



MAJOR TREATMENT ISSUES FOR OFFENDERS WHO USE SUBSTANCES

6 Continuing Education Credits

Asynchronous Distance Learning Course

Content Level: Intermediate

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Last Updated: 2026

Approved by such credentialing bodies as:

- **National Association of Alcoholism and Drug Abuse Counselors (NAADAC) #94564**
- **National Board of Certified Counselors (NBCC) #6310**

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ABOUT THE INSTRUCTOR

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Substance Use Treatment for Justice-Involved Populations: Updated Evidence

The treatment framework this course provides covers clinical strategies, population-specific treatment considerations, and the unique challenges of working with offenders who use substances. Since this course was published, the evidence base for treating substance use disorders in criminal justice settings has expanded dramatically, particularly in medication-assisted treatment, post-release mortality, the psychosocial determinants of reentry outcomes, gender-specific treatment barriers, and the effectiveness of specialized courts and compulsory treatment programs.

The most consequential development since this course was written is the accumulation of mortality data that transforms the clinical urgency of providing treatment during and after incarceration. A 2026 synthetic analysis published in *Addiction* estimated that 21,784 individuals released from U.S. jails and prisons in 2022 died from opioid overdose that year, roughly 27 percent of all opioid overdose deaths nationwide, and projected that comprehensive screening, medication while incarcerated, and post-release care linkage could have prevented approximately 13,288 of those deaths, about 16 percent of the national total (Smith et al., 2026). For the treatment framework this course describes, which addresses basic needs, criminality, denial, and stages of change as clinical priorities, this establishes that medication access is not an adjunct to treatment but a survival issue. The period immediately following release represents the highest overdose risk an individual with opioid use disorder will ever face, because tolerance has decreased during incarceration while the behavioral patterns and environmental triggers that drove use remain intact. Programs that address criminal thinking without simultaneously providing medication coverage during the transition to community settings are leaving their highest-risk clients unprotected during the most dangerous period of their recovery.

The psychosocial dimensions of post-release substance use, directly relevant to this course's emphasis on basic needs, housing, employment, and life skills, were documented in a 2026 study of 244 previously incarcerated individuals with drug use histories, of whom 97 resumed drug use within 30 days of release and 147 maintained abstinence. Those with recent drug use reported substantially higher rates of hazardous alcohol consumption, 35.4 percent versus 18.1 percent, food insecurity, 58.8 percent versus 42.9 percent, unemployment or underemployment, 61.7 percent versus 49.0 percent, low social support, 44.3 percent versus 24.7 percent, and depressive symptoms, 50.5 percent versus 21.8 percent (Paquette et al., 2026). For the clinical strategies this course teaches, this confirms that substance use after release is not primarily a failure of motivation. It is a consequence of unmet needs in housing, food, employment, social connection, and mental health that converge during reentry, and programs that discharge clients into environments where these needs are unmet should expect relapse rates consistent with the conditions they have failed to address.

The fundamental question of whether treatment in criminal justice settings reduces recidivism was addressed in a 2025 quasi-experimental study comparing 279 offenders receiving court-ordered addiction treatment under Germany's forensic treatment system with 274 matched incarcerated individuals who received no specialized treatment. Over a mean of 6.5 years, the treatment group showed a recidivism rate of 63.4 percent compared to 80.3 percent in the comparison group, an absolute risk reduction of about 16.5 percentage points that persisted at the seven-year mark, and that remained significant even though nearly half of the treatment group returned to prison during the course of treatment (Schalast et al., 2025). This provides two critical data points. First, compulsory substance use

treatment produces measurable, sustained reductions in recidivism, validating the therapeutic use of the justice system's coercive authority that this course describes. Second, the persistence of the effect despite frequent mid-program returns to prison suggests that treatment programs should not read setbacks as failure; the cumulative effect of treatment exposure persists even when the path is nonlinear.

The women's treatment issues this course describes have been extended by recent research on the barriers incarcerated women face. A 2025 study of 900 women from Kentucky jails found that those with opioid use disorder who had used hospital services in the 90 days before incarceration reported significantly greater enacted and anticipated stigma from healthcare workers than those who had not, suggesting that hospital-based stigma may discourage future healthcare-seeking precisely when these women most need medical engagement (Webster et al., 2025). Many women entering the justice system have already learned that seeking help for substance-related problems exposes them to judgment, and building a therapeutic alliance with them requires explicitly acknowledging and counteracting the stigma they carry from prior encounters. A related 2026 analysis of the same 900 women across nine Kentucky jails found that those from counties with stronger health rankings had better access to substance abuse treatment, while counties with fewer primary care providers showed higher rates of chronic conditions (Urhahn et al., 2026), establishing that the geographic disparities affecting treatment access in the general population are amplified in the justice population.

The specialized courts that have emerged since this course was published were evaluated in a 2026 study of 877 participants across 10 Quebec mental health courts, which found that among the 261 participants with substance use disorders, those who received medical and psychosocial services specifically targeting substance use benefited the most in completing the court program (Boucher-Rehel et al., 2026). For this course's discussion of co-occurring disorders, the finding validates the integrated approach: courts that provide substance-use-specific interventions alongside psychiatric treatment produce better completion than courts that treat the mental health condition alone.

Medication for Opioid Use Disorder: The Survival Issue

If this course's treatment framework has one non-negotiable addition from the past two decades, it is that opioid use disorder in a justice-involved client is a condition for which medication saves lives, and treating it without addressing medication access leaves the most dangerous problem untouched. The evidence is now overwhelming. A systematic review of 126 studies found that opioid agonist treatment sharply reduced the risk of death both in custody, with a hazard ratio of 0.25, and in the community during the first weeks after release, with a risk ratio of 0.24, and that therapeutic community programs reduced re-arrest, with an odds ratio of 0.72, and reincarceration, at 0.66 (Macdonald et al., 2024). A 2025 study of 6,400 jail detainees with opioid use disorder found that those who received medication during incarceration had roughly half the risk of fatal overdose after release, an adjusted hazard ratio of 0.48, along with lower nonfatal overdose, all-cause mortality, and reincarceration, and more than three times the rate of treatment engagement a month after release, 60.2 percent versus 17.6 percent (Friedmann et al., 2025).

For the counselor, whose role is rarely to prescribe but very often to inform and advocate, the work is easier when the common objections can be answered. The claim that agonist medication merely substitutes one addiction for another confuses physical dependence, a manageable pharmacological state, with addiction, a behavioral disorder marked by compulsive use and harm. A client stabilized on a

therapeutic dose of methadone or buprenorphine is not intoxicated, can work and parent and participate in counseling, and is far less likely to die. Being fluent in that distinction lets the counselor protect a client's access to medication at the exact transitions, arrest, sentencing, transfer, and release, when it is most likely to be interrupted, and each interruption resets tolerance and raises the risk of a fatal outcome.

A realistic caution accompanies the enthusiasm. A study of statewide prison buprenorphine implementation found that scaling medication roughly doubled post-release treatment engagement among men, 21.2 percent versus an expected 10.6 percent, and reduced all-cause mortality, 1.9 percent versus an expected 2.8 percent, but did not by itself eliminate overdose deaths (Bovell-Ammon et al., 2024). Medication is necessary and powerful, and it is not sufficient alone; it works best as the pharmacological floor beneath the behavioral and social treatment this course describes, not as a replacement for it. The counselor who understands both the power and the limits of medication is positioned to insist on access while continuing the harder work of helping a client rebuild a life.

It also helps the counselor to understand the three medications well enough to support an informed client choice, since the physician prescribes but the client lives with the decision and often turns to the counselor to talk it through. Methadone, a full agonist dispensed through structured programs, offers strong retention and suits clients with long, severe histories, at the cost of daily attendance. Buprenorphine, a partial agonist available through office-based prescribing, offers more flexibility and a strong safety profile that fits many clients returning to work and family. Extended-release naltrexone, an antagonist that blocks opioid effects, appeals to clients committed to an opioid-free approach but requires a completed withdrawal before the first dose and lacks the same population-level mortality evidence as the agonists. The counselor's contribution is not to steer toward a favored option but to ensure the choice is driven by the client's clinical situation and preference rather than by institutional ideology, which in correctional settings has too often meant a blanket refusal of the agonist medications that the evidence most strongly supports.

A distinct treatment issue that this course's population raises acutely is the interruption of medication at the point of arrest, when a client stabilized in the community is often forced into withdrawal on entering custody. Beyond the immediate suffering, this needless interruption resets tolerance, erodes trust, and sets up the very post-release overdose risk the system should be preventing. Advocating for continuity across the jailhouse door, so that a client already on medication is maintained rather than withdrawn, is among the most concrete ways a counselor can act on the mortality evidence, and it is a message worth carrying to the correctional decision-makers who control whether that continuity happens.

The counselor should also be prepared to address the concern, common in correctional environments, that medication will be diverted or misused within the facility. The worry is not baseless, but it is manageable through supervised dosing, formulation choices, and monitoring, and it does not begin to outweigh the mortality benefit demonstrated across dozens of studies. Framing the choice honestly, as a trade between a manageable diversion risk and a documented reduction in deaths and reincarceration, tends to move the conversation further than either dismissing the concern or conceding to a blanket ban, and it positions the counselor as a credible voice for the evidence rather than an advocate who ignores the institution's real operational pressures. Being able to hold both the clinical evidence and the security concern in view at once is part of what makes a counselor effective in a correctional setting, where treatment always operates within a custodial system that has its own legitimate priorities.

The Reentry Period: Treatment at the Highest-Risk Moment

This course rightly treats the transition to the community as a distinct clinical challenge, and the evidence has sharpened just how dangerous that transition is. The foundational study of post-release mortality found that during the first two weeks after release the risk of death was 12.7 times that of the general population, with the relative risk of death from drug overdose reaching 129 (Binswanger et al., 2007). A later study using a self-controlled design found that non-fatal overdose risk in the one-to-two weeks after release rose with an adjusted incidence rate ratio of 2.92, while being on medication for opioid use disorder cut that risk substantially, with rate ratios from 0.33 to 0.41 (Keen et al., 2021). The mechanism is exactly the loss of tolerance this course's clients experience during incarceration, and the window in which it turns lethal is measured in days.

For treatment, this converts reentry planning from paperwork into a time-limited survival task. Tolerance education delivered concretely, take-home naloxone in the client's hands at release, an appointment scheduled within days rather than weeks, and, wherever possible, medication that is never interrupted are the practical expression of the reentry evidence, and where a client is leaving custody without medication arranged, same-week linkage to a prescriber belongs at the very top of the plan.

The reentry evidence also confirms this course's emphasis on basic needs, because survival through the window depends on more than medication. The study of psychosocial needs after incarceration found that those who resumed use faced a convergence of unmet needs, housing instability, food insecurity, unemployment, isolation, and untreated depression, and that treatment access alone, disentangled from these supports, was insufficient (Paquette et al., 2026). The client released with a prescription but into a shelter bed, no job, and the same network faces conditions that would challenge anyone's recovery, and a reentry plan that addresses the medication but not the surrounding needs has done only part of the job.

Tolerance education deserves to be delivered concretely rather than as a general warning, because clients routinely underestimate how much their bodies have changed during a period of enforced abstinence. A client who used a given quantity daily before incarceration often believes that returning to that quantity will feel normal, when in fact the months away have reset his tolerance and made the remembered dose potentially lethal. Saying this plainly, that the first use after release is the single most dangerous dose he will take, and pairing it with take-home naloxone and instruction to a family member on how to use it, converts a frightening statistic into a survival plan the client and his people can actually execute.

The reentry window also reframes what counts as success in the days around release. It is tempting to define the goal as continued abstinence and to read any use as failure, but for a client at the highest-risk moment the more immediate goal is survival, and harm-reduction steps that keep the person alive through the danger window are not a betrayal of recovery but a precondition for it. A client who survives a lapse in the first two weeks can continue the work; a client who does not, cannot. Holding that priority clearly, without abandoning the longer aim of recovery, is part of what it means to apply the reentry evidence responsibly, and it is a stance this course's emphasis on meeting clients where they are prepares practitioners to take.

What Works in Offender Treatment: Risk, Need, and Responsivity

Beyond specific interventions lies the larger question this course raises of what, across the field, actually reduces the reoffending that substance use drives. The dominant framework for three decades has been Risk-Need-Responsivity, which holds that the intensity of treatment should match the client's risk level, that treatment should target the changeable factors linked to reoffending rather than needs that do not drive crime, and that services should be delivered in a manner matched to the client's abilities and motivation.

The recent evidence is more nuanced than the framework's popularity implies, and the nuance serves practitioners better than slogans. A 2023 meta-analysis of randomized trials of community-correction programs found that full participation in a program significantly reduced recidivism, confirming that engaged, completed treatment works, yet that programs strictly following the Risk-Need-Responsivity template performed similarly to those that did not, suggesting that engagement and dose matter at least as much as fidelity to any single model (Duan et al., 2023). This reading is reinforced by a Cochrane review of interventions for drug-using offenders with co-occurring mental health problems, which found that therapeutic community programs, compared with usual care, were associated with substantially less subsequent criminal activity, with a risk ratio of 0.67, and a much lower likelihood of return to prison, at 0.40 (Perry et al., 2019).

Two applied principles follow. First, match intensity to risk. The natural pull in any program is toward its most cooperative, lowest-risk clients, yet intensive intervention aimed at low-risk clients yields little benefit and can even do harm by disrupting the stability that was already protecting them, so the most intensive services should be reserved for higher-risk clients as a clinical safeguard, not merely an efficiency. Second, target the factors that actually drive this client's offending, antisocial thinking, antisocial associates, and substance use chief among them, and then attend relentlessly to engagement and completion, because that, more than the label on the program, is where the measurable reductions in crime come from.

The risk principle deserves particular emphasis because it is the one most often violated in ordinary practice, and violating it can actively backfire. The natural pull in any program is toward its most cooperative, lowest-risk clients, the people who show up and engage easily and make the work feel successful, yet intensive intervention delivered to low-risk clients yields little and can worsen outcomes, partly by disrupting the employment, family, and prosocial ties that were already protecting them, and partly by grouping them with higher-risk peers whose influence runs the wrong way. Reserving the most intensive services for higher-risk clients is therefore a clinical safeguard, not merely a matter of allocating scarce slots efficiently, and it argues for using a validated risk assessment rather than a gut impression to decide who receives what.

The responsivity principle, which concerns how treatment is delivered rather than what it targets, is easy to underestimate and central to the engagement this course emphasizes. It holds that services should be matched to the individual client's abilities, learning style, culture, and readiness, because even a well-targeted intervention fails if the client cannot absorb it as delivered. A client with limited literacy handed a dense workbook, or one in the grip of untreated depression asked to do demanding cognitive homework, will disengage from treatment that might have worked if it had met him where he was. Much of what a skilled counselor does intuitively, adjusting pace and language, building motivation before demanding change, and shaping the work to the person, is responsivity in action, and the evidence that

engagement drives outcomes is, in large part, evidence for taking it seriously.

Criminal Thinking and Cognitive Programs

This course addresses the thinking patterns that sustain both substance use and criminal behavior, and the evidence on programs designed to change them rewards a careful, two-sided reading. The most widely used such program, Moral Reconnection Therapy, was examined in a meta-analysis of 33 studies and more than 30,000 offenders that found a small but genuine effect on recidivism, an overall correlation of about .16, larger for adults than juveniles and larger in institutional than community settings (Ferguson & Wormith, 2013). More recent and more rigorous evidence tempers easy optimism: the first true randomized trial of the program, in 341 justice-involved adults, found no significant reduction in one-year rearrest, largely because only 37 percent of those assigned to it received even a minimum dose, though the subgroup that did engage improved on criminal associates, days incarcerated, legal problems, and alcohol use (Blonigen et al., 2022).

The lesson aligns with this course's framing. Cognitive change is work the client has to do, and a curriculum delivered on paper, or completed by a minority of those referred, will not reproduce the average effects reported in the literature. There is also a deeper point about compliance versus change. A client can move through a workbook and give the expected answers without any genuine shift in how he construes his choices, his victims, or his options, and the distortions this course names, minimization, entitlement, the victim stance, yield only when the client examines his own thinking rather than performs agreement. That is why the counseling relationship matters as much as the curriculum, and why a facilitator who builds enough trust that the client will risk honesty produces more real change than one who simply administers the material.

Research on the interaction of substance use and criminal thinking over time supports treating both together. A longitudinal study of 341 veterans with criminal histories found four trajectories, with 53 percent showing improvement in both domains, 27 percent maintaining high criminal thinking, 11 percent experiencing substance use recurrence, and 9 percent showing persistent high use, and with depression elevated in the higher-risk classes (Timko et al., 2022). The thinking and the substance use travel together and change together, which is exactly why this course teaches practitioners to engage both rather than treating one as a symptom of the other.

Working with criminal thinking well requires distinguishing it from the states that mimic it, which is harder than it sounds. The deceit, impulsivity, and disregard for others that mark an entrenched antisocial pattern can also be produced by active addiction or acute withdrawal, and these tend to soften as the substance use is treated, whereas a genuine characterological pattern does not. A treatment plan built on a snapshot taken at intake, when a client may be in withdrawal, frightened, and guarded, risks mistaking a temporary state for a fixed trait, and reassessing over time is what separates the two. This matters because it changes what treatment can realistically expect, and because a premature label can shape how a client is handled for the rest of his involvement in ways that are hard to undo.

There is also a deeper lesson in the gap between compliance and change that bears directly on how cognitive treatment is delivered. Distortions such as minimization, the victim stance, entitlement, and a hostile reading of others' intentions are not merely bad attitudes to be corrected by argument; they are load-bearing beliefs that have protected the client from shame and organized his behavior for years, and

they do not fall to confrontation. They loosen when the client, in a relationship safe enough to allow it, begins to notice the cost of the distortion in his own life and to test what happens when he sets it down. This is why the manner of delivery matters as much as the curriculum, and why a facilitator who treats resistance as information rather than insubordination is far more likely to produce genuine change than one who simply enforces the material.

Co-Occurring Disorders: Treating Two Conditions Together

Because roughly half of justice-involved people with a substance use disorder also carry a psychiatric condition, co-occurring disorders are not a specialty concern but the ordinary condition of the work, and this course's integrated approach is exactly right. A meta-analysis of 50 studies covering 24,915 incarcerated individuals found that about half of those with a serious mental illness also had a substance use disorder (Baranyi et al., 2022), and a statewide cohort of 2,039 people with opioid use disorder and criminal-legal involvement found that nearly half had a co-occurring mental health condition, that co-occurrence predicted higher early recidivism, and yet that group and individual therapy were associated with lower odds of recidivism (Lawson et al., 2024).

The common clinical error is sequencing, the belief that the client must first get clean and only then have the psychiatric condition addressed. The integrated-treatment consensus holds that treating the two together works better than treating them one after the other, in part because each untreated condition tends to reactivate the other: a client whose depression or panic goes unaddressed has a powerful reason to keep using, and a client who keeps using has a powerful obstacle to psychiatric recovery. The counselor does not need to personally treat both conditions but does need to ensure both are being treated, which means building and maintaining the connections to psychiatric care that integrated treatment requires.

The specialized courts discussed earlier make the same point at the system level. The evaluation of Quebec mental health courts found that participants with co-occurring disorders benefited most when the court provided substance-use-specific services alongside psychiatric treatment (Boucher-Rehel et al., 2026), confirming that addressing the mental health condition while leaving the substance use untreated, or the reverse, produces worse outcomes than addressing both. For the practitioner, the discharge point deserves particular attention, because clients with co-occurring conditions need more intensive support exactly when it tends to thin out, and planning for that added intensity in advance rather than discovering the need after a client destabilizes is one of the concrete ways the co-occurring evidence changes practice.

A practical diagnostic caution belongs alongside this, because active substance use and acute withdrawal can mimic almost every psychiatric presentation, producing depression, anxiety, paranoia, and mood instability that may recede with sustained abstinence. This makes premature diagnosis a real hazard in a correctional intake where clients frequently arrive intoxicated or withdrawing. The resolution is not to ignore mental health symptoms until some arbitrary period of sobriety has passed, which leaves the client suffering and at risk, but to treat the presenting symptoms while holding the diagnosis loosely, reassessing as the person stabilizes. A counselor who documents what he observes carefully, communicates it to the prescriber, and revisits the picture over time serves the client far better than one who either dismisses every symptom as drug-related or locks in a diagnosis during the least reliable window for making one.

The engagement lesson from the co-occurring research also deserves emphasis, because the clients at highest risk of early reoffending are precisely the ones a stretched program is most tempted to discharge for missed appointments or difficult behavior, yet they are the ones for whom continued treatment makes the largest difference. Building in the flexibility to keep working with a client who is struggling, rather than treating instability as grounds for termination, is both clinically indicated and, given the recidivism stakes, a matter of public safety. In this population the co-occurring client who is hardest to keep is often the one who most needs to be kept, and a program designed to hold rather than to shed its most difficult members is the one most likely to change outcomes.

Integrated care for co-occurring disorders also depends on coordination that reaches beyond the counselor's own caseload, because the substance use and the psychiatric condition are frequently treated by different providers and systems that do not naturally communicate. A client whose depression is managed by a psychiatric prescriber and whose substance use is addressed by a counselor can fall into the gap between them, receiving two partial treatments that never add up to integrated care, and the counselor is often the person best positioned to bridge that gap by maintaining contact with the prescriber, sharing observations, and ensuring the two efforts pull in the same direction. This coordination is unglamorous and time-consuming, but for the co-occurring client it is frequently the difference between fragmented care that fails and integrated care that works. The course's emphasis on treating the whole person rather than a single diagnosis is, in practice, largely a matter of doing this connective work that no instrument or protocol can perform on the counselor's behalf.

Personality and the Limits of Treatment

Among the harder realities this course prepares practitioners to face is that some clients carry, alongside their addiction, an antisocial personality pattern that independently drives the same behavior the substance use produces. A meta-analysis of 21 studies found that any personality disorder was associated with roughly 4.5 times the odds of violence, with antisocial personality disorder at 7.6 and borderline at 2.6, and identified comorbid substance use disorder as a key source of variation (Chow et al., 2025). When both conditions are present, the counselor is working with two interacting pathologies rather than one, and the treatment plan must reflect that.

The practical difficulty is that the surface behaviors overlap. Deceit, manipulation, and disregard for others can all be products of active addiction and frequently resolve as the addiction is treated, or they can be expressions of an enduring personality structure that will not resolve simply because the substance use stops. Distinguishing the two is not a matter of labeling a difficult client as antisocial and giving up, but of noticing whether the pattern predates the addiction and persists across periods of abstinence, because that changes what treatment can realistically accomplish and over what timeframe.

Where an antisocial pattern is genuinely present, the evidence counsels neither despair nor naivety. Progress tends to come through structure, clear and consistently enforced expectations, and interventions that target antisocial thinking directly, rather than through insight-oriented approaches that assume a wish to change the client may not yet have. It also counsels honesty in the treatment relationship. A counselor who can see the pattern clearly, name its consequences without contempt, and still hold the door open is doing exactly the work this population requires, and is far more useful than one who is repeatedly surprised and wounded by behavior the diagnosis predicts.

This course's attention to the erosion of choice offers a useful way to think about clients in whom addiction and an antisocial pattern combine. Addiction narrows a person's options over time, converting what began as choices into compulsions, and an antisocial pattern narrows them from a different direction, through a habitual disregard for the constraints that ordinarily shape behavior. When both are present, the client's felt sense of having any real choice can be very thin, and part of the counselor's work is to help rebuild the experience of choice one small, concrete decision at a time rather than demanding a wholesale transformation the client cannot yet imagine. Progress with such clients is often measured in the accumulation of small kept commitments rather than in dramatic declarations, and a counselor attuned to that scale of change will see movement where one waiting for a breakthrough sees only stagnation.

There is a boundary lesson here that protects both the client and the counselor. Working with clients who have an antisocial pattern requires clear limits, consistent follow-through, and a refusal to be drawn into either the role of the mark who is manipulated or the role of the adversary who is fought. Holding a warm but firm structure, in which expectations are explicit and consequences predictable, is not coldness; it is the environment in which a client whose life has been organized around evading structure can begin to experience structure as something other than a threat, and it models the kind of reliable relationship that many of these clients have rarely had. Sustaining that stance without burning out is itself a professional skill, and one this course's realism about the population is meant to support.

It also helps to be honest about the limits of what treatment can accomplish with the subset of clients whose antisocial pattern is severe and entrenched, because unrealistic expectations set up both the client and the counselor for a demoralizing cycle. For some clients, the achievable goals are more modest than full transformation, reductions in the frequency and severity of harm, longer intervals between offenses, incremental gains in stability, and treating those modest gains as real successes rather than as failures to reach an idealized outcome keeps the work sustainable and the client engaged. This is not lowered expectations in the sense of giving up; it is calibrated expectations grounded in what the evidence says is achievable, and it protects the counselor from the burnout that comes from measuring every client against a standard few will fully meet. The practitioner who can hold high hope and realistic goals at the same time is the one who lasts in this work and who, over a career, moves a great many clients further than a more idealistic colleague who abandons the hard cases.

Trauma-Informed Treatment

Beneath a large share of the substance use and offending this course addresses sits a history of trauma, and treating it is not a soft add-on but a clinical necessity, because untreated trauma drives the very conditions treatment is trying to change. The prevalence is substantial and sharply gendered. A meta-analysis of 56 samples covering 21,099 prisoners found post-traumatic stress disorder in 6.2 percent of men but 21.1 percent of women (Baranyi et al., 2018), and a meta-analysis of 36 studies covering 9,594 prisoners found that post-traumatic stress disorder was significantly associated with depression, at an odds ratio of 3.4, anxiety at 2.9, substance use at 1.9, and suicidality at 3.0 (Facer-Irwin et al., 2019). Trauma sits at the center of the web of co-occurring problems that complicate treatment.

The developmental roots run deep. A study of 417 detained youth found that cumulative childhood adversity significantly predicted reoffending, in part through its effect on substance use severity (Weber & Lynch, 2021), and a review of 12 studies found a higher prevalence of adverse childhood experiences

among people with substance use disorder along with an association between such experiences and both the development and the severity of the disorder (Leza et al., 2021). For the practitioner, this reframes what a correctional setting often reads as defiance or manipulation as, frequently, a trauma adaptation, and it argues for trauma-informed treatment that does not lower the expectation of accountability but recognizes that punishment layered onto an untreated trauma history tends to reinforce the very cycle it intends to interrupt.

Trauma-informed treatment in a correctional setting requires attention to how the environment itself can retraumatize, since searches, restraint, and the loss of control that define incarceration can echo earlier experiences of powerlessness, and a client may arrive at a session already activated. The practical response is predictability, explaining what will happen and why, offering choices where the setting allows, and avoiding unnecessary confrontation, so that the underlying material can be worked with rather than continually defended against. Treating the trauma and treating the substance use are not competing priorities but two angles on the same underlying structure, and progress on one often opens room for progress on the other.

Screening and treating trauma in a correctional setting carries an obligation that distinguishes it from other clinical work, because the act of asking can itself reopen a wound, and doing so in an environment offering little privacy or immediate support can compound rather than relieve the harm. This is not an argument against addressing trauma, which is essential given the prevalence, but an argument for doing it thoughtfully: explaining why the questions are asked, giving the client some control over the pace of disclosure, and ensuring that acknowledging a trauma history connects to something rather than to silence. Inviting someone to reveal a trauma history and then offering nothing in response can do more harm than not asking, and the treatment plan should be ready to hold what the disclosure surfaces.

The gendered nature of the trauma evidence has direct implications for how programs allocate their attention. With post-traumatic stress disorder roughly three times more prevalent among incarcerated women than men, and with sexual victimization histories the norm among justice-involved women, trauma-responsive programming is central to serving women competently rather than an optional refinement. For men, whose trauma is more often overlooked precisely because it is less expected and less readily disclosed, the challenge is different but real: a treatment culture that does not require men to present as victims before their histories can be addressed catches what a program built around stereotypes would miss. In both cases the underlying point is that trauma sits beneath so much of the substance use and offending this course confronts that a treatment plan which ignores it is working with half the story.

Stimulants: Treatment When There Is No Medication

The encouraging evidence on medication for opioid use disorder can create a false impression that pharmacology has solved the treatment problem, and for the growing share of justice-involved clients whose primary drug is a stimulant, that impression is dangerously wrong. There is no approved medication for stimulant use disorder, a fact a Cochrane review of 64 randomized trials involving 8,241 participants states plainly (Minozzi et al., 2024). This matters greatly for offender treatment, because stimulant use is rising in exactly the populations that cycle through the justice system, and the counselor cannot reach for a medication solution.

What the evidence does support is a behavioral intervention. Contingency management, which provides tangible incentives contingent on verified drug-negative test results, has the strongest evidence of any treatment for stimulant use disorder. A meta-analysis of 157 studies and 15,842 participants found that only contingency management was significantly associated with an increased likelihood of a cocaine-negative test result, with an odds ratio of 2.13, the sole treatment category with a consistent objective benefit (Bentzley et al., 2021). For the practitioner, the applied message is twofold. First, do not wait for a pill; the best-supported treatment for stimulant use disorder is behavioral, deliverable now, and unfortunately underused because incentive-based programs sometimes meet moral resistance from staff and funders. Second, calibrate hope honestly, because relapse remains common and the counselor who frames stimulant recovery as a long process punctuated by setbacks serves clients better than one who treats a single relapse as failure.

It is worth naming why contingency management remains underused despite being the best-supported behavioral treatment in this space, because the practitioner will encounter the resistance directly, and nowhere more than in correctional settings. The intervention rewards drug-negative tests with vouchers, small prizes, or escalating draws, and to some staff and funders this feels like paying people to do what they should do anyway. The evidence answers the objection on its own terms: the incentives are modest, they are far cheaper than another incarceration, and they work by engaging the same reward circuitry that stimulants hijack, giving the client something tangible to move toward while the natural reward system slowly recovers. A counselor who understands the rationale can advocate for these programs and can deliver the behavioral principles, immediate reinforcement, frequent monitoring, and gradual shaping of longer abstinence, even inside a program that has not adopted a formal incentive structure.

A further reality for this population is that stimulant and opioid use increasingly travel together, whether through deliberate co-use or a contaminated drug supply, so a client whose criminal history is tied to methamphetamine may also be at acute risk from fentanyl exposure. The treatment plan and the reentry precautions therefore cannot be organized around the single drug that appears in the charging documents, and assessment should ask about every substance the client uses, because the drug named in the arrest record is often not the one most likely to cause a fatal outcome. This is a concrete instance of the broader principle this course teaches, that effective treatment answers the whole clinical picture rather than the narrow slice the legal system happened to record.

The rise of stimulants in justice-involved populations also changes what the counselor should expect and prepare for at intake and in early treatment. Stimulant withdrawal, unlike opioid withdrawal, is marked less by acute physical danger than by profound fatigue, depression, and anhedonia that can last weeks and that can look like, or coexist with, a mood disorder, and a client in that state may present as unmotivated or hopeless in ways that are partly pharmacological. Recognizing this protects the client from being written off as uncommitted during a period when his capacity to engage is genuinely diminished, and it argues for patience and for behavioral supports during the window when the natural reward system is slowly recovering. The counselor who understands the distinct course of stimulant recovery, and who does not expect it to resemble opioid recovery, is better equipped to keep a client engaged through the discouraging early phase during which contingency management and steady support do their work.

Gender-Responsive Treatment for Women Offenders

This course addresses the distinct treatment needs of women, and the evidence confirms that women's pathways into the justice system through substance use differ in ways that change what effective treatment looks like. Women in the justice system carry significant histories of trauma, poor mental health, and high rates of substance use disorders, more tightly interwoven than the traditional models assume. A systematic review of 12 post-release programs for women with substance use disorders, covering 3,799 women, found that recidivism was significantly reduced in 5 of them, and that the programs which succeeded were transitional and gender-responsive, provided individualized support, and delivered substance treatment alongside mental health and trauma services with continuity of care from prison to the community (Edwards et al., 2022).

The value of a genuinely gender-responsive approach is illustrated by a randomized trial of 115 women in prison that compared a gender-responsive program built on trauma and women's-recovery curricula against a standard prison therapeutic community, finding that women in the gender-responsive condition remained in aftercare longer and were significantly less likely to be reincarcerated within twelve months of parole, 31 percent versus 45 percent (Messina et al., 2010). The recent research on stigma reinforces the point: incarcerated women with opioid use disorder who had sought hospital care carried significant stigma from prior healthcare encounters (Webster et al., 2025), and rural women arrived at jails with more severe conditions and fewer options (Urhahn et al., 2026). For the practitioner, the gender evidence cautions against applying a one-size-fits-all model drawn from male samples to women, and argues for treatment that addresses trauma, works with rather than against the client's relational world, actively counteracts the stigma she carries, and maintains continuity across the reentry transition.

Two further considerations sharpen the point for everyday practice. The first is caregiving, because a large share of justice-involved women are mothers, often the primary or sole caregivers for their children, and a treatment plan that ignores the client's role as a parent, the practical demands of reunification, and the motivation that children can provide misses one of the strongest levers available. The second is the design of the treatment setting itself, because confrontational, hierarchical program models developed on male populations can replicate for a traumatized woman the dynamics of past abusive relationships, provoking the withdrawal or dropout that the program then misreads as lack of motivation. Gender-responsive models succeed in part because they are built on safety, connection, and collaboration rather than confrontation, which is not a matter of being softer but of removing an obstacle that would otherwise defeat the work.

For a counselor who cannot change the program model, the same principles can still shape the individual relationship, offering predictability, respecting the client's relational reality, refusing to interpret trauma responses as defiance, and taking active steps to counteract the healthcare stigma the recent evidence documents. That last point has a concrete form: naming openly that the client may have been judged or mistreated when she sought help before, and committing to a different kind of encounter, can begin to repair the mistrust that prior stigma created and that would otherwise undermine engagement. In a population where women have often learned that asking for help brings punishment, the deliberate creation of a non-judgmental treatment relationship is itself a clinical intervention.

Coerced Treatment: Does Mandated Care Actually Work?

A large share of the clients this course prepares practitioners to serve arrive not because they chose treatment but because a court ordered it, and the central question is whether treatment delivered under coercion can produce genuine change. The evidence says it can. The German forensic study found that compulsory addiction treatment produced a durable 16.5 percentage point reduction in recidivism over seven years (Schalast et al., 2025), and a nationwide registry study of 11,893 people found that treatment-based diversion as an alternative to imprisonment reduced substance misuse by 7 percentage points, reduced adverse mental health events by 5 percentage points, and produced about 3 fewer criminal charges than standard incarceration (Virtanen et al., 2024). Mandated treatment is not a lenient alternative that trades safety for compassion; it is, on this evidence, one of the more effective responses to the drug-crime problem.

The qualitative evidence gives texture to what mandated clients experience. A synthesis of 25 studies found that justice-involved adults frequently perceived real benefit from treatment orders, a reduced risk to health and life and an improved sense of self, while some experienced the coercion as a source of stress and, for those with trauma histories, as something that could reopen old wounds (France et al., 2025). Both are true at once, and the counselor's stance has to accommodate both.

The practical mistake is to treat mandated status as a verdict on the client's potential. Coerced entry does not preclude genuine change, and clients who begin under external pressure can, over time, internalize goals that were initially imposed. The counselor's task is to work with the ambivalence rather than against it, acknowledging openly that the client did not choose to be there while inviting him into a version of the work that serves his own stated interests, staying out of trouble, keeping custody of children, holding a job, staying alive. Meeting mandated clients with respect for their autonomy, even inside a coercive structure, is not softness; it is the condition under which the mandate has a chance of producing anything durable.

A concrete way to work with the ambivalence is to separate the parts of the situation the client cannot control from the parts he can. He did not choose to be ordered into treatment, and pretending otherwise insults his intelligence and invites resistance; what he can choose is what he does with the time, and framing the work around his own goals rather than the court's requirements gives him a reason to participate that is his rather than the system's. Many mandated clients have been told what to do for most of their lives, by families, schools, and the justice system, and a counselor who instead asks what the client wants and aligns the work with it is offering something genuinely different that can, over time, convert compliance into investment.

The dual role that court-mandated work creates deserves honest handling as well. The counselor who must report on a client's progress to a court occupies a position that mixes help and monitoring, and clients know it, so naming that reality openly, being clear about what will and will not be reported, and refusing to pretend the surveillance is not there tends to build more trust than an unconvincing posture of pure alliance. Clients at this intersection are highly attuned to being handled, and a counselor who is straight with them about the constraints of the role, while still advocating for them within it, earns a credibility that makes the rest of the work possible. This is the practical shape of the therapeutic use of authority that this course describes: not pretending the coercion away, but using the structure it provides in the service of a change the client can come to own.

Basic Needs and the Social Determinants of Recovery

This course places unusual and appropriate emphasis on basic needs, and the recent evidence vindicates that emphasis by showing how decisively housing, employment, food security, and social connection shape treatment outcomes. The study of psychosocial needs after incarceration found that unmet needs across every domain distinguished those who resumed use from those who stayed abstinent (Paquette et al., 2026), and the broader reentry literature consistently finds that treatment access without the surrounding scaffolding tends to erode.

A sobering illustration comes from an Australian study of 5,549 people released from prison, in which a program that successfully increased access to opioid agonist treatment, with an odds ratio of 1.21, and produced a short-lived mortality benefit nonetheless did not reduce return-to-custody at all over two years, with a hazard ratio of 1.01 (Sullivan et al., 2024). Treatment access moved one outcome and left another untouched, which is a crucial corrective against measuring success by enrollment. Getting a client into treatment is a beginning, not an accomplishment, and the addiction-crime relationship is not severed by a referral.

For the practitioner, this means the work reaches past the treatment hour into coordination that is often unglamorous, the housing referral, the employment linkage, the warm handoff to a community provider. For a justice-involved client, the seams between systems are where outcomes are won or lost, and treating those seams as part of the clinical work, rather than as someone else's problem, is what turns access into desistance. This course's insistence that basic needs are clinical business, not a distraction from the real treatment, is exactly what the evidence supports.

Housing deserves singular emphasis among the basic needs, because it is so often the factor on which everything else turns. A client released to stable housing has a platform from which to attend appointments, hold a job, avoid the network and settings associated with use, and keep custody of children, while a client released to homelessness or to the same environment that drove his use faces conditions under which even excellent treatment tends to fail. The evidence on unmet needs after incarceration makes housing instability one of the clearest markers distinguishing those who return to use from those who do not, and a treatment plan that produces an excellent cognitive intervention but sends the client back to a shelter bed in a drug-saturated neighborhood has left the most powerful variable unaddressed. The counselor cannot always secure housing, but treating it as central rather than peripheral, and advocating for it as vigorously as for any clinical service, is acting on what the outcome data actually show.

Employment and meaningful activity occupy a similar place. Work provides not only income but structure, identity, prosocial contact, and a stake in conformity that the desistance research consistently links to leaving crime behind, and the reentry evidence ties unemployment directly to the resumption of use. For a justice-involved client, the barriers are real, a criminal record, gaps in work history, lost skills, but the counselor who treats employment and education as part of the treatment plan rather than as afterthoughts, connecting clients to the vocational and educational resources that exist and helping them navigate the barriers, is addressing a criminogenic need that the risk framework itself identifies as changeable. This is the concrete meaning of the course's insistence that recovery for this population is rebuilt across the whole of a life, not only inside the counseling hour.

From Treatment to Desistance: The Long View

This course teaches that recovery from the intersection of addiction and criminal behavior is a matter of sustained change rather than a single decision, and the research assembled here explains why the change has to be sustained. Desistance from crime, like recovery from addiction, is a process rather than an event. It unfolds over years, it is punctuated by setbacks that are part of the pattern rather than proof of failure, and it depends on changes not only inside the person but in the conditions of the person's life. The German forensic study made this vivid, showing a durable reduction in recidivism even though nearly half of the treatment group returned to prison during treatment (Schalast et al., 2025); the path was nonlinear, and the cumulative effect held anyway.

Several threads converge on this long view. Medication interrupts the pharmacology but does not by itself rebuild a life. Cognitive programs shift thinking, but only when the client genuinely engages and only alongside the other conditions of change. Trauma and co-occurring conditions sit beneath the surface and reassert themselves if left untreated. Treatment access without housing, work, and prosocial connection tends to fade. Taken together, these findings describe recovery and desistance as the slow accumulation of small, reinforcing changes, in the person's thinking, health, and circumstances, rather than as a switch that flips.

For the practitioner, the practical meaning is a particular kind of patience, one that holds high expectations and a long horizon at the same time. It means reading a relapse or a new charge as information about which part of the cluster still needs attention rather than as a reason to give up on the client. It means recognizing that the counselor is rarely the only force acting on the outcome, and that the housing worker, the prescriber, the employer, and the client's own relationships are all part of the work. That combination of accountability and compassion, informed by exactly the evidence gathered here, is the ground on which effective work with justice-involved clients is built.

It is worth naming what this long view asks of the counselor personally, because the work exposes the practitioner to repeated relapse, to clients who return to custody, and to the slow pace of change in people whose lives have been organized against it, and that exposure can harden into cynicism or wear down into burnout. The evidence assembled here is, among other things, a defense against both. It shows that the interventions work, that medication saves lives, that engaged treatment reduces crime, that even compulsory treatment produces durable gains despite a nonlinear path, and it shows equally that a single relapse or a new charge is a predictable feature of a long process rather than a verdict on the client or the counselor. Holding that realistic hope, neither the naive expectation that treatment transforms people quickly nor the despair that concludes nothing helps, is itself a clinical skill, and it is sustained by knowing what the research actually shows.

The German forensic finding captures the point in a single image worth carrying: a treatment group in which nearly half returned to prison during treatment still ended with a large and durable reduction in reoffending. Recovery and desistance in this population do not look like a clean line, and a counselor who expects a clean line will be repeatedly disappointed and will misread ordinary setbacks as failure. A counselor who expects the real shape of change, halting, punctuated by return, cumulative over years, will keep working through the setbacks toward the gains that the evidence says accumulate, and will offer clients the steadiness that a chaotic and coercive system rarely provides. That steadiness, grounded in accurate knowledge of what treatment can and cannot do, is among the most valuable things a practitioner brings to this work.

The Counselor's Stance: Holding Accountability and Compassion Together

Working at the intersection of addiction and crime pulls a practitioner toward one of two distortions. One is a purely punitive stance that treats the client as a wrongdoer whose addiction is an excuse and reads every relapse as proof of bad character. The other is a stance so focused on the client's trauma and disadvantage that it loses sight of the real harm the behavior has caused, to victims and to the client's own life. The evidence reviewed here supports neither extreme and points instead toward a stance that holds accountability and compassion together.

Accountability, understood clinically, is not punishment. It is the expectation that the client is capable of change and responsible for participating in it, an expectation that itself communicates respect, and the cognitive and correctional treatment research is built on the premise that thinking and behavior can change through real work. At the same time, the trauma, co-occurring, and gender research makes clear that behavior which looks like defiance frequently has roots the client did not choose, and that a plan which ignores those roots will not hold. Compassion, understood clinically, is not lowered expectations; it is an accurate understanding of what the person is up against, used to build a plan that can actually work.

Held together, these commitments describe a practitioner who can say to a client, in effect, that the past explains a great deal and excuses nothing, that change is both expected and possible, and that the work of getting there will be shared. That stance is not a personality trait but a skill, informed by the kind of evidence this supplement has assembled, and it is what allows a counselor to stay in this demanding work for the long horizon it requires, offering, case after case, the patient and evidence-informed help on which recovery and desistance depend.

This stance also has an ethical dimension particular to correctional treatment, where the counselor's work can affect a client's liberty and where the pressures of the setting can quietly erode the treatment relationship into something more custodial than clinical. The volume of the caseload, the pull of documentation, and the authority of the institution can all tempt a counselor toward processing clients rather than treating them, and resisting that drift, insisting on seeing each client as a person with a history and a future rather than a case to be moved through, is not sentimentality. It is the condition under which treatment produces the honest engagement that makes it work, because the trust that yields disclosure and the motivation that sustains change are both built in a genuine human encounter rather than a bureaucratic one. The evidence and the ethics point the same way: treatment that reaches the person works better than treatment that processes the file.

Finally, the counselor working in this field does well to remember that the effort is justified by what it prevents as much as by what it achieves. Every client whose opioid use disorder is treated and whose medication continues across release is a person less likely to die in the two weeks after he goes home. Every co-occurring condition identified and treated, every trauma addressed, every basic need met is a thread pulled from the cluster that drives reoffending. The gains are often invisible, measured in the crises that did not happen and the returns to custody that did not occur, and a practitioner sustained by understanding that quiet arithmetic can do this demanding work for a long time and do it well. That is the ultimate purpose of the treatment issues this course addresses, and of the evidence assembled to support them.

Part 1: Major Treatment Issues and Approaches

Clinical Strategies

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

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

Addressing Basic Needs

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

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

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

Detoxification

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

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

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

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

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

For more on information on detoxification, see the CEU Matrix course

“Screening and Assessment of Clients in the Criminal Justice System.”

Homelessness

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

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

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

Life skills

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

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

Advice to the Counselor: Homelessness

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

Addressing Criminality

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

Criminal thinking

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

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

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

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

Figure 1 Common Thinking Errors

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

Source: Wanberg and Milkman 1998.

Thinking for a Change

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

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

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

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

Client manipulateness

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

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

Criminal code

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

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

Advice to the Counselor: Criminal Thinking

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

Addressing Anger and Hostility

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

Clients may be angry for a variety of reasons, including

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

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

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

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

In summary, interventions addressing emotions should encompass

1. Identifying the feeling(s). Maybe other feelings are involved, such as embarrassment or guilt.
2. Understanding clearly where the feeling is coming from. What is the real source of the anger?
3. Identifying the goals the anger is serving (e.g., deflecting attention).
4. Identifying the goals the anger is undermining (e.g., staying out of jail or keeping a job).
5. Working toward taking the longer view (e.g., beginning to use a prosocial thought process to manage the anger).

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

Addressing Identity Issues

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

Criminal identity

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

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

Cultural identity

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

Role as a family member and/or parent

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

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

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

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

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

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

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

Role as a person of status

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

Advice to the Counselor: Family Involvement

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

Addressing Denial

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

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

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

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

Addressing Resistance

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

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

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

Addressing Guilt, Shame, and Stigma

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

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

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

Advice to the Counselor: Addressing the Coerced Client

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

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

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

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

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

Establishing Boundaries

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

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

Advice to the Counselor: Establishing Boundaries

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

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

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

Striving for counselor credibility

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

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

Striving for cultural competence

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

Advice to the Counselor: Establishing Counselor Credibility

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

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

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

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

Program Components and Strategies

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

Engagement

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

Program incentives and sanctions to encourage engagement

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

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

Enhancing motivation

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

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

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

Effective Use of Coercion at the Program Level

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

Does Coerced Treatment Work?

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

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

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

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

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

Retention in Treatment

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

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

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

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

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

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

Incentives and sanctions to improve retention

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

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

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

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

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

Prosocial Activity

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

Staff Modeling Accountability

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

Peer Support and Feedback

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

Program Phasing

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

Self-Management Skills—Relapse Prevention

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

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

- *Relapse prevention is a key issue for community supervision.* Beyond the obvious applicability of self-management training to offenders, this work provides key information to parole and probation officers. If the supervision officer knows that a primary overt relapse sign for a particular offender is isolating in his room, for example, the officer has critical supervision information. Knowing an offender's early warning signs for relapse is probably as important to supervision as employment and living situation.
- *Relapse prevention emphasizes taking responsibility for oneself.* Relapse prevention work makes it difficult for the offender to blame others. Self-management training puts responsibility squarely on the individual. The occurrence of a partial or full relapse is a signal that the individual has more work to do in developing or performing his own relapse prevention and recovery plan. Relapse prevention work, then, can be a primary means of moving from necessary external controls (on the offender) early

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

- *Relapse prevention work emphasizes the long-term nature of many disorders.* Many major life problems, such as addictions, are life-long problems, requiring continuing work by the individual. The concept of relapse prevention implicitly communicates this point to criminal justice clients.
- *Relapse prevention work is easy to communicate.* Warning signs in the individual's behavior, and specific actions by the individual in response to those signs are easy to communicate between corrections program staff, offenders, supervision officers, and others in the offender's support network. Relapse prevention plans aid communication from institutional programs to community supervision and to community programs.
- *Relapse prevention is applicable across theoretical perspectives.* Practitioners from the theoretical perspectives of behaviorism and disease concepts are currently using relapse prevention and recovery planning techniques with equal facility. Relapse prevention strategies seem to ring true regardless of beliefs about the etiology of addictions or criminality.
- *Relapse prevention is a unifying concept across programs.* Whether the problem is alcohol abuse, drug abuse, mental illness, sex offending, or criminality generally, the same basic process seems to occur in relapses, and the same basic strategies seem to be needed in recovery. Relapse prevention work therefore offers a unifying concept and means of communication across types of programs and service populations.

Spiritual Approaches

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

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

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

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

Advice to the Counselor: Spiritual Approaches

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

Part 2:

Adapting Offender Treatment for Specific Populations

Treatment Issues Related to Cultural Minorities

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

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

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

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

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

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

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

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

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

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

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

Advice to the Counselor: Culture and the Counselor

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

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

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

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

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

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

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

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

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

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

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

Advice to the Counselor: Treating Female Offenders

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

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

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

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

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

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

Low Self-Esteem

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

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

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

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

Parenting and Child Custody

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

A Program for Paroled Women and Their Children

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

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

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

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

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

The DWCF Program for Women and Their Children

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

Advice to the Counselor: Parent Training

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

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

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

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

Men's Treatment Issues

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

Fathering

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

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

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

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

Developing Relationships

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

Working with Violent Offenders

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

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

Relationship Between Substance Abuse and Violence

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

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

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

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

Managing Violence

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

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

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

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

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

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

Treatment Issues Based on Client's Sexual Orientation

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Treatment Issues for Older Adults

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

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

Treatment Issues for Clients from Rural Areas

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

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

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

Advice to the Counselor: Rural Clients, Rural Counselors

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

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

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

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

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

Identifying Co-Occurring Disorders

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

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

Co-Occurring Disorders Treatment Programs

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

Diversionary programs for offenders with co-occurring disorders

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

Prison- and jail-based programs for offenders with co-occurring disorders

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

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

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

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

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

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

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

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

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

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

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

Programs for offenders with co-occurring disorders under community supervision

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

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

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

Medication Management

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

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

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

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

Case Management Services

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

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

Special Considerations in Treating Antisocial Personality Disorder (ASPD)

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

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

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

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

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

Figure 1 Traits of ASPD (DSM-IV)

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- Deceitfulness, as indicated by repeated lying, use of aliases, or conning others for personal profit or pleasure
 - Irritability and aggressiveness, as indicated by repeated physical fights and assaults
 - Consistent irresponsibility, as indicated by repeated failure to sustain consistent work behavior or honor financial obligations
 - Failure to conform to social norms with respect to lawful behaviors as indicated by repeatedly performing acts that are grounds for arrest
 - Impulsivity or failure to plan ahead
 - Reckless disregard for safety of self or others
 - Lack of remorse, as indicated by being indifferent to or rationalizing having hurt, mistreated, or stolen from another
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Source: Hare et al. 1991.

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

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

Special Considerations in Treating Borderline Personality Disorder (BPD)

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

Figure 2 Borderline Personality Disorder

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

- Frantic efforts to avoid real or imagined abandonment
 - A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation
 - Identity disturbance or markedly and persistently unstable self-image or sense of self
 - Impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating)
 - Recurrent suicidal behavior or gestures, or self-mutilating behavior
 - Affective instability due to marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days)
 - Chronic feelings of emptiness
 - Inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights)
 - Transient, stress-related paranoid ideation or severe dissociative symptoms
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Source: APA 2000.

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

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

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

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

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

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

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

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

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

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

Special Considerations in Treating Depressive and Bipolar Disorders

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

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

Special Considerations in Treating Schizophrenia/Psychotic Disorders

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

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

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

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

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

People with Infectious Diseases

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

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

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

Project ARRIVE

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

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

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

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

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

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

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

Medical Care

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

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

Prevention and Education

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

Advice to the Counselor: Infectious Diseases

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

fear of infection.

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

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

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

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

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

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

Some Relevant Facts About Sex Offenders

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

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

Sex-Offender-Specific Treatment

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

SHARPER FUTURE

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

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

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

Relapse Prevention: The Common Thread

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

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

Areas of Divergence

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

Conclusions and Recommendations

Part 1:

- Whenever possible, treatment should be modified as needed to meet the individual client's specific needs. A thorough client assessment covering multiple dimensions will enable treatment providers to determine what modifications to treatment are required.
- Individual needs should be considered in adapting the sequence, focus, and intensity of treatment.
- It is important for offenders to have appropriate peer and staff role models who have overcome the stigma of a criminal past and a history of substance abuse. Provisions should be made whenever possible to allow criminal justice programs to hire staff who are ex-offenders and who are in recovery. Treatment programs have found it useful to maintain a blend of recovering and nonrecovering staff.
- While legal pressures may be sufficient to leverage a client into treatment, specific engagement strategies are necessary if the client is to be motivated to commit to change and to maintain recovery.
- Anxiety, guilt, and remorse related to past substance abuse and criminal behavior can be productive in motivating offenders to change their lives.

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

- There is a risk that treatment could become overly coercive and susceptible to charges of "cruel and unusual punishment." It is important that participants in treatment be offered the opportunity to leave the program after a minimum period of time (e.g., 90 days).
- Internal motivation for treatment is a better predictor of retention than external motivation. It is recommended that counselors target those with low internal motivation for an intervention to increase readiness.
- Motivation to enter treatment frequently occurs at particularly stressful times such as after being arrested, after one's children have been removed by authorities, or following an overdose or a "bad high." Substance abuse treatment and criminal justice staff should watch for these opportune times and respond quickly so that the client can be engaged in treatment while their motivation is still strong.
- While clients in criminal justice settings are often coerced and resistant to treatment, they can become invested in treatment through the use of motivational interviewing and similar techniques.
- Clients who agree to enter treatment may be seen as "traitors" by other offenders, as the prison culture makes it a point to resist anything that is seen as a further attempt to control the lives of inmates. For this reason, it is useful to provide treatment services in residential areas or separate prisons that are isolated from the general inmate population.
- In jurisdictions that involve probation/parole officers or corrections staff in treatment team activities, roles need to be very clearly defined. Criminal justice staff who do not have treatment-related experience or specialized training can become overly involved in the treatment process and overly invested in treatment issues.
- Criminal justice professionals have been effectively involved in facilitating psychoeducational groups and other treatment activities and are often included in treatment teams and treatment and discharge planning. Criminal justice professionals providing group treatment services should receive specialized training in therapeutic techniques and treatment approaches and should consider obtaining substance abuse certification and licensure.
- Many correctional treatment programs in jails and prisons have found it useful to establish co-coordinators from both treatment and correctional/security systems. These arrangements provide a sense of

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

- To operate within a prison or jail and maintain inmates' respect, corrections and treatment staff need to maintain a certain distance from offenders. Cross-training can assist staff in defining appropriate "boundaries" that should be maintained in relationships with inmates, and to identify related situations that can compromise the effectiveness of security/public safety and treatment operations.
- Treatment providers need not condone an offender's past criminal activity, but they should accept it as part of the client's past, and not a permanent character flaw or insurmountable obstacle to recovery.

Part 2:

- Screening and assessment for a history of physical/sexual abuse should be included as part of intake assessments for men and women in criminal justice treatment settings. Referral information should be provided to inmates who report prior abuse and who are interested in receiving services related to this abuse.
- Use of "strengths-based" approaches to substance abuse treatment is highly recommended, particularly for female offenders. These interventions are considered effective in improving self-esteem.
- Substance abuse treatment programs in jails and prisons (including TCs) should include vocational programs for men and women. Offenders under community supervision also should have access to community vocational programs.
- Treatment programs in women's institutions are encouraged to use the segregation of genders within the criminal justice system to the advantage of their clients by developing treatment programs that specifically address women's needs.
- Jail and prison programs need to allow for more interaction between incarcerated mothers and their children; the 2–4 hours of supervised visitation per week that many institutions allow is not sufficient for mothers or their children.
- Given the high rates of co-occurring mental disorders in the offender population, more treatment programs need to be developed for offenders with COD.

- Given the prevalence of cognitive and physical disabilities in incarcerated populations, especially among offenders with substance use disorders, treatment providers need to be able to screen for and to provide accommodations for offenders who have these co-existing disabilities.
- Because mental health and substance use disorders can mask or imitate each other, accurate diagnosis of these disorders requires skilled screening and assessment. Assessment should look for evidence of both disorders, rather than providing separate assessments for the disorders. Regular reassessment for COD also is important, and should be conducted at major transition points in the criminal justice system by staff with specialized training in this area.
- Substance abuse treatment programs for offenders should include staff who reflect the cultural diversity of the population they are treating. Efforts need to be made to adopt treatment to specific cultural populations (e.g., ethnicity, race, age, sexual orientation, rural cultures, socioeconomic class, and language). Counselors need to be aware of different cultural sets of values, biases, and assumptions related to communication, therapeutic style, and interpersonal contact and should be trained in techniques for adapting treatment approaches to reflect these differences, in order to more effectively engage and maintain clients in program services.
- The therapeutic community has been successfully modified to treat specific populations, including female offenders and offenders with COD.

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

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

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

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

<http://www.ceumatrix.com/studentcenter>

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

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

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

NOTE: THE EXAM QUESTIONS AND /OR ANSWERS MAY BE IN A DIFFERENT ORDER IN THE ONLINE EXAM

Answer the following questions by selecting the most appropriate response.

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

2. Symptoms of withdrawal vary by substance, but may include which of the following:
 - A. Yawning, sleepiness, exhaustion, lethargy
 - B. Depression, crying fits, disorientation
 - C. Suicidal thoughts or behavior
 - D. Profuse sweating, muscle jerks, constant blinking
 - E. All of the above

3. One of the most underdeveloped skills in offender-clients is:
 - A. Financial
 - B. Reading
 - C. Problem-solving
 - D. Social
 - E. All of the above

4. Examples of cognitive distortions or “thinking errors” in criminal thinking include all but which of the following:
 - A. Seeing themselves as superior to others
 - B. Seeing themselves victims or mistreated
 - C. Seeking instant gratification
 - D. Rigid thinking
 - E. Being highly needy of others

5. One of the primary reasons it is necessary to separate inmates in treatment from the general inmate population is:
 - A. Withdrawal symptoms
 - B. Personal safety
 - C. The “convict code” and prison culture
 - D. So that they can get incentives and special treatment

6. Criminal thinking is so deeply ingrained and part of the offender's personality that it is virtually impossible to change it.
- a. True
 - b. False
7. Clients in prison-based treatment may exhibit anger as a result of which of the following:
- A. To deflect attention away from themselves
 - B. To maintain an adrenaline high
 - C. Limited emotional range and resources
 - D. Genuine feelings of being treated unfairly
 - E. All of the above
8. Often what offenders think is anger is actually shown to be frustration, hurt, loneliness and fear.
- a. True
 - b. False
9. Slaght (1999) found that the only independent variable related significantly to relapse at 3 months after release to the community was:
- A. Whether they were employed or unemployed
 - B. Whether they went back to their old friends
 - C. Whether they were getting along with family members
 - D. Whether they could deal with the requirements of parole.
10. Because the prison culture itself is so hierarchical, treatment programs need to have an egalitarian "everyone-is-equal" culture.
- a. True
 - b. False
11. Because boundaries between staff and clients have a special significance in criminal justice settings, treatment staff need to be especially vigilant about
- A. Self-disclosure
 - B. Confidentiality
 - C. Personal safety
 - D. Asking about the client's feelings

12. The process of getting a client involved in treatment is called:
- A. Contemplation
 - B. Motivation
 - C. Engagement
 - D. Persuasion
13. Offenders will be more influenced by the treatment and less likely to return to incarceration if the treatment staff are perceived as
- A. Fair
 - B. Competent
 - C. Empathetic
 - D. Tolerant
14. In a study of offenders on probation, Broome *et al* found that a positive correlation between engagement in treatment and
- A. Family dysfunction
 - B. Recognition of the existence of a substance problem
 - C. The degree of peer deviance in the client's social network
 - D. All of the above
15. Coercion (e.g. from the criminal justice system) can get a client into treatment, but internal motivation predicts retention and positive outcome.
- a. True
 - b. False
16. Individuals coerced into treatment should be separated into different treatment tracks from non-coerced clients because they will undermine the efforts of those who truly want to get help.
- a. True
 - b. False
17. In using treatment incentives and sanctions, it is important to:
- A. Emphasize incentives over sanctions
 - B. Apply sanctions as rapidly as possible
 - C. Be creative with incentives
 - D. Using repeated mild sanctions is more effective than using threats of stronger sanctions,
 - E. All of the above

18. Without prosocial (positive) activity, criminal justice clients tend to use unstructured time for anti-social thinking and behavior.
- a. True
 - b. False
19. Both treatment staff and criminal justice staff need to model personal accountability in their behavior.
- a. True
 - b. False
20. Peers using a group treatment modality have the capacity to give more immediate feedback for positive steps to change and for negative thinking and behavior than staff because they:
- A. Spend more time together
 - B. Their opinion is more valued than staff's
 - C. They are watching for others to trip up
 - D. They are seeking recognition
21. Rituals and ceremonies used to mark positive events can be important for clients since they may have previously been exposed to those associated with gang activity or substance abuse.
- a. True
 - b. False
22. In a study of Alaska Native men, Glass and Bieber found that the stress of trying to adapt to two cultures (their own and the dominant culture) was associated with violent activity. This is an example of:
- A. Social isolation
 - B. Social disintegration
 - C. Resource deprivation
 - D. Violent culture orientation
23. Treatment programs should include staff who reflect the cultural diversity of the population they are treating to every extent possible.
- a. True
 - b. False

24. A barrier to creating culturally-specific treatment programs within a prison or jail is:
- A. The variety of populations who enter the facilities
 - B. The need to provide equal levels of treatment for all offenders
 - C. Significant cultural identification cannot be assumed for all members of a particular group
 - D. B and C
 - E. All of the above
25. The most common misunderstandings in counseling originate in culture, socioeconomic class and language.
- a. True
 - b. False
26. Women:
- A. Numbered nearly one million under supervision
 - B. Report higher rates of physical and sexual abuse in their pasts than men.
 - C. Reported higher drug use than men at the time of the incident.
 - D. Were found to have a higher incidence of mental disorders than male inmates.
 - E. All of the above
27. Harsh confrontational techniques are generally counterproductive with women in treatment because they resemble abusive interpersonal situations experienced by many of them while in the community.
- a. True
 - b. False
28. Peugh and Belenko (1999) found that female inmates with substance use disorders had better employment histories than their male counterparts.
- a. True
 - b. False
29. Male offenders feel conflicted about their roles as fathers since being a good father is looked down on in prisons as a sign of "weakness."
- a. True
 - b. False

30. The prison culture reinforces violent behavior and individuals who are incarcerated without a history of violence quickly learn its value in jail or prison.
- a. True
 - b. False
31. Several resources may be useful in managing violence and anger, including all of the following except:
- A. Cognitive-behavioral therapy (CBT)
 - B. Anger management groups
 - C. Medication
 - D. Electro-convulsive therapy
32. One of the reasons that people with cognitive disabilities are overrepresented in the prison system, is that they are more likely to be arrested for, and confess to, crimes they did not commit.
- a. True
 - b. False
33. Given the prevalence of disabilities in incarcerated populations, especially among offenders with substance use disorders, treatment providers need to be able to screen for co-existing disabilities and make accommodations for those who have them.
- a. True
 - b. False
34. Illicit drug use is still more prevalent in large urban areas than in small communities or rural areas, with the exception of marijuana.
- a. True
 - b. False
35. Identifying and treating co-occurring disorders in a correctional setting is complicated by all but which of the following:
- A. One disorder can mask or imitate the other
 - B. Mental disorders carry a great deal of stigma in the prison culture.
 - C. Psychotropic and other prescribed medications are prohibited.
 - D. Accurate diagnosis requires a greater level of skill.

36. When assessing co-occurring disorders, one diagnosis needs to be designated as primary and the other as secondary.
- a. True
 - b. False
37. Counselors must be alert to inmates who skillfully mimic the symptoms of mental disorders in order to receive medications.
- a. True
 - b. False
38. Anti-social Personal Disorder and Psychopathy share the following characteristics except for:
- A. Treatment focuses on behavior management rather than on counseling or other therapeutic techniques.
 - B. Treatment is more structured and monitored
 - C. The behavioral patterns diminish after the age of 40
 - D. They have a lower incidence of substance abuse than the general population.
39. Offenders with attention deficit/hyperactivity disorder (AD/HD) should have treatment information conveyed visually as well as orally whenever possible.
- a. True
 - b. False
40. Although rapists, child molesters, incest offenders and exhibitionists were once thought to be discrete offender types, an increasing body of evidence derived from polygraph examinations reveals that there is considerable “crossover” behavior.
- a. True
 - b. False