# BARRIERS TO IMPLEMENTING EFFECTIVE CORRECTIONAL DRUG TREATMENT PROGRAMS

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*During the past several years, a number of aggressive federal and state initiatives have been undertaken to expand substance abuse treatment within correctional settings. These efforts have been fueled by the high rates of substance involvement among offenders and the growing body of research literature suggesting that intensive, prison-based treatment efforts can significantly reduce postprison substance use and recidivism. However, the rapid expansion of these programs increases their vulnerability to common implementation problems that could lead to pessimistic, and erroneous, assumptions about their effectiveness. This article summarizes both the research literature and the experiences of the authors regarding six common barriers to developing effective correctional treatment programs and offers potential solutions for each.*

Primarily as a result of increased vigilance and mandatory sentences, state and federal criminal justice systems in the United States have witnessed substantial growth in the proportions of their populations who are serving time for drug-specific or drug-related crimes. From 1980 to 1995, drug law violators

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accounted for 30% of the increase in the state prison population and 68% of the increase in the federal population (Department of Justice, Federal Bureau of Prisons, 1997). Moreover, according to a recent analysis of state, federal, and local inmate surveys, approximately 80% of state and federal inmates either committed drug offenses, were under the influence of drugs or alcohol at the time of their crime, committed their crime to support their drug use, or had histories of problematic substance use (Center on Addiction and Substance Abuse, 1998).

In response to this trend, the 1994 Violent Crime Control and Law Enforcement Act amended Title I of the Omnibus Crime Control and Safe Streets Act (1968) by appropriating $63 million in fiscal year 1998 and $72 million in fiscal years 1999 and 2000 to expand the capacity for residential substance abuse treatment for state prisoners. These increases in federal funding parallel a number of state-based initiatives to provide substance abuse treatment for the growing number of drug-involved offenders under correctional supervision.

These aggressive initiatives are based on the assumption that prison-based substance abuse treatment effectively reduces substance use and, in turn, postrelease criminality. Although there is some empirical evidence supporting this assumption (Field, 1989; Inciardi, Martin, Butzin, Hooper, & Harrison, 1997; Knight, Simpson, Chatham, & Camacho, 1997; Prendergast, Wellisch, & Wong, 1996; Wexler, Falkin, Lipton, & Rosenblum, 1992), these findings generally represent well-funded, stable programs that have benefited from formative process evaluations and/or technical assistance efforts. It is unlikely that most of the newly activated programs will be implemented under such controlled and supportive conditions. Thus, along with the rapid expansion of correctional treatment programs in the United States comes an increased threat to the fidelity of their implementation and a consequent decrease in their ability to meet expectations for reductions in recidivism and drug use.

This article summarizes the research literature and the experiences of the authors regarding six common barriers to developing effective treatment programs in correctional settings. Although not an exhaustive account of the problems likely to be encountered by new prison programs, these six barriers are particularly important to consider during program planning and early implementation.

## BARRIERS AND PROPOSED SOLUTIONS

The barriers identified below were reached by consensus of the authors, based on their observations of prison-based programs they have evaluated. Although many of these potential problems must be handled creatively within the context of each specific program, we have included recommendations for addressing these barriers that have demonstrated some success in our own experience. The barriers to be discussed relate to (a) client identification, assessment, and referral; (b) recruitment and training of treatment staff; (c) redeployment of correctional staff; (d) over reliance on institutional versus therapeutic sanctions; (e) aftercare; and (f) coercion.

### CLIENT IDENTIFICATION, ASSESSMENT, AND REFERRAL

There is a tendency for criminal justice systems to use limited criteria (e.g., any lifetime drug use, possession drug sales, trafficking) to determine the need for treatment. This is particularly common for large programs that struggle to maintain their funded capacity. At the same time, many otherwise appropriate treatment candidates are excluded from participating in treatment for reasons unrelated to their substance abuse problems, such as having a prison gang affiliation, having committed a sex or violent offense, or because they are already providing valuable operational support (e.g., clerical tasks, cooking, cleaning) at another institution.

The use of broad definitions of substance abuse, combined with a host of non drug-related filters, can result in a large proportion of the treatment population low in substance abuse severity. There is also a tendency for institutions to send problematic inmates to new programs at other institutions, regardless of their treatment need; this is sometimes referred to as inmate "dumping." As a result, the development of a stable, treatment-oriented environment is often delayed until a critical mass of appropriate residents is referred to the program.

According to a large-scale evaluation of the Treatment Alternatives for Safe Communities (TASC; formerly Treatment Alternatives to Street Crime) programs, TASC referrals with the lowest problem severity demonstrated the least improvement overall-most likely due to their restricted range for improvement. In contrast, substance abuse treatment (as delivered by the

TASC model) appeared to have more favorable effects on "hard core" TASC referrals, as defined by high levels of baseline drug use prior to TASC involvement (Anglin et al., 1996). Although we are not aware of a similar analysis for incarcerated substance abuse treatment clients, it is worth noting that the substantial reductions in recidivism reported by Wexler, De Leon, Thomas, Kressel, and Peters (1999) were among more criminally involved inmates than those comprising the samples of other major therapeutic community (TC) studies (e.g., Inciardi et al., 1997; Knight et al., 1997). More generally, treatment type and level should be matched with the needs of the clients.

Unfortunately, the literature regarding the criteria for patient-treatment matching has yet to provide much guidance beyond the need to place those with more severe substance use problems in more intensive, structured programs (Andrews & Bonta, 1994; Thorton, Gottheil, Weinstein, & Kerachsky, 1998). The importance of targeting treatment efforts toward the most serious offenders is further underscored by criminal career research indicating that the majority of crimes are committed by a small proportion of criminals (Holden, 1986).

One promising strategy to avoid inappropriate referrals from other institutions is to target recruiting efforts at the program's host institution, rather than soliciting referrals system-wide. Wardens presiding over both general population and treatment yards at a single institution will be less concerned with transferring desirable inmates within their own institution than sending them elsewhere.

This approach raises another important issue regarding program size. Establishing treatment programs that serve local institutions, rather than using large facilities to receive statewide referrals, requires an increase in the number of programs and a decrease in their size. Not only does this approach circumvent some of the problems related to recruitment and referrals, but it also increases the likelihood that programs will be more manageable and focused in their implementation.

Regardless of whether participants are recruited locally or system-wide, treatment staff must be involved in the selection of new admissions to ensure the appropriateness of the program population. Providers need to actively

recruit participants from the general inmate population to avoid populating their programs with less appropriate inmates due to the pressure to fill beds.

## RECRUITMENT AND TRAINING OF TREATMENT STAFF

Prison-based treatment settings can pose two unique problems that affect the hiring and training of effective treatment staff. First, it is difficult to locate and recruit qualified and experienced staff in the remote areas where prisons are typically built. Second, counselors who are well suited for community-based treatment programs will not necessarily be effective in the prison setting. In particular, problems related to over familiarization and resistance to rigid custody regulations are common among treatment providers who lack experience in criminal justice settings (Palumbo & Hallett, 1993).

New prisons often. provide economic salvation for impoverished rural communities (Schlosser, 1998). This fact, combined with the lower cost of land, has prompted the widespread development of prisons in remote areas. As a result, a number of operational challenges have arisen-most notably, locating and hiring local individuals with prior training and/or experience in the treatment modality being offered. Limited human resources and typically high turnover rates for drug abuse treatment counselors make staffing a perennial problem for prison-based treatment administrators. Often, the number of potential candidates is further reduced by the limited acceptability of employing recovering drug users as counselors. More experienced criminal justice treatment programs have come to recognize the potentially powerful role recovering users can play, given that they have demonstrated at least 2 years of abstinence.

Adding to the complexity of this problem are the unique environmental constraints associated with prison treatment programs. Common elements of traditional drug abuse counseling approaches, such as mutual self-disclosure between counselor and client, are limited in prison. Consequently, even experienced community-based counselors must learn to adjust their counseling styles to be effective in this environment.

The most obvious way to overcome the barriers associated with recruiting staff in remote areas is to offer sufficient wages to induce counselors to move and stay. Wages for substance abuse counselors are traditionally low-a problem commonly cited to account for their substantial turnover in

community-based programs (Gustafson, 1991). Given the relocation issues and the stressful working conditions of prison-based treatment programs, prison-based providers should plan to allocate more of their budgets for staff wages than they would for a similar program based in the community.

A strategy for reducing the stress and workload of prison-based treatment staff is to recruit and train "lifers" as inmate counselors and mentors. In general, recovering inmates carry substantial credibility on the yard. Moreover, lifers who are well trained in the program philosophy can assist in carrying out basic program duties, enhance program continuity in spite of shift changes and turnover among staff, and serve as credible examples for other inmates (Graham & Wexler, 1997). All of this can occur at little or no additional cost to the provider.

Regarding the problem of the conflicting goals of correctional and treatment staff, cross-training should be a core component of staff orientation. Without integrated training for these groups, custody goals will eventually eclipse treatment goals (Morrissey, Steadman, & Kilburn, 1983). All treatment staff and program-involved correctional officers should be required to attend crosstraining so that the goals of both groups can be clearly stated and compromises can be reached. Often, both groups falsely assume that treatment and control are mutually exclusive when, in reality, both can be achieved simultaneously (Leukefeld, Gallego, & Farabee, 1997).

## REDEPLOYMENT OF CORRECTIONAL STAFF

Evaluations of community-based offender treatment programs suggest that staff turnover underminds program stability and effectiveness (Harland, Warren, & Brown, 1979; Petersilia, 1990). Turnover appears to be especially destructive when it occurs among senior staff and in newer programs.

Although turnover among correctional staff is not unique to prison-based treatment pro grams, the fact that it occurs by design is unique. Professional advancement typically requires that correctional officers be frequently transferred to different yards or institutions. Consequently, this lack of continuity affects the stability of the treatment environment.

One approach to this problem is to institutionalize stability, rather than allowing policies to be contingent on the management style of individual yard

captains. Obviously, this requires that correctional and treatment staff work closely together prior to and during program activation to develop a written set of standards to guide the more subjective elements of the program. For example, staffs need to decide when inmate noncompliance merits an institutional versus a therapeutic response. How closely should treatment and correctional staff work together? To what extent can correctional officers be involved in the treatment process? To what extent should treatment staff be allowed to carry out correctional duties?

Another strategy for maintaining continuity among correctional staff is to professionalize treatment positions for correctional officers. Although a dual emphasis on security and treatment goals can lead to inadequate performance of both, it is important that correctional officers on treatment yards have a basic understanding of the nature of addiction and the program philosophy. Certification and financial incentives for correctional officers who have a given number of hours of cross-training and on-the-job experience with substance abuse treatment programs would help, both to retain staff, and to enhance their professional development and appropriateness for the treatment setting.

## OVERRELIANCE ON INSTITUTIONAL VERSUS THERAPEUTIC SANCTIONS

Most substance abuse treatment programs rely on peer influence and the overall treatment culture to shape clients' behavior. Perhaps the most exemplary of these is the TC that emphasizes the community-as-method approach (De Leon, 1995). An inmate who is acting out or is not contributing to the community is confronted in peer encounter groups and encouraged to change. Those who do not will be alienated from the community and will not progress through the program hierarchy.

These types of sanctions and reinforcers are considered to be critical elements of the social learning process that is central to the TC model. However, within the prison setting, program noncompliance is often met with a correctional-rather than a therapeutic-response. Understandably, staff working in the stressful and conflictive prison environment are often seduced by the immediacy of issuing formal disciplinary sanctions rather than relying on the therapeutic process itself.

Conversely, correctional treatment providers must also be able to invoke institutional sanctions (whether directly or through correctional staff) with minimal delay. The importance of close criminal justice-provider ties was demonstrated in the federally funded Narcotic Addiction Rehabilitation Act (NARA) of 1966, which provided addiction treatment for drug offenders through the U.S. Public Health Service hospitals in Lexington, Kentucky, and Fort Worth, Texas. One of the most significant barriers to the successful implementation of these programs was the providers lack of authority to issue sanctions for noncompliance (Anglin & Hser, 1991). Programs must be able to remove inmates who persistently violate rules or threaten other participants. The ability to remove non-compliant inmates is a critical component of the program's authority and integrity.

Enhanced awareness and cooperation between treatment and security staff are the most effective means for overcoming this problem. The conditions for imposing either therapeutic or institutional sanctions should be clearly delineated in the course of clinical training for new counselors, which should include case studies and practice sessions. As an ongoing assurance, program administrators (or program evaluators) should monitor the mean monthly proportions of serious versus administrative violations on the treatment and a comparable non-treatment yard. Relative to the non-treatment yard, the treatment yard should have lower overall rates of infractions. Moreover, the proportion of serious infractions should be higher for the treatment than the non-treatment yard, if lower-level infractions are indeed being addressed with therapeutic responses from fellow residents or treatment staff.

## AFTERCARE

Although few clinicians or researchers would challenge the importance of providing aftercare services to parolees, several elements in the criminal justice system temper their effectiveness. First, because many prison-based treatment clients enter treatment involuntarily, only a minority volunteer to continue with these services once they are no longer required to do so, and even if they do enter a program, they may leave early. For example, of the female inmates paroling from a prison-based program to a residential program in the community, more than one third dropped out within the first month and more than half failed to remain in aftercare long enough to receive any lasting benefit (i.e., at least 3 months) (Prendergast et al., 1996). Second, many community-based providers are reluctant to admit parolees-particularly those

with violent or sex offender statuses. And third, there is limited control over the type and quality of treatment available in a parolee's county of residence, making it difficult to ensure a continuum of care consistent with their in-prison treatment model.

Low rates of aftercare attendance and/or retention can seriously diminish the impact of prison-based treatment. There is increased evidence that the prison-based component of treatment may serve primarily as an orientation or transitional phase to the community-based component. In fact, one recent evaluation revealed that inmates participating in prison treatment only (i.e., without aftercare) tend to have similar long-term post-treatment outcomes as those receiving no treatment at all (Lowe, Wexler, & Peters, 1998).

The low rates of parolees who continue into aftercare may be symptomatic of the over-reliance on institutional control. As mentioned above, the effectiveness of institutional control in managing inmate behavior can lead to an underestimation of the importance of internal motivation. As a result, once the institutional controls are removed (i.e., the inmate is paroled), the parolee is unlikely to voluntarily enter aftercare. This may pose one of the greatest threats to the measured effectiveness of prison-based substance abuse treatment. Efforts to strengthen clients' engagement with the program (e.g., providing more individual sessions during the initial phases of treatment, demonstrating success of previous program graduates, motivational interviewing [Miller, 1989]) should be incorporated as basic elements of the prison treatment program. Likewise, because the provision of aftercare services requires coordination between the prison-based provider, the community provider, and parole, the emphasis on postrelease treatment participation should begin at least 3 months prior to the inmates' parole release date.

Efforts to increase treatment engagement can be further enhanced by offering external motivators for aftercare participation. An example of this would be to offer inmates early release from prison with residential aftercare required as a condition of parole. This condition should also stipulate frequent, random urine testing and close parole supervision. Another possible incentive would be to offer court-ordered classes (e.g., spousal abuse, victim awareness) as part of the aftercare treatment programs. In both cases, however, it should be noted that community supervision functions primarily to

hold clients in treatment until intrinsic motivational and engagement factors can be sufficiently addressed.

As mentioned above, many community-based treatment providers are reluctant to admit criminal justice referrals. This is particularly true for offenders with violent or sex offense histories. Still, criminal justice clients account for more than 40% of outpatient, drug-free treatment admissions and nearly one third of the admissions to long-term residential programs (Craddock, Rounds-Bryant, Flynn, & Hubbard, 1997). Thus, in spite of their stigma among community-based providers, criminal justice referrals are a reality of the publicly funded treatment system.

With the expansion of prison-based programs, however, many states will likely begin to encounter difficulties in placing parolees in aftercare. Limited availability, combined with provider reluctance to serve this population, pose serious threats to the long-term effectiveness of correctional treatment programs. One possible solution to this problem is to establish community-based treatment centers designated specifically for parolees. Not only can this approach address the problem of capacity, it also circumvents the problems (whether real or perceived) associated with integrating criminal justice and noncriminal justice clients in community treatment programs.

## COERCION

Although not all participants in corrections-based treatment are involuntary, coercion undoubtedly plays a role in most prison treatment admissions. Much of the growth in criminal justice treatment is based on the widely accepted dictum that involuntary substance abuse clients tend to do as well as, or better than, voluntary clients (Leukefeld & Tims, 1988; Simpson & Friend, 1988). Although it has been demonstrated that clients referred to community-based treatment through the criminal justice system remain in treatment longer than those not referred by the criminal justice system (Collins & Allison, 1983; Leukefeld, 1978), the long-term implications of external versus internal motivation as they relate to treatment outcomes are still unclear (Gerstein & Harwood, 1990).

Unfortunately, the research literature regarding the effectiveness of coerced substance abuse treatment offers little guidance in this regard. A recent review of the coerced treatment literature revealed considerable variation in

findings, most of which could be attributed to inconsistent methodologies, including different program types, different outcome measures, and various measures of legal involvement or coercion (Farabee, Prendergast, & Anglin, 1998). Furthermore, none of these studies assessed the clients' perception of coerced or voluntary status. Rather, involuntary status was typically inferred from the client's criminal justice status at the time of treatment admission. As a result, there are few data available comparing treatment outcomes of involuntary and voluntary clients in the criminal justice system.

A number of studies have demonstrated the importance of the early phases of treatment as they relate to client motivation for change and willingness to engage in the treatment process. In community-based treatment, increasing the number of individual counseling sessions during the first month of treatment has been shown to significantly improve client retention (De Leon, 1991). Clearly, given the higher proportions of involuntary clients in correctional treatment programs, the initial phase of treatment must emphasize problem recognition and willingness to change before introducing the tools to do so.

There is also compelling evidence in the cognitive psychological literature that the stress associated with the loss of control or freedom (e.g., legal coercion into treatment) can be significantly reduced by providing the client informational control (Monahan et al., 1995). Informational control refers to the enhanced sense of personal control a person experiences when he or she is given specific information (e.g., description of the timeline and procedures, the normal feelings that people typically experience in these conditions) regarding an upcoming stressful event. According to Fiske and Taylor (I 984), the client does not actually have to have control over his or her treatment to gain perceived control. Some clinical gains can be made by simply giving the client a better understanding of the process he or she will undergo.

But the above solutions assume that the clients are entering treatment in-voluntarily. Ideally, the majority of clients referred to prison-based programs (and particularly new programs) should be inmates with at least a modicum of a desire to change their behavior through the assistance of a treatment pro-gram. Unfortunately, many inmates with substance abuse problems are unwilling to volunteer for treatment because of the stigma associated with sub-stance abuse treatment, the additional structure and rules of a treatment

program, the loss of institutional seniority, and reduced job opportunities. Hence, denial is only one of a host of reasons that otherwise eligible clients choose not to enter treatment.

Overcoming these perceived, and often legitimate, barriers requires that programs not only remove disincentives to treat participation, but also incorporate incentives that would be meaningful inducements for their target population. Coercion alone is rarely sufficient. In Gendreau's (1996) review of effective correctional programs, positive reinforcers outnumbered punishers by at least four to one. Possible incentives for treatment participation include early release, improved living quarters, enhanced vocational or employment opportunities, and reduced restrictions on parole.

## CONCLUSION

Program evaluators commonly point out that the means by which a program is implemented is at least as important as the program model itself (Harris & Smith, 1996; Petersilia, 1990). Surely, much of the "nothing works" sentiment of the 1970s and 1980s could have been avoided had prior research included more long-term, well-funded programs that were developed in conjunction with formative process evaluations. The current decade's energetic resurrection of correctional treatment in the United States, al-though commendable, is no less vulnerable to these problems.

Though a number of prison-based treatment programs, particularly therapeutic communities, have shown promise in reducing substance use and recidivism, the extent to which these model programs are being faithfully replicated is not clear. What is clear is that the rapid and poorly planned implementation of correctional treatment programs places these programs at risk of being less effective than the programs after which they were modeled.

Based on our experiences in evaluating prison-based substance abuse treatment programs across the country, we have identified the following six common implementation issues for developing programs: (a) client identification and referral, (b) recruitment and training of treatment staff, (c) redeployment of correctional staff, (d) over-reliance on institutional versus therapeutic sanctions, (e) aftercare, and (f) coercion.

We have suggested solutions for each of these potential implementation barriers, recognizing that the actual solutions will likely be unique to the constraints of a given system. Perhaps more important than our recommended solutions are the problems themselves. By identifying what we have observed to be some of the most pernicious barriers to effective correctional program implementation, we hope to encourage program administrators to consider these potential problems and to work with providers, correctional staff, and policy makers to address these issues prior to program activation. Researchers conducting evaluations of criminal justice treatment programs must also consider these issues in determining program effectiveness.

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