002.* Current Population Reports, P20-545. Washington, DC: U.S. Census Bureau, 2002. www.census.gov/prod/2003pubs/p20-545.pdf [Accessed April 19, 2004].

Raymond NC, Coleman E, Ohlerking F, Christenson GA, Miner M. Psychiatric comorbidity in pedophilic sex offenders. American Journal of Psychiatry 156(5):786-788. 1999.

Roberts AC, Nishimoto RH. Predicting treatment retention of women dependent on cocaine. American Journal of Drug and Alcohol Abuse 22(3):313-333. 1996.

Robins, L.N., and Regier, D.A., eds. Psychiatric Disorders in America: The Epidemiologic Catchment Area Study. New York: Free Press, 1991.

Robinson, M., and Kelley, T. The identification of neurological correlates of brain dysfunction in offenders by probation officers. In: Fishbein, D.H., ed. *The Science, Treatment, and Prevention of Antisocial Behaviors: Application to the Criminal Justice System.* Kingston, NJ: Civic Research Institute, 2000. pp. 12-1-12 –20.

Sacks, S., Peters, J., Wexler, H., Roebuck, C., and De Leon, G. "Modified Therapeutic Community for MICA Offenders: Description and Interim Findings." Unpublished manuscript, 2001.

Slaght E. Focusing on the family in the treatment of substance abusing criminal offenders. Journal of Drug Education 29(1):53-62. 1999. (PubMed)

Smith, R. Walden House Scores with Services for Women! *The Walden House Staff News* (March) 2001.

Stein LI, Test MA. Alternative to mental hospital treatment: I. Conceptual model, treatment program, and clinical evaluation. Archives of General Psychiatry 37(4):392-397. 1980. (PubMed)

Stevens, S.J., and Patton, T. Residential treatment for drug addicted women and their children: Effective treatment strategies. In: Stevens, S.J., and Wexler, H.K., eds. *Women and Substance Abuse: Gender Transparency* . New York: Haworth Press, 1998. pp. 235 –249.

Strauss SM, Falkin GP. The relationship between the quality of drug user treatment and program completion: Understanding the perceptions of women in a prison-based program. Substance Use and Misuse 35(12–14):2127-2159. 2000.

Sue, D.W., and Sue, D. *Counseling the Culturally Different: Theory and Practice* . 3d ed. New York: John Wiley and Sons, 1999.

Teplin LA, Abram KM, McClelland GM. Prevalence of psychiatric disorders among incarcerated women: I. Pretrial jail detainees. Archives of General Psychiatry 53(6):505-512. 1996. (PubMed)

U.S. Census Bureau. *Profile of General Demographic Characteristics for the United States: 2000* . Washington, DC: U.S. Census Bureau, 2001. www.census.gov/Press-Release/www/2001/tables/dp_us_2000.pdf [Accessed March 14, 2002].

Vacc, N.A., DeVaney, S.B., and Wittmer, J. *Experiencing and Counseling Multicultural and Diverse Populations* . 3d ed. Bristol, PA: Accelerated Development, 1995.

Valdez A, Yin Z, Kaplan CD. A comparison of alcohol, drugs, and aggressive crime among Mexican-American, black, and white male arrestees in Texas. American Journal of Drug and Alcohol Abuse 23(2):249-265. 1997.

Varese T, Pelowski S, Riedel H, Heiby EM. Assessment of cognitive-behavioral skills and depression among female prison inmates. European Journal of Psychological Assessment 14(2):141-145. 1998.

Varghese, S., and Fields, H.F. *The Link Between Substance Abuse and Infectious Disease in Correctional Settings* . Washington, DC: Association of State and Territorial Health Officials, 1999. nicic.org/Library/016863 [Accessed March 29, 2005].

Walters GD, White TW, Denney D. The Lifestyle Criminality Screening Form: Preliminary data. Criminal Justice and Behavior 18(4):406-418. 1991.

Wanberg, K.W., and Milkman, H.B. Criminal Conduct and Substance Abuse Treatment: Strategies for Self-Improvement and Change. Thousand Oaks, CA: Sage Publications, 1998.

Welle D, Falkin GP, Jainchill N. Current approaches to drug treatment for women offenders: Project WORTH, Women's Options for Recovery, Treatment, and Health. Journal of Substance Abuse Treatment 15(2):151-163. 1998. (PubMed)

Wender PH, Wolf LE, Wasserstein J. Adults with ADHD. An overview. Annals of the New York Academy of Science 931:1-16. 2001.

Wexler HK. Progress in prison substance abuse treatment: A five-year report. Journal of Drug Issues 24(1–2):349-360. 1994.

Wexler, H.K., and Graham, W.F. "Prison-based therapeutic community for substance abusers: Six-month evaluation findings." Paper presented at the American Psychological Association, Toronto, ON, 1993.

Wood, H.R., and White, D.L. A model for habilitation and prevention for offenders with mental retardation: The Lancaster County (PA) Office of Special Offenders Services. In: Conley, R.W., Luckasson, R., and Bouthilet, G.N., eds. *The Criminal Justice System and Mental Retardation: Defendants and Victims* . Baltimore: Paul H. Brookes Publishing, 1992. pp. 153 –165.

Appendix B: Post Test and Evaluation ***Major Treatment Issues for Offenders Who Use Substances***

Directions: To receive credits for this course, you are required to take a post test and receive a passing score. We have set a minimum standard of 80% as the passing score to assure the highest standard of knowledge retention and understanding. The test is comprised of multiple choice and/or true/false questions that will investigate your knowledge and understanding of the materials found in this CEU Matrix – The Institute for Addiction and Criminal Justice distance learning course.

After you complete your reading and review of this material, you will need to answer each of the test questions. Then, submit your test to us for processing. This can be done in any **one** of the following manners:

1. *Submit your test via the Internet.* All of our tests are posted electronically, allowing immediate test results and quicker processing. First, you may want to answer your post test questions using the answer sheet found at the end of this appendix. Then, return to your browser and go to the Student Center located at:

   http://www.ceumatrix.com/studentcenter

   Once there, log in as a Returning Customer using your Email Address and Password. Then click on 'Take Exam' and you will be presented with the electronic exam.

   To take the exam, simply select from the choices of "a" through "e" for each multiple choice question. For true/false questions, select either "a" for true, or "b" for false. Once you are done, simply click on the submit button at the bottom of the page. Your exam will be graded and you will receive your results immediately. If your score is 80% or greater, you will receive a link to the course evaluation. , which is the final step in the process. Once you submit the evaluation, you will receive a link to the Certificate of Completion. This is the final step in the process, and you may save and / or print your Certificate of Completion.

   If, however, you do not achieve a passing score of at least 80%, you will need to review the course material and return to the Student Center to resubmit your answers.

   OR

2. *Submit your test by mail using the answer sheet found at the end of this package.* First, complete the cover page that will identify the course and provide us with the information that will be included in your Certificate of Completion. Then, answer each of the questions by selecting the best response available and marking your answers on the sheet. The final step is to complete the course evaluation (most certifying bodies require a course evaluation before certificates of completion can be issued). Once completed, mail the information, answer and evaluation sheets to this address:

   CEU Matrix - The Institute for Addiction and Criminal Justice Studies
   P.O. Box 2000
   Georgetown, TX 78627

   Once we receive your exam and evaluation sheets, we will grade your test and notify you of the results.

   If successful, you will be able to access your Certificate of Completion and print it. Access your browser and go to the Student Center located at:

   http://www.ceumatrix.com/studentcenter

   Once there, log in as a Returning Customer using your Email Address and Password. Then click on 'Certificate' and you will be presented with a download of your Certificate of Completion that you may save / and or print. If you would rather have your Certificate of Completion mailed to you, please let us know when you mail your exam and evaluation sheets; or contact us at ceumatrix@ceumatrix.com or 800.421.4609.

   If you do not obtain the required 80% score, we will provide you with feedback and instructions for retesting.

   OR

3. *Submit your test by fax.* Simply follow the instructions above, but rather than mailing your sheets, fax them to us at **((512) 863-2231**.

If you have any difficulty with this process, or need assistance, please e-mail us at **ceumatrix@ceumatrix.com** and ask for help.

Answer the following questions by selecting the most appropriate response.

1. Counselors should be aware of the symptoms of detoxification even if substance dependence was not identified at intake or assessment.

    a. True
    b. False

2. Symptoms of withdrawal vary by substance, but may include which of the following:

    A. Yawning, sleepiness, exhaustion, lethargy
    B. Depression, crying fits, disorientation
    C. Suicidal thoughts or behavior
    D. Profuse sweating, muscle jerks, constant blinking
    E. All of the above

3. One of the <u>most</u> underdeveloped skills in offender-clients is:

    A. Financial
    B. Reading
    C. Problem-solving
    D. Social
    E. All of the above

4. Examples of cognitive distortions or “thinking errors” in criminal thinking include all but which of the following:

    A. Seeing themselves as superior to others
    B. Seeing themselves victims or mistreated
    C. Seeking instant gratification
    D. Rigid thinking
    E. Being highly needy of others

5. One of the primary reasons it is necessary to separate inmates in treatment from the general inmate population is:

    A. Withdrawal symptoms
    B. Personal safety
    C. The “convict code” and prison culture
    D. So that they can get incentives and special treatment

6. Criminal thinking is so deeply ingrained and part of the offender's personality that it is virtually impossible to change it.

    a. True
    b. False

7. Clients in prison-based treatment may exhibit anger as a result of which of the following:

    A. To deflect attention away from themselves
    B. To maintain an adrenaline high
    C. Limited emotional range and resources
    D. Genuine feelings of being treated unfairly
    E. All of the above

8. Often what offenders think is anger is actually shown to be frustration, hurt, loneliness and fear.

    a. True
    b. False

9. Slaght (1999) found that the only independent variable related significantly to relapse at 3 months after release to the community was:

    A. Whether they were employed or unemployed
    B. Whether they went back to their old friends
    C. Whether they were getting along with family members
    D. Whether they could deal with the requirements of parole.

10. Because the prison culture itself is so hierarchical, treatment programs need to have an egalitarian "everyone-is-equal" culture.

    a. True
    b. False

11. Because boundaries between staff and clients have a special significance in criminal justice settings, treatment staff need to be especially vigilant about

    A. Self-disclosure
    B. Confidentiality
    C. Personal safety
    D. Asking about the client's feelings

12. The process of getting a client involved in treatment is called:

    A. Contemplation
    B. Motivation
    C. Engagement
    D. Persuasion

13. Offenders will be more influenced by the treatment and less likely to return to incarceration if the treatment staff are perceived as

    A. Fair
    B. Competent
    C. Empathetic
    D. Tolerant

14. In a study of offenders on probation, Broome *et al* found that a positive correlation between engagement in treatment and

    A. Family dysfunction
    B. Recognition of the existence of a substance problem
    C. The degree of peer deviance in the client's social network
    D. All of the above

15. Coercion (e.g. from the criminal justice system) can get a client into treatment, but internal motivation predicts retention and positive outcome.

    a. True
    b. False

16. Individuals coerced into treatment should be separated into different treatment tracks from non-coerced clients because they will undermine the efforts of those who truly want to get help.

    a. True
    b. False

17. In using treatment incentives and sanctions, it is important to:

    A. Emphasize incentives over sanctions
    B. Apply sanctions as rapidly as possible
    C. Be creative with incentives
    D. Using repeated mild sanctions is more effective than using threats of stronger sanctions,
    E. All of the above

18. Without prosocial (positive) activity, criminal justice clients tend to use unstructured time for anti-social thinking and behavior.

    a. True
    b. False

19. Both treatment staff and criminal justice staff need to model personal accountability in their behavior.

    a. True
    b. False

20. Peers using a group treatment modality have the capacity to give more immediate feedback for positive steps to change and for negative thinking and behavior than staff because they:

    A. Spend more time together
    B. Their opinion is more valued than staff's
    C. They are watching for others to trip up
    D. They are seeking recognition

21. Rituals and ceremonies used to mark positive events can be important for clients since they may have previously been exposed to those associated with gang activity or substance abuse.

    a. True
    b. False

22. In a study of Alaska Native men, Glass and Bieber found that the stress of trying to adapt to two cultures (their own and the dominant culture) was associated with violent activity. This is an example of:

    A. Social isolation
    B. Social disintegration
    C. Resource deprivation
    D. Violent culture orientation

23. Treatment programs should include staff who reflect the cultural diversity of the population they are treating to every extent possible.

    a. True
    b. False

24. A barrier to creating culturally-specific treatment programs within a prison or jail is:

    A. The variety of populations who enter the facilities
    B. The need to provide equal levels of treatment for all offenders
    C. Significant cultural identification cannot be assumed for all members of a particular group
    D. B and C
    E. All of the above

25. The most common misunderstandings in counseling originate in culture, socioeconomic class and language.

    a. True
    b. False

26. Women:

    A. Numbered nearly one million under supervision
    B. Report higher rates of physical and sexual abuse in their pasts than men.
    C. Reported higher drug use than men at the time of the incident.
    D. Were found to have a higher incidence of mental disorders than male inmates.
    E. All of the above

27. Harsh confrontational techniques are generally counterproductive with women in treatment because they resemble abusive interpersonal situations experienced by many of them while in the community.

    a. True
    b. False

28. Peugh and Belenko (1999) found that female inmates with substance use disorders had better employment histories than their male counterparts.

    a. True
    b. False

29. Male offenders feel conflicted about their roles as fathers since being a good father is looked down on in prisons as a sign of “weakness.”

    a. True
    b. False

30. The prison culture reinforces violent behavior and individuals who are incarcerated without a history of violence quickly learn its value in jail or prison.

    a. True
    b. False

31. Several resources may be useful in managing violence and anger, including all of the following except:

    A. Cognitive-behavioral therapy (CBT)
    B. Anger management groups
    C. Medication
    D. Electro-convulsive therapy

32. One of the reasons that people with cognitive disabilities are overrepresented in the prison system, is that they are more likely to be arrested for, and confess to, crimes they did not commit.

    a. True
    b. False

33. Given the prevalence of disabilities in incarcerated populations, especially among offenders with substance use disorders, treatment providers need to be able to screen for co-existing disabilities and make accommodations for those who have them.

    a. True
    b. False

34. Illicit drug use is still more prevalent in large urban areas than in small communities or rural areas, with the exception of marijuana.

    a. True
    b. False

35. Identifying and treating co-occurring disorders in a correctional setting is complicated by all but which of the following:

    A. One disorder can mask or imitate the other
    B. Mental disorders carry a great deal of stigma in the prison culture.
    C. Psychotropic and other prescribed medications are prohibited.
    D. Accurate diagnosis requires a greater level of skill.

36. When assessing co-occurring disorders, one diagnosis needs to be designated as primary and the other as secondary.

    a. True
    b. False

37. Counselors must be alert to inmates who skillfully mimic the symptoms of mental disorders in order to receive medications.

    a. True
    b. False

38. Anti-social Personal Disorder and Psychopathy share the following characteristics except for:

    A. Treatment focuses on behavior management rather than on counseling or other therapeutic techniques.
    B. Treatment is more structured and monitored
    C. The behavioral patterns diminish after the age of 40
    D. They have a lower incidence of substance abuse than the general population.

39. Offenders with attention deficit/hyperactivity disorder (AD/HD) should have treatment information conveyed visually as well as orally whenever possible.

    a. True
    b. False

40. Although rapists, child molesters, incest offenders and exhibitionists were once thought to be discrete offender types, an increasing body of evidence derived from polygraph examinations reveals that there is considerable “crossover” behavior.

    a. True
    b. False

Fax/Mail Answer Sheet

CEU Matrix - The Institute for Addiction and Criminal Justice Studies

Test results for the course "Major Treatment Issues for Offenders Who Use Substances"

If you submit your test results online, you do not need to return this form.

Name*:_____

(* Please print your name as you want it to appear on your certificate)

Address: _____

City: _____

State: _____

Zip Code: _____

Social Security #*: _____

(*Most certifying bodies require a personal identification number of some sort – last 4 digits or License is perfect.)

Phone Number: _____

Fax Number: _____

E-mail Address: _____

On the following sheet, mark your answers clearly. Once you have completed the test, please return this sheet and the answer sheet in ***one*** of the following ways:

1. Fax your answer sheets to the following phone number: **(512) 863-2231**. This fax machine is available 24 hours per day. **OR**

2. Send the answer sheet to:
   CEU Matrix - The Institute for Addiction and Criminal Justice Studies
   P.O. Box 2000
   Georgetown, TX 78627

You will receive notification of your score within 48 business hours of our receipt of the answer sheet. If you do not pass the exam, you will receive instructions at that time.

Name: _____

Course: Major <u>Treatment Issues for Offenders Who Use Substances</u>

1. [A] [B] [C] [D] [E]
2. [A] [B] [C] [D] [E]
3. [A] [B] [C] [D] [E]
4. [A] [B] [C] [D] [E]
5. [A] [B] [C] [D] [E]
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9. [A] [B] [C] [D] [E]
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39. [A] [B] [C] [D] [E]
40. [A] [B] [C] [D] [E]

The Institute for Addiction and Criminal Justice Studies

Course Evaluation – Hard Copy Format

The final step in the process required to obtain your course certificate is to complete this course evaluation. These evaluations are used to assist us in making sure that the course content meets the needs and expectations of our students. Please fill in the information completely and include any comments in the spaces provided. Then, if mailing or faxing your test results, return this form along with your answer sheet for processing. **If you submit your evaluation online, you do <u>not</u> need to return this form.**

NAME:_____

COURSE TITLE: **<u>Major Treatment Issues for Offenders Who Use Substances</u>**

DATE:_____

<u>COURSE CONTENT</u>		
Information presented met the goals and objectives stated for this course	☐ Start Over ☐ Good ☐ Excellent	☐ Needs work ☐ Very Good
Information was relevant	☐ Start Over ☐ Good ☐ Excellent	☐ Needs work ☐ Very Good
Information was interesting	☐ Start Over ☐ Good ☐ Excellent	☐ Needs work ☐ Very Good
Information will be useful in my work	☐ Start Over ☐ Good ☐ Excellent	☐ Needs work ☐ Very Good
Format of course was clear	☐ Start Over ☐ Good ☐ Excellent	☐ Needs work ☐ Very Good
POST TEST		
Questions covered course materials	☐ Start Over ☐ Good ☐ Excellent	☐ Needs work ☐ Very Good
Questions were clear	☐ Start Over ☐ Good ☐ Excellent	☐ Needs work ☐ Very Good
Answer sheet was easy to use	☐ Start Over ☐ Good ☐ Excellent	☐ Needs work ☐ Very Good

COURSE MECHANICS		
Course materials were well organized	☐ Start Over ☐ Good ☐ Excellent	☐ Needs work ☐ Very Good
Materials were received in a timely manner	☐ Start Over ☐ Good ☐ Excellent	☐ Needs work ☐ Very Good
Cost of course was reasonable	☐ Start Over ☐ Good ☐ Excellent	☐ Needs work ☐ Very Good
OVERALL RATING		
I give this distance learning course an overall rating of:	☐ Start Over ☐ Good ☐ Excellent	☐ Needs work ☐ Very Good
FEEDBACK		
How did you hear about CEU Matrix?	☐ Web Search Engine ☐ Mailing ☐ Telephone Contact ☐ E-mail posting ☐ Other Linkage ☐ FMS Advertisement ☐ Other: _____	
What I liked BEST about this course:		
I would suggest the following IMPROVEMENTS:		
Please tell us how long it took you to complete the course, post-test and evaluation:	_____ minutes were spent on this course.	
Other COMMENTS:		