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The Success of Therapeutic Communities for Substance Abusers in  
American Prisons

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*Residential treatment provides opportunities for intensive interventions and support as contrasted with the limited opportunities found in out-patient settings. In the area of substance abuse treatment the therapeutic community (TC) has become synonymous with residential treatment. A growing body of prison TC outcome research is provided and the overview of prison of TC outcome research is provided and the emergence of the TC as the primary substance abuse treatment programs is described and contrasted with the relapse recovery model. The theoretical principles of the TC model are discussed and two main variants of the prison TC model are described and contrasted. Finally, recommendations are offered for expanding the TC approach and increasing its effectiveness by treating comorbidity problems that are prevalent among prison inmates with substance abuse.*

## Introduction

Residential treatment provides opportunities for intensive interventions and support as contrasted with the limited opportunities found in out-patient settings. In the area of substance abuse treatment the therapeutic community (TC) has become synonymous with residential treatment. The widespread acceptance of TCs is directly associated with a number of studies showing successful outcomes for community TCs over the years (e.g., DeLeon, Wexler & Jainchill 1982; DeLeon & Ziegenfuss 1986), and more recently similar results are appearing for prison TCs (Falkin, Wexler & Lipton 1992). The prison TC outcome research has led to recent acceptance of prison TCs as a major innovation in American prisons (Wexler 1994).

The recent prison TC outcome research and emergence of the TC as the primary substance abuse treatment in prison will be briefly described. (See Falkin, Wexler & Lipton 1992, for a comprehensive literature review.) The self-help orientation that provides the basis for both residential and 12-step substance abuse treatment programs will be presented and contrasted with

the relapse recovery model. The theoretical principles of the TC model, a form of self-help, which comprise the underpinnings of prison TC treatment will be discussed and two main variants of the prison TC model will be described and contrasted. Finally, a suggestion will be presented for expanding the TC approach and increasing its effectiveness by treating comorbidity problems that are prevalent among prison inmates with substance abuse problems.

## **Emergence of Prison TCs**

### Outcome Research

The positive outcomes demonstrated by community TCs in the last 25 years helped pave the way for the acceptance of prison TCs. The basic argument was that since crime and drug abuse were closely related, interventions that would reduce substance abuse would help decrease crime. This is the kind of formulation that has been accepted and found useful to many policy makers. Some of the research and policy implications of the relationship of drugs crime and prison drug treatment, which has been discussed in several publications, Wexler, Blackmore & Lipton (Lipton & Wexler 1988; Wexler 1994; Wexler & Lipton 1993; Wexler, Lipton & Johnson 1988) are summarized below.

A substantial body of research has demonstrated a very strong link between drugs and crime (Ball 1986, Ball et al. 1983, 1982, 1981; Chaiken & Chaiken 1982; Chaiken & Johnson 1988; Collins, Hubbard & Rachal 1985; Inciardi 1979; Wish & Johnson 1986). For example, Inciardi (1979) has reported that active heroin users commit an average of 248 crime-days (24-hour period in which an individual commits one or more crimes) per year at risk when using heroin daily and 40.8 crime-days per year at risk when using heroin less than daily.

Policy makers realized that a considerable amount of crime was attributable to a small number of chronic drug abusers and that they could be effectively treated in correctional TCs. Additionally, they became aware of the great promise that prison TCs held for reducing drug abuse, criminal violence and recidivism. The TC provided a treatment technology that was both

demonstrably effective and capable of being imported into correctional settings without undermining discipline and security.

Many evaluation research studies have consistently demonstrated the effectiveness of community TCs (De Leon 1979; Gerstein & Harwood 1990; Hubbard et. al., 1988; Simpson, 1979,1980). These studies show that the community TCs had demonstrated their effectiveness in reducing crime and substance abuse while increasing pro-social behavior (e.g., employment.) A key finding in these studies was that positive outcomes increased with time spent in program. The community TC findings encouraged policy makers to consider a systematic test of the hypothesis that recidivism decreases as time in program increases at a prison TC setting where time-in-treatment could be more easily controlled. Interest in testing of the time in program hypothesis contributed to the establishment of the Stay'n Out program at two New York State prisons in 1977: one for men at the Arthur Kill Correctional Facility on Staten Island, and the other for women at the Bayview Correctional Facility in Manhattan.

In an initial analysis of outcome data from the first three years of the program, Wexler et al. (1988) found that participation in Stay'n Out contributed to a reduction in parole revocations. Both male and female clients who had completed the program had lower parole revocation rates than those who dropped out before six months, and significantly fewer revocations than a comparison group of inmates on a waiting list for the program, but who had not participated.

These positive findings were replicated and extended in a large scale outcome study of Stay 'n Out, funded by the National Institute on Drug Abuse (Wexler, Falkin & Lipton 1990, 1988). They found steady improvements in post-release performance as the time in program increased to nine - 12 months, followed by an unexpected decline in positive outcomes after 12 months in treatment. On the basis of this result, the authors suggested that inmates who have successfully completed the treatment phases of the program, which typically requires nine to 12 months, be released to community settings as soon as possible. Similar findings were reported by Field for the Cornerstone TC in Oregon (Field, 1989, 1984).

Recently, NIDA funded a five year evaluation of the Amity TC at R.J. Donovan prison in California in 1991. The first outcome findings that were

released in 1994 (Wexler and Graham, 1994) indicate that a somewhat different prison TC model was also capable of producing positive outcomes. After a year at risk the preliminary data showed that 34% of program completers were reincarcerated as compared to 53% of the program drop outs and 60% of the random control group. The differences were statistically significant. The Stay'n Out and Amity prison TCs, which are different expressions of the TC model, will be described and contrasted below.

### Acceptance of Prison TC Programs

The well known slogan "nothing works" was accepted as an accurate appraisal of the effectiveness of prison rehabilitation efforts until the mid 1980s when the positive prison TC outcome data began to appear. A major policy shift occurred with the "Anti-Drug Abuse Act of 1986" that included substantial funding for substance abuse treatment of which a large proportion was directed at correctional drug treatment. Several major technical assistance projects were funded which focused considerable productive energy on developing meaningful substance abuse treatment programs in state departments of corrections throughout the country. The TC model has been accepted as the most effective kind of prison drug treatment intervention and it has been widely adopted. A brief description of two major national technical assistance projects is offered since these efforts have provided the impetus and expert guidance that have supported the growth of prison drug treatment . (See Wexler & Lipton 1993; Wexler 1994, for a detailed description of these historical developments.)

The first of these projects was Project REFORM ("Comprehensive State Department of Corrections Treatment Strategy for Drug Abuse" project) was funded by the Bureau of Justice Assistance (BJA). During the five years of its operations (1987-1991), 11 participating state departments of correction developed state plans and implemented many substance abuse initiatives (Wexler, Blackmore & Lipton 1991). When the BJA funding of REFORM was completed, the Center for Substance Abuse Treatment (CSAT) established Project RECOVERY (Technical Assistance and Training Services to Demonstration Prison Drug Treatment Programs) to continue these technical assistance activities for 18 months (1991-1992) in a total of 14 states.

The technical assistance activities were designed to provide leadership, expert guidance and support for the development of prison substance abuse treatment. Program operators, researchers and correctional administrators who had been recognized as leaders in their respective fields, were hired as project consultants. Specific activities included semi-annual workshops, development of a resource center, dissemination of information on prison drug treatment, and on-site consultation. The training workshops provided inspiration and fostered a sense of community among participants.

Participants in Projects REFORM and RECOVERY believed that a primary goal for corrections is the reduction of recidivism; that is, to intervene in the lives of offenders so that they do not return to prior patterns of criminal behavior (Wexler & Lipton 1993). A large number of drug treatment programs were implemented by the states that participated in these two projects. Many of these treatment programs are being evaluated and effectiveness data will be available in the near future (Wexler 1992). In 1993 CSAT funded another 11 correctional drug treatment projects along with a technical assistance effort to support these programs following the model established by projects REFORM and RECOVERY.

The important shift in correctional policy emphasis from deterrence to rehabilitation is dramatically demonstrated in Texas. As a direct outgrowth of the REFORM and RECOVERY initiatives and of the growing body of evidence supporting the effectiveness of prison therapeutic community drug treatment, Texas criminal justice treatment agencies made correctional drug treatment a major goal.

In 1991, landmark legislation passed in Texas which called for the development of a comprehensive treatment system for chemically dependent offenders. Under this plan, three criminal justice substance abuse treatment programs are to be established by 1995. The Treatment Alternatives to Incarceration Program provides screening and assessment for chemical dependency and refers offenders to appropriate community-based treatment. The In-Prison Therapeutic Community Treatment Program dedicates 2,000 prison beds to long-term intensive substance abuse treatment prior to the inmate's release and, in conjunction with community services, provides continuing care in the community upon re-entry. The Substance Abuse Felony Punishment Program offers 12,000 secure treatment beds for an indeterminate sentence of 6 to 12 months to

offenders who are convicted of non-violent felonies and who have crime-related substance abuse problems. Together, these programs are intended to service all levels of substance abusing adult offenders, from the non-violent to those with long histories of crime and drug use. This effort represents the largest correctional substance abuse treatment program in the world.

### **The Self-Help Approach**

The TC is a residential approach that comes out of the self-help tradition. Most workers in criminal justice and substance abuse treatment agree that it is necessary to intervene in the criminal lifestyle to produce significant outcomes. The pervasive problems of incarcerated substance abusers often include early abuse, poverty, gang membership and a variety of psychiatric comorbidities. Most traditional professionals have little experience or interest in working -with this population. For example, it is unlikely that many professionals would be willing to accept the relatively low paying jobs in harsh prison environments which are often accepted by a recovering person interested in "giving back" some of what they have received from other recovering persons in self-help programs. The self-help tradition offers a reasonable and hopeful approach to making a difference with this population because it welcomes them, provides believable paths for change, impacts values, helps heal emotional wounds, and provides the long term community support necessary for lifestyle changes.

Many self-help programs were started by disenfranchised members of society who believed that conventional help was inadequate or unavailable. These individuals shared common problems and a personal commitment to do something about their condition. Self-help programs are not conceived as "services" which require client dependence on providers. Instead, they are programs based on a philosophy of self-responsibility. The self-help philosophy provides a powerful belief system which elicits strong individual commitment to one's own healing. For many, this approach has proven both inspiring and successful.

A major goal of the self-help approach is altering the fundamental negative beliefs and unhealthy lifestyles of participants. By taking responsibility for one's own problems, individuals can gain control over their situation and

develop a new sense of self-respect and competence. Support and guidance is provided by credible role models who have experienced the changes they profess. In addition, extensive personal support is provided by peer group networks. The entire approach results in far-reaching changes in personal lifestyles and social relationships. In general, the self-help movement successfully instills self-reliance and responsibility.

The self-help approach has been embraced by a variety of groups distressed by the failure of traditional health systems to adequately meet their needs. An extensive review of the self-help movement reports the existence of over half a million self-help groups (Gartner & Reissman 1977). Self-help groups have been formed for practically every major disease listed by the World Health Organization and for most problems that affect behavioral, psychological and social groups. The historical antecedents of the modern self-help movement have been well chronicled (Baris, 1971; Gartner & Reissman 1977; Hurvitz 1976; Katz & Bender 1976; Sagarin 1969; Thomsen 1975). Worth mentioning are several highlights of the movement relevant to the origins of the modern TC.

Early American religious groups, such as the Washingtonians, used concepts of mutual criticism and penance to help reform members who confessed to guilt and wrongdoing at community meetings. This group was founded in 1840 and attempted to rehabilitate alcoholics. The 1930s was a fertile period for self-help groups and that decade set the stage for their current popularity. Some of the self-help groups formed during this period include the Unemployment Cooperatives (organized to fight the economic hardships caused by the Depression) groups formed to assist former concentration camp victims, and groups concerned with handicapped children (these groups became the United Cerebral Palsy Foundation and the American Association of Retarded Children).

Of all the groups, Alcoholics Anonymous (AA) has had the greatest impact upon self-help efforts dealing with behavioral problems (i.e., addictions and antisocial behavior). Participation in AA lessens the sense of helplessness commonly felt by alcoholics. Involvement with AA groups and acceptance of a philosophy of abstinence allows alcoholics to develop the self-control necessary to curb compulsive behavior. The AA model has been adopted by many groups that focus on criminals and substance abusers such as Narcotics Anonymous, Cocaine Anonymous, Pills Anonymous, Marijuana

Anonymous, Parents of Youth in Trouble Anonymous, and Sexual Child Abusers Anonymous. AA is primarily a support model as contrasted with the TC which is a self-help intervention model.

A fuller understanding of the prison TC can be attained by briefly summarizing the self-help principles found in published descriptions of the self-help/ TC approach that have appeared in recent years. (See reviews by Katz & Bender 1976; Kennard 1983; Levy 1976; Wexler, Falkin & Lipton 1988).

### Self-Help Principles

- Notion of the shared problem: all members have suffered and are involved in a joint effort to deal honestly with their problems.

A sense of mutuality engenders a high level of trust and sensitivity among members and the sense of mutual suffering facilitates a depth and intensity of confrontation among peers. In self-help groups, long-term members and newcomers alike perceive each other as sharing common needs. Honesty is highly valued and members find it difficult to mislead each other or avoid the truth about themselves.

- The individual as the source of change.

As active participants in their own healing, individuals engage in structured experiences designed to nurture self-sufficiency and competence.

- "Helper therapy principle" (Reissman 1976).

The advocate/ advisor role, which is central to the self-help process, increases a helper's commitment to the healing process. Inherent in the helper role is a sense of strength and empowerment, feelings that contrast with helplessness and dependence. In the act of providing assistance and support, the helper develops a more objective perspective which then gives rise to a "therapeutic" analysis of one's own problems. Helpers earn status within one's community of peers, and they experience associated improvements in feelings of self-worth.

- The self-help network provides a means for sustaining a particular set of values and lifestyle.

People who have often been perceived as deviant and social rejects receive a sense of community, of belonging and acceptance. There are prescribed consequences (rewards and punishments) aimed at increasing constructive behaviors and decreasing self-destructive behaviors. The self-help network provides a stable reference group that supports and maintains positive changes.

- Self-help groups as "fixed communities of belief" (Antyze 1976).

New members who arrive in a state of despair are very receptive to a new belief system that promises relief and improvement. Older members are impressive role models and teachers based on their success at solving their own problems and are dedicated to helping new members.

- Self-help processes are geared to invoke and develop a sense of power among members.

The idea of "bottom line" responsibility for the conditions of one's life teaches members that they have the power to alter aspects of their internal reality and external environments. The role of helper encourages members to use their personal strength in enabling others to feel less helpless. This, in turn, verifies the power of the helper. Since self-help programs are peer centered, they encourage assertiveness and offer many opportunities for leadership.

- A fierce independence is an integral part of the self-help ideology.

Self-help groups often have an anti-professional attitude, which is based on a belief that their particular needs are not met by conventional service providers or government funding. Members help each other and usually exclude professionals from primary therapeutic procedures. Professional and government involvement is usually on an invitational basis and of secondary importance.

### Relationship Between the Self-Help and Professional Approaches

Academically oriented- professionals and policy makers often fail to fully appreciate the power of the self-help approach. The emphasis on interventions such as relapse prevention probably reflects a preference for more traditionally rooted psychological concepts that are widely accepted by the medical and mental health professionals. Spokespersons for self-help groups assert that the more traditional professionals who are part of the "establishment" are oriented primarily toward meeting middle class needs rather than toward the needs of the "disenfranchised" with whom they may feel less comfortable and sometimes threatened. An examination of some major relapse prevention techniques (Marlatt & Gordon 1985) is illustrative of their limited applicability as a primary intervention for substance abusing criminal justice clients and helps to indicate a more productive relationship between self-help oriented and academically trained workers.

During the 1980s, relapse prevention became one of the most widely-adopted strategies in the substance abuse treatment field. Many aspects of relapse prevention are cognitive behavioral, based on the theory that changing an individual's perceptions and underlying beliefs are potential means of altering behavior. Relapse prevention emphasizes the difference between a lapse in sobriety and a full relapse or return to addiction. The strategies are aimed at both preventing the first lapse and at preventing any lapse from growing into full relapse.

Drug education in a classroom setting which is often part of relapse prevention is poorly suited for clients who have had little success in school settings; they usually find the complex physiological and behavioral concepts difficult to understand and irrelevant to the harsh realities of their inner city lives. While a key relapse prevention strategy is to identify high risk situations and to avoid "triggers" to relapse, it is almost impossible to

avoid the easy availability of drugs and drug using friends when living in the inner city. The relapse prevention strategy of changing ones lifestyle (e.g., by acquiring new leisure, recreational, social and employment activities that support a drug free lifestyle) or developing effective coping skills (e.g., exercising instead of going to happy hour, learning to verbally express upsetting feelings 'instead of using drugs, and the use of cognitive strategies like "thought stopping" to avoid thoughts of drug craving) often seems unrealistic and out of reach for disenfranchised populations.

For the relapse recovery strategies to be especially helpful, the typical criminal justice client must first have achieved some basic social and vocational rehabilitation (or habilitation) goals necessary for starting a productive prosocial life style. Accomplishment of these goals often requires a self-help residential approach that can engage, hold and support individuals during the difficult and often painful change process. Training of relapse prevention is an important component that can be very helpful during the latter phases of treatment.

### **The Therapeutic Community**

The modern substance abuse TC began as an offshoot of AA. In 1958 Charles Dederich founded Syrlanon in California. He was a recovering alcoholic who broke away from AA because of his dislike of their rigid alcohol focus and their rejection of substance abusers who were more likely to be poor and members of minority groups. Synanon became a prototype of the concept-based TC (Kennard 1983).

This section provides a description of the concept-based TC, the model upon which most early substance abuse community and prison TCs were based. Although, many modern TCs have altered the classic concept-based TC model, it is helpful to understand the basic model in order to appreciate the latter modifications.

The concept-based TCs represented a radical departure from traditional mental health care. This type of TC which was designed to assist substance abusers was developed by ex-addicts who helped themselves. Some of the best examples of concept-based TCs are Synanon (Casriel 1963), Daytop (Sugarman 1974), and Phoenix House (Rosenthal & Biase 1972). The ex-

addict self-help TC has become widely accepted as a legitimate and effective treatment approach for drug addiction and other anti-social problems.

Community TCs are usually situated in large private homes that hold 15 to 100 residents (average is 40). The staff primarily consists of ex-addicts and a limited number of professionals. Typical length of stay is 9 to 18 months, although dropout rates are high. A central dimension of treatment is resident involvement in all aspects of the facility's operations, including administration, maintenance, and food preparation. To enhance a sense of self-reliance within the community, as well as minimize costs, outside workers are rarely used.

Drug addiction, considered a symptom of immaturity, suggests that the individual is unable to postpone gratification or tolerate frustration, has difficulty maintaining stable relationships, and fails to take responsibility for his/her own life. The concept-based TC seeks to address these problems by setting several therapeutic goals for participants. Among these are: either a decline in or abstinence from substance abuse, termination of criminal behavior, employment and/or school enrollment, and successful social adjustment (e.g., establishment of positive, stable relationships).

There is a hierarchical structure to the organization of concept-based TCs. At the top of the hierarchy, a charismatic leader commands the respect of staff and residents. As former addicts, these leaders are important role models for all participants. The concept of the credible role model who has demonstrated the efficacy of the treatment by his/her own personal achievement is a major program component.

All staff and resident roles are aligned in hierarchical fashion and there is an explicit chain of command. New residents are assigned to work teams with the lowest status, and are responsible for the most menial maintenance tasks (e.g., cleaning toilets). As residents demonstrate increased competency and emotional growth, they are moved up the hierarchy, earning positions with improved status and privileges. These rewards are highly reinforcing. Success within the TC requires surrendering to healthy authority and developing a new set of expectations for moving into positions of power.

As in all other TCs ' group meetings are central to house operations and treatment. A typical day begins with a morning meeting which covers

program and individual announcements, criticisms for improper behavior ("pull-ups" and "image breakers"), and morale building exercises (e.g., comedy routines and/or singing). General meetings are periodically called by staff to "tighten-up" house operations and confront residents on sloppy work habits and poor attitudes.

The primary therapy sessions are encounter groups, held two or three times a week. These groups are intense confrontational sessions geared to destroy defenses, and disturb residents with comments on their "dope fiend" mentality and immature behavior. The encounter also provides opportunities to share helpful information on how to make the positive changes needed to become successful in the TC. Residents are expected to contain normal emotional reactions in everyday situations until the next encounter session.

Efforts are made to inspire residents to higher levels of competency by constantly providing new challenges. For example, TC staff are quite artful in sensing when a resident is becoming too comfortable in a job function. The staff member then proceeds to institute a job change, much to the annoyance of the resident. Also, through the encounter sessions, residents learn to develop appropriate levels of tolerance, effective ways of handling frustration and stress, and appropriate ways of expressing their feelings. During encounters, residents share feelings and the intimate details of their lives, which help strengthen bonds between residents and staff. These bonds are important as residents endure the painful process of successful rehabilitation.

Regular group sessions are supplemented with special "marathons" -- extended groups that last from 24 to 48 hours. Generally held periodically, these sessions are viewed with a mixture of awe, trepidation, and hopeful expectation. Many consider these sessions important spiritual events which transform the lives of participants.

Residents and staff have recalled profound emotional experiences and in sights long after the completion of a marathon.

The emotional experiences that occur in encounters and marathons tend to open up the deeper conflicts and problems that inhibit maturation. These deeper issues are attended to in a variety of ways. Individual counseling provides members with opportunities to work through these important issues. Advanced groups, called "tutorials," are comprised of residents who have been in the program longer and the more clinically astute staff members.

Educational seminars are a major part of the TC program. These groups are held several times a week and are used to disseminate information on current events and select topics. Topics range from philosophical ideas to the meaning of psychological concepts. Other group sessions include orientation groups for new members and groups that prepare older residents for re-entry into society.

There are several basic requirements for successful outcomes within the concept-based TC. A primary condition is the acceptance of the "act as if" concept, which requires that new residents suspend judgment and make believe that they accept the basic TC values and rules of conduct. The resident continues to "act as if" until the positive community values and attitudes become internalized. Maturity develops as specific roles and responsibilities are undertaken. The hierarchical character of the TC facilitates the working through of authority problems, which prepares residents to accept appropriate authority and to assume responsible roles within society. The intense TC atmosphere provides a blend of confrontation and support that enables residents to undergo the arduous changes necessary for successful rehabilitation. Open discussion and the sharing of intimate experiences helps develop the skills necessary for positive and stable relationships. Finally, many efforts are made to connect residents to the external community during the latter phases of treatment. Many of the relationships formed with peers in the TC extend into the community and provide ongoing support after program completion.

Empirical study of TC Components

Important empirical work has begun aimed at identifying essential TC components that are common to most modern community TCs (DeLeon, Melnick and Zingaro, 1993). A panel of recognized TC experts that included clinicians, researchers and program administrators agreed on 27 program essential elements common to all TCs in six areas: "TC Perspective;" "The Agency: Treatment Approach and Structure;" "Community as "Therapeutic Agent;" "Educational and Work Activities," Formal Therapeutic Elements"; and, "Process." Many of the elements identified by De Leon, et. al. are included in the description of the concept-based TC presented above.

### **TCS Modified for Prisons**

Therapeutic Communities and prisons are highly structured organizations that assert great control over their participants. These similarities provide a basis of understanding and cooperation between both organizations. However, the first requirement for the successful implementation of a credible TC is the understanding and full acceptance by program management that the TC is a "guest" of corrections, and that while treatment is highly important it is secondary to security. On the other hand, the effectiveness of a prison TC is also related to the degree that the program can maintain reasonable autonomy and commitment to supporting the growth of its members as contrasted with the usual coercive nature of prisons with their limited emphasis on "doing time" and simple custody concerns.

#### Implementing TCs in Prison

The arduous process of establishing the pioneering Stay'n Out TC in a difficult correctional environment is described by Wexler and Williams (1986). An analysis of effective drug treatment programs implemented in prison (Wexler 1994) suggested the following central features which contributed to their success: (1) treatment approach based on a clear and consistent treatment philosophy; (2) establishment of an atmosphere of empathy and physical safety; (3) recruitment and retention of qualified and committed treatment staff; (4) specification of clear and unambiguous rules of conduct; (5) employment of ex-offenders and ex-addicts as role models, staff, and volunteers- (6) use of peer role models and peer pressure; (7) inclusion of a relapse prevention component; (8) establishment of continuity of care from treatment to community aftercare; (9) integration of treatment

evaluations into the design of the program; and (10) maintenance of treatment program integrity, autonomy, flexibility, and openness.

There are a number of important factors to consider when designing residential treatment in prisons. A comprehensive handbook which offers guidance for the many steps of planning and implementing residential drug treatment has been produced by the Center for Substance Abuse Treatment (Wexler 1993). A few of the key considerations are presented below.

- It is important to isolate a residential program from the rest of the prison population to diminish the highly negative influence of untreated inmates and to develop a healthy atmosphere.
- Independent contractors who have a history of successfully operating programs have the greatest likelihood of developing effective prison programs. It is especially important that external program operators maintain ongoing communication with security staff.
- Adequate time in program is necessary to produce meaningful results. The literature shows that 9 to 12 months is a minimum duration needed to produce reductions in recidivism.
- The cost of implementing residential programs in prison is relatively economical since the costs of housing are already -covered by corrections; the major additional program cost is for personnel. The annual cost per treatment bed is approximately \$5,000.

### Similarities and Differences Between Stay'n Out and Amity Prison TCs

The Stay'n Out prison TC and the Amity TC at Donovan prison represent two variants of the TC model adapted for prisons. (See E\Wexler & Williams 1986 for a description of Stay'n Out and Wexler & Graham 1992 for a description of Amity at Donovan prison.) These prison TCs have received considerable attention because they have participated in large scale NIDA funded evaluations. Both TCs have been able to successfully operate in correctional environments, demonstrate successful outcomes and they share the same basic TC components. However, they also differ in the emphasis they place on specific program components.

Both programs have isolated treatment areas segregated from the general prison population who are usually negative to authority and anti-treatment. Duration of program participation is approximately one year. Stay'n Out male resident capacity is 140 and Amity is 200. The staff of each program is comprised primarily of ex-addicts/felons who serve as credible role models that residents can trust and accept as teachers. Participation in the prison TC community is essential to treatment and staff and residents refer to each other as family. The programs have three basic phases including orientation, treatment and re-entry (they use somewhat different names). The programs are clearly structured which some form of staff and resident hierarchy, status levels that residents can earn and daily schedules of group, work and community activities. Rules and expectations are clearly specified during orientation and both positive and negative consequences are provided when deserved. Both behaviors and feelings are examined in groups and self disclosure is expected from residents and staff. In general most of the aspects of the concept-based TC described above are present to some degree in each prison program.

The Stay'n Out and Amity programs have associated community TCs for those residents that choose to continue treatment after release from prison. Both programs provide training and consultation for other prison drug programs and have recently opened prison TCs in Texas.

The major differences in emphasis between the programs concerns the relative importance of community hierarchy, self disclosure, degree of staff participation in the community, and utilization of structured program curriculum.

While both programs have structure Stay'n Out depends more on the structure for authority and some of residential growth is related to movement up the hierarchical program structure. Amity, on the other hand, maintains a minimum hierarchical necessary for program operations and uses the analogy of the circle which emphasizes equality and inclusion. While the Stay'n Out staff talk about themselves in group the focus of most groups are behavioral change. In contrast, Amity groups often explore some of the most emotionally painful issues (e.g., molestation, rape, and physical abuse) and staff openly share related experiences. The Amity staff live in a staff house which is unique for prison TCs. This living arrangement provides ongoing

support for program staff who are at varying points of their own recovery and strengthens their TC values outside of prison.

There is relatively little formal curriculum in TCs because program information is communicated verbally. The preference for verbal communication is part of a rich oral tradition. The reliance on verbal communication is more comfortable for ex-addicts/felons since they usually have limited formal education. Amity has broken new ground by initiating the development of a formal TC curriculum which is becoming an essential program component. The curriculum which includes workbooks, teachers guides and video tapes focus on such topics as: “Basic Assumptions of a Teaching and Therapeutic Community”, “The Therapeutic Community as a School for Moral Development,” and “Violence.”

An Amity produced description of the unit on “Violence” will illustrate the scope and depth of the curriculum:

“This workbook helps each participant define violence and identify violence that they have witnessed, participated in, or were victim of. Participants will understand how their experience with violence has shaped their behavior and thinking. The workbook helps participants realize how violence can sometimes be used, not only as an outlet for feelings, but as a negative bonding system. The teacher’s guide lists many popular video tapes that can be used to show how violent imagery pervades out culture.”

### Other Prison TCs

Other types of TC deserve mention as well as a new TC model that includes work release. A significant advance in prison TC treatment has been achieved by Inciardi and his colleges in Delaware (Inciardi & Lockwood, in press). Although the Stay’n Out and Amity TCs has aftercare TCs in the community the Delaware group has introduced the first in-prison work release TC. A three stage model has been developed which includes a primary stage in-prison work release TC (Crest Outreach Center), followed by an outpatient aftercare third stage comprised of one-on-one and group counseling. Early outcomes indicate that this model is effective in reducing rates of recidivism.

The Cornerstone TC in Oregon (Field 1989,1984) has many components of the concept TC except it includes the criminal thinking approach (Samenow 1984) as a main part of the treatment. There is less emphasis on hierarchical structure, community involvement and self disclosure. This model has demonstrated success outcomes and should be considered when planning new prison TCs. As reported above, the Cornerstone TC has demonstrated significant reductions in recidivism.

### **Recommendations for Expanding and Improving Prison TC Effectiveness**

Within the past few years, there has been a growing support for expanding and improving substance abuse treatment in the correctional system. For example, a set of recommendations were generated by a panel of national leaders, policy makers, and practitioners who represented the fields of corrections, social services, and substance abuse at a CSAT conference in July 1992 (Wexler, 1993). Some of the more important recommendations addressed: clarifying the correctional mission in respect to drug treatment; expanding drug treatment to include literacy, numeracy, vocational preparation, problem-solving skills, life skills, and mental health; and implementation of an intensive substance abuse TC in every federal prison and state prison system. These recommendations were similar to those produced by other groups (American Bar Association, 1992; American College of Physicians, National Commission on Health Care, and American Correctional Health Services Association, 1992; and the, National Institute on Drug Abuse, Leukefeld and Tims, 1992).

### A New Direction for Prison TC Research and Treatment

The issue of comorbidity is receiving considerable attention from policy makers interested in expanding and improving substance abuse treatment. Recent studies of adult prison inmates participating in a drug treatment TC indicate that the most prevalent diagnoses comorbid with substance abuse are antisocial personality (ASP) and attention-deficit/hyperactivity disorder (ADHD). ADHD is a learning disability (LD) characterized by distractibility, impulsiveness and hyperactivity. The DSM IV (1994) identifies "ADHD, predominantly inattentive type" and "ADHD, predominantly hyperactive-impulsive type" as well as "ADHD, combined type." As part of the

evaluation of the Amity TC at Donovan, Wexler and Graham (1993) reported a 51% incidence of ASP, and Wexler (1994) reported a 42% incidence of ADHD. Several recent literature reviews have indicated strong linkages between ADHD, substance abuse and criminality as well as ADHD and ASP.

The TC has consistently demonstrated success with substance abusers who are also antisocial personalities. The use of credible ex-addict/offender role models and emphasis on basic personality change and values training is well suited for socializing ASP individuals. Adult attention deficit disorder is rarely considered in the substance abuse treatment or correctional communities because it is only recently that adult ADHD has been recognized by educators and mental health practitioners.

It is quite possible that if the comorbid conditions of ADHD (and other learning disorders) and ASP are addressed as part of prison TC treatment, greater reductions in recidivism might be achieved. The following recommendations are offered:

1. Conduct a systematic exploration of the incidence and relationships between ADHD, ASP, and substance abuse among criminal justice clients.
2. Explore the integration of self help/TC models with ADHD psychopharmacological and cognitive approaches for the treatment of substance abusers who are ADHD and suffer from other LDs. (Carefully introduce ADHD psychopharmacological treatments into traditionally drug free TC programs.)
3. Create a National Task Force on Substance abuse, ADHD and Crime consisting of representatives from concerned professional groups who are charged with collecting and disseminating information to the field.

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