Chemical Dependency Treatment Alternatives

2009 Report to the Legislature

MINNESOTA DEPARTMENT OF CORRECTIONS

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Introduction

Laws 2009, Chapter 83, Article 1, Section 14, Subd. 2, requires the commissioner of corrections to review the department's chemical dependency (CD) treatment programs and identify alternatives that represent best practices in offender treatment. Targets for these alternatives were to include:

(a) Reducing the length of time between offender commitment to the custody of the commissioner and graduation from CD treatment;

(b) Reducing the cost of treatment;

(c) Expanding the number of treatment beds;

(d) Improving treatment outcomes; and

(e) Lowering the rate of substance abuse relapse and criminal recidivism.

This report addresses the above and provides a summary of the department's current approaches to treatment and treatment availability.

Current Treatment Systems Overview

Availability

In FY08, 3,800 newly-committed offenders and release violators were assessed for substance abuse problems. Fully 90 percent of those assessed were determined to have problems with drugs or alcohol. Eighty percent of the offenders assessed were directed to complete treatment programming, and over 1,300 offenders participated in treatment in FY08. The Department of Corrections (DOC) currently has funding for 925 CD treatment beds. In accordance with best practices, the department's programs are provided in the context of modified therapeutic communities. By separating offenders involved in treatment from general population offenders, the programs are able to establish and maintain treatment environments that support and enhance the treatment process. These treatment "communities" also provide additional opportunities for offenders to practice key social problem-solving skills and address entrenched criminal thinking along with their CD issues.

The department offers a continuum of CD treatment services for adult and juvenile males as well as for the adult female population. Services include pretreatment, primary treatment, and aftercare. Many facilities provide access to AA, NA, and other self-help groups through community volunteers. Treatment programs are located at both medium- and close-custody levels. Self-help groups are also available in minimum-security units. Approximately 34 percent of offenders directed to treatment enter a program prior to their release. Research related to resource allocation in corrections indicates that targeting those offenders with higher risk and higher needs profiles returns the greatest risk reduction benefits. For this reason, the department developed and utilizes a system of prioritizing the higher risk/higher needs offenders for treatment. Those who do not receive a treatment opportunity may be required by conditions of release to participate in community treatment after release.

Effectiveness

The department routinely reviews its programs for quality and effectiveness. The most recent evaluation of CD programming found that substance abuse treatment participation reduced recidivism (risk of time to reoffense) by 21 percent for reconvictions and 25 percent for reincarcerations. Dropping out of treatment did not have a significant effect on recidivism, although completing treatment lowered the risk of reoffending from 20-27 percent. In addition, the evaluation found that both psycho-educational (duration of approximately 90 days) and primary (duration of approximately 180 days) programming significantly lowered the risk of future offending, whereas extended treatment programs (duration of approximately 365 days) did not have a statistically significant effect on recidivism. The study tracked through December 31, 2008, the post-release conduct of 1,852 offenders released to the community in 2005. This cohort included a group of 926 offenders who participated in DOC treatment programs, along with a matched comparison group of 926 offenders who had been determined to need treatment but did not receive it prior to release.

Program Standards

DOC treatment programs meet certification standards established in collaboration with the Departments of Human Services (DHS) and Public Safety (DPS). These standards were updated in 2009 and closely mirror Minnesota Rule 31 standards for community-based residential treatment and evidence-based treatment practices. Standards provide minimum criteria related to staffing structure and ratios, hours and types of programming provided, staff credentials and training, treatment documentation, etc. Programs are audited for compliance with standards no less than every three years (see Appendix A, *Certification Standards for Department of Corrections Chemical Dependency Treatment Programs*, August 2009).

Best Practices

Minnesota recently played a leadership role along with ten other jurisdictions in a project sponsored by the Association of State Correctional Administrators (ASCA) to summarize current best practices in the treatment of corrections populations (see Appendix B, *Substance Abuse Treatment in Correctional Settings: Recommended Practices*, September 30, 2009). The DOC is continually reviewing scientific literature that informs best practices in correctional CD treatment and adheres to key principles, including:

- Treatment that addresses the offender's CD and criminogenic factors (criminal attitudes and beliefs, lifestyle, associates, etc).
- Group therapy is the primary treatment modality, and programs are embedded into modified therapeutic communities.
- Co-occurring diagnoses are assessed and addressed (i.e., mental health concerns).
- Staff are appropriately credentialed to provide CD treatment and specially trained to work with offender populations.
- Relapse prevention is included as a treatment focus, along with release planning services provided to assist offenders in successfully transitioning back to their communities.

Treatment Alternatives Discussion and Recommendations

(a) Reducing the length of time between offender commitment to the custody of the commissioner and graduation from CD treatment.

From a prison operations perspective, barriers to reducing the period between an offender's initial intake and subsequent treatment admission are not significant. However, there is good evidence that treating offenders earlier in their incarceration and then releasing them from the treatment program back to general population prior to release results in an erosion of treatment gains. To minimize this negative effect, the DOC's current system is structured to provide treatment near the end of an offender's incarceration. Housing that provides aftercare and other supports to maintain treatment gains are crucial following completion of treatment. DOC programs work to provide access to such settings, separate from the general population, in order to maintain treatment gains prior to release.

In the past few years, the department has identified offenders who are eligible to transfer to minimum custody once they have completed treatment. This is an effort to create a "sober house" environment in some of the minimum units and provide a stronger aftercare treatment component. As of the most recent quarter, the following percentages of offenders in DOC minimum units had completed treatment:

- 74 percent – Minnesota Correctional Facility (MCF)-Lino Lakes;
- 30 percent – MCF-Faribault;
- 34 percent – MCF-Red Wing; and
- 18 percent – MCF-Stillwater.

This effort enhances the DOC's goals to separate treatment completers from general population and maintain treatment gains. Additional resources will be needed to more fully implement this initiative, including additional release planner positions. These positions would work closely with the treatment completers housed in these minimum units, providing aftercare services to assist them in maintaining their treatment gains and working closely with them on their transition back to the community.

Option – Transfer to lower custody level

This initiative would reduce an offender's custody status upon treatment completion. While this process would not result in early release, it is likely that custody reduction would serve to increase offender motivation in some cases. The increase in motivation has the potential to increase successful completions and shorten treatment length.

There is already a process in place to divert minimum eligible treatment completers to the DOC's minimum-custody units (additional detail below). Over the past two years, the percentage of treatment completers housed in minimum units has been increased with the public safety advantage of having a more stable and reliable population housed in those units. With this process already well underway and the limitations on minimum-custody beds, the remaining opportunity is with close-custody offenders who could reduce to medium custody. This group represents only nine percent of the offenders completing treatment.

For reasons identified above, the DOC would need to provide a supportive environment for offenders transferring to a lower-custody facility to help ensure their treatment gains would not be eroded by living with general population offenders. Offering aftercare resources for these completers prior to their release would be essential in maintaining their gains and would require additional staffing resources. Increasing staffing costs will add to the DOC per diem. Aftercare and transition support services have the potential to solidify treatment gains and reduce relapse and new offenses. These services could be provided within the context of the "institutional aftercare program" described below.

Option – Increase the number of treatment completers at minimum units
As noted above, the DOC has initiated a process for diverting some of its treatment completers to minimum-security housing prior to their release. This allows the benefits of a "step down" in custody level as an incentive for offenders as well as a stable and more secure offender population in the department's minimum-custody units. In order to help reduce the risks of treatment erosion, the DOC has provided staff-facilitated aftercare services at one of the minimum units and has developed volunteer AA/NA support group involvement at all of the minimum units. It is recommended that any expansion in treatment completers at minimum units be supported with an increase in staffing that would provide consistent aftercare and transition planning services at each of the minimum units to help protect the treatment investment in these offenders. Increasing staffing costs will add to the DOC per diem.

Option – Develop an institutional aftercare program
Expanding the DOC's institutional aftercare program capacity could shorten average treatment length and improve transition planning to the community. This option would entail designating an entire living unit(s) or cell hall(s) as an aftercare program and providing the needed services to support that program, including aftercare programming, AA/NA meetings, release and reintegrating planning services, therapeutic community meetings, etc.

Creation of a sizeable aftercare unit to house treatment completers offers a clinically appropriate transition out of primary treatment and the opportunity to increase "flow" through the DOC's existing programs. The additional aftercare and transition services are likely to solidify treatment gains and reduce relapse and recidivism. Aftercare is a lower-intensity intervention than primary treatment; therefore, staffing costs would be reduced from those required in primary treatment. However, the DOC would need additional staffing resources to create this program. Increasing staffing costs will add to the DOC per diem. Availability of programming space is another limiting factor. If appropriate space to provide the needed aftercare programming is not found, this option would require space construction and associated capital costs.

(b) Reducing the cost of treatment.

Reducing the department's overall treatment budget would result in treatment bed cuts. Because the department was asked to provide options for increasing treatment availability as part of this report, cost reduction through a reduction in treatment services was not explored. Instead, the department has been pursuing a strategy of increasing treatment efficiency and thereby reducing treatment costs on a *per offender* basis. Examples of initiatives being implemented to increase treatment efficiency include (additional information is included later in this report):

- *Treatment completion rates.* Treatment failures are inefficient. Therefore, the DOC has committed to increasing treatment completion rates by five percent over the next two years as part of the department's strategic planning process. Specific elements of this plan include:
  - ✓ *Motivational Interviewing (MI):* This evidence-based practice works to improve client engagement in the treatment process, which may improve both treatment completion rates and shorten treatment length, as suggested by research in community-based treatment. (Offenders may benefit more quickly from treatment.)
  - ✓ *Integrated Dual Disorder Treatment (IDDT):* The DOC is implementing this evidence-based approach that improves outcomes with treatment participants who experience both chemical dependency and mental illness.
  - ✓ *Traumatic Brain Injury:* There are high rates of brain injury among the offender population. These injuries can affect an offender's ability to benefit from treatment while at the same time increase the risks for drug and alcohol abuse after release. The DOC has been investing in staff training to improve treatment effectiveness with brain-injured offenders.
- *Time to failure.* Offenders may be terminated from treatment for a variety of reasons including conduct that results in formal discipline, lack of progress, and self-termination (quitting). The DOC has begun to review "time to failure" across programs. To the extent that offenders remain in treatment longer than is warranted by their investment in the treatment process, they prevent other offenders from having an opportunity to benefit from treatment. With more accurate and consistent appraisals of offender treatment progress, treatment efficiency may be improved.

Option – Privatization

Privatization is sometimes recommended as a method to hold down costs. It is not recommended here for several reasons. Most importantly, it is not believed that privatization would result in significant cost savings. Almost all of the variable costs of treatment are related to staff salaries and benefits, which are determined by the state's bargaining process. Current salaries for treatment staff appear to be generally comparable with salaries outside of the DOC. Even so, qualified staff remain difficult to recruit and retain within the current salary structure in outstate facilities. Staffing ratios are set within program certification standards, which parallel Rule 31 standards for CD treatment in the community. Ratios are 1:12 - 1:15 for adult males and 1:8 - 1:10 for adult females. DOC certification standards were developed in collaboration with the DHS and are approved and monitored by a joint committee including DPS, DHS, and DOC staff.

Staffing cost reductions cannot be achieved by downgrading position qualifications, as privatization strategies sometimes propose. CD treatment in Minnesota is regulated under Minnesota Statute 148C. Persons providing CD treatment are required to hold credentials as outlined in that chapter (primarily the licensed alcohol and drug counselor). DOC staff who provide treatment meet these credentialing standards. There is no option to reduce staffing qualifications while remaining in compliance with Minnesota statutes and DOC program certification standards.

The stability of having state employees in these positions is critical to the department's longer-term strategies to increase program effectiveness and efficiency. Department prison-based programs target an offender population that is clinically complex and highly challenging. Efforts to become even more effective with the target population require staff training and program development initiatives that have lengthy timelines (see additional detail below). The effectiveness of these longer-term investments would be compromised by the variability and lack of staff continuity that is inevitable with privatization.

Because DOC current salary and benefit costs are in line with other employers and program staffing structures are fixed by certification standards, it is not believed that privatization could succeed with meaningful cost reductions without jeopardizing either compliance with standards or undermining program effectiveness. For these reasons, privatization of prison treatment programs is not recommended.

(c) Expanding the number of treatment beds.

The DOC has long understood the strong correlation between crime and the abuse of drugs and alcohol. CD treatment programs have been established to help address these risks with the offender population going back to the 1970s. The department has worked with the legislature and federal granting agencies to significantly increase treatment availability over the years. These combined efforts have increased treatment beds to the current level of 925, a 40 percent increase over the past ten years.

Option – Expand beds at the existing MCF-Faribault program
A significant barrier to further expansion of services has been the lack of availability of suitable programming space. When new construction was designed for the MCF-Faribault expansion, a significant expansion of the facility's CD program was included. While the necessary remodeling was completed last year, budget issues in FY09 did not allow for staff funding for the expansion. The department subsequently applied for and successfully obtained a two-year, $1.52M federal Byrne grant through the DPS to expand the MCF-Faribault CD program by 104 beds. Implementation of this expansion will begin in January 2010. This grant sunsets on December 31, 2011. The department intends to request permanent funding from the legislature to sustain this expansion should a grant renewal not be made available.

Option – Expand treatment beds at other facilities
It is important to note that further expansion of treatment beds will require additional capital construction costs. This means additional investment in construction as well as staffing costs. Treatment expansion proposals in the early planning phases include:

- The DOC is looking at the feasibility of developing a programming space capital project at the close-custody facility at Rush City. Because of programming space limitations, only nine percent of the DOC's CD treatment beds are currently located at close custody. Given the increased levels of person offenses (i.e., sexual offense, assault, homicide) at the higher-custody levels, it will be important to focus additional resources on this higher-risk population in future bed expansions. The capital project being considered, if funded, would provide programming space for an additional 34-bed CD program at close custody as well as a program for release violators (which would include additional CD treatment components) and improved programming space for the existing sex offender

treatment program at that facility. Depending on the results of the pre-design phase, this project may be proposed during the 2012 bonding cycle.

- An additional longer-term proposal is to construct a medical and behavioral health treatment facility to expand the current residential-level treatment services. This would be a system-wide resource serving all custody levels. A CD treatment component would be included with this proposal, which would make this service available for the first time to maximum-custody offenders who may be housed at this new facility.

(d) Improving treatment outcomes.

The department has been investing in improving treatment outcomes for many years. Highlights include:

Option – Improve clinical effectiveness with offenders with Traumatic Brain Injury (TBI)
The department was the co-recipient with DHS of a multi-year federal grant to better understand the prevalence and severity of traumatic brain injury among incarcerated populations and to identify clinical system enhancements for more effectively working with offenders with TBI. A survey of offenders indicated a very high prevalence of head injury in Minnesota prisons. Brain injury is associated with a wide range of problematic symptomology, including impulsivity, decreased learning ability, increased mood variability, mood disorders, and increased risk for substance abuse, among others. A portion of the funding from the original grant included clinical skills training, with a special focus on working with offenders with TBI in DOC treatment programs. The original grant expired, but the DOC has again partnered with DHS to submit additional grant applications to continue this important work. The most recent application would extend the previous initiatives and add a TBI-specific release planner position.

Option – Improve treatment effectiveness through enhancement of the department's co-occurring treatment capabilities
The DOC has partnered with DHS as part of their federally-funded CoSig project designed to improve Minnesota CD programs through enhancement of co-occurring disorder treatment capability. A significant proportion of offenders needing CD treatment also has mental health disorders that co-occur with their substance abuse problems. These mental health and substance abuse disorders interact to exacerbate the complexity and severity of the condition, complicating the treatment and recovery process. Research clearly indicates that treating persons with these co-occurring CD and mental health disorders is most effective when the treatment combines interventions for both with a seamless approach within the same treatment program.

While integrating treatment makes good common sense, the development of a co-occurring treatment approach requires careful planning, sustained managerial and supervisory support, and a significant investment in staff development and cross-training. CD and mental health professionals often have little prior training in each other's fields. The integrated approach requires both professions to understand both treatment areas sufficiently to support one another and to provide interventions in an integrated fashion.

Over the past three years, this project has been successfully implemented in the CD programs at the MCF-Shakopee (women's program) and MCF-Stillwater (men's program). Resources for this three-year pilot project were provided in part by collaborating with the Co-sig project implemented by DHS. The Co-sig project was supported by a 3M grant to DHS. Although the DOC was not the recipient of grant monies, the department benefitted by participating in the project. DOC staff, for example, participated in extensive training of the mental health, CD treatment, and supervisory staff, as well as technical assistance and survey services by DHS staff to improve fidelity of the integrated treatment model. In the coming year, the DOC will begin plans to implement the co-occurring approach throughout the rest of the system. Based on current resource allocation limits, full implementation across all of the DOC's programs will be a multi-year project as implementation in the remainder of the facilities will not have the resources provided through the initial DHS grant support. Training, consultation, and improvement efforts will depend on DOC staff and will be limited by staff resources and the DOC training budget. This exciting project is in line with best practices in the field and has the potential to significantly improve short- (i.e., completion rates, treatment duration) and long-term (i.e., relapse and recidivism) treatment outcomes. Additional resources for training and technical assistance would serve to accelerate the implementation process.

Option – Use of Motivational Interviewing (MI) techniques

MI strategies have been shown to be effective in increasing treatment motivation and reducing treatment dropouts and terminations. These techniques can be utilized by both treatment and non-treatment staff with good results, and the DOC has begun plans to implement MI training in several areas. Treatment staff involved in the CoSig project (above) received MI training as part of that project. An MI "train the trainer" training is scheduled to begin in February 2010. This process is designed to systematically reach all behavioral health staff in coming years so that all treatment staff are skilled in MI utilization. With improved staff skill in this evidence-based modality, increased treatment completion rates and shortened treatment length are anticipated. With current resources, all behavioral health staff should be trained in MI techniques within the next five years. Additional training resources would allow this important project to reach completion more rapidly.

Option – Develop new and expanded treatment services for release violators

A significant subgroup of the incarcerated offender population includes those offenders who have violated the terms of their release and are returned to prison by the courts. Approximately 1,600 offenders with a prior identified need for CD treatment re-enter the prison system as release violators (RVs) each year. Of these, more than 20 percent have completed a DOC treatment program. Historically, a very small proportion of this group has been provided with the option to enter CD treatment prior to their re-release, despite the fact that it appears a large majority of them have been returned to prison either directly or indirectly as a result of substance abuse relapses. Treatment has historically been withheld from the RV population, primarily because of resource limitations and because many RVs have insufficient lengths of stay to complete primary treatment.

An alternative currently being explored would create a new clinical approach targeted on the unique clinical needs of the portion of the RV population that has already completed treatment and then relapsed while on supervised release. The proposed level of service, while intensive, would be focused and relatively short term. Recent work with this population in-

creasingly suggests that those offenders who have completed treatment may benefit from an increased focus on relapse prevention and reintegration, along with a selective review of issues addressed in primary treatment. It is anticipated that this more focused approach could be successfully administered within a 60-90 day program. This would allow for a more efficient and potentially more effective intervention for RV treatment completers. This project may be eligible for a technical assistance grant from SAMSHA, a potential funding source that would help speed the development and implementation process.

(e) Lowering the rate of substance abuse relapse and criminal recidivism.

With the program enhancements identified above, DOC treatment programs will become increasingly more efficient and effective than they already are – reducing the treatment costs on a *per offender* basis. Offender treatment gains, however, are at risk once the offender is released. Research indicates that investments in release preparation are well spent.

Option – Expand release planning for treatment completers

Substance abuse treatment programming is effective in reducing both rates of relapse and recidivism. Even stronger results are noted when prison treatment is augmented with substance abuse-specific transition services and followed by community-based aftercare. In recent years, there has been increased attention focused on transitional services for offenders being released from prison. Released offenders have transitional needs such as housing, employment, family issues, medical and mental health care, educational/vocational training, and restoration of certain privileges such as having one's driving privileges reinstated. Chemically dependent offenders have additional needs to support their ongoing recovery in the community, including sober support systems and access to professional counseling services.

The DOC admits approximately 1,200 offenders to CD treatment each year. Of these, approximately 875 complete primary CD treatment prior to release. The DOC employs only three release and reintegration specialists (release planners) working within only two of the seven CD programs. In FY09, these staff were only able to complete CD release plans for a small percentage (less than 10%) of those completing treatment. While transitional services are offered to CD clients as they are with any DOC offender, the vast majority do not receive specialized planning targeted to their assessed and ongoing recovery needs.

CD reintegration specialists work with offenders, DOC case managers, supervising agents, and community resources to match client transitional needs with resources in the community. These resources often include CD aftercare, halfway house placements, sober or other transitional housing, assistance with the health care application process, arranging for disability coverage for those who qualify, and setting up psychological or psychiatric help if needed. Increasing the department's ability to work with CD treatment participants and their individual reintegration needs will better prepare more offenders to transition into life in the community during the critical first months following release. It is recommended that the number of release planner positions be increased as an effective method to help protect DOC investments in treating offenders and to reduce the rates of drug and alcohol relapse and related criminal recidivism. Increasing staffing costs will add to the DOC per diem.

To enhance release planning efforts for those offenders in CD treatment, the department is contemplating assigning case managers to treatment units. Case managers can assist the offender with aspects of reintegration relating to housing and employment, while CD reintegration specialists can focus their efforts on community treatment and funding for that treatment.

Appendix A

Certification Standards
for
Department of Corrections
Chemical Dependency Treatment Programs

August, 2009

CERTIFICATION STANDARDS FOR DEPARTMENT OF CORRECTIONS CHEMICAL DEPENDENCY TREATMENT PROGRAMS

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I. DEFINITIONS

Subp. 1. **Scope.** As used in parts I to XII, the following terms have the meanings given them.

Subp. 2. **Primary Residential CD Treatment Program.** A Primary Residential Program is a long-term (average minimum 7-9 months in length) therapeutic community operated in a residential setting separate from the general prison population

Subp. 3. **Primary Intensive Outpatient CD Treatment Programs.** A Primary Intensive Outpatient CD Treatment Program is a shorter-term (5-6 months in length) CD treatment program designed to serve participants in Challenge Incarceration Programs (CIPs). The CIP is a modified therapeutic community which operates in a military boot-camp setting, separated from the general prison population.

Subp. 4. **Certification.** Means that a program has met the minimum standards agreed to in parts I to XII.

Subp. 5. **Chemical.** Chemical means alcohol, solvents, and other mood-altering substances, including controlled substances as defined in Minnesota Statutes, chapter 152.

Subp. 6. **Chemical Dependency Program.** A program operated by the MN-DOC in one of the MN correctional facilities that have as a primary goal to serve chemically dependent offenders.

Subp. 7. **Chemical Dependency Treatment.** "Chemical dependency treatment" means treatment of a substance use disorder, including the process of assessment of a client's needs, development of planned interventions or services to address those needs, provision of services, facilitation of services provided by other service providers, and reassessment by a qualified professional. The goal of treatment is to assist or support the client's efforts to recover from a substance use disorder

Subp. 8. **Client.** Client means an individual who seeks or obtains chemical dependency services from a program as defined in subpart 2 or 3 in order to alter his or her own pattern of chemical use. An individual remains a client until the program no longer provides or plans to provide the individual with rehabilitation services.

Subp.9. **Co-occurring or Co-occurring Client.** "Co-occurring" or "co-occurring client" means a diagnosis that indicates a client who suffers from a substance use disorder and a mental health problem, currently or by history.

Subp. 10. **Clinical Staff.** Staff hired and trained specifically for the purpose of providing treatment services in a DOC chemical dependency program, including corrections program therapists/CD, mental health professionals, and CD supervisors/directors

Subp. 11. **Corrections Program Therapist.** Corrections Program Therapist (CPT) means a staff person of a chemical dependency program who meets the qualifications specified under part VI subpart 1 and 3.

Subp. 12. **Group Therapy.** Psychotherapy administered in a group setting with a trained clinical staff facilitator. Personal and group dynamics are discussed and explored in a therapeutic setting allowing emotional catharsis, instruction, insight and support that results in a modification of undesirable behaviors.

Subp. 13. **Oversight Committee.** This committee includes those individuals or their successors as described in the interagency agreement among the Minnesota Departments of Corrections, Human Services, and Public Safety.

Subp. 14. **Program Design**. Program design means the amount and type of client services a program provides, the methods used to achieve desired client outcomes, the schedule of program services, program requirements, staff to client ratio, and target population to be served.

Subp. 15. **Program Director.** Program director means an individual who meets the qualifications specified under part VI, subparts 1 and 2 and who is designated by the certification holder to be responsible for all operations of a chemical dependency program.

Subp. 16. **Student Intern.** "Student intern" means a person who is enrolled in an alcohol and drug counselor education program at an accredited school or educational program and is earning a minimum of nine semester credits per calendar year toward the completion of a bachelor's, master's, or doctorate degree requirements. Degree requirements must include an additional 18 semester credits or 270 hours of alcohol and drug counseling related course work and 440 hours of practicum.

Subp. 17. **Substance**. "Substance" means a "chemical" as defined in subpart 5.

Subp. 18. **Substance Use Disorder**. "Substance use disorder" means a pattern of substance use as defined in the Diagnostic and Statistical Manual of Mental Disorders-IV-TR (DSM), et seq. The DSM-IV-TR is incorporated by reference. The DSM was published by the American Psychiatric Association in 1994, in Washington D.C., and is not subject to frequent change. The DSM-IV-TR is available through the Minitex interlibrary loan system.

Subp. 19. **Treatment Services.** “Treatment services” means a therapeutic intervention or series of therapeutic interventions.

Subp. 20. **Variance.** Variance means written permission given by the Oversight Committee allowing the applicant or certificate holder to depart from specific provisions of the standards for a specific period of time.

II. TREATMENT SERVICES

A. The following treatment services must be provided unless clinically inappropriate and the justifying clinical rationale is documented:

(1) individual and group counseling to help the client identify and address problems related to chemical use and develop strategies to avoid inappropriate chemical use after discharge;

(2) client education strategies to avoid inappropriate chemical use and health problems related to chemical use and the necessary changes in lifestyle to regain and maintain health. Client education must include information concerning the human immunodeficiency virus, according to Minnesota Statutes, section 245A.19, other sexually transmitted diseases, drug and alcohol use during pregnancy, hepatitis, and tuberculosis;

(3) transition services to help the client integrate gains made during treatment into daily living and to reduce reliance on the license holder's staff for support;

(4) services to address issues related to co-occurring mental illness, including education for clients on basic symptoms of mental illness, the possibility of comorbidity, and the need for continued medication compliance while working on recovery from substance use disorder. Groups must address co-occurring mental illness issues, as needed. When treatment for mental health problems is indicated, it is integrated into the client's treatment plan; and

(5) service coordination to help the client obtain the services and to support the client's need to establish a lifestyle free of the harmful effects of substance use disorder.

B. Treatment services provided to individual clients must be provided according to the individual treatment plan and must address cultural differences and special needs of all clients.

III. PROGRAM DESIGN

Subp. 1. **Primary Residential CD Program.** These programs are designed for clients with a treatment directive who demonstrate a higher risk and need as a result of the assessment process. Group and individual therapy are an essential part of programming. Client to staff ratio is a maximum of 12:1, except for programs serving female clients which requires an 8:1 ratio. The supervisor and/or director, as well as volunteers and interns may not be counted in the required ratio.

These treatment programs meet the requirements for a DOC program directive, as detailed in the assessment recommendations and program review team directive. Primary treatment programs must provide an average minimum of 25 hours of services per week over the course of the client's stay in the program. Of these 25 hours of services per week, an average minimum of 12 hours per week of direct services facilitated by clinical staff must be provided. The 12 hours per week of direct services must meet the following minimum requirements:

- 4 hours of group therapy;

- 4 hours of psycho-educational programming;
- 4 additional hours of group therapy, psycho-educational programming, community meeting time and milieu building, lectures, video discussions, role plays, structured classroom activities, individual therapy, and/or family counseling.

The additional minimum of 13 hours per week of programming per client can include more of the direct services and other services, such as education and employment skills, therapeutic recreation opportunities offered by the primary treatment program and/or programming offered by the correctional facility as described in the client treatment plan or routine services descriptions.

Any exceptions to the above requirements will be noted in the client file detailing the reasons why an exception was made.

Subp. 2. **Intensive Outpatient CD Treatment Programs in CIP (Challenge Incarceration Program) Settings.** These programs are designed to provide treatment services for selected offenders within CIP programs. The admission criteria to CIP excludes offenders convicted of many violent crimes, ensuring that CIP participants are less dangerous, more emotionally stable, and generally more motivated for treatment than those offenders who do not qualify for CIP. Challenge Incarceration Programs are intensive, rigorous, highly structured and disciplined programs which provide constant structure and accountability.

Each CIP squad is assigned to a primary CD counselor to maintain the integrity of the squad. Adjunctive counselors are assigned to provide services to squads that number more than 15 men, or 8 women, so that the required ratio of 15:1 for men, 8:1 for women, is met. The director/supervisor, as well as volunteers and interns, may not be counted in the required ratio. These treatment programs meet the requirements for a DOC program directive, as detailed in the assessment recommendations and program review team directive. IOP treatment programs must provide 12 hours of direct CD services provided by clinical staff with the following minimum requirements:

- 4 hours of group therapy;
- 4 hours of psycho-educational programming;
- 4 additional hours of group therapy, psycho-educational programming, community meeting time and milieu building, lectures, video discussions, therapeutic recreation focused on CD recovery provided by qualified recreation therapists, role plays, structured classroom activities, individual therapy, and/or family counseling.

An additional minimum of 13 hours per week of programming per client is provided by the structure and additional activities in the CIP Therapeutic Community. Additional activities promote positive change and self-discipline, including drill and ceremony, physical training, restorative justice, community meetings with CD professionals, work crew, education, and documented attendance at sober support groups.

Any exceptions to the above requirements will be noted in the client file detailing the reasons why an exception was made.

IV. ADMISSION AND DISCHARGE POLICIES

Subp. 1. **Admission Policy**. Each chemical dependency program shall have a written admission policy or operating guideline, containing specific admission criteria. The program shall not admit individuals who do not meet these admission criteria. The admissions policy shall also designate which staff members are authorized to admit and discharge clients.

Subp. 2. **Discharge and Transfer Policies.** Each chemical dependency program shall have a written policy that specifies conditions under which clients shall be discharged. The policy shall include the following:

A. Procedures staff must follow when discharging a client for reasons that would have constituted a denial of admission according to subpart 1 had the condition been known or present at the time of admission;
B. Posting of client behavioral criteria that could constitute a reason for termination from the program,
C. Procedures for appeal of client termination;
D. Procedures staff must follow when a client leaves against staff or medical advice and when the client may be dangerous to self or others;
E. A provision that expectations for a staff approved discharge will be discussed with the client and included in the treatment plan according to part V, Subp. 5.

V. CLIENT SERVICES

Subp. 1. **Comprehensive Assessment of a Substance Use Disorder**. A comprehensive assessment of the client's substance use disorder must be coordinated by an alcohol and drug counselor and completed within thirty calendar days after admission to a primary program. The alcohol and drug counselor may rely on current information provided by the client and must include other sources as a supplement when information is available, and must include information from direct observation of the client in individual interview(s). If the comprehensive assessment cannot be completed in the time specified, the treatment plan must indicate how and when it will be completed.

The comprehensive assessment must include information about the client's problems that relate to chemical use and personal strengths that support recovery, including:

A. age, sex, cultural background, sexual orientation, living situation before incarceration, economic status, and level of education;
B. previous attempts at treatment for chemical use or dependency, compulsive gambling, or mental illness;
C. chemical use history including amounts and types of chemicals used, frequency and duration of use, periods of abstinence, and circumstances of relapse, if any.

For each chemical used the information must include the date of the most recent use and any previous experience with withdrawal;

D. specific problem behaviors exhibited by the client when under the influence of chemicals;
E. current family status, family history, including history or presence of physical or sexual abuse, level of family support, and chemical use, abuse, or dependency among family members and significant others;
F. physical concerns or diagnoses, the severity of the concerns, and whether or not the concerns are being addressed by a health care professional;
G. mental health history and current psychiatric status, including symptoms, disability, and psychotropic medication needed to maintain stability;
H. arrests and legal interventions related to chemical use;
I. ability to function appropriately in a work and educational setting;
J. ability to understand written treatment materials, including rules and client rights;
K. risk-taking behavior, including behavior that puts the client at risk of exposure to blood borne or sexually transmitted diseases;
L. social network in relation to expected support for recovery and leisure time activities that have been associated with chemical use;
M. whether the client is pregnant and if so, the health of the unborn child and current involvement in prenatal care;
N. whether the client recognizes problems related to substance use and is willing to follow treatment recommendations.

Subp. 2. **Comprehensive Assessment Summary**. An alcohol and drug counselor must prepare a comprehensive assessment summary within thirty calendar days of admission to a primary program or completion of an orientation phase. If the comprehensive assessment cannot be completed in the time specified, the treatment plan must indicate how and when it will be completed. The narrative summary of the comprehensive assessment results must meet the requirements of items A and B:

A. An assessment summary must be prepared by an alcohol and drug counselor and include:
(1) an admission severity rating for each dimension listed in item B;
(2) a narrative supporting the ratings; and
(3) a determination of whether the client meets the DSM criteria for a person with a substance use disorder.

B. Information relevant to treatment planning and recorded in the ASAM six dimensions in subitems (1) to (6):
(1) Dimension 1, acute intoxication/withdrawal potential. The likelihood of withdrawal symptoms and the client’s ability to cope with them must be considered as well as the risk of current intoxication. Consider information regarding any use since incarceration.
(2) Dimension 2, biomedical conditions and complications. The degree to which any physical disorder would interfere with treatment for substance abuse, and the client's ability to tolerate any related discomfort must be considered. The license holder must determine the impact of continued chemical use on the unborn child if the client is pregnant.

(3) Dimension 3, emotional, behavioral, and cognitive conditions and complications. The degree to which any condition or complications are likely to interfere with treatment for substance abuse or with functioning in significant life areas and the likelihood of risk of harm to self or others.
(4) Dimension 4, readiness for change. The amount of support and encouragement necessary to keep the client involved and motivated in treatment must be considered.
(5) Dimension 5, relapse, continued use, and continued problem potential. The degree to which the client recognizes relapse issues and has the skills to prevent relapse of either substance use or mental health problems must be considered.
(6) Dimension 6, recovery environment. The degree to which key areas of the client's life are supportive of or antagonistic to treatment participation and recovery must be considered, including anticipation of the living environment after incarceration.

Subp. 3. **Client education.** Topics that must be covered in all chemical dependency programs include: (1) drug and alcohol education; (2) criminal and addictive thinking; (3) socialization; (4) co-occurring disorders (mental health and chemical health), (5) relapse prevention; (6) HIV and blood-borne pathogens information, and (7) release and reintegration preparation.

Subp. 4. **Initial Services Plan. t**he program must complete an initial services plan during or immediately following the intake interview. The plan must address the client's immediate health and safety concerns, identify the issues to be addressed in the first treatment sessions, and make treatment suggestions for the client during the time between intake and completion of the treatment plan. Information regarding the expectations of the program, must be provided upon admission, and initial paperwork must be signed, including releases and informed consent documents.

Subp. 5. **Individual Treatment Plans.** Individual treatment plans for clients in treatment must be completed by an alcohol and drug counselor and implemented within thirty (30) days after program admission or completion of an orientation phase, and is subject to amendment until the client is discharged. If the individual treatment plan cannot be completed in the time specified, documentation must indicate how and when it will be completed. Each change to the treatment plan must be noted in the client file. Treatment plans must continually be updated, based on new information gathered about the client's condition and on whether planned treatment interventions have had the intended effect. Treatment planning must include ongoing assessment in each of the ASAM six dimensions. The plan must provide for the involvement of the client's family and those people selected by the client as being important to the success of the treatment experience at the earliest opportunity, consistent with the client's treatment needs and written consent. The plan must be developed after completion of the comprehensive assessment summary and is subject to amendment until services to the client are terminated. The client must have an opportunity to have active, direct involvement in selecting the anticipated outcomes of the treatment process and in developing the individual treatment plan. The individual treatment plan must be signed by the client and the alcohol and drug counselor.

An individual treatment plan must be recorded in the ASAM six dimensions, and address each problem identified in the assessment summary, and include:

A. specific methods to be used to address identified problems, including amount, frequency, and anticipated duration of treatment service. The methods must be appropriate to the client's language, reading skills, cultural background, and strengths;
B. resources to which the client is being referred for problems when problems are to be addressed concurrently by another provider;
C. goals the client must reach to complete treatment and have services terminated
D. plans for support for ongoing recovery following incarceration.

Subp. 6. **Progress notes and Plan Review.**
A. Progress notes must be entered in the client file weekly and must reference the treatment plan. Progress notes must be recorded and address each of the ASAM six dimensions listed in part B. Progress notes must:
(1) reflect significant events, to include those events which have an impact on the client's relationship with other clients, staff, the client's family, or the client's treatment plan;
(2) indicate the type and amount of each treatment service the client has received;
(3) include monitoring of any physical and mental health problems and the participation of others in the treatment plan;
(4) document the participation of others; and
(5) document that the client has been notified of each treatment plan change and that the client either does or does not agree with the change.

B. Treatment plan reviews must:
(1) occur weekly or after each treatment service, whichever is less frequent;
(2) address each goal in the treatment plan that has been worked on since the last review;
(3) address whether the strategies to address the goals are effective, and if not, must include changes to the treatment plan.

C. Progress notes and plan review do not require separate documentation if the information in the client file meets the requirements of subpart 6, items A and B. All entries in a client's record must be legible, signed, and dated. Late entries must be clearly labeled "late entry." Corrections to an entry must be made in a way in which the original entry can still be read.

Subp. 7. **Discharge Summary**. An alcohol and drug counselor must write a discharge summary for each client who leaves the program. The summary must be completed within ten (10) working days of the client's service termination.

The summary at termination of services must be recorded in the six dimensions, and include the following information:

1. client’s problems, strengths, and needs while participating in treatment, including service provided
2. clients progress toward achieving each of the goals identified in the individual treatment plan
3. reasons for and circumstances of service termination.

For clients who successfully complete treatment the summary must also include:

1. living arrangements upon discharge;
2. continuing care recommendations, including referrals made or recommended if applicable
3. diagnosis at service termination
4. client's prognosis

Subp. 8. **Staff to Provide Direct Services.** Core services must be provided by clinical staff qualified according to part VI unless the individual providing the service is specifically qualified according to the accepted standards of that profession. Supervisors/directors will provide oversight of core services provided by other professionals.

VI. STAFF QUALIFICATIONS

Subp. 1. **Qualifications Applying to all Employees with Direct Client Contact.** All employees who have direct client contact must be at least 18 years of age and must at the time of their application for employment document that they meet the qualifications of their respective profession and the requirements of Minnesota Management and Budget Division and Department of Corrections in their respective positions.

Subp. 2. **Program Director and Corrections Program Therapist Supervisor Qualifications.** In addition to meeting the requirements specified under subpart 1, the program director/supervisor must know and understand the implications of parts I to XII.

Subp. 3. **Corrections Program Therapist Qualifications**. Corrections program therapists in CD programs must be licensed alcohol and drug counselors (LADC), or have a temporary permit to practice alcohol and drug counseling, or be a member of another profession excepted from the license requirements under Minnesota Statute148C. 11. Student interns who are supervised by licensed alcohol and drug counselors are also exempt from the license requirement under Minnesota Statute 148C. 11. The individual knows and understands the implications of parts I. to XII.

Subp. 4. **Individuals with Temporary Permits, and Student Interns.** Individuals with a temporary permit from the Board of Behavioral Health and Therapy, and student interns, may provide chemical dependency treatment services under the conditions in either item A or B.

A. The individual is supervised by a licensed alcohol and drug counselor assigned by the program. The licensed alcohol and drug counselor must document the amount and type of supervision at least weekly, and must sign all progress notes and treatment plans. The supervision must relate to clinical practices. One licensed alcohol and drug counselor may not supervise more than three individuals with temporary permits, according to Minnesota Statutes, section 148C.01, subdivision 12a.

B. The individual is supervised by a clinical supervisor approved by the Board of Behavioral Health and Therapy. The supervision must be documented and meet the requirements of Minnesota Statutes, section 148C.044, subdivision 4.

VII. STAFFING REQUIREMENTS

Subp. 1. **Program Staffing Requirements**. Each CD treatment program must meet the following staffing requirements:

CPTs in Program	Director/Supervisors required
01 – 08	1 Full time Director/Supervisor
09 – 16	2 Full time Directors/Supervisors
16 – +	1 Full time Director & 2 full time Supervisors

Subp. 2. **Responsible Staff Person**. In the absence of the Program Director a staff member will be designated to be responsible for the program.

Subp. 3. **Staff Time Allocation**. For each one hour of program services delivered by each CPT, a minimum of .5 additional hours will be allocated for planning and documentation purposes.

Subp.4. **Volunteers and Interns**. Volunteers and interns must be approved according to Department of Corrections policy. Volunteers and interns may be used to provide rehabilitation services, but may not be included in the CPT to client ratio as required in part III, subparts 1 and 2.

VIII. PROGRAM OPERATIONS MANUAL

Subp. 1. **Operations Manual.** Each certificate holder shall develop a written operating manual. The manual must contain at a minimum the following materials:

A. Mission and goals of the program;
B. Applicable DOC policies and procedures;
C. A program design, as defined in part III., subpart 1 and 2;
D. Program rules and guidelines;
E. Routine treatment services provided to all clients;
F. Admission, and discharge guidelines that comply with part IV;
G. Guidelines for maintaining clients' records that comply with part XI.

IX. PROGRAM EVALUATION

Subp. 1. **Program research and evaluation**. All DOC Chemical Dependency programs shall comply with all program research and evaluation projects as directed by the DOC administration.

X. PERSONNEL POLICIES AND PROCEDURES

Subp. 1. **Program Personnel Policies.** Programs will comply with all DOC policies and procedures including, but not limited to:

A. Documentation that each program staff has completed the requirements of DOC Policy 103.420 “Pre-Service and Orientation Training”.
B. Include a program orientation for all new staff based on a written plan that, at a minimum, must provide for training related to the specific job functions for which the employee was hired, program operating guidelines, the needs of clients to be served, and the areas identified in Subp. 1 C.
C. The certificate holder must assure that each staff person working directly with clients receives at least 40 hours of training each year with at least 15 hours related to treating the chemically dependent offender and that a written record is kept demonstrating completion of that training. Training must be completed annually on the subjects identified in items a to c.
    1. Confidentiality rules and regulations and how they specifically pertain to clients;
    2. Blood borne pathogens and its relationship to drug use/abuse;
    3. Ethics and boundary issues training.

XI. CLIENT RECORDS

Subp. 1. **Client Records Required**. Chemical dependency programs shall maintain a central file of current client records on the program premises. The content and format of client records must be uniform and entries in each case record must be signed and dated. Client records must be protected against loss, tampering, or unauthorized disclosure in compliance with Code of Federal Regulations, title 42, sections 2.1 to 2.67, as amended through October 1, 1992; and, if applicable, Minnesota Statutes, chapter 13, MN Statutes 609.342, 609.345, 609.1352, and 253B.185.

Subp. 2. **Records Retention**. The chemical dependency program must retain records of clients discharged from the program for three years or per Department of Corrections policy if it is greater. Programs that cease to provide services must retain client records for three years from the date of closure and must notify the DOC commissioner of the location of the records and the name of a person responsible for their maintenance.

Subp. 3. **Client Records and Contents**. At a minimum, client records must include the following:

A. A copy of a chemical dependency assessment;
B. A treatment plan, in accordance with part V, subpart 5;
C. Progress notes, in accordance with part V, subpart 6;
D. A discharge summary, written in accordance with part V, subpart 7.

XII. VARIANCE APPLICATION

Subp. 1. **Request for Variance.** An applicant or certificate holder may request a variance for up to one year from any of the requirements of these certification standards. A request for a variance must be submitted to the Oversight Committee. The request must specify:

A. The part number of the standard requirement from which the variance is requested;

A. The reasons why the applicant cannot comply with the standard requirement;
B. The period of time for which the variance has been requested; and
C. The equivalent measures the applicant must take to ensure the quality and outcomes of the treatment services and the health, safety, and rights of clients and staff, and to comply with the intent of the standards, if the variance is granted.

Subp. 2. **Evaluation of a Variance Request.** A variance may be granted if the Oversight Committee determines that the conditions in items A to F exist.

A. Compliance with one or more of the provisions shall result in undue hardship, or jeopardize the quality and outcomes of the treatment services or the health, safety, security, detention, or well being of clients or program staff.
B. The chemical dependency treatment program otherwise conforms to the standards or is making satisfactory progress toward conformity.
C. Granting the variance shall not preclude the facility from making satisfactory progress toward conforming to the standards.
D. Granting the variance shall not leave the well being of the clients unprotected.
E. The program shall take other action as required by the Oversight Committee to comply with the general purpose of the standards.
F. Granting the variance does not violate applicable laws and rules.

Subp. 3. **Notice by the Oversight Committee.** Within 30 days after receiving the request for a variance and documentation supporting it, the Oversight Committee must inform the applicant in writing if the request has been granted or denied and the reasons for the decision. The Oversight Committee's decision to grant or deny a variance request is final and not subject to appeal under Minnesota Statutes, chapter 14.

Substance Abuse Treatment in Correctional Settings:

"Recommended Practices"

By

The Association of State Correctional Administrators

Substance Abuse Committee

September 28, 2009

Message from the Chair

We are currently fighting our way out of a severe economic recession, and governments at all levels have been forced to cut budgets in order to make ends meet. One of the fastest growing areas of government spending during the last 30 years has been in corrections. Almost seven and a half million citizens are currently in prison, jail, on probation or parole in the United States, and one of the most common characteristics of this unfortunate group is chemical dependency. In most cases, an offender's ability to successfully navigate their way out of the criminal justice system depends to a great extent on avoiding drug and alcohol use/abuse. Providing institutional-based and community-based assessments, treatment and aftercare is absolutely essential if we are to have any hope of reducing recidivism in great measure. It gives me great pleasure to present this body of best practices relating to providing proven chemical dependency treatment in the criminal justice setting. It represents a great deal of collaboration on the part of the professionals that attended who are committed to making a difference in the lives of offenders who struggle with chemical dependency. I want to thank the Bureau of Justice Assistance for their funding and support that has made this paper possible (2008-MU-MU-K001) and in particular, Dr. Gary Dennis of BJA for his tremendous support and guidance. I also want to express my sincere gratitude to George Camp, Camille Camp and Bob May of ASCA for their undying commitment, and my Assistant Committee Chair, George Little of Tennessee for all of his great help. Most of all I want to thank Steve Allen, Director of Behavior Health Services for the Minnesota Department of Corrections. Without his leadership and guidance this publication would not have been possible.

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Introduction

In May 2009, ASCA Substance Abuse Committee Chair, Tim Reisch, invited representatives from eleven jurisdictions across the country to meet in Chicago in order to review and discuss current practices in correctional substance abuse treatment with several goals in mind. Those goals were to:

- Develop an inventory of current approaches to correctional substance abuse treatment;
- Identify evidence-based and promising practices;
- Determining gaps in services; and
- Suggest courses of action to fill those gaps.

As we neared the end of the second day of the meeting, we found ourselves impressed at the commonalities in approaches across our jurisdictions while remaining concerned that there has not been enough written on correctional substance abuse treatment. We felt fortunate to have had the opportunity to collaborate with each other and found a renewed appreciation for the value of collaboration. As the meeting came to an end, the substance abuse directors made a number of commitments, including to:

- Form an ongoing work group;
- Create a list serve to facilitate ongoing communication and collaboration;
- Create a common web site to share resources;
    - Provide access to studies and materials presented by group;
    - Provide links and electronic copies of influential, well-founded studies;
    - Provide electronic versions of public domain treatment materials;
    - Provide helpful “links” (i.e., SAMHSA, TCU); and
- Create a “position paper” on practice recommendations for substance abuse treatment in corrections settings based on evidence-based practices and the preponderance of current research in field.

Since the meeting, we have made important progress on these goals. The document that follows is the result of this group’s efforts to summarize our understanding of current evidence-based and promising practices for substance abuse treatment with correctional populations. We hope that others will find this document to be a useful reference and we invite others to further develop and improve our work.

I offer my sincere appreciation to all of the contributors. Each of them took time from their very busy schedules to invest in this project and their contributions went well beyond our original commitments. I want to recognize Beth Weinman from the Bureau of Prisons along with Gib Sudbeck and Jeff Bathke from South Dakota who, in addition to their own submissions, spent many hours helping to edit and improve this project. A special thanks goes to L. Sam Borbely who volunteered to help finish the white paper during the final weekend of the project. In addition to numerous edits, Sam helped re-write one of the sections and then took on another complete section that we hadn’t been able to write. I also need to recognize all of the hard work by Minnesota DOC staff. Special thanks to Dawn Ryan who created the group’s work site, my great boss, Nanette Larson, who provided unhesitating support whenever I needed it and to Sally Richter who put in countless hours on this project and quickly solved every problem sent her way.

Steve Allen
Director of Behavioral Health Services
Minnesota DOC

1. Challenges and Opportunities

Challenges

The cost of correctional supervision continues to climb. Recent PEW research finds that one out of every 100 U.S. citizens is now behind bars[1]. With approximately 70 percent of persons under correctional supervision having a history of drug or alcohol abuse associated with their criminality[2], it is clear that substance abuse is a major catalyst for criminal behavior. The consequences of substance abuse have a staggering effect on public safety and on federal, state and local budgets with the cost to society estimated at more than $181 billion in 2002, with 60 percent of this cost - $107 billion – associated with drug-related crime[3]. Crime and the costs of crime attributable to substance abuse by offenders have been ballooning at rates higher than other social growth figures. Between 1992 and 2002 substance abuse related crime costs rose 5.7 percent annually. Law enforcement and corrections are where the primary increases are found, while our communities lost productivity from the overwhelming number of citizens incarcerated. This rate of increase is greater than the total increase of population growth and general inflation (3.5 percent) and the growth of the general economy (5.1 percent)[4].

Opportunities

For decades, criminal justice and drug abuse treatment research has continued to demonstrate that offenders treated for substance use disorders are less likely to relapse to drug use and criminal behavior than those substance abusing offenders who do not receive treatment. A vast body of research produced over the past several decades has consistently demonstrated that evidence-based substance abuse treatment programs, when implemented with fidelity, reduce recidivism rates and associated taxpayer costs.

For example, in 2006 the Washington State Institute of Public Policy published findings from a systematic review of treatment programs research that showed:

- a reduction in recidivism rates of 16.7% for intensive supervision;
- a recidivism decrease of 12.4% associated with community drug treatment programs; and
- recidivism rate reduction of 6.9% for in-prison therapeutic communities coupled with aftercare.

Other states and federal institutions have also experienced positive returns on investments in substance abuse services. Dozens of studies have examined the results of substance abuse treatment programs and determined that this treatment yields a net economic cost reduction to society[5] .

The most comprehensive and widely referenced cost studies are those conducted by California and Oregon which estimated cost reductions of $7 for every $1 invested in treatment. A similar study based on a sample of federally funded treatment programs found returns of $4 for $1 in treatment. Still, other studies focused on smaller populations[6] found cost reductions ranging from $1.30 to $23 for every $1 invested in treatment. Across each of these studies, most cost reductions are derived from reductions in criminal behavior and increased employment.

Studies on the reduction of recidivism and the overall benefit in cost reduction demonstrated that drug treatment can be incorporated into criminal justice settings in a variety of ways. Treatment may occur as a condition of probation, through the drug court process; within prison treatment - especially when followed by community aftercare - or in special residential care, such as Boot Camps with appropriate

aftercare; provided they operate on the model of fidelity that produced positive outcomes.

Today we know that correctional policy and funding decisions based on sound correctional data and the latest research can reduce recidivism, reduce costs and increase the safety and security of the institution and the community. Unfortunately, today funding no longer allows the majority of persons with substance abuse problems who are currently under correctional supervision and in need of treatment to receive the appropriate treatment. The challenges and opportunities faced by contemporary correctional professionals is to become knowledgeable of evidence-based strategies in policy development, in practice and in resource distribution to effectively treat the substance disordered offender thereby reducing the likelihood of recidivism and the costs and social impact of crime.

2. Staffing

Staff Credentialing and Qualifications

Substance dependent offenders present unique clinical challenges beyond those faced with community populations. There are high rates of co-occurring disorders with offender populations, including; criminogenic factors, personality disorders, mental illness, traumatic brain injuries, etc. For these reasons, adequate levels of education, training and experience should be required for individuals treating corrections populations. Trainees and counselors should be recognized by the chemical dependency licensing or certification board in the state. Most state boards have credentials that reflect differing levels of education, training, and experience. The state's licensing or certification standards should reflect accepted nationally recognized standards and the Board should be a member of either the International Certification & Reciprocity Consortium of Alcohol and Other Drug Abuse Counselors (IC&RC/AODA), or NAADAC the Association for Addictions Professionals. In addition to employing licensed or certified professionals it is important for substance abuse treatment programs to conform to accepted rules and standards for treatment at either a state or national level. This will help to ensure that the treatment delivered to offenders is competent and in keeping with standards found in the community.

Staff Ratios

Staffing ratios set the allowable caseload span that a therapist is allowed to maintain. Establishment of consistent and appropriate staffing levels is essential to the quality of treatment programs. Ratios should be based on the treatment approach, the offender population characteristics and the intensity of the program. Generally speaking, female and juvenile populations should have smaller ratios than adult male populations. Educational and outpatient programs may have higher ratios than inpatient programs.

Training

The credentialing process assures the clinician has received a foundation to practice in the field. The professional development of any clinician, however, requires on-going professional training and clinical supervision to reinforce the training process. This process is especially important in working with offender populations for the reasons cited above. Credentialing boards set standards for the number of ongoing training hours required annually to maintain the clinician's credential along with required and recommended training topics. Common topic areas for training include the twelve "core functions" of providing substance abuse treatment[7]; (see appendix for the twelve "core functions).

Clinical Supervision of Chemical Dependency Professionals

Clinical supervision is a unique and identifiable educational process that enables the counselor to integrate theoretical information, practice skills and self-knowledge into a personalized, effective counseling style. Clinical supervision is an essential element in the development of beginning therapists, but it is also considered sound practice for therapists of all experience levels. This is especially true for staff working with offender populations as these clients present complex challenges, both professional and personal.

Clinical supervision should not be confused with therapy, case management, or in-service training. The structure for clinical supervision is typically face-to-face, one-to-one and/or group(s) and should be scheduled on an ongoing basis with a predictable schedule. The methods used are intensive case review and discussion; direct observation of a counselor in action via videotape, sitting in on sessions, process recordings, simulations, role playing, etc.; and indirect observation of clinical practice via case

presentations, case review, review of clinical documentation and quality of care reviews. Supervision through the use of email, Internet, video or audio-conferencing and teleconferencing is not likely to be as effective. While it may be a useful adjunct when distance is a factor, these supervisory forms are not recommended as the primary mode of supervisory interaction.

Clinical supervisors should be engaged in the practice of his/her profession that assures a high level of professional competency and should be qualified to supervise, which assumes the abilities to teach, communicate, and support those receiving supervision. Credentialing boards typically establish minimum educational, training and experiential requirements for supervisors.

Clinical supervision responsibilities should be clearly defined by the agency so that the counselor is not overwhelmed by excessive and vague tasks. This allows the counselor and clinical supervisor to negotiate a "contract for learning within the counselor's duties that sets clear learning objectives and limits to the clinical supervision." Clinical supervision requires that the roles of clinical supervision and counselor be appropriate to their professional identity. This means the clinical supervisor's level of professional competency should be greater than that of the counselor, giving him/her a role model and a level of competency for which to strive.

Educational institutions have specific supervisory requirements for internships as do certification boards during the period when clinicians are working to complete their credentialing requirements. Clinical supervisors must understand and follow these requirements to ensure proper supervision and guidance. Supervisors are responsible to monitor their supervisee's professional development and to highlight problem areas. Supervisors typically sign off on their supervisee's clinical documentation during internships and pre-credentialing periods and are required to sign off on their supervisee's application for credentialing. When appropriate, supervisors should withhold their support for supervisee credentialing when the supervisee has not shown sufficient professional development to practice independently.

All supervisee work experience must be documented and verifiable. Clinical supervisors shall ensure that each supervisee is familiar with all applicable ethical standards adopted by their credentialing Board.

3. Offender Assessment

Substance abuse is considered the nation's number one health problem, and the link between substance abuse and crime is undeniable. The importance of identifying offenders who are in need of substance abuse intervention and treatment cannot be overstated. Thorough substance abuse screening and assessment provides the foundation for subsequent intervention, treatment, recovery maintenance, and risk reduction efforts. Correctional policy and procedures should be in keeping with the prevailing best practice literature recognized as the standard for substance abuse screening and assessment (e.g. TIP 44: *Substance Abuse Treatment for Adults in the Criminal Justice System, and* TIP 7: *Screening and Assessment for Alcohol and Other Drug Abuse Among Adults in the Criminal Justice System*[8]) and be in compliance with applicable federal and state regulations and standards.

In practice, screening and assessment should be an ongoing process that is offender focused, cultural and gender sensitive, and provides for differing levels of screening and assessment depending on clinical need, program involvement, and the court's sentencing structure. Based on the presenting symptoms and problems, further assessment of special conditions and circumstances may be indicated. This could include medical, mental health, disability, traumatic brain injury, etc. It is crucial that substance abuse assessment take into consideration information from standardized correctional risk and need assessments. This is necessary in order to better evaluate the impact of criminal risk and criminogenic needs, to recommend levels of care, and to guide treatment and relapse prevention planning. The optimum process for screening and assessment would involve a semi-structured clinical interview supported by nationally recognized screening tools and assessment instruments, and corroborated via collateral information, official documentation and drug and alcohol testing.

Substance abuse intervention and treatment recommendations should be assessment driven and guided by accepted patient placement criterion such as the *American Society of Addiction Medicine Patient Placement Criteria for the Treatment of Substance-Related Disorders*[9]. Assessment recommendations, diagnosis, and placement decisions should be adjusted accordingly when an offender is in a controlled environment[10]. Considering the heterogeneity of the offender population, recommendations for individualized treatment matching is an essential component of a comprehensive substance abuse assessment. Offenders can be matched to treatment based on a variety of characteristics and needs (i.e., motivation for treatment, criminal risk and need, responsivity factors, special condition, etc.). Recommendations from comprehensive screening and assessment provide necessary support and direction for addressing an offender's substance abuse intervention and treatment needs at key clinical and correctional decision points.

4. Substance Abuse Treatment Planning for Corrections Populations

A common misperception made by substance use treatment providers is to view clients, referred from the corrections population, as individuals primarily having problems of addiction. Criminal behavior and thinking is often seen as a symptom or consequences of addiction rather than the basis of their corrections involvement. It is important to put this in perspective—the majority of individuals with substance use disorders do not commit crimes that violate the rights and safety of others. This means that there are additional factors to consider in the assessment and effective treatment of substance dependent offenders.

Treatment providers are often of the belief that through remediation of the substance use disorder, the client's criminality will subside. We now know that the opposite is often true, that it is the criminal thinking and criminal lifestyle that often leads to the substance use disorder. To be successful, a core component of any corrections-based treatment program must include a treatment process that targets the criminal thinking patterns that reinforce the criminal lifestyle.

A. Treatment Plan Development

Treatment goals and the treatment planning processes are derived from the thorough multimodal biopsychosocial assessment. The skills of the assessing clinician need to include a broad perspective of human behavior. Individualized assessments completed on corrections clients need to inquire about and assess not only the severity of the substance use problem, mental/physical health conditions, family/social supports, the readiness or stage of change, etc., but also the criminal values/beliefs/attitudes and criminogenic risk factors. Convergent validation of assessment information through standardized tests (e.g., LSI-R, COMPAS, TCU Criminal Thinking Scales) and file review is critical in light of the correction-connected client's reluctance for complete disclosure. The interrelatedness of the assessment process, treatment programming and treatment planning cannot be stressed enough. Treatment planning efforts will typically take the shape of traditional substance use disorder treatment and correctional goals will not be considered if clinicians are not trained in psychopathy, do not have accurate problem definition, and do not use programming that supports correctional treatment goals.

The fundamentals of effective treatment plan development are relevant no matter what conditions the client presents. The therapist has a responsibility to the client to facilitate refinement of the client's goal in order to define the heart of the problem as the client experiences it. Goal statements are global, long-term statements that reflect the positive outcome from treatment efforts (i.e., "Establish a consistently alcohol and drug-free lifestyle." or "Accept responsibility for my decisions and actions that have led to arrests and develop pro-social values, beliefs and behaviors."). On the other hand, the objectives for each goal statement are incremental, behaviorally specific and measurable in order to guide the client and therapist as well as to allow for measuring goal attainment, (i.e., "Learn, demonstrate and implement coping strategies to manage my urges to relapse into use," or "Identify and replace my thinking errors and distortions that have led to my antisocial behaviors."). Interventions are the actions or activities of the client and/or therapist that help clients complete the objectives. Multiple problem areas may be identified in the assessment, but not included in the treatment plan. The problem areas out of the scope of the treating agency or of a less pressing nature may be addressed by referral or deferred until a later date.

Individualized, distinct and separate treatment goals, objectives and interventions that address the

process of addiction and recovery, target skill building in domains such as refusal skills, trigger/urge recognition, urge management and relapse prevention plan development need to be established. Motivational enhancement objectives and interventions that acknowledge the client's reluctance and ambivalence need to be included in the treatment plan. To ignore the client's readiness or lack of readiness to change would result in poorly matched interventions and poor outcomes.

Equally important to treatment are separate and distinct correctional goals. These goals must be included in the treatment plan. Often the therapist needs to do some work with the client to clarify and define the problem before the goal can be established. Most offenders put the focus on their parole/probation status when identifying their correctional goal. The therapist needs to work with the client to recognize their behavior, thinking and attitudes as problematic and a primary focus of treatment. Without this effort the client often moves through treatment without acknowledging the fundamental issues of their criminality. Clients are much more inclined to admit to substance use problems, and blame their criminal behavior on their use. Unfortunately, the poorly trained clinician will fall into the same trap. The focus of correctional goals, objectives and interventions needs to be on empathy-based skill development that increases prosocial thinking, attitudes, and conduct, as well as on the development of a sense of social/community responsibility. Additional skill development in problem resolution, anger/conflict management and distress tolerance is essential. The development of a recidivism prevention plan, often in conjunction with the relapse prevention plan development, is a necessary working document that is a product of treatment and guides the client after treatment discharge.

B. Treatment Processes

Treatment curriculum at the program level needs to be specific to the corrections population and geared toward addressing both relapse prevention and recidivism prevention. Programming needs to incorporate "correctional" perspectives that help clients develop thinking and behaviors that foster moral responsibility towards others and society. Cognitive restructuring and skill building, including empathy skills, are critical components of the curriculum and are delivered from a cognitive behavioral approach. Fidelity to curriculum and best practices is essential to ensure that adequate attention is focused on community relatedness and responsibility. Also inherent in the treatment process are efforts to move a client along the continuum of the stages of change. Curriculum content should include trans-theoretical change concepts and motivational enhancement exercises that encourage discussion about the client's ambivalence in order to consciously address an often pervasive client sentiment. Limited resources dictate the emphasis on group interventions which are most efficacious and efficient when manual driven. Basic concepts of cognitive-behavioral processes, such as cognitive restructuring and formalized skill development sessions, are the underpinnings of the work in this area. This emphasizes the importance of manual driven treatment delivered by skilled clinicians. This approach should be evident in the treatment plan, particularly in the defined objectives and interventions.

Group Therapy

There are a number of therapy approaches to treating the substance abusing criminal offender. These include individual therapy, didactic presentations and group treatment.

Group-based programs are more efficient and effective than other methods in developing a commitment to a drug-free life by fostering introspection and facilitating the acquisition of coping skills for substance abusing criminal offenders[11] .

Treatment groups offer members the opportunity to learn or relearn the social skills they need to cope with everyday life instead of resorting to substance abuse. Groups members can learn by

observing others, being coached by others, and practicing skills in a safe and supportive environment. Groups can effectively confront individual members about substance abuse and other harmful behaviors. Such encounters are possible because groups speak with the combined authority of people who have shared common experiences and common problems. Confrontation often plays a part of substance abuse treatment groups because criminally-inclined substance abusers tend to deny their problems. Participating in the confrontation of one group member can help others recognize and work through their own internal processes of resistance.

A group treatment approach adds needed structure and discipline to the lives of people with substance use disorders, who often enter treatment with their lives in chaos. Groups reduce the sense of isolation that most people who have substance abuse disorders experience. At the same time, groups can enable participants to identify with others who are struggling with similar issues. Groups help the members learn to cope with their substance abuse and other problems by allowing them to see how others deal with similar problems.

Perhaps most importantly, group treatment enables people who abuse substances to witness the recovery of others. Clients can learn how to avoid certain triggers for use, the importance of abstinence as a priority, and how to self-identify as a person recovering from substance abuse. Groups instill hope, a sense that “If he can make it, so can I”.

Group treatment is also cost effective as it allows a single treatment professional to help a number of offenders at the same time. Positive group facilitation provides the opportunity for each group member to eventually become acculturated to group norms. Positive group facilitation provides members the opportunity to act as quasi-therapists, thereby ratifying and extending the treatment influence of the group leader.

Successful group approaches with substance abusing criminally involved offenders utilize a cognitive behavioral framework that will focus on cognitive behavioral and skills development in two ways. Cognitive approaches address both deficits in problem solving reasoning and social skills, while addressing thinking distortions or errors. Skills development, especially relapse and recidivism prevention skills, assist the offender in coping with urges, triggers for criminal behavior, refusal of offers to use, etc. (See appendix for Guiding Principles for Corrections-Based Treatment).

C. Treatment Content

Evidence-based practices show that a cognitive behavioral therapy (CBT) approach to treatment is both appropriate and effective with corrections populations. A number of published curricula are available that incorporate CBT and, to a varying extent, may be specific to offender populations. The following is a partial list of treatment curricula currently available and in use with correction populations: Women Offender Case Management Model (WOCMM); Hazelden Co-occurring Disorders Program; Hazelden New Direction Program; Dialectical Behavioral Therapy (DBT); MATRIX; Criminal Conduct and Substance Abuse Treatment: Strategies for Self-Improvement and Change; TCU Model of Substance Abuse Treatment in Corrections; Thinking for a change; Motivational Interviewing; and Cognitive Therapeutic Community (CTC).

Treatment programs should address the range of treatment issues identified in the assessment and programs commonly utilize a comprehensive approach to offender treatment. In addition to the

curriculum identified above, many programs utilize specific curricula to address the offender's criminogenic factors in addition to their chemical dependency or substance abuse. These curricula may include, but are not limited to: Criminal Thinking Errors, Thinking for a change, Anger Management, Cognitive Restructuring (Criminal Lifestyles; Rational Thinking); Cultural Diversity, Conflict resolution, Life Skills: Parenting, Money Management, Wellness, Relationships, etc.

The use of standardized curricula throughout a given corrections system allows for continuity of approach and stable transitions of offenders as they are stepped down to re-entry and into the community. While there are advantages to the use of standardized curricula, there are also pitfalls. Workbooks can be expensive and their use may result in therapists and offenders over-relying on these materials with the result that the offenders successfully "complete" the workbooks while avoiding the therapy processes that can result in meaningful internal change. Packaged curricula, therefore, are best utilized as an element of the overall treatment process.

D. Treatment Duration

Treatment duration is not well-established in the research literature for corrections population. Within the jurisdictions represented by this workgroup, treatment duration ranged from as little as 2 months up to 24 months. As with many other issues dealing with offender management and offender treatment, a one size fits all model does not fit well. Many factors play into the duration of treatment programs including treatment design, the clinical needs of the offender population being served as well as pragmatic factors such as budgets, staffing limitations, offender population management, facility physical restraints, sentencing lengths, etc.

Many programs have a static length of stay, (i.e., 12 months, 60 days). Current research is showing that for low risk offenders, a long intensive treatment regimen may actually have an adverse effect of causing the offender to reoffend at a higher rate than if they had received no treatment. The research is showing that completion of treatment should be based on the offender's mastery of the curriculum. Advancement and completion of the treatment program should be variable and not a static length.

E. Modified Therapeutic Communities

Therapeutic Communities (TCs) have been demonstrated to be among the most successful substance abuse treatment programs in the correctional setting. The hallmark of the TC method is its explicit perspective on substance use disorder, the person, recovery and right living, and the use of the "Community as Method"[12] to facilitate change. TCs operate as highly structured environments that utilize a psychosocial, experiential learning process in which positive peer pressure, pro-social modeling, and an expected adherence to rules is used to influence and reinforce positive behavior change. It is this unique context, comprised of the highly structured social environment in which peers and staff members interact using TC principles and methods, which ultimately facilitates behavior change and recovery.

Many of correctional substance abuse residential programs have borrowed some of the identifiable structures of TCs (e.g., morning meeting, structure board, written philosophy), but they often lack those core processes that are at the essence of what George De Leon, Ph.D., describes as the "community as method" approach and have become known as "modified," TC programs"[13]. This confusion that surrounds TCs will likely continue until there is a clear understanding of the TC method and an acceptance of the salient aspects of the model itself.

There is a growing body of Therapeutic Community Treatment literature[14] and research[15] that can be

used to inform and guide correctional practitioners in the implementation and maintenance of TC programs. One example the theoretical writings of George De Leon, Ph.D., including De Leon, G (2000) *The Therapeutic Community: theory, Model and Method*, New York: Springer Publishing[16]; standards set forth in Therapeutic Communities in Correctional Settings – the Prison Based TC Standards Development Project, Final Report of Phase II published by the Executive Office of the President, Office of National Drug Control Policy; and the American Correctional Associations Performance Based Standards for Therapeutic Communities.

F. Treatment for Female Offenders

In 2001, there were over one million female offenders in prison, and in the past ten years there has been an 81% increase in female offenders who are under criminal justice supervision. Treatment for women in correctional facilities has been traditionally based on male programming, and it has only been in the past decade that there has been recognition that female offender programming must be different if it is to be effective. Male and female criminality and pathways to crime appear to be very different. One in three women commit crimes to obtain money to support a drug habit, and over 80% of the female offenders have substance abuse issues. The following are some characteristics of incarcerated women:

- Disproportionately more women of color.
- Single women who are the primary caretaker of minor children.
- Histories of sexual and physical abuse as children and as adults.
- High prevalence of co-occurring disorders.
- Low self-esteem.
- Substance abuse issues are severe and the primary drug of choice is crack-cocaine.
- Crimes are often economically motivated, driven by substance abuse and poverty.
- Convicted of drug or drug-elated and property offenses.

Review of literature, as well as the experience of running a therapeutic community for female offenders, suggests that programming for women must be gender-responsive to be effective. Programming must take into account critical issues such as trauma, substance abuse, mental health and concerns about their children. How these areas are addressed will have a major impact on the woman's treatment needs and, ultimately, their successful re-entry into the community.

A number of factors need to be considered when developing programming for female offenders.

- *Therapeutic Communities:* Utilize TCs in treatment design.[17] As described above, TCs are effective in the provision of substance abuse treatment and female offenders tend to be especially responsive to the positive social structures and dynamics within these communities.

- *Treatment duration:* Treatment design should take into account the additional clinical complexities presented by this population and should, therefore, provide adequate treatment duration and intensity. Six or more months of residential treatment has been effective in some jurisdictions.

- *Treatment modality:* As noted above, group therapy is the preferred treatment modality for substance abuse treatment but it is especially well-suited as the primary intervention modality for women as the social dynamics inherent in group processes are congruent with most women's preferred interaction style.

- *Children and families:* Loss of contact with children and family and the issues related to reconnecting are often primary concerns with female offenders. Treatment should include these issues as well as preparation for successful reunification, (i.e., parenting skills, child development, etc.).

- *Trauma:* The incidence rate for trauma (physical, mental, sexual) within this population is tremendously high. To achieve long-term psychological stability, these issues must be identified and addressed in treatment. It is also recommended that all staff members working with this group have some knowledge of trauma theory to support the treatment process and to avoid inadvertently triggering reactions to trauma and retraumatization.

- *Co-occurring disorders:* There is a growing appreciation for the role of co-occurring disorders in the effective treatment of substance abuse[18]. Co-occurring Disorders are common among this population and need to be addressed. Female offender populations tend to have very high rates of psychiatric needs compared to their male counterparts. Integrated treatments and interdisciplinary approaches are highly recommended.

- *Safety:* The establishment of a safe and supportive environment is essential in any effective treatment setting. This is even more the case with female populations, given their heightened rates of trauma history and increased physical and mental vulnerabilities. Establishing an environment perceived to be safe in a prison setting requires a review of standard practices, including how strip searches are done, offender monitoring processes, showering practices, etc.

A sensitive approach to implementing these security processes can have a significant impact.
As with other specialized populations, staff preparation, staffing levels and continuum of care are important considerations. Treatment staff should receive specialized training when working with female offenders to ensure awareness of the unique treatment needs of this population. Generally speaking, staffing levels should be more stringent, given the clinical complexity and high needs rates typically found. Transitional services are especially important with female offenders because children are so often going to part of the offender's world at release. As preparation for release, consideration should be given to housing, education, job training, community-based substance abuse treatment, community mental health services, as needed, economic support, positive female role models and most importantly physical and psychological safety. Statistics have also shown that the level of long term success is much more likely if an offender goes into a transitional and/or residential treatment center upon discharge. Prison treatment programs serve act as advocates for female offenders, providing a safe environment and assisting them in transitioning back into the community and society at large.

G. Treatment for Juvenile Offenders[19]

Adolescent users differ from adults in many ways. Their drug and alcohol use often stems from different causes, and they have even more trouble projecting the consequences of their use into the future. In treatment, adolescents must be approached differently than adults because of their unique developmental issues, differences in their values and belief systems, and environmental considerations, (e.g., strong peer influences). At a physical level, adolescents tend to have smaller body sizes and lower tolerances, putting them at greater risk for alcohol-related problems even at lower levels of consumption. The use of substances may also compromise an adolescent's mental and emotional development from youth to adulthood because substance use interferes with how people approach and experience interactions.

The treatment process must address the nuances of each adolescent's experience, including cognitive,

emotional, physical, social, and moral development. An understanding of these changes will help treatment providers grasp why an adolescent uses substances and how substance use may become an integral part of an adolescent's identity. In addition to age, treatment for adolescents must take into account gender, ethnicity, disability status, stage of readiness to change, and cultural background.

Some delay in normal cognitive and social-emotional development is often associated with substance use during adolescence. Treatment for adolescents should identify such delays and their connections to academic performance, self-esteem, or social interactions.

Programs should make every effort to involve the adolescent client's family because of its possible role in the origins of the problem and its ability to change the youth's environment. [Federal Confidentiality Regulations (42 C.F.R.) must be complied with in treating young people for chemical health disorders.] However, it is not uncommon for state data sharing practices to be in conflict with federal rules and statutes especially as they related to adolescent treatment.

Several models of treatment have been found effective in treating adolescents, including the 12-Step model, therapeutic community models (12 to 18 months), and family therapy models. All levels of care should be considered in recommending treatment for adolescents, and it is desirable to refer the adolescent to the next higher level of care when a particular level of care is not available.

The core components of treatment programs for adolescents should include orientation, daily scheduled activities of school, chores, homework, and positive recreational activities, peer monitoring in a group setting, conflict resolution processes to determine treatment plan modification, client contracts, (e.g., behavioral contracts including abstinence, schooling and/or vocational training).

As with adult offenders, treatment for juveniles must also assess for and address the criminogenic factors that underlie the juvenile's entry into the justice system. Gang involvement is a common component of juvenile criminality and needs to be factored not only into the offender's treatment planning but also as an issue to monitor closely within the program's therapeutic community as an important element of maintaining the integrity of the program's therapeutic milieu.

H. Treating Special Needs Populations

Integrated Dual Disorder Treatment

Incarcerated populations have rates of mental health and substance use disorders that are significantly higher than those in the general population[20]. Evidence-based practices for the incarcerated population involve integrating mental health and substance abuse services[21]. Several prison co-occurring disorders treatment (CDT) programs have conducted extensive outcome evaluations, including the Personal Reflections program in Colorado, the Turning Point program in Oregon, the Hackberry, Estelle, and Jester 1 programs in Texas, and the MICA and WINSAT programs in Wisconsin. Key outcome findings from the various programs include reductions in criminal recidivism among CDT program graduates in comparison to offenders who received traditional prison mental health services. Reductions in criminal recidivism were also associated with post-release community aftercare treatment. The WINSAT program results included reduction in criminal recidivism, substance abuse, and mental health symptoms[22].

Treatment of Cognitively Impaired Offenders

In order for substance abusers to benefit from psychological treatment, they must be capable of attending, receiving new information, integrating it with existing information, and translating this input into more concrete behavioral change. Most widely used treatments include psychoeducational or cognitive behavioral components which require goal setting, planning ability, sustained attention, response inhibition, skill acquisition, and problem-solving capability. These are the same cognitive abilities that tend to be most impaired in many drug abusers. In addition, there is a high prevalence of comorbid psychiatric disorders, like ADHD and antisocial personality disorder in drug abusers. These co-occurring disorders can independently contribute to cognitive impairment and cause an additional burden on the offender's cognitive abilities. For these reasons, the efficacy of many behavioral interventions may be inadequate for impaired clients. The research suggests that substance abusers with cognitive limitations may be insufficiently able to successfully process the interventions and as a result that they are more likely to drop out of treatment, relapse faster, and have poorer long-term outcomes in comparison to cognitively intact substance abusers[23].

An important first step in drug abuse treatment is to conduct a brief cognitive status exam that accurately identifies individuals that have a neuropsychological impairment. Early functional analysis of skills and resources that these clients lack is a key component of behavioral addiction treatments. Clients who are recommended for chemical dependency treatment and who also are cognitively impaired need to be identified at intake. The clinical team should decide if the client is able to function in a group setting, or if individualized treatment is needed. Severely cognitively impaired offenders who require individual therapy must be identified early on in their sentence so that sufficient time and resources may be allocated for treatment in advance.
After identifying the core cognitive deficits, a treatment approach may be focused on accelerating cognitive recovery of brain function. A cognitive rehabilitation approach includes methods designed to enhance cognitive processing and teach compensatory techniques. Clients may be assigned tasks designed to improve the identified deficits. Sessions would involve memory training and the development of problem-solving strategies. Environmental interventions may also be used to compensate for information processing weaknesses. For instance, unambiguous cues may be used to prompt or discourage specific behaviors to help persons with memory impairment. Additional research is required to determine to what extent cognitive rehabilitation is effective in enhancing treatment response.

Other approaches to treating substance abusers with cognitive limitations include modifying existing treatments. It is important to identify the core cognitive demands of the treatment, as well as the deficits and abilities of the patient and then tailor the treatment to meet the client's abilities. Some recommended adaptations include: decreased session length; increased session frequency; repeated presentation of therapeutic material; use of multi-modal presentation of material (visual, verbal, experiential); use of memory aids, such as appointment books, calendars, and mnemonics; provision of stress management to improve attention and concentration; use of simple language; assessment of retention of immediate feedback to clarify misunderstandings; and assignment of homework practice exercises. Other strategies include increasing the length of the treatment period so that more difficult abstract concepts presented are presented later in treatment when cognitive processing has improved and to present information with less demanding content early in treatment.

Treatment for Individuals with Traumatic Brain Injury

It has been well recognized within the chemical health treatment community that many

individuals presenting for substance use treatment have a history of Traumatic Brain Injury (TBI) and that in many cases, the brain injury was acquired while the person was under the influence of alcohol and/or drugs[24]. Studies have indicated that approximately one third of individuals incurring a TBI were intoxicated at the time of injury and that more than half present to treatment with a history of alcohol abuse or dependence prior to their injury[25].

The combination of TBI and a substance use disorder has an increased negative affect upon the individual in terms of neuropathological changes in the brain, cognitive function, and psychosocial outcomes than either of these conditions in isolation[26]. Chemical health treatment for individuals with TBI can be particularly challenging given the cognitive, behavioral, physical, and emotional factors that accompany TBI. Unfortunately, traditional methods of substance abuse treatment programs are often insufficient to meet the presenting issues of individuals with TBI[27].

Given the increasing evidence that TBI is more prevalent among persons in treatment for a substance use disorder, suggested accommodations and treatment interventions for TBI in substance abuse programs have been proffered[28]. Proposed guidelines[29] for integrated treatment of TBI and Substance Abuse Treatment include:

1. Substance abuse treatment and brain injury rehabilitation are interwoven-not sequential and not just parallel.
2. Is holistic-addressing all aspects of lifestyle, not just TBI and substance abuse.
3. Key staff members are skilled in working with TBI and substance abuse disorders.
4. Consumers collaborate with clinicians to develop an individualized treatment plan.
5. Clients go through a process over time in which different services are helpful at different stages of recovery.
6. Clinicians use specific listening and counseling skills to help consumers develop awareness, hopefulness, and motivation for recovery.
7. Smaller staff caseloads, more experienced staff, and long-term treatment are usually required.

Substance Abuse Treatment for Sexual Offenders

As with other offender subtypes, there are high rates of drug and alcohol abuse among sexual offenders[30]. Substance abuse is commonly part of an offender's offending pattern and, therefore, becomes a dynamic and acute key risk factor for reoffending. In addition, failure to address the substance abuse issues with this population carries an additional risk. Most offenders enter treatment with some degree of denial or resistance. Sex offenders, in particular, shoulder a deeper denial due to embarrassment, shame, or the need to maintain secrecy. Substance abusing sex offenders frequently place blame for their offending on their chemical use or claim to not remember the offense, contributing to denial and resistance. Unfortunately, there is little current research on the subject of substance abuse treatment for sexual offenders, despite the relevance of this factor in managing the unique risks presented by this population. Experience shows that when sex offenders are treated for substance abuse within traditional substance abuse treatment programs, they are too frequently targeted (openly and behind the scenes) by other offenders because of the nature of their crimes. While these programs do not address the sex offending elements directly, they typically include a focus on criminogenic factors, requiring offenders to disclose their offending histories and link their offending to their substance abuse. These dynamics may lead to higher than average rates of drop-out for sex offenders in traditional substance abuse programs.

To address these dynamics and in the effort to increase the effectiveness of substance abuse treatment for this population, some jurisdictions are developing specialty sex offender substance abuse programs. These programs are not designed to treat the sexual offense, per se, but do address the substance abuse as it relates to the offender's history. This specialization allows the substance abuse clinicians to develop expertise in sex offending behavior, increasing the potential effectiveness of these interventions. The homogeneity of these programs affords the sex offenders additional safety and the expectation to disclose their histories candidly.

Another approach deserving attention involves embedding substance abuse treatment for sexual offenders within the sex offender treatment program. Based on the Minnesota Department of Corrections experience, it is essential that the offender's substance dependency be addressed prior to the sex offending issues. A continuum of substance abuse treatment and sex offender treatment offers treatment staff consistency in their communication with the offender, and with each other, regarding the offender's treatment issues. Offenders participate in psycho educational classes, sex offender therapy, group work that focuses on their co-morbidity, addresses distorted thought patterns, criminogenic needs and intervenes with identified risk factors.

With an understanding that substance dependency and sexual offending share a parallel process, cognitive behavioral therapy that addresses thoughts, behaviors and emotions is an appropriate treatment in working through the denial, resistance and the stigma of sexual offending. When addressing substance use disorders in advance of sex offender treatment within the same program – creating a built-in aftercare results in resource savings, decreases the likelihood of relapse which, in turn, leads to a reduction in recidivism for both substance dependency and sexual re-offending.

I. Developing Cultural Proficiency in Corrections Based Substance Abuse Treatment Programs

Cultural proficiency is the impact individual cultural competence has on a *system.* It is considered one of the core competencies of today's evidenced-based correctional treatment environment. Its roots lie in our historic *cultural learning*. Culture in a broad definition is considered a lens through which we view the world. It is the common heritage or set of beliefs, norms and values people share. The variety of ways by which culture is defined includes the following: ethnicity, religion, geographic region, age group, sexual orientation, or profession. It is our life experiences and the filters in our minds through which those experiences pass that form our cultural perspectives regarding ourselves and the world around us. These perspectives are often distortions that lead to *Cultural Encapsulation.* This perspective contains five identifiable features:

1) *Reality is defined by one set of cultural assumptions and stereotypes;*
2) *We become insensitive to cultural variations and assume our view is the only real or legitimate one;*
3) *Each of us has unreasonable assumptions which we accept without proof and protect without regard to rationality;*
4) *Technique oriented job definitions contributes to and reinforces the encapsulations; and*
5) *When there is no evaluation of other viewpoints, then there is no responsibility to accommodate or interpret the behavior of others except from the viewpoint of a self-reference criterion*

The National Institute of Corrections approximates that 30% of America's prisoners are behind bars for drug-related crimes. In addition, what has traditionally been done once the offender is behind bars is to create a culture where we expect something good to come out of putting all of the people with self-

defeating/destructive behavior and like minds together. One way to positively impact today's correctional environment is to identify where we are individually in the continuum of our own cultural development. The following are examples of the trajectory of cultural development:

- Culturally Destructive - relates to self and others in harmful, denigrating, and destructive ways because of differences
- Cultural Blindness - refuses to see ethnic or racial distinctions as a way of avoiding confronting biases
- Cultural Awareness – recognition of cultural similarities and differences
- Cultural Sensitivity – an awareness of nuances of one's own and other cultures
- Cultural Diversity – differences in race, language, ethnicity, nationality, or religion among various groups
- Cultural Competency – a set of academic and interpersonal differences, allowing individuals to increase their understanding and appreciation of cultural differences and similarities within, among and between groups
- Cultural Proficiency – a systems level approach displaying cultural competence through research, developing new services and delivery approaches and disseminating results of those efforts

Here then are some suggestions for creating a more culturally proficient correctional environment:

- Know yourself- know your own values, beliefs, personal attributes and ways of living that inevitably influence the way you function as a professional;
- Beware of the "seven set-up's":
    - A need to "fix" or straighten out people
    - A desire to take away all pain from offenders
    - A need to have all the answers and to be perfect
    - A need to be recognized and appreciated
    - A tendency to assume too much responsibility for the change of offenders
    - A fear of doing harm, however inadvertently
- Know your population- does your team understand how to address the idiosyncrasies of offenders with different cultural and ethnic backgrounds?
- Multidisciplinary teams:
    - Do the team members have an array of expertise, backgrounds, etc?
    - Does the team use strength-based approaches?
    - Are team members trained to use culturally relevant interventions?

J. Treatment Components

With the increasing recognition of the significant impact that substance abuse plays in both crime and recidivism, the need for connecting the various treatment components into a more seamless continuum of care is warranted. This supports the paradigm shift from acute care to long-term recovery maintenance with an emphasis on behavioral and lifestyle change. It is important to maintain the continuity of intervention and service delivery as individual's progress through the various treatment components. Adequate levels of communication and joint case management is needed, both internally as well as with other human service providers to ensure an offenders initial engagement in treatment, retention in primary treatment, and linkage to appropriate levels of continuing care (aftercare); including joint case management and service delivery. Correctional substance (See National Institute on Drug Abuse *Principles of Drug Abuse Treatment for Criminal Justice: A Research Based Guide, 2006; and research from the Treatment Research Institute, and Texas Christian University – Institute for Behavioral Research)*

Correctional substance abuse treatment programs should include established processes that assess and addresses offender treatment needs through the continuum of care. This should include a range of services from drug education to intensive therapeutic communities and be designed to accommodate individual differences, ensure appropriate treatment matching and to maximize the use of resources. The continuum of care is commonly characterized by the transition through the following four stages of treatment involvement:

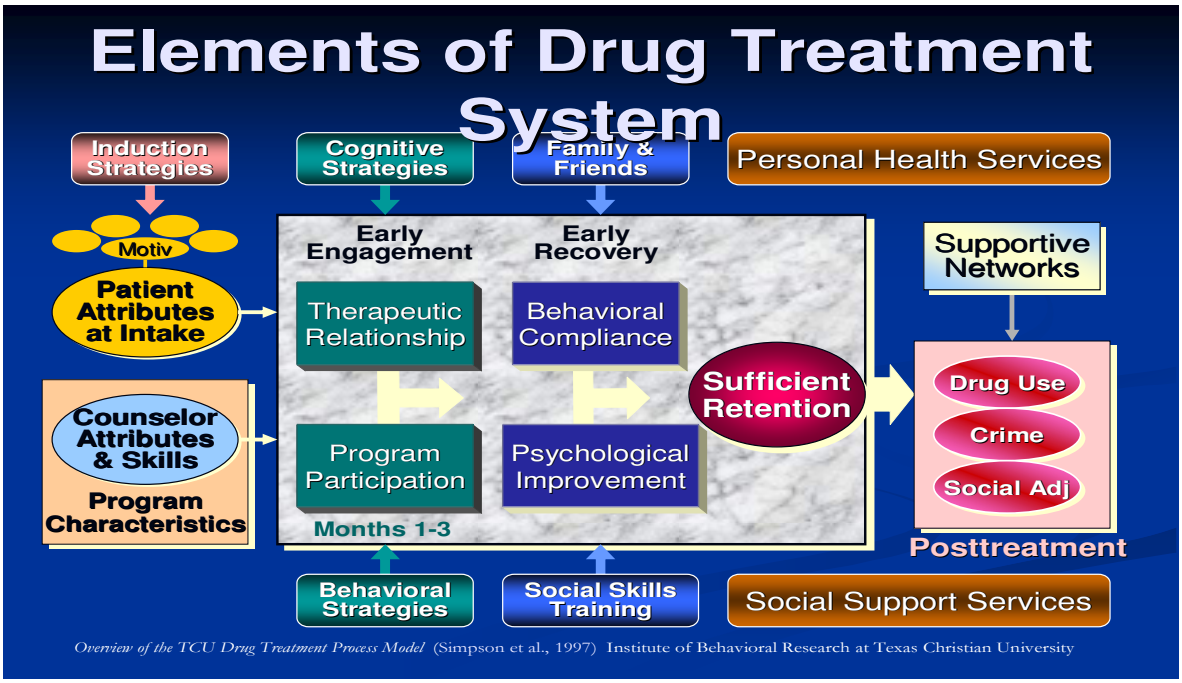
- Pre-Treatment - Once screening and assessment has indicated the need for substance abuse treatment it becomes important to gain an understanding of the offenders risk and protective factors, role of substance abuse in cycle of crime, patterns of substance use, triggers and cues, and motivation/readiness to participate in treatment. Depending upon the offenders needs specific strategies to strengthen motivation for treatment, provide other intervention (criminal thinking) prior to involvement in substance abuse treatment can be undertaken. Assess stage of change

- Primary Treatment – This component provides the substance abuse treatment indicated by the assessment and is driven by an established placement criterion such as the *American Society of Addiction Medicines Patient Placement Criterion*, which indicates the treatment environment (outpatient, residential, etc.), intensity, and duration of services. It is at this stage that primary treatment needs are addressed such as abstinence from drugs and alcohol; development of adaptive life /problem-solving skills; identify needed changes in living situation, peers and friends, and recreational activities; increased awareness of how to avoid STD/HIV infections; an increased understanding of the dynamics of their substance abuse and criminal behavior.

- Transition Services – Adequate preparation for discharge (release) or the step down to a less intensive level of treatment can enhance the effectiveness of treatment. This usually includes identification of treatment and other service needs such as drug-free housing, job placement and needed social services, and referrals to community-based programs. Support to help offenders avoid people, places and situations that trigger relapse (relapse prevention planning) as well as the establishment of adequate post-release supervision (if applicable) and recovery support. (See TIP 30: Continuity of Offender Treatment for Substance Use Disorders from Institution to Community[31])

- Aftercare (continuing care) – It is clear from the literature that continued involvement in recovery oriented activity or services is needed to maintain and extend the impact of primary treatment. In fact, outcome studies clearly demonstrates that inmates who participate in aftercare after completing an in-prison therapeutic community program do significantly better that those who do not[32]. Aftercares services are designed to assist offenders in maintaining a pro-social, recovery oriented lifestyle. Aftercare can occur in a variety of settings, such as periodic outpatient aftercare, relapse/recovery groups, self-help or other 12-step groups, work release centers, and halfway houses.

For example, the TCU Treatment Model[33] illustrates how this process and components can be put into practice and targets interventions, as well as health and social support services that are indicated at different point, along the continuum of care.



5. Program Standards, Quality Assurance and Continuous Improvement

For most of the past two decades, our societal beliefs have been challenged through numerous articles and research publications supporting the need for change and the creation of new approaches to improve outcomes in corrections. A key role and responsibility that corrections treatment professionals share is to contribute to improvements in public safety. Being effective lies with *how* we treat the offender population and under what circumstances we release the offender back to the community.

In this quest we find there are standards for parole and probation, for jails and prisons, for hospitals, for addiction treatment providers, for mental health professionals, medical professionals, and residential community corrections programs to name a few. As we search for standards or guidelines for delivering treatment in corrections, we are best served by the studies and recommendations for evidence-based practices demonstrated through a body of literature compiled since the 1990s to the present. Two significant sources, along with the numerous studies from collaborations with academia, include the U.S. Department of Health and Human Services/SAMHSA and the U.S. Department of Justice/National Institute of Corrections.

Standards for corrections-based treatment programming should consider the 8 principles of evidence-based practice for effective intervention as a common theme: (by following these principles of evidence-based practice we are promoting public safety by better preparing offenders to return to the community and succeed.)[34]

1. Assessment of Risk and Needs.
2. Enhance Intrinsic Motivation.
3. Target Interventions:
   a. Risk – prioritize treatment resources to higher risk offenders;
   b. Needs – target intervention strategies to dynamic needs contributing to crime;
   c. Responsivity – assign or match individual to appropriate service; and
   d. Dosage – provide adequate intensity and duration to affect change.

4. Skill train with opportunity for offender to practice to improve outcomes.
5. Increase positive reinforcement and opportunity for experiencing reward.
6. Provide continuum of support and opportunity in the community.
7. Measure Process and Change:
   a. Cognitive behavioral and skill development of offender; and
   b. Evaluate staff performance to achieve program fidelity and sustain outcome.
8. Provide Feedback – critical to monitoring delivery and enhance fidelity and integrity of program.

Programs and treatment services should be subject to process evaluation to help determine the strengths and weaknesses of the program and contribute to improving practices. The fidelity to model and theory may be assessed to help sustain the continued progress and success. An instrument/tool to consider for this purpose is the Correctional Program Assessment Inventory (CPAI).

Another source providing guidance is the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA)[35]. SAMHSA's recommendations help to establish programs and services that are designed following evidence-based practices targeting specific treatment needs. SAHMSA provides a National Register of Evidence-Based Programs and Practices that may guide program development considering targeting specific needs and risks for individuals requiring intervention through treatment.

Finally, a prominent source working toward evidence based practices and standards-setting in health care is the National Quality Forum, established in 1999 pursuant to federal legislation. Their recommendations may be seen at www.qualityforum.org/projects/ongoing/sud.asp and include:

1. Screening
2. Initial Intervention
3. Prescription of Services
4. Psychosocial Interventions
5. Pharmacotherapy
6. Patient Engagement and Retention
7. Recovery Management

A challenge we have in corrections in pursuing standards for quality assurance and improvement of programs is the industry recognizing the value of integrating clinical professional staff with correctional programs to achieve improved outcomes. The expertise of treatment professionals can be realized further in corrections following the principles of assessing risk, needs and matching individuals with appropriate services and programs designed and developed in a system that is still working to build capacity to meet the offender's needs to reduce recidivism.

6. Using Resources Wisely Matching the Intensity of Services to Risk

Increasing evidence indicates that matching the intensity and duration of treatment to an offender's degree of risk produces the most effective outcome at the lowest cost. Related research suggests that providing high intensity treatment to low risk offenders is not only costly but is likely counterproductive. The policy implications of these findings are clear, offenders assessed with a medium to high-risk of recidivism should receive intensive treatment while low-risk offenders are more effectively served with low intensity interventions. When resources do not permit treatment of all offenders for their substance abuse problems, these principles also suggest that those offenders at highest risk with greatest needs should be prioritized for treatment ahead of those offenders with lower risk and needs profiles. Risk and needs are defined as follows:

- *Risk:* Risk refers to the likelihood of criminal behavior recurring in the future. Risk assessment is an empirically-based process for determining an individual's potential to reoffend.

- *Need:* To be effective, treatment must focus on those needs that both predict recidivism and are subject to change, (i.e., "criminogenic" needs). Criminogenic needs are subsets of an offender's risk level. They are dynamic attributes of an offender that, when changed, are associated with a reduction in the probability of recidivism. In short, individuals whose criminogenic needs are not addressed in treatment are at higher risk of reoffending. Non-criminogenic needs may also be dynamic and changeable, but are not necessarily associated with the probability of recidivism[36].

Establishing a system for matching offenders to level of treatment intensity/duration requires use of assessment tools that accurately measure the offender's level of risk and specific areas of need. The available assessment tools have evolved significantly in recent years. Risk assessment is now undergoing its fourth generation of change[37].

First generation risk assessments involved conducting unstructured or semi-structured interviews and were based largely on the assessor's experience and qualitative observation.

Second-generation risk assessments were empirically-based instruments that measured risk factors related to future antisocial behavior. These assessments focused primarily on static risk factors (typically historical and not likely to change over time, (e.g., age, history of violence, previous substance use) that did little to identify treatment needs.

Third generation assessments, also empirically-based instruments, incorporated both static and dynamic risk factors. Dynamic risk factors, such as interpersonal relationship problems, impulsivity, antisocial attitudes, current substance abuse and presence of psychopathy, are susceptible to change. Thus, third generation assessments provided the opportunity for continuing re-assessment and, consequently, the measurement of change over time. An example of a third generation risk assessment instrument is the Level of Service Inventory-Revised (LSI-R).[38]

Fourth generation risk assessments measure needs in adult correctional populations using static and dynamic risk factors and follow the offender through the entire criminal justice system from arrest to parole. These assessments incorporate the factors most related to recidivism. The Correctional Offender Management Profiling for Alternative Sanctions (COMPAS)* is an example of fourth generation risk assessment.

Many offenders, especially high-risk offenders, have a variety of needs. As examples, they may have housing and employment needs and may have inadequate skills to establish and maintain a productive (drug free) lifestyle. They may have poor self-efficacy, poor parenting skills and poor work histories. In addition, many are hindered by medical problems, such as hepatitis-C, and mental health problems, including personality disorders, depression and cognitive disorders.

Formal assessment of risk can guide our decision making in ways that an interview alone cannot. Reviewing static and dynamic risk factors, by combining structured and semi-structured interview techniques, standardized assessment and case review serve to reduce clinician case bias. It also increases the probability of an appropriate program placement and thus, contributes to efficient resource utilization. As a practical illustration, if an offender's recidivism is related to antisocial thinking, we should be targeting antisocial thinking not low self esteem. Similarly, if an offender's pattern of recidivism demonstrates difficulty in maintaining employment, we should be targeting keeping a job not getting a job[39].

Clearly assessments should focus on those risk factors most related to antisocial behavior. *Andrews and Bonta* identified the four most important factors as antisocial attitudes, antisocial associates, antisocial behavior history and antisocial personality. To these they added four additional risk factors related to criminality: problems at home, problems at school or work, problems in leisure circumstances, and problems with substance abuse. All eight of these factors are empirically related to criminal offending[40].

Research has shown that intensive treatment for high-risk offenders reduces recidivism at a far greater rate than for low-risk offenders. *Bonta* found that low-risk offenders who participated in intensive treatment programming recidivated at a higher rate than low-risk offenders who did not participate in treatment at all (32.3 percent vs. 14.5 percent). Further research by *Andrews and Bonta* found that while low-risk offenders who are interested in treatment may do well in programming and may not recidivate, the fact that they are "low-risk" indicates that they were not statistically likely to recidivate even before they engaged in programming. In other words, the risk principle finds that the greatest recidivism reduction benefit is achieved when the highest-risk offenders are provided with our most intensive treatment services. Therefore, we should be targeting our resources toward the delivery of treatment services to the most difficult high-risk offenders (see appendix for resource targeting matrix).

7. LOOKING TO THE FUTURE - NEEDS AND RECOMMENDATIONS

The treatment of offenders with substance use disorders is a sound investment in public safety. There is a compelling body of research that demonstrates the strong relationship between crime and the abuse of drugs and alcohol. Studies also now demonstrate important recidivism reductions linked to the application of evidenced-based substance abuse treatment provided within well-designed, well-executed treatment programs that are run by properly credentialed and trained staff.

These research developments are important as they provide policymakers and administrators a viable approach to help mitigate the social and economic costs associated with crime and the management of our offender populations. There is much work remaining in order to fully take advantage of these insights and the important advancements in treatment approaches. Some of this work includes:

- *Utilize the Advances in the Field:* Most jurisdictions have had substance abuse programs in operation for many years. Not all of these programs are keeping up with the developments in the field, especially those innovations that require substantial staff development investments to implement such as motivational interviewing and integrated treatment models for co-occurring treatments. Yet these approaches are well supported by theory and research and provide "low hanging fruit" for jurisdictions to make substantive gains in program effectiveness with their existing programs.

- *Supportive and Consistent Public Policy Investments:* Developing and refining effective programs for offender populations can be years in the making and these efforts require substantial investments in staff development. For this reason, effective programs are not well suited to weather inconsistent public policy, variability in program staffing or funding levels. As example, many jurisdictions have attempted to contain rising corrections costs through privatization. Because privatizing treatment all but assures periodic provider transitions, it will be especially challenging to develop and sustain high-quality, effective programs in an environment where vendors and their staff are not assured long-term commitments.

- *Investments in Ongoing Research:* While current treatment approaches are showing important correlations with recidivism reductions, many of these gains still remain relatively modest in scope. More can and should be done to support ongoing research to further develop creative new approaches to treating this challenging population, to support promising emerging practices and to refine existing treatment strategies. Where feasible, research across jurisdictions is recommended as this broadens the research base and helps narrow confounding variables across systems. Research, however, is expensive and time consuming and requires financial and policy support. A national level strategic research plan that includes cross-jurisdictional studies and stable funding streams is strongly recommended.

- *Additional Treatment Capacity:* While most jurisdictions have made significant investments in treatment programming, the level of overall offender substance abuse needs is so great in corrections settings that almost all systems have inadequate resources to provide sufficient treatment opportunities to meet the needs of their offender populations, even when doing so would provide a substantial public safety benefit. Additional treatment capacity should be added while working to improve the efficiency and effectiveness of existing programs.

- *Treatment Targeted to Specific Populations:* To be most effective, the treatment approaches for women, juveniles, those with cognitive limitations, co-occurring disorders, traumatic brain injury

and sexual offenders should be tailored to meet the needs of the population(s) being treated and all treatment provided should be done with cultural proficiency.

- *Release Planning and Coordination:* The best efforts of corrections systems, treatment programs and our offender populations in prison can quickly erode once offenders are released to their communities when there has been inadequate release preparation and supports provided. Housing, employment, social supports, treatment supports, accountability are critical to transition success and need to be in place with resources available immediately upon release, to prevent gaps in ongoing recovery support. Prison facilities should have release preparation services available, including staff with expertise in facilitating release planning services specific to substance abusing offenders.

- *Staff Development Resources*: Providing effective substance abuse treatment for offenders is rewarding but challenging work. Staff are only partially prepared for effective work in correctional settings through their education, training and work histories. Corrections work requires additional workplace staff development that is unique to working with offenders. The implementation of motivational interviewing skills and integrated treatment models is resource intensive but can pay significant dividends in more effective treatments and increased program completion rates.

- *Increased Collaboration:* The meeting sponsored by ASCA that sparked the creation of this document reinforced the importance of establishing ongoing forums for communication and collaboration in this field. While this group intends to continue to work together, the issues faced are national in scope and further work needs to be done to establish nationally-based professional forums for communication, collaboration and research.

- *National Standards:* As this field continues to mature, providing evidence-based practices for effective treatment, there is an increased need to begin development of program standards for corrections-based substance abuse programs. Specific areas to address include all of those reviewed in this paper.

APPENDIX I

Twelve "Core Functions"

(1) "Screening" means the process by which a client is determined appropriate and eligible for admission to a particular program.

(2) "Intake" means the administrative and initial assessment procedures for admission to a program.

(3) "Orientation" means describing to the client the general nature and goals of the program; rules governing client conduct and infractions that can lead to disciplinary action or discharge from the program; in a nonresidential program, the hours during which services are available; treatment costs to be borne by the client, if any; and client's rights.

(4) "Assessment" means those procedures by which a counselor identifies and evaluates an individual's strengths, weaknesses, problems, and needs to develop a treatment plan or make recommendations for level of care placement.

(5) "Treatment planning" means the process by which the counselor and the client identify and rank problems needing resolution; establish agreed upon immediate and long-term goals; and decide on a treatment process and the sources to be utilized.

(6) "Counseling" means the utilization of special skills to assist individuals, families, or groups in achieving objectives through exploration of a problem and its ramifications; examination of attitudes and feelings; consideration of alternative solutions; and decision making.

(7) "Case management" means activities which bring services, agencies, resources, or people together within a planned framework of action toward the achievement of established goals.

(8) "Crisis intervention" means those services which respond to an alcohol or other drug user's needs during acute emotional or physical distress.

(9) "Client education" means the provision of information to clients who are receiving or seeking counseling concerning alcohol and other drug abuse and the available services and resources.

(10) "Referral" means identifying the needs of the client which cannot be met by the counselor or agency and assisting the client to utilize the support systems and available community resources.

(11) "Reports and recordkeeping" means charting the results of the assessment and treatment plan, writing reports, progress notes, discharge summaries, and other client-related data.

(12) "Consultation with other professionals regarding client treatment and services" means communicating with other professionals in regard to client treatment and services to assure comprehensive, quality care for the client.

APPENDIX II
Guiding Principles for Corrections-Based Treatment

I. Treatment for offenders is a sociocentric as well as an egocentric therapy that makes the focus of caring about and responsibility to the community and society of equal importance to self-caring and responsibility to self. This is in contrast to past psychological treatment models that focused on personal growth/change, enhancing responsibility to self and easing psychological pain.

II. Resolution of psychological problems are integrated with "correctional" goals of helping client develop thinking and behaviors that demonstrate moral responsibility towards others and society.

III. Cognitive-behavioral approach is a basic platform for implementing learning and change. Cognitive restructuring as well as training in social and interpersonal skills enhance change. A cognitive and behavioral skills approach is necessary to help offenders become morally and socially responsible to the community and society.

IV. Treatment planning needs to include separate relapse and recidivism goals. These are separate problems and phenomena. Integrating therapeutic and correctional interventions is fundamental to the treatment planning and treatment design.

V. The clinical skill set needed to provide treatment to the corrections population is specific and goes beyond typical substance use disorder treatment practices. Clinicians must be competent at multimodal assessment, have understanding of psychopathy and be skilled at cognitive-behavioral treatment regimen.

VI. Group based programs are more efficient and effective than other methods in developing a commitment to a drug-free life by fostering introspection and facilitating the acquisition of coping skills for substance abusing criminal offenders.

APPENDIX III

Resource Allocation Matrix

Targeting Resources	High Drug (Dependent)	Low Drug (Abuse)
High and Moderate Risk for Reoffending	High Intensity - 9 mos + (Criminal Lifestyle/Addiction Track) Type of Offender Targeted: Participants are substance dependent with extensive criminal history. From a risk management standpoint, this is the population that we are most interested in treating. Type of Treatment: Participants would spend maximum time in group (i.e., daily manual groups enhanced with process groups). Treatment Regimen: 1) Treatment Engagement 2) Rational Behavioral Therapy 3) Interpersonal Relationships 4) Criminal Lifestyle 5) Recovery Maintenance 6) Transition 7) Other adjuncts, (e.g., anger management)	Moderate Intensity - 9 mos (Criminal Lifestyle Track) Type of Offender Targeted: Participants are "lifestyle criminals" with antisocial behavior patterns. This would include participants whose substance abuse was largely a function of their criminal lifestyle /participation in a criminal subculture. Type of Treatment: Challenge of participants' offense supporting beliefs, attitudes, and values; and orientation away from antisocial peer influences. Much of the 9 months (e.g. 4 to 5 months) is spent in skills practice (challenging criminal thinking) with frequent participation in groups practicing pro-social values, attitudes, and beliefs. Treatment Regimen: 1) Treatment engagement 2) Criminal lifestyle 3) Cognitive skill building to address offense- supporting beliefs and attitudes 4) Transition including developing a social network that does not include antisocial peers but does include positive interaction with authority figures

Lower Risk for Reoffending	Moderate Intensity 9 mos (Addiction Track) Type of Offender: Participants are substance dependent with minimal criminal history. Type of Treatment: A traditional inpatient substance abuse treatment model is appropriate for this group (i.e., recovery maintenance) Much of the 9 months is spent in skills practice (i.e., practicing those skills identified in their Recovery Maintenance Plan) with a specified frequency of participation in groups. Participants may only have only two or three groups per week for 4 or 5 months of the program). Treatment Regimen: 1) Treatment engagement 2) Socio-affective cognitive skills - Emotional self regulation - Intimacy skills 3) Recovery Maintenance	Low Intensity 6 mos (Abuse Track) Type of Offender: Participants are substance abusers with low criminality. Type of Treatment: A traditional low-to-moderate intensity (outpatient) substance abuse treatment model would be appropriate if they were in the community, but in-prison residential treatment for 6 months within a separate unit will support a healthy lifestyle, pro-social attitudes and provide peer support. Treatment Regimen: 1) Treatment engagement 2) Entitlement 3) Healthy lifestyle 4) Other cognitive skills as required by treatment plan, (e.g., building positive attitudes). 5) Other institution programs (education and work).

APPENDIX IV

Contributors

This project was a collaborative effort between all of the members of the work group listed in the acknowledgements section that follows. Each section was assigned a primary author or authors and those individuals are identified below. After the individual sections were authored, various members of the work group offered suggested additions, changes and edits so that the document provided here represents the efforts of the group as a whole.

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   d) Treatment Duration—*Rick Deady*
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Winters, Ken C. PhD, consensus panel chair. The TIP series provides excellent and up to date information on a broad range of treatment topics.

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