Correctional Treatment: An Effective Model for Change

Abstract

The growth of our nation's prison and jail population in the last decade has been dramatic. Drugs and the problems they cause have overwhelmed the criminal justice system. Increases in the number of individuals convicted of drug-related crimes and violence have jammed the courts and filled correctional institutions beyond capacity. The fact that these offenders constitute a disproportionate number of recidivists who, in turn, are responsible for a relatively large amount of criminal activity within our society makes the need for effective prison drug treatment programs a criminal justice system imperative.

Introduction

The concept of the therapeutic community (or TC as it is commonly called) was pioneered by Dr. Maxwell Jones in England at the end of World War II. It was originally designed as a type of residential treatment for psychiatric patients. In Jones's TC, "the patients, in collaboration with the staff, became active participants in their own therapy and that of other patients, and in the general conduct of the community" (Edwards, Arif, & Jaffe, 1983, p. 148). "It had as its hallmark a democratic sharing of power by all members of the community--staff and patients alike--in decisions which affected no only the running of the community but also the treatment of the patients" (Kennard, 1983, p. 4). Patients became auxiliary therapists, and official hierarchies were replaced by open communication, information sharing, decision making by consensus, and problem solving.

In the late 1950s the concept of a drug-free TC, directed by former addicts, was introduced to substance abusers in the United States. TCs in the United States were designed as a basic treatment for users of illicit drugs, particularly opiate users. The first TC, Synanon, was founded in California by Charles Dedrich in 1958. Dedrich, himself a recovering alcoholic, observed that many alcoholics and addicts were able to maintain long periods of sobriety through the support and communal atmosphere of the residential environment. Growing out of the Alcoholics Anonymous movement, Dedrich's self-help group for drug addicts introduced two new principles to the self-help philosophy: First, "drug addiction was so severe that it required more than weekly meetings; rather, addicts must live together in a supportive climate for months, if not years, to overcome their dependency" (Silverman, 1995, p. 134; Rom-Rymer, 1981). Second, an intensive sort of group therapy (called an encounter group) that had never been tried before was developed to assault the mentality of the drug addict in order to rebuild a healthy personality.

A distinctive feature of Synanon was a confrontational therapeutic orientation that is in many ways the forerunner of what prevails in contemporary TCs: the belief that only former addicts, as therapists, can break through the manipulation, denial, and lying common to the addict. Synanon drew national attention for its success and ultimately became the model for other TCs, such as Day Top Village, Phoenix House, Odyssey House, Delancey Street, and Gateway House, that were being developed throughout the United States (Carroll, 1993, p. 197; Goldberg, 1994, p. 384). By the mid-1970s, more than 2,000 drug treatment programs for addicts and alcoholics could be traced to

Synanon (De Leon & Beschner, 1976).

Public Perceptions and Social Change

Americans have reported increasingly negative attitudes toward drug use. Despite the prevalence of drug use among Americans, the U.S. population has favored eradicating illicit drug use. For the most part, public and private responses to alcohol and drugs in U.S. society have been relatively impotent. These approaches are often riddled with emotional and political biases that deny the real dimensions of the drug problem (Fields, 1992, p. xvii). Attitudes toward drugs and rising public awareness of the drug abuse problem in all sectors of society during the 1970s and 1980s led to national drug treatment strategies for reducing and controlling illicit drug consumption. The strategy reflected "a coordinated plan of attack involving all basic anti-drug initiatives and agencies: the criminal justice system; the drug treatment system; the collection of education, workplace, public awareness, and community-based prevention campaigns; international policies and activities; and efforts to interdict smuggled drugs before they cross the nation's borders" (Carroll, 1993, p. 440). The introduction of public funding made it possible to establish prevention programs for polydrug abusers, juvenile substance abusers, addicted pregnant women, and offenders under criminal justice supervision. Community-based programs such as drug-free schools, community outreach, Alcoholics Anonymous, Narcotics Anonymous, and TCs became a high priority and received substantial support from local and state governments. Many of the programs were connected to the criminal justice system, which initiated a variety of TC-oriented programs within local and state correctional settings.

One in every four inmates is in jail for drugs-related offenses today, compared with about one in every ten inmates jailed for drug offenses ten years ago (Beck & Brien, 1995, p. 51; Bureau of

Justice Statistics, 1997). In the last fifteen years, the prison population in the United States has increased by more than 188 percent; for adult women it has increased by 200 percent (Bureau of Justice Statistics, 1997). By the end of 1997, more than five million men and women were under criminal justice system supervision. Nearly 1.6 million are confined to federal and state prisons. The rest are on probation or parole. With 615 persons incarcerated per 100,000 residents (Bureau of Justice Statistics, 1997), the United States has the highest rate of incarceration of any nation that maintains prison statistics. This increase in the nation's prison population has been fueled largely by increases in the number of individuals accused or convicted of drug offenses. These offenders constitute a disproportionate number of recidivists who, in turn, are responsible for a relatively large amount of criminal activity within society.

The relationship between drug use and crime/violence is compelling. "Individuals who drink alcohol and/or use drugs are significantly more likely to commit crimes, to commit a wider range of crimes, to commit more violent crimes, and to commit more serious crimes than are individuals who neither drink nor use illegal drugs" (Goode, 1993, p. 123). Traditional law enforcement strategies (e.g., apprehension, conviction, and incapacitation) to deal with offenders engaged in drug use and criminal behavior have been relatively impotent. Law enforcement approaches have had limited rehabilitative impact on the nation's offender population. At best, they have been successful in temporarily removing these malefactors from society.

The Bureau of Justice Statistics (1997) reported that 62 percent of all offenders under state correctional supervision and 42 percent of all persons admitted to federal prison had poly-substance abuse problems prior to their incarceration. Arrest data show that a large proportion of offenders had

used alcohol and drugs before the commission of the crime for which they were arrested. In some cities 70 to 80 percent of arrestees tested positive for recent drug use. A vast majority of the offenders were arrested for committing violent crimes. Most of the offenders are disadvantaged minorities, unemployed, uneducated, and poor who have entered into a "revolving door" relationship with the police, courts, and correctional institutions. Returning to crime-ridden environments, the stigma of incarceration, and the lack of social support, the cycle continues. Whatever the case, both "the state and federal correctional systems are reeling under the weight of these offenders" (Durham, 1994, pp. 157-158; Bureau of Justice Statistics, 1997).

Therapeutic Communities in Corrections

The TC culture became a part of corrections in 1962. Modeled after the Synanon program, the first corrections-based TC was established in Nevada State Prison. By 1967 several more corrections-based TCs were established: the Federal Bureau of Prisons facility in Danbury, Connecticut, Green Haven Prison in New York, and New York City's Rikers Island and Hart Island penitentiaries (Bol & Meyboom 1988; Pan, Scarpitti, Inciardi, & Lockwood, 1993).

Prison-based TCs were established in numerous state and federal prisons across the U.S. throughout the 1970s and early '80s. However, many TCs in prisons, along with rehabilitation efforts, were closed as a result of a general shift in society toward greater conservatism, prison crowding, state budget deficits, staff burnout, and changes in prison leadership (Inciardi, 1995, p.

408; Falkin, Wexler, & Lipton, 1990). Critics of penal treatment argued that "relatively-little-works" to rehabilitate criminals (Martinson, 1974). Skepticism about most correctional rehabilitation programs was fueled by the so-called Martinson Report. Published in 1974, Robert Martinson's article titled "What Works? Questions and Answers about Prison Reform," described an assessment of 231 research studies that had been conducted to assess the effectiveness of correctional programs. Martinson's major conclusion "with few and isolated exceptions, the rehabilitative efforts that have been reported so far have had not appreciable effect on recidivism" (pp. 22-45), became the prevailing attitude on rehabilitation. As a result, "furloughs were out, mandatory incarceration was in; overcrowding endemic, and new, stricter laws guaranteed plenty of prisoners" (McShane & Williams, 1989, p. 567).

Throughout the 1980s American corrections struggled with issues of institutional crowding, rising costs, and controlling offenders' behavior. The "prison population increased dramatically to more than half a million, and the overall prevalence of drug involvement among incarcerated offenders also rose markedly" (Tims & Leukefeld, 1992, p. 1). Despite political rhetoric about getting tough on crime, locking up offenders and "throwing away the key," prison drug treatment began to gain strength in terms of focus, direction, and legitimacy. Its new focus resulted primarily from its relevance and responsiveness to a growing interest by both the public and policy makers in addressing serious or multiple offenders. Of perhaps equal importance is the fact that this interest reflected the impact of the war on drugs on the nation's prisons and jails and the growing volume of crime related to drug use and abuse.

Prison-based treatment is attractive for the treatment and control of those whose criminality is associated with addiction to alcohol and drugs. The prison and jail environment is a suitable setting

for the treatment of our nation's most accessible population of addicts. Contrary to popular belief, treatment programs do have an appreciable effect on the level or reinvolvement in arrest, conviction, or incarceration. Numerous studies have illustrated the efficacy of treatment in reducing post treatment alcohol and drug use (Anglin & McGlothlin, 1988; Coombs, 1981; De Leon, 1984, 1988; De Leon, Wexler, and Jainchill, 1982; Tims, 1981; Wexler, Lipton, & Foster, 1990; Wexler, Early, Williams, and Trotman, 1996; Simpson, 1988). The data show that increased time in treatment resulted in a greater propensity for post treatment success. Many offenders continue their drug treatment in the community after their release. Treatment has shown demonstrable results not only in improving retention, a problem in many community-based programs, but also in improving institutional management of inmates. Finally, prison treatment programs are the foundation on which the offender may continue treatment and support in the community on release.

Throughout the criminal justice system, the demands of housing, overcrowding, and custody for an ever-expanding offender population is the number-one priority. In an attempt to meet this challenge, correctional authorities are developing substantial substance abuse services for offenders in need. This is being done with the recognition that incarceration without intervention will only be a short-term solution to a complex and serious problem. While correctional authorities appreciate the need for treatment programs, few programs throughout the criminal justice system have the institutional backing or necessary resources to develop a substantial track record of achievement.

The goal of prison continues to be both punitive and rehabilitative. Rehabilitation is an important goal of punishment and an appropriate correctional objective. Treatment is rehabilitative

in intent: facilitating the development of a drug-free life-style; reducing drug dependency among offenders, thereby increasing the probability of crime reduction; and helping offenders to successfully reintegrate into society without fear of being labeled and stigmatized. Whether these objectives can be realized may be a matter of debate, but the data on the success rate of offenders participating in prison treatment programs are promising.

War on Drugs: What Price?

It has been nearly two decades since the U.S. declared its "war on drugs". Since then, taxpayers have spent billions of dollars on border interdiction, law enforcement, incarceration, and international supply reduction activities. Despite the impressive increase in law enforcement efforts, America is losing its battle against drugs. The supply of illegal drugs, drug arrests, drugs seizures, and prison sentences for drug dealers are all up. Moreover, federal funds for prevention, treatment, and supply reduction have not reduced the overall availability of drugs, especially cocaine. Neither have they produced significant reductions in drug use. This dilemma clearly points to the need of policymakers and even law enforcement officials to shift the balance of efforts in the direction of prevention and treatment.

Studies of jail and prison inmates show that 72 percent of all inmates reported they used at least one illegal drug regularly (Kish and Masumura, 1983; Baunach, 1985; Innis, 1988; Emshoff, Margolin-Mankoff, & Good, 1990; National Institute of Justice, 1997). Intensive, long term-drug interventions are scarce in prisons and are practically nonexistent in county and state jails. Currently 13 percent of jail inmates receive drug treatment in jail compared to 8.1 percent in 1989 (Bureau of

Justice Statistics, 1991b, 1997). Of the over 1,630,940 men and women confined to federal and state prisons in the United States, 17.1 percent or 277,259 are participating in treatment programs (Camp, C. and Camp, G., 1995, p. 65; Bureau of Justice Statistics, 1997). Although this represents a substantial increase, from 51,500 inmates in 1987, the vast majority of inmates still do not receive treatment while in prison.

Criminal justice sanctions alone cannot be effective in the fight against drug addiction and related crime. Some evidence of this is seen in the high rates of recidivism that result in a "revolving door" for offenders. With new prison space averaging $100,000 per cell (Crouch, B., Alpert, G., Marquart, J., & Haas, K., 1997, p. 75) and the average cost of incarceration costing $25,000 per year, some initiative to prevent reincarceration and repeated criminal activity begins to look more attractive.

TCs Make Sense

The major problem with regard to the rehabilitation of offenders is the paucity of effective prison-based treatment programs. Few people appear to be interested in the seemingly futile task of helping offenders go straight. The prevailing "just desserts" attitude for the treatment of offenders, coupled with a growing public demand for a more punitive criminal justice system, has increased funding for law enforcement and prison construction. As a result of this "brick and mortar" mentality, funding for prison treatment programs has been virtually nonexistent.

Drug and alcohol abuse problems among offenders within the criminal justice system is

extensive. Considering the frequency of these problems among offenders, there is surprisingly little systematic treatment available; 17.1 percent of offenders incarcerated in state prisons and 7.1 percent of offenders in the federal prison system are in drug treatment programs. Both the state and federal prison systems offer several different types of drug abuse programs, such as AA, NA, and TCs. However, there are far fewer programs available than there are offenders who need such services, and the majority of offenders with alcohol and drug abuse problems still do not receive treatment while in prison.

There are several reasons to support the need for offering prison-based TC treatment to offenders under correctional supervision. Prison and jail based TCs are an effective approach in reducing recidivism. The data show that more than 40 percent of TC program completers released from prison have a lower probability of illicit drug use, criminal activity, and rearrest (De Leon, 1989; Field, 1985, 1989; Wexler, Falkin, and Lipton, 1990; Wexler, Williams, Early, and Trotman, 1996). An additional 30 percent improve over their pretreatment status (De Leon, 1989; Wexler, Falkin, and Lipton, 1990; Wexler, Williams, Early, and Trotman, 1996).

Jail and prison TCs are cost effectiveness. While they add between $10 and $18 per day per inmate to incarceration costs, they can, by reducing recidivism rates among drug-abusing felons, reduce health, social, crime-related and drug use-associated costs that add up to billions of dollars over the long term. Resources not diverted to attempts to deal with crime by an ever-increasing rate of incarceration can be diverted to rebuilding the social infrastructure in devastated neighborhoods that disproportionately contribute to the stream of drug users marching into our prisons and jails.

Treatment in correctional settings focusses on the multiple needs of the drug using offender.

"For many offenders, incarceration is the first lengthily period of abstention since initiation of regular

drug use and provides an enforced removal from drug-using peers, family conflict, or other cues that often precipitate drug use" (Peters and May, 1992, p. 38). Moreover, many offenders have educational and vocational deficits which require long-term intensive habilitative interventions to help them develop life skills and drug coping skills for subsequent societal reintegration and involvement in community-based treatment. Correctional drug treatment provides an important opportunity to engage offenders, of which the largest and most accessible population of addicts is in our prisons and jails, in a therapeutic milieu who otherwise would not seek treatment (Wexler, Williams, Early, and Trotman, 1996; Wexler, Lipton, and Johnson, 1988; Peters and May, 1992, p. 38).

Evaluation Studies

There is evidence that prison drug treatment is an effective means of controlling recidivism and prison TCs are appropriate for the treatment of substance abusers while incarcerated. Findings from outcome studies of offenders who have received treatment while incarcerated have rekindled interests in effective prison-based drug treatment programs.

Evaluation and outcome data (Field, 1985, 1989) from the Cornerstone Program, a TC program within the Oregon correctional system, tracked 200 offender program participants for three years prior to their release from prison. The study divided offenders into four groups: program graduates, offenders with more than 6 months in the program, offenders with 2 to 6 months in treatment, and offenders with less than 2 months in treatment. Data were obtained on arrests,

convictions, and incarceration for each of the groups. The research indicate that the length of time in treatment is related to treatment success, that is, improvement in pro-social behaviors, lower rates of arrests, conviction, and incarceration. Field's study indicated that 74 percent of program graduates were not rearrested compared to 37 percent of nongraduates who had spent up to six months in treatment and 15 percent for nongraduates who were in treatment for less than 2 months.

Outcome data from the Stay `N Out, a prison TC in New York State modeled after Phoenix House, demonstrated that prison-based TC treatment could produce significant reductions in recidivism rates for both male and female offenders with histories of drug use (Wexler and Williams, 1986; Wexler, Falkin, and Lipton, 1990). Among the most important results of the Stay 'N Out evaluation study (Table 1) was the finding that male participants experienced a 26.9 percent re-arrest rate during parole versus a 34.6 percent rate for the milieu treatment group, a 39.8 percent rate for the counseling treatment group and a 40.9 percent rate for the no treatment group. Similarly, the percent of TC females rearrested (17.8 percent) was significantly lower than the no-treatment control group (23.7 percent) and counseling group (29.2 percent). When correlated with the length of time in treatment (up to 12 months) the data demonstrated a higher probability of a positive release from parole.

The data indicate that the Stay 'N Out TC was effective in reducing recidivism rate and that the time spent in treatment was positively related to greater periods between rearrest and to a greater probability of positive parole outcome. Men and women spending 9 to 12 months in treatment were three times less likely to become recidivists than those spending less time in the program. The data indicated that 77 percent of male offenders with 9 to 12 months in treatment successfully completed parole compared to 92 percent for their female counterparts.

The Amity prison-based TC at Donovan prison in San Diego and the CREST project in Delaware have prison and community TC components. Both programs are participating in major evaluations funded by the National Institute on Drug Abuse. Preliminary outcome results have shown that the Amity (Wexler & Graham, 1994) and CREST (Inciardi & Lockwood, 1995) programs are producing positive psychological changes, parole outcomes, and significantly reducing recidivism rates.

Conclusion

No one can deny the severity of our nation's criminal justice crisis. Since 1980 the prison population in the United States has tripled. The largest source of growth among inmates in local jails and state and federal prisons was persons arrested for drug law violations. Inmates sentenced for a drug offense accounted for 40 percent of the increase in the prison population from 1979 to 1994 (Bureau of Justice Statistics, 1995). With almost every jail, state, and federal prison system operating at or beyond capacity, it is evident that criminal justice sanctions have not been effective in the war on drugs and the fight against drug-related crime. To complicate matters further, the public's demand for a more punitive criminal justice system has forced state and federal officials to meet public demands that offenders be incarcerated and at the same time control prison overcrowding. In response to public pressure to get tough on crime, most state correctional authorities have met the public outcry by adding more bed space. Other states, "such as Texas, Ohio, and California, have attempted to build enough prison space to meet demand" (Crouch, B., Alpert, G., Marquart, J., &

Haas, K., 1995, p. 75). When we consider that the average cost of crimes committed by each released offender is in access of $430,000 per year (Zedlewski), initiatives to prevent criminality and incarceration become an imperative.

Several reasons to support the need for offering prison-based TC treatment to offenders under correctional supervision have been articulated in this paper. The prevailing belief is that, first, prison-based TC treatment is particularly attractive for the treatment and control of those offenders whose crimogenic behavior is associated with addiction to alcohol and drugs. Second, compared with residential treatment programs in the community, the costs of operating prison-based TC treatment programs are modest. Depending on modality form, length of program participation, and intensity, the average program cost varies between $200 to $4,000 per year per offender (Wexler & Graham, 1994) beyond the ordinary cost of incarceration. Even though this increases the overall cost of incarceration, TC treatment is cost-effective to the degree that it lowers crime and recidivism as well as associated social and criminal justice system costs that add up to billions of dollars in the final analysis. Hence, prison-based TC treatment provides an effective vehicle to prevent offenders from returning to chronic patterns of drug abuse and crime. Third, the data show that correctional treatment programs have demonstrated to be effective in reducing posttreatment drug use (Wexler, Williams, Early, and Trotman, 1996; Anglin & McGlothlin, 1984; Bureau of Justice Assistance, 1988; Hubbard, Rachal, Craddock, & Cavanaugh, 1984; Simpson, 1983; Tims, 1981; Tims & Ludford, 1984; Wexler, H., Lipton, D. and Foster, 1985) and reduces future crimogenic behavior following both prison-based and community-based programs (Anglin & McGlothlin, 1984; De Leon 1985; Gendreau & Ross, 1981; Simpson & Friend, 1988). Evaluation results from the Stay 'N Out Program

in New York (Wexler, Falkin, & Lipton, 1988; Wexler, Williams, Early, and Trotman, 1996) and the Cornerstone program in Oregon (Field, 1984, 1989) provide evidence that prison-based TC treatment could produce reductions in recidivism rates for both male and female offenders. NIDA outcome research results provide further evidence that offenders participating in correctional drug treatment show significant reductions in post-treatment drug abuse, criminality, and recidivism, while simultaneously demonstrating improved parole outcomes, employment, and other pro-social behavior (Wexler, Lipton, & Foster, 1985; Wexler, Falkin, & Lipton, 1988). Other evaluations (De Leon, Wexler, & Jainchill, 1982; De Leon 1984; Field, 1989) indicate that the length of involvement in treatment is inversely related to the likelihood of re-arrest and that prison-based treatment is the most appropriate strategy for treating offenders whose criminogenic behavior and incarceration is related to alcohol and drugs. Finally, despite the temptation of drugs, the prison environment, however inappropriate, is a suitable setting for drug treatment "since a great proportion of American drug users are processed through some part of the criminal justice system during their drug-using careers" (Lipton, Falkin, & Wexler, 1992, p. 11).

Today's offender population presents correctional authorities with a challenge because it comprises individuals who are younger, drug dependent and more prone to violence. Complicating matters further, "massive institutional overcrowding, at both the state and federal levels, has crippled the ability of the penal system to fully pursue its objectives. Drastically rising correctional costs have placed extraordinary restrictions on both the practical and political realities of addressing the crime problem. Public concern and frustration is further exacerbated by the endless upward spiral of resource commitment and the apparent failure of such commitment to provide an adequate solution to crime" (Durham, 1994, p. 170). The dilemma of scarce resources compels us not only to look for

more but also to develop correctional approaches that do not rely primarily on incarceration for the treatment of a growing offender population whose criminogenic behavior is associated with alcohol and drugs. It is evident to many correctional authorities that if drug-related crime is to be reduced, significant progress must be made in weaning offenders away from drug use. Prison-based TC treatment is committed to such an objective. Providing treatment is a part of good incarceration practice; it engages the drug-dependent offender in a rehabilitation process, curtails drug-seeking behavior by the incarcerated population, and ensures that those offenders released from prison can be successfully reintegrated into society.

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Table 1. Parole Outcomes

Comparison Groups	Arrested N	Arrested Percent	Mean Months Until Arrest*	Positive Parole Discharge** N	Positive Parole Discharge** Percent
Male Groups					
TC treatment	117	26.9	13.1	157	58.1
Milieu	198	34.6	11.4	164	52.6
Counseling	104	39.8	12.0	69	52.7
No treatment	65	40.9	15.0	66	60.6
Statistic	Chi-square=17.2		F=2.32		F=3.40
Significance	p<.001		p=.07		NS
Female Groups					
TC treatment	44	17.8	12.4	98	77.2
Counseling	33	29.2	14.6	58	68.2
No treatment	9	23.7	8.6	9	52.9
Statistic	Chi-square=5.37		F=1.03		Chi-square=5.35
Significance	p=.07		NS		p=.07

*Represents amount of time until arrested for offenders who were arrested after their release from prison.

**For parole discharge data, 401 cases are missing for males and 169 cases are missing for females because these subjects had not been discharged by the time the data set was prepared for analysis.

KEY: NS=not significant

Source: Wexler, Falkin, & Lipton, 1990