# Prison-Based Therapeutic Community Substance Abuse Programs—Implementation and Operational Issues

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**SINCE THE 1980s,** attempts to break the cycle of drug use and crime have included providing treatment to substance-abusing offenders at various stages of the criminal justice system, including in prison. Although a variety of approaches to treating substance-abusing inmates have been developed, the therapeutic community (TC) is the treatment modality that has received the most attention from researchers and policy makers.

Therapeutic communities in prisons have several distinctive characteristics: 1) they present an alternative concept of inmates that is usually much more positive than prevailing beliefs; 2) their activities embody positive values, help to promote positive social relationships, and start a process of socialization that encourages a more responsible and productive way of life; 3) their staff, some of whom are recovering addicts and former inmates, provide positive role models; and 4) they provide transition from institutional to community existence, with treatment occurring just prior to release and with continuity of care in the community (Pan, Scarpitti, Inciardi, & Lockwood, 1993). Because prison environments stress security and custody, the designs of prison-based TCs are modified versions of the community-based TC model. However, the goals of prison-based TCs remain the same as community-based TCs, and they are generally designed to operate in much the same way (Inciardi, 1996; Wexler & Love, 1994).

Evaluations of prison-based TC programs that have been conducted in several states and within the federal prison system have provided empirical support for the development of these programs throughout the nation. An early study that had a substantial impact on policy was the evaluation of the "Stay'n Out" prison TC in New York (Wexler, Falkin, Lipton, & Rosenblum, 1992), which found that the TC was more effective than no treatment or other types of less intensive treatment in reducing recidivism, and that longer time in TC treatment was associated with lower recidivism rates after release to parole. The positive findings from this evaluation became the foundation for federal and state initiatives to support the expansion of prison-based TCs during the 1990s.

The Stay'n Out evaluation did not examine the impact of aftercare on outcomes by program graduates following release to parole, but more recent evaluations have assessed the provision of aftercare in connection with other prison-based TCs. These studies have provided consistent evidence that adding aftercare to prison-based TC treatment for graduates paroled into the community significantly improves clients' behavior while under parole supervision (Field, 1984, 1989; Knight, Simpson, & Hiller, 1999; Martin, Butzin, Saum, & Inciardi, 1999; Prendergast, Wellisch, & Wong, 1996; Wexler, Blackmore, & Lipton, 1991; Wexler, De Leon, Kressel, & Peters, 1999; Wexler, Melnick, Lowe, & Peters, 1999) and thus increases the likelihood of positive outcomes (i.e., reduced recidivism and relapse to drug use).

It should be noted that most of these studies did not employ a true experimental design in which study-eligible inmates were randomly assigned to either a treatment or a non-treatment condition. Therefore, it is possible that some of the presumed effects of these programs may have been the result of self-selection bias, that is, systematic differences between inmates who opted for, and remained in, treatment and those who did not. However, a recent evaluation of treatment programs within the Federal Bureau of Prisons found that inmates who had completed treatment in one of the federal prison programs were significantly less likely to relapse to drug use or experience new arrests in the six months following release than were inmates in a comparison group, even after controlling for individual- and system-level selection factors (Pelissier et al., 2000).

## The California Initiative

California has more individuals under correctional supervision (i.e., prison and parole) than any other state (Bureau of Justice Statistics, 2001a,b). As of September 30, 2001, there were 161,497 inmates in California's 33 prisons (California Department of Corrections [CDC], 2001a). Of these, 45,219 (28 percent) were incarcerated for an offense involving drugs, at an annual cost of approximately $1.2 billion (CDC, 2001b). Another 21 percent were incarcerated for a property offense, which in many cases was related to drug use (Lowe, 1995). As of September 30, 2001, there were 119,636 individuals on parole in California. Of these, 38 percent had been incarcerated for a drug offense and 26 percent had been incarcerated for a property offense (CDC, 2001a). Furthermore, according to CDC (2000), 67 percent of the individuals entering the state's prison system in 1999 were parole violators; 55.5 percent of these were returned to custody for a drug-related offense.

In response to the large number of prisoners and parolees with substance abuse problems, and in an attempt to reduce recidivism rates, the California legislature has ap-

propriated approximately $94 million toward the expansion of prison-based substance abuse programs based on the TC model of treatment. As a result, since 1997, the number of prison-based TC beds within the California state prison system has increased from 500 in 3 programs at 3 prisons to 7,650 in 32 programs at 17 institutions. Additional expansions are planned to further increase these numbers to approximately 38 programs providing substance abuse treatment to approximately 9,000 inmates at 19 institutions (CDC, 2001c). The initiative is operated by CDC's Office of Substance Abuse Programs (OSAP). The treatment is provided by contracted treatment providers with experience in TC treatment for correctional populations.

The selection of the TC as the model of treatment for these programs was based largely on the positive results that emerged from the evaluation studies (cited above) of prison-based TCs in other parts of the country and, more specifically, the results of an evaluation of the Amity TC in San Diego, California (Wexler, 1996). Also, as a result of those evaluation findings, the California initiative includes a major aftercare component for graduates from the prison-based TC programs that provides funding for up to six months of continued treatment (residential or outpatient services) in the community following release to parole.

The TC substance abuse programs (SAPs) in the California state prison system provide between 6 and 24 months of treatment at the end of inmates' prison terms. Combined, these programs cover all levels of security classification (Minimum to Maximum) and male and female inmates. With few exceptions, participation in these programs is mandatory for inmates who have a documented history of substance use or abuse (based on a review of inmate files) and who do not meet established exclusionary criteria for entrance into a TC SAP (e.g., documented in-prison gang affiliations, being housed in a Security Housing Unit within the previous 12 months for assault or weapons possession, Immigration and Naturalization Service holds). Also, most of the TC SAPs are not fully separated from the general inmate populations of the institutions within which they are located.[1] Outside of their designated housing unit and the 20 hours per week of programming activities in which they are required to participate, TC SAP inmates remain integrated with the general population inmates of the facility in which they are located.

Inmates who successfully parole from these prison-based TC SAPs have the option of participating in up to six months of continued treatment in the community. Unlike prison-based treatment, participation in aftercare is voluntary, and failure to enter community-based treatment in accordance with the established aftercare plan does not constitute a parole violation.[2]

As part of the ongoing expansion of these prison-based TC SAPs, UCLA Integrated Substance Abuse Programs (ISAP) is conducting process evaluations of 17 of these programs (located in 10 institutions and totaling approximately 4,900 beds). ISAP (previously known as the Drug Abuse Research Center [DARC]) has an extensive background in corrections-based treatment research, including some of the earliest studies done on prison-based treatment of drug-involved offenders (Anglin, 1988; McGlothlin, Anglin, & Wilson, 1977; Hall, Baldwin, & Prendergast, 2001; Hser, Anglin, & Powers, 1993; Hser, Hoffman, Grella, & Anglin, 2001; Prendergast, Hall, Wellisch, & Baldwin, 1999). The main purpose of these process evaluations is to 1) document the goals and objectives of CDC's drug treatment programs and any additional goals and objectives of each provider, 2) assess the degree to which the providers are able to implement these goals and objectives in their programs, 3) determine the degree to which the provider conforms to the therapeutic community model of treatment, and 4) collect descriptive data on SAP participants. The process evaluations use data drawn from program documents; observations of programming activities; interviews with program administrators, treatment and corrections staff, and OSAP personnel; periodic focus groups with treatment staff, custody staff, and inmates assigned to each program; and standardized program assessment instruments. Client-level information is derived from the records of the in-prison treatment providers and from an intake assessment instrument administered by the providers at the time clients enter the TC SAPs.[3]

## Implementation and Operational Issues

The process evaluations have revealed a number of macro-level issues that are relevant to the implementation and ongoing operations of prison-based TC substance abuse treatment programs in general; that is, these issues are not unique to California. The first three issues (collaboration and communication, supportive organizational culture, sufficient resources) represent system-related issues, while the remaining four issues (screening, assessment, and referral; treatment curriculum, incentives and rewards; and coerced treatment) represent treatment-related issues. Many, if not most, states that establish or expand TC substance abuse treatment for inmates face the same, or similar, issues (Farabee et al., 1999; Harrison & Martin, 2000; Moore & Mears, 2001). Thus, these issues will be discussed in terms of their importance as key elements in developing and sustaining effective TC substance abuse treatment programs in correctional environments.

***Collaboration and communication.*** Any initiative that is aimed at implementing and/or expanding substance abuse treatment in a correctional environment represents an effort to bring together two systems (i.e., corrections and treatment) that have conflicting core philosophies regarding substance use and abuse. Correctional systems view drug use as a crime. As such, their goals are based on philosophies of punishment and incarceration. The focus of a correctional system is on the crime that was committed and the sanctions to punish the offender and deter him/her from engaging in subsequent criminal activity. Treatment is secondary. On the other hand, substance abuse treatment systems view drug use as a chronic, but treatable disorder. The focus of the treatment provider is on treating the person for his/her substance abuse problem with the goal of reducing the drug use and improving the mental and physical health of the person (Prendergast & Burdon, 2001). Furthermore, the reality of the relationship between these two systems is that the treatment system operates *within* the correctional system, with the latter typically serving in the role of contractor. As such, the correctional system can be viewed as a "superordinate" system within which the "subordinate" treatment system operates.

This organizational reality, combined with the conflicting philosophies of the two systems, places constraints on what treatment providers are able to accomplish in their attempt to provide effective substance abuse treatment services to inmate populations. Most important, the goals and philosophies of the subordinate treatment system do not have as much influence as those of the superordinate correctional system. Because of this, effective and open communication and collaboration between the two become critical. Both systems need to be committed to

developing and maintaining an inter-organizational "culture of disclosure" (Prendergast & Burdon, 2001). That is, they need to develop a common set of goals and they need to share system-, program-, and client-level information in an atmosphere of openness and mutual understanding and trust. However, it is ultimately incumbent upon the larger controlling superordinate system (i.e., the correctional system) to ensure the presence of an environment within which this level of communication and collaboration can occur. To the extent that this does not occur, the ability of treatment providers to operate prison-based TC SAPs as intended and to create a culture that is conducive to therapeutic change is negatively impacted.

***Supportive organizational culture.*** Developing and sustaining an environment that facilitates and supports effective communication and collaboration among treatment and correctional staff is difficult at best. Most departments of corrections are, by nature, highly bureaucratic organizations that require personnel to operate in accordance with written policy and procedure manuals and/or legislative code. This fact, combined with the underlying philosophies and objectives of correctional systems, supports and reinforces a well-developed and firmly entrenched organizational culture that emphasizes safety, security, and strict conformance to established policies and procedures. For the most part, such an organizational culture does not facilitate or support the presence of a system, such as a substance abuse treatment program, that has different philosophies and objectives. Yet, in order for substance abuse treatment programs to operate with any degree of effectiveness, there must be some degree of meaningful *integration* of the criminal justice and treatment systems. For this to occur, the organizational culture must be altered in a way that facilitates the work of treatment programs, while ensuring the continued safety and security of the inmates, staff, and public. While it is not realistic to expect that treatment programs operating within a correctional environment should be exempt from departmental and institutional policies and procedures, it is also not realistic to expect treatment programs, especially those that are designed as TC treatment programs, to operate effectively in a prison environment that is not designed for and does not support the existence and operation of such programs.

Altering an organizational culture requires time. In a correctional environment, it is also likely to require changes or additions to existing policies, procedures, and possibly even legislative penal code. Most important, however, and given the paramilitary nature of correctional systems, change must be initiated at the top of the organizational hierarchy and directed downward to line staff. Thus, the commitment and continued support of correctional management at both the departmental level (e.g., department director, deputy directors) and institutional level (e.g., wardens, deputy wardens, associate wardens) are required for treatment programs to exist and operate effectively within the prison environment.

To this end, departmental and institutional management can facilitate the successful implementation of treatment programs by issuing regular written and verbal statements of support for them. Also, efforts should be made to incorporate policies and procedures into existing departmental operations manuals and (if necessary) penal code that facilitate the ongoing operation of these programs, while ensuring the continued safety and security of staff (custody and treatment) and inmates. Over time, such efforts may result in a shift in the organizational culture to one characterized by strong support for the presence of substance abuse programs. Without this commitment and support from correctional management and the resulting change in organizational culture, treatment programs will not be able, and should not be expected, to operate at their full potential.

***Sufficient resources.*** As important as open communication and collaboration and the existence of a supportive organizational culture are to the existence and effectiveness of prison-based treatment programs, the continued availability of sufficient resources (primarily financial resources) properly directed at these services is essential to ensuring treatment effectiveness. Indeed, most discussions of the elements of an integrated system of care address the issue of resources (Field, 1998; Greenley, 1992; Rose, Zweben, & Stoffel, 1999; Taxman, 1998). While departments of corrections understandably want to control costs, commitment of insufficient financial resources, especially in the form of funds for salaries, will likely prevent the recruitment and retention of experienced and qualified treatment staff, resulting in persistent staff turnover.

Paying treatment staff salaries that are competitive with the local markets from which they are recruited may not suffice. Even for individuals who have previous experience as substance abuse treatment counselors, working in a prison environment is often a far more stressful experience than they may expect. More often than not, new counselors will have little or no experience working with prisoners or in a prison setting, and many may not even be familiar with the TC model of treatment. Indeed, because of the shortage of experienced staff for prison programs, it is not unusual for the minimum requirements for entry-level counselors in prison-based treatment programs to omit requirements that they be certified to provide substance abuse treatment in a criminal justice setting, or even have any previous experience as a substance abuse treatment counselor. In most cases, these requisites are obtained after the counselors have been hired and have begun working with client populations, generally through organized training and certification courses that they are required to attend within a prescribed period of time. In addition, most (if not all) new counselors are subjected to long periods at the beginning of their employment (usually the first 2–3 months) during which they are "tested" by the inmates and struggle to establish their personal boundaries of interaction. Also, unlike previous experiences that they may have had in substance abuse treatment settings, their counseling methods and interpersonal interactions (both formal and informal) with inmates may be severely restricted and closely watched by both their supervisors and custody staff to ensure that they do not become overfamiliar with the inmates.

In short, many individuals who come to work in prison-based treatment programs are unprepared for the realities of working with inmates in a prison environment. In addition, low pay, combined with a highly stressful working environment, quickly diminish whatever altruistic motivations most counselors had when they were hired. Many of them may fail to develop appropriate boundaries of interaction with SAP participants, "burn-out" within a short period, and end up being terminated or resigning.

The difficulty treatment providers have in recruiting and (more important) retaining experienced counseling staff negatively impacts almost every aspect of a treatment program's operations. Most important, frequent staff turnover prevents inmates from developing therapeutic bonds with counselors and becoming engaged in the treatment process. Sufficient resources in the form of higher pay scales that reflect the uniqueness of working in a correctional environment, higher prerequisites for newly hired treatment

staff (e.g., previous experience working with inmate populations, certification to provide counseling services in a correctional environment), and adequate administrative support for counseling staff are among the keys to minimizing staff turnover. The presence of a stable and experienced treatment staff who are properly supported administratively will, in turn, result in a more stable and consistent treatment curriculum, which will further engage clients in the treatment process.

***Screening, assessment, and referral.*** Therapeutic community treatment is the most intensive form of substance abuse treatment available. It is also the most costly to deliver. In addition, not all substance-abusing offenders are alike in terms of their characteristics or needs. As these characteristics and needs vary, so too do individuals' needs for specific types of substance abuse treatment. Simply put, not all substance-abusing offenders are in need of TC treatment. This clearly demonstrates the need for a scientifically valid and reliable method of identifying substance-abusing offenders, assessing their specific treatment needs, and matching them to an appropriate modality and intensity of treatment.

Given the bureaucratic nature of correctional systems and their philosophical foundations of punishment and incarceration, entrenched organizational cultures, and pressures to conform to existing policies and procedures, many correctional systems may opt instead to identify and assign inmates to treatment programs based on reviews of inmates' criminal files by department personnel for any history of drug use or drug-related criminal activity. Indeed, in correctional systems characterized by a less than supportive organizational culture, decisions to place inmates into treatment programs may be based less on whether they have a substance abuse problem than on other factors relating to such things as institutional management and security concerns. When this occurs, inmates who could or should be placed into these programs (i.e., those with substance abuse disorders) may be *excluded*, whereas inmates who may not be amenable to or appropriate for treatment programs may be *included* (e.g., those who have severe mental illness or are dangerous sex offenders). This, in turn, directly impacts the treatment providers' ability to provide efficient and effective treatment services to those who are most in need of them. Also, inmates with minimal substance abuse involvement may be referred to intensive TC treatment, which they may not need. The use of a scientifically valid and reliable method of screening inmates for substance abuse problems and assessing their specific needs will aid in ensuring that each inmate is referred to the proper modality and intensity of treatment. This will further enhance the effectiveness of existing programs by not populating them with inmates who do not have serious substance abuse problems or who are not amenable to treatment.

***Treatment curriculum.*** "Community as method" refers to that portion of TC philosophy that calls for a full immersion of the client into a community environment and culture that is designed to change the "whole person." In correctional environments where treatment programs are not fully segregated from the general inmate population, inmates participating in the treatment curricula remain exposed to the prison subculture and its negative social and environmental forces, which may weaken or negate whatever benefits they receive during programming activities. This is especially true in the case of mandated treatment programs, where problem recognition and motivation for change among many treatment participants may be lacking, at least initially. In addition, SAP participants, most of whom have become indoctrinated into the prison subculture, with its taboos on self-disclosure and sharing of personal information, have difficulty discussing personal issues in group settings, which is a basic component of most TC treatment curricula.

To counteract the negative influence that exposure to the prison subculture has on participants in treatment, it is important that treatment curricula be structured, rigorous, and void of repetitiveness. In addition, the early phases of treatment are important because of their potential effect on a client's 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, 1993). Clearly, given the higher proportions of involuntary clients in correctional treatment programs, the initial phase of treatment should emphasize problem recognition and willingness to change before introducing the tools to do so. Also, one-on-one counseling in the early phases of the treatment may serve as a useful tool for gradually introducing inmate participants to and engaging them in the TC treatment process, which relies more on group dynamics and community.

***Incentives and rewards in treatment.*** By their nature, correctional environments enforce compliance with institutional rules and codes of conduct through negative reinforcement—the contingent delivery of punishment to individuals who violate these rules and codes of conduct. Seldom, if ever, do inmates receive positive reinforcement for engaging in pro-social behaviors (i.e., complying with institutional rules and codes of conduct). Similarly, the TC model specifies disciplinary actions that should be taken in response to TC rule violations (De Leon, 2000), but says little about rewarding *specific* acts of positive behavior (e.g., punctuality, participation, timely completion of tasks). Rather, reinforcement for positive behavior takes the form of moving the client to more advanced stages of the TC program and conferring on him/her additional privileges. As such, this type of reinforcement "tends to be intermittent and, in contrast to sanctions, less specific, not immediately experienced, and based on a subjective evaluation of a client's progress in treatment" (Burdon, Roll, Prendergast, & Rawson, 2001, p. 78).

Where participation in prison-based TC treatment programs is mandated for inmates meeting established criteria, the emphasis on punishments and disincentives in the treatment process acts to compound the resentment and resistance that inmates feel and exhibit as a result of being coerced into treatment. Incentives and rewards would likely alleviate much of this resentment and resistance and may even increase motivation to participate in treatment. However, at some institutions, the ability of treatment providers to develop and implement incentive or reward systems may be limited by departmental and institutional policies and procedures that forbid the granting of special privileges, rewards, or other incentives to specific groups of inmates (e.g., those participating in a treatment program). In sum, the ability of treatment providers to implement effective systems of incentives and rewards in the treatment process may be restricted due to the priority that the penal philosophy takes over the treatment philosophy within the context of a prison-based treatment program.

Coercion alone is rarely sufficient to promote engagement in treatment. Overcoming inmates' resentment over having been mandated into treatment and their resulting resistance to participating in treatment requires that programs and institutions not only remove disincentives, but also incorporate incentives,

when possible, that would serve as meaningful inducements to participating in the treatment process. Gendreau, in his 1996 review of effective correctional programs, recommended that positive reinforcers outnumber punishers by at least 4 to 1. Possible incentives for treatment participation could include such things as improved living quarters and enhanced vocational or employment opportunities, or, where allowed, early release.

***Coerced treatment.*** Much of the growth in criminal justice treatment (both in California and nationally) is based on the widely accepted dictum that involuntary substance abuse clients tend to do as well as, or better than, voluntary clients (Farabee, Prendergast, & Anglin, 1998; Leukefeld & Tims, 1988; Simpson & Friend, 1988). However, these studies were based on community-based treatment samples. As mentioned above, coerced participation in prison-based treatment programs breeds a high degree of resentment and resistance among many of the inmates forced into these programs. Some inmates desire to change their behavior and welcome the opportunity to participate. Other inmates may, over time, *develop* a desire to remain and participate. However, a substantial portion of the inmates coerced into treatment remain resentful, refuse to participate, and, in many cases, actively disrupt the programs and the existing community culture. Furthermore, despite their continued disruptive behavior and the negative impact that it has on providers' ability to deliver effective programming, efforts to remove these disruptive inmates from the programs in a timely fashion often prove elusive due to correctional department policies and procedures governing the movement and classification of inmates in the prison environment.

One possible strategy to overcome this resentment and resistance and to expedite the development of a TC culture would be to limit admissions during a program's first year or so to a relatively small number of inmates who volunteer for treatment. Once a treatment milieu is established, issues such as program size and the presence of involuntary inmates may prove more tractable. Also, motivation for treatment should be a consideration for prison-based treatment referral and admission. Ideally, the majority of clients referred to prison-based programs (particularly new programs) should be inmates with at least a modicum of desire to change their behavior through the assistance of a treatment program.

## Summary

Since prison-based TCs first appeared in the 1980s, numerous evaluations have been conducted at both the state and federal levels that have provided empirical support for the effectiveness of these programs in reducing recidivism and relapse to drug use, especially when combined with continuity of care in the community following release to parole. Other studies have focused on the so-called "black box" of treatment (i.e., the treatment process) in an effort to identify relevant factors that predict success among participants in TC treatment programs (e.g., Simpson, 2001; Simpson & Knight; 2001). However, few have focused on the system- and treatment-level process issues relating to the implementation and ongoing operations of TCs in correctional environments and how these issues impact the ability of treatment providers to effectively provide treatment services to inmate populations.

It is also important to note that most (if not all) of the issues discussed in this paper have application beyond prison-based TCs and should be considered in any initiative that seeks to implement or expand substance abuse treatment in correctional settings. In addition, although these issues may appear to address different aspects of treatment program operations, they are not mutually exclusive. Indeed, to maximize the operational effectiveness of substance abuse treatment programs in correctional environments, they should be considered in their entirety.

## References


Anglin, M. D. (1988). The efficacy of civil commitment in treating narcotic addiction. In C. G. Leukefeld & F. M. Tims (Eds.), *Compulsory treatment of drug abuse: Research and clinical practice* (NIDA Research Monograph 86, pp. 8-34). Rockville, MD: National Institute on Drug Abuse.

Burdon, W. M., Roll, J. M., Prendergast, M. L., & Rawson, R. (2001). Drug courts and contingency management. *Journal of Drug Issues, 31*(1), 73-90.

Bureau of Justice Statistics. (2001a). *Prisoners in 2000* (NCJ 188207). Washington, DC: Bureau of Justice Statistics, U.S. Department of Justice.

Bureau of Justice Statistics. (2001b). *Probation and parole in the United States, 2000 – Press release* (NCJ 188208) Washington, DC: Bureau of Justice Statistics, U. S. Department of Justice.

California Department of Corrections. (2000). *California prisoners and parolees–2000 preliminary.* Sacramento, CA: Offender Information Services Branch, California Department of Corrections.

California Department of Corrections. (2001a). *CDC facts–Third quarter 2001.* Sacramento, CA: Offender Information Services Branch, California Department of Corrections.

California Department of Corrections. (2001b). *CDC facts–Fourth quarter 2001.* Sacramento, CA: Offender Information Services Branch, California Department of Corrections.

California Department of Corrections. (2001c). *Office of substance abuse programs: Weekly in-prison population report–November 6, 2001.* Sacramento, CA: Office of Substance Abuse Programs, California Department of Corrections.

De Leon, G. (1993). What psychologists can learn from addiction treatment research. *Journal of Addictive Behaviors, 7*, 103-109.

De Leon, G. (2000). *The therapeutic community: Theory, model, and method.* New York: Springer Publishing Company.

Farabee, D., Prendergast, M. L., & Anglin, M. D. (1998). The effectiveness of coerced treatment for drug-abusing offenders. *Federal Probation, 62*(1), 3-10.

Farabee, D., Prendergast, M. L., Cartier, J., Wexler, H., Knight, K., & Anglin, M. D. (1999). Barriers to implementing effective correctional treatment programs. *Prison Journal, 79*(2), 150-162.

Field, G. (1984). The cornerstone program: A client outcome study. *Federal Probation, 48*, 50-55.

Field, G. (1989). A study of the effects of intensive treatment on reducing the criminal recidivism of addicted offenders. *Federal Probation, 53*(10), 51-56.

Field, G. (1998). From the institution to the community. *Corrections Today, 60*(6), 94-97, 113.

Gendreau, P. (1996). The principles of effective intervention with offenders. In A. T. Harland (Ed.), *Choosing correctional options that work* (pp.117-130). Thousand Oaks, CA: SAGE.

Greenley, J. R. (1992). Neglected organizational and management issues in mental health systems development. *Community Mental Health Journal, 28*(5), 371-384.

Hall, E. A., Baldwin, D. M., & Prendergast, M. L. (2001). Women on parole: Barriers to success after substance abuse treatment. *Human Organization, 60*(3), 225-233.

Harrison, L. D., & Martin, S. S. (2000). *Residential substance abuse treatment for state prisoners formula grant: Compendium of program implementation and accomplishments. Final report.* Newark, DE: Center for Drug and Alcohol Studies, University of Delaware.

Hser, Y., Anglin, M. D., & Powers, K. I. (1993). A 24-year follow-up of California narcotics addicts. *Archives of General Psychiatry, 50*(7), 577-584.

Hser, Y. I., Hoffman, V., Grella, C. E., & Anglin, M. D. (2001). A 33-year follow-up of narcotics addicts. *Archives of General Psychiatry*, 58, 503-508.

Inciardi, J. A. (1996). The therapeutic community: An effective model for corrections-based drug abuse treatment. In K. Early (Ed.), *Drug treatment behind bars: Prison based strategies for change*. Westport, CT: Praeger Publishers.

Knight, K., Simpson, D. D., & Hiller, M. L. (1999). Three-year reincarceration outcomes for in-prison therapeutic community treatment in Texas. *Prison Journal, 79*(3), 337-351.

Leukefeld, C. G., & Tims, F. M. (1988). *Compulsory treatment of drug abuse: Research and clinical practice* (NIDA Research Monograph 86, Department of Health and Human Services Publication No. ADM 89-1578, pp. 236-249). Washington, DC: U.S. Government Printing Office.

Lowe, L. (1995). *A profile of the young adult offender in California prisons as of December 31, 1994* (Prepared for the Substance Abuse Research Consortium, Spring 1995). Sacramento: Office of Substance Abuse Programs, California Department of Corrections.

Martin, S. S., Butzin, C. A., Saum, C. A., & Inciardi, J. A. (1999). Three-year outcomes of therapeutic community treatment for drug-involved offenders in Delaware: From prison to work release to aftercare. *Prison Journal, 79*(3), 294-320.

McGlothlin, W. H., Anglin, M. D., & Wilson, B. D. (1977). *An evaluation of the California civil addicts program*. (NIDA Services Research Monograph Series, Department of Health and Human Services Publication No. ADM 78-558). Rockville, MD: National Institute on Drug Abuse.

Moore, G. E., & Mears, D. P. (2001). *Strong science for strong practice: Linking research to drug treatment in the criminal justice system. Views of practitioners*. Washington DC: The Urban Institute.

Pan, H., Scarpitti, F. R., Inciardi, J. A., & Lockwood, D. (1993). Some considerations on therapeutic communities in corrections. In J. A. Inciardi (Ed.), *Drug treatment and criminal justice* (pp. 30-43). Newbury Park, CA: SAGE.

Pelissier, B., Rhodes, W., Saylor, W., Gaes, G., Camp, S., Vanyur, S. D., & Wallace, S. (2000). *TRIAD drug treatment evaluation project: Final report of three-year outcomes*. Washington, DC: Federal Bureau of Prisons.

Prendergast, M. L., & Burdon, W. M. (2001). Integrated systems of care for substance abusing offenders. In C. Leukefeld, F. Tims & D. Farabee (Eds.), *Treatment of drug offenders: Policies and issues*. New York: Springer.

Prendergast, M. L., Hall, E., Wellisch, J., & Baldwin, D. (1999). *A process evaluation of the Forever Free Substance Abuse Treatment Program*—(Final Report, Grant 97-RT-VX-K003, submitted to the National Institute of Justice). Los Angeles: UCLA Drug Abuse Research Center.

Prendergast, M. L., Wellisch, J., & Wong, M. (1996). Residential treatment for women parolees following prison drug treatment: Treatment experiences, needs and services, outcomes. *Prison Journal, 76*(3), 253-274.

Rose, S. J., Zweben, A., & Stoffel, V. (1999). Interfaces between substance abuse treatment and other health and social systems. In B. S. McCrady & E. B. Epstein (Eds.), *Addictions: A Comprehensive Guidebook*. New York: Oxford UP.

Simpson, D. D. (2001). Modeling treatment process and outcomes. *Addiction, 96*(2), 207-211.

Simpson, D. D., & Friend, H. J. (1988). Legal status and long-term outcomes for addicts in the DARP follow-up project. In C. G. Leukefeld & F. M. Tims (Eds.), *Compulsory treatment of drug abuse: Research and clinical practice* (NIDA Research Monograph 86, Department of Health and Human Services number (ADM)89-1578, pp. 81-98). Washington DC: U.S. Government Printing Office.

Simpson, D. D., & Knight, K. (2001). The TCU model of treatment process and outcomes in correctional settings. *Offender Substance Abuse Report, 1*(4), 51-53, 58.

Taxman, F. S. (1998). *Reducing recidivism through a seamless system of care: Components of effective treatment, supervision, and transition services in the community*. (Prepared for Office of National Drug Control Policy Treatment and Criminal Justice System Conference). Greenbelt, MD, University of Maryland, College Park.

Wexler, H. K. (1996, November). *The Amity prison TC evaluation: Inmate profiles and reincarceration outcomes*. Presented tot the California Department of Corrections, Youth and Adult Correctional Agency, Sacramento, CA.

Wexler, H. K., Blackmore, J., & Lipton, D. S. (1991). Project REFORM: Developing a drug abuse treatment strategy for corrections. *Journal of Drug Issues, 21*(2), 469-490.

Wexler, H. K., De Leon, G., Kressel, D., & Peters, J. (1999). The amity prison TC evaluation: Reincarceration outcomes. *Criminal Justice and Behavior, 26*(2), 147-167.

Wexler, H. K., Falkin, G. P., Lipton, D. S., & Rosenblum, A. B. (1992). Outcome evaluation of a prison therapeutic community for substance abuse treatment. In C. G. Leukefeld & F. M. Tims (Eds.), *Drug Abuse Treatment in Prisons and Jails* (NIDA Research Monograph 118, Department of Health and Human Services Pub No. [ADM] 92-1884, pp.156-175) Rockville, MD: National Institute on Drug Abuse.

Wexler, H., & Love, C. (1994). Therapeutic communities in prison. In F. Tims, G. De Leon & N. Jainchill (Eds.), *Therapeutic community: Advances in Research and Application (*NIDA Research Monograph Series 144, pp. 181-208). Rockville, MD: National Institute on Drug Abuse.

Wexler, H. K., Melnick, G., Lowe, L., & Peters, J. (1999). Three-year reincarceration outcomes for Amity in-prison therapeutic community and aftercare in California. *Prison Journal, 79*(3), 312-336.

## Endnotes

[1] Two programs located at the Substance Abuse Treatment Facility (SATF) in Corcoran exist within completely separate prison facilities that are devoted to substance abuse treatment.

[2] The exception to this are "civil addicts," inmates classified as drug-dependent by the sentencing court. Participation in aftercare is mandatory for civil addicts who parole from prison.

[3] Outcome evaluations are being conducted at 5 SAPs. Findings will be reported as they become available.