

TITLE

Therapeutic Communities in Prison: An evidence-based tool for treating drug involved offenders in prison. A review and discussion of the literature on prison-based therapeutic communities in the United States.

BY

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“Therapeutic Communities in Prison: An evidence-based tool for treating drug involved offenders in prison. A review and discussion of the literature on prison-based therapeutic communities in the United State.”, a terminal project prepared by Brent Canode in partial fulfillment of the requirements for the Master of Public Administration or Master of Community and Regional Planning degree in the Department of Planning, Public Policy and Management. This project has been approved and accepted by:

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Introduction: Intersection of Crime and Substance Abuse

It is estimated that between 70% and 85% of the US prison population are substance abusers in need of some level of treatment (Office of National Drug Control Policy, 2001). This includes those incarcerated on drug possession and drug trafficking convictions, those who commit a crime to either support a drug habit, and those who commit crimes while under the influence of a drug. In 1996 it was reported that 7 out of 10 new arrestees tested positive on a urine screen for an illicit drug, and 62% of state prison inmates and 42% of federal inmates reported being regular drug users, further demonstrating the strong relationship between criminality and drug use (National Institute of Justice, 1996). And in a 1998 analyses it was determined that nearly 80% of state and federal inmates 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 for Substance Abuse and Addiction, 1998).

The cost to society of these drug-involved crimes is estimated at more than \$65 billion, annually (Miller, Levy, Cohen, Kenya & Cox, 2006). Indeed, the lives of many drug abusing prisoners play out in a predictable and resource intensive pattern of drug use, arrest, incarceration, release, drug use, and rearrest. While it is estimated that 40% of first-time offenders have a drug and/or alcohol abuse problem at the time of arrest, by the time a person has been convicted of their fifth offense, the chance that person is a drug addict or alcoholic exceeds 80% (CASA, 1998). The costs to society as a result of this pattern are manifold, and increase exponentially with each repetition of its cycle, as scarce public dollars are continually diverted from other tax payer funded priorities like education, health care and the environment. How best to intervene and disrupt the cycle of recidivism and drug use for the drug using prison population is an important policy question, one that merits serious attention from policy makers.

The incarceration rate in the US has been rising at a rate far surpassing the rate of population growth for more than two decades and is projected to do so well into the future. Recent population forecasts predict that the Nation's prison population will grow 13% in the next five years, more than tripling the 4% projected growth for the general US population (Pew Charitable Trust, 2006). Our Nation's growing prison population is driven by a number of factors, including mandatory minimum sentencing laws and truth in sentencing laws. But perhaps the greatest contributing factor to our escalating prison population is the heightened focus on incarcerating drug offenders, which began with the war-on-drugs policies that came to prominence in the 1980's. The impacts of the war-on-drugs policies were further amplified by more punitive sentencing guidelines for certain classes of drug offenders in the 1990's, most notable in provisions of the 1994 Violent Crime Control Act. These policies have resulted in a 1000% increase in the number of

inmates incarcerated for drug possession between the years 1980-2005 (Vera Institute of Justice, 2007).

The growing prison population in the US is also consuming a greater proportion of public resources at the expense of many other important, publicly funded programs and services. With the exception of Medicaid, corrections expenditures, was the only state budget item that increased as a percentage of total state spending for the past two decades (Vera Institute of Justice, 2007). In fact, from 1985-2002, corrections spending increased by 202%, as education spending in the states only increased by 58% during the same time period (Vera Institute of Justice, 2007). Most research associates the growth in prison populations with a corresponding increase in drug prosecutions and stricter drug laws. This then suggests that a heightened focus on incarcerating and punishing drug offenders over the past two decades has contributed significantly to the corresponding growth and imbalance in corrections spending during this same time period

If drug-involved offenders are the primary catalyst driving the unsustainable trajectory of our Nation's corrections systems, than providing effective drug and alcohol treatment services to the drug involved inmate population should be a top priority of every corrections system. It is estimated that 95% of all incarcerated persons are eventually returned to the community. Providing treatment services within the prison system might best prepare these individuals for successful reentry into the community (Partnership for Safety and Justice, 2007). In the report that follows, I will synthesize the current body of research on the most prevalent and to date, most effective prison-based drug treatment modality—the Therapeutic Community (TC)—for high-risk, drug-involved offenders. and identify a set of working best practices from the literature.

Background

In the past ten years, a growing body of peer-reviewed research has emerged on the effectiveness of prison-based drug treatment programs in reducing recidivism rates, especially for high-risk prisoners. Prison-based drug treatment programs in the US date back to the 1930's, and have a checkered history of falling in and out of favor with corrections officials and politicians. Early efforts at prison-based treatment lacked sophistication in design, implementation, and administrative oversight. In part because of flawed research methodologies, poor data collection and monitoring practices, and erroneous interpretations of research findings, prison-based treatment programs experienced a sharp decline in the 1970's, ushering in what was commonly referred to as the "nothing works" era of corrections policy (Lipton, 1995).

The "nothing works" era derived its moniker from a widely read summary article in 1975 on the scholarly assessment of 30 years of prison based rehabilitative programs as having no significant impact on the reduction of recidivism. The prevailing "nothing works" mentality in the corrections community eventually led to the dismantling of a great many of the Nation's prison-based drug treatment programs and marked an end to what Douglas Lipton termed the "rehabilitative era" in corrections policy. Other factors in the 1980's also precipitated the decline and disappearance of most residential treatment programs in

prison including prison crowding issues, state budget deficits, staff burnout, and changes in prison leadership (Martin, Butzin, Saum & Inciardi, 1999).

Beginning in the mid-1990's, with the passage of the Violent Crime Control Act of 1994, which provided substantial federal and state funding for drug treatment services in prison, prison-based treatment programs experienced resurgence in popularity within the corrections community (Lipton, 1995). This new found popularity and funding was spurred on by new research refuting earlier claims that these programs had no substantive impact on recidivism rates and a growing concern about the volume of incarcerated drug-involved prisoners and the attendant costs associated with this sub-population of prisoners.

Therapeutic Communities in Prison

The most prevalent modality for the delivery of intensive drug treatment services in prisons is the Therapeutic Community (TC) (Prendergast, Hall, Wexler, Melnick & Cao). A TC is a group-based residential treatment program where participants are involved in all aspects of TC operations, including administration and program maintenance. Within this modality, the participant's crime and drug abuse is viewed as problem rooted in the person, not just the drug abusing behavior. At their core, TC programs use the community as the primary therapeutic tool to achieve cognitive growth, behavioral change, and the development of pro-social attitudes. The TC program aims to rehabilitate the whole person through a mix of cognitive and behavioral therapies (Pearson & Lipton, 1999). While other treatment models and tools are utilized within the corrections system, most, if not all treatment programs targeted at high-severity, high-risk offenders are provided in a TC-style format.

TCs first were implemented in the US in psychiatric hospitals in the 1950's, and then later in community-based substance abuse programs in the 1960's (Pieri, 2002). It wasn't until the late 1960's that TC-style programs first appeared within the confines of a prison environment. For the purposes of this paper, TC-inspired prison-based programs will be referred to as TC despite the fact that very few of these programs are a pure form of TC. Accommodations to address security and inmate control reasons.

Early studies of community-based TCs demonstrated that the model was effective in reducing the criminal activity and drug use of program participants, including many participants who had significant criminal histories (De Leon, 1984). De Leon also was one of the first researchers to observe what is referred to in the TC literature as the Time-In-Program (TIP) effect. The longer a person remained in a TC program, the better they performed on outcomes measures pertaining to criminality and drug use. In a set of analyses of male opiate addicts enrolled in a TC program, De Leon found that zero percent of those who dropped out after one month or less were drug and crime free one year later. For those who spent a year or more in the TC program, 50% were drug and crime free at one year out. The TIP effect was also observed by Wexler during of the first program evaluations of a prison-based TC. In Wexler's study of the Stay'n Out TC in New York, he found that clients who dropped out of the TC prior to 3 months had a mean re-arrest

time of 9 months. Conversely, those who stayed for 9-12 months had a mean re-arrest time of 18 months – twice the success rate of the under 3 month cohort.

While most prison-based TC programs vary widely in their design and deployment, most have a set of core commonalities that define them in a general sense. These often include the following: separation from the general population of inmates, highly structured and hierarchical group environment, a safe and secure environment where inmates feel comfortable opening up emotionally and expressing their feelings, peer encounter groups, individual counseling, substance abuse curriculum, participation in 12-step recovery groups like AA or NA, very specific rules and clear sanctions for violating rules, ex-offenders and recovering people serving as treatment staff and mentors, and program duration lasting 6-12 months, which is typically served by at the end of their sentence, prior to release and transition back into the community (Wexler and Love, 1994; Pearson and Lipton, 1999; Field 1989).

The first TC program to be studied in depth was the Stay'n Out program in New York State in the mid-1980's. This was also the first study to evaluate the Time-In-Program (TIP) effect that De Leon determined to be associated with positive treatment outcomes in his research on community-based TCs. The initial research on Stay'n Out was indeed promising. The percentage of those rearrested during the 18-month post-release study period was substantially lower for the TC treatment group (27%) than for a randomized comparison group (41%) (Wexler, 1988). The TIP effect at Stay'n Out was also strong and consistent with De Leon's earlier findings. TC participants who spent from 9-12 months in the TC, had an average time until next arrest of 18 months, as opposed to those who spent 3 months or less in the TC, whose average time until next arrest was 9 months (Wexler, 1988). Considering the high severity nature of the Stay'n Out clients—most were long-time heroin and cocaine addicts with lengthy criminal histories—findings from the program provided a promising departure point for future studies of the TC model in a corrections context.

On the west coast, around the same time the Stay'n Out study was underway, Dr. Field, Director of Substance Abuse Programs for the State of Oregon, was completing his second program evaluation of the Oregon Cornerstone TC. Cornerstone served high-risk, high severity offenders, who averaged 7 felony convictions, began their drug use around the age of 12 and were polydrug abusing at the time of incarceration. Unlike Stay'n Out, Cornerstone had a mandatory 6-month aftercare component for program graduates upon post-release. This was the first evaluation of a program that included an integrated aftercare component. Unfortunately the aftercare element was not isolated and evaluated in a manner that would allow for a full and precise understanding of its relationship and impact on program outcomes.

In the first program evaluation of Cornerstone in 1984, 71% of program graduates remained incarceration free after three years, compared to 63% of Oregon parolees with substance abuse histories who didn't receive treatment (Field, 1984). Five years later, Cornerstone was reevaluated, and again, TC graduates had the lowest returns to prison: 51% were not incarcerated after three years of post release, compared to 28% of those who

spent up to six months in the Cornerstone program, and 11% of those who were in the program for 2 months or less (Field, 1989). Cornerstone, like Stay'n Out, substantiated the TIP effect observed originally in community-based TCs, clearly demonstrating the benefit of increased exposure to treatment. In sum, both studies suggest that the TC model has the potential to be an effective tool for treating high-risk, high severity inmates and significantly reducing their attendant recidivism rates.

Ten years following the New York and Oregon studies, three studies were released on TC programs in California, Delaware and Texas. Unlike past studies, these particular program evaluations examined the additional impact and relevance of aftercare and structured work release on the recidivism rates of TC program participants. Additionally, the California study was the first to report 5-year post-release program outcomes, whereas all previous TC studies had been limited to 1, 2 and 3-year post-release outcomes. A discussion of these more recent studies follows below.

In the early 1990's the state of Texas embarked on an ambitious prison treatment initiative to expand treatment services to drug-involved offenders in state prisons (Knight, Simpson and Hiller, 1999). The largest program enacted at the time under this initiative was a 500 bed segregated TC-unit located within a state prison in Kyle, TX. The Texas program differed from those studied earlier in that inmates were mandated to attend a community-based residential aftercare program, also known as a transitional therapeutic community, for at least 3 months post-release. After residential aftercare was completed, inmates were further required to enroll in outpatient counseling that lasted up to 12 months. During the aftercare process inmates were required to meet with their parole officer and submit to random urine testing.

The three-year post-release findings of the Texas study suggest that an integrated and mandated aftercare component is perhaps necessary to maximize the effectiveness of prison-based TC treatment. Without taking aftercare participation into account, reincarceration rates for TC (41%) and non-TC (42%) offenders were nearly identical after three years of release from prison (Knight, et al., 1999). However, for inmates who completed both in-prison and community-based aftercare, the reincarceration rate was 25%, compared to 65% for TC graduates who dropped out of aftercare (Knight, et al., 1999). These findings seem to suggest that a continuum of care that includes residential aftercare and traditional outpatient aftercare is necessary to achieve desirable reductions in recidivism.

Like the Oregon and New York studies, the Texas study also found that high-severity inmates had the best treatment outcomes. While the Oregon and New York studies were limited to examining survival rates under 2-years post-release, the Texas study now suggested that treatment benefits (with aftercare) could extend out at least 3-years following release from prison.

In 1991, at the same time the Texas treatment initiative was undergoing implementation, the state of Delaware launched an innovative TC demonstration project funded by the National Institute on Drug Abuse (NIDA). The Delaware TC model was similar to the

Texas model in its continuum of care approach, but unlike Texas, Delaware's program, the first of its kind in the US, includes a work-release component that operated concurrently with the transitional residential aftercare stage. The Delaware program, called KEY (prison based TC) Crest (work-release and residential treatment TC) was a three-stage model that includes a prison-based TC stage, a work-release transitional TC stage, and outpatient aftercare services.

An evaluation of 3-year post-release outcomes substantiated findings from the Texas, Oregon and New York studies discussed above, while also demonstrating the added benefit of successfully structuring a work-release program within a transitional TC. Graduates of Key-Crest-Aftercare had the best outcomes, with 69% of participant's arrest-free 3-years out, compared to 28% who just participated in the prison-based Key TC and 29% of those who received no treatment (Martin, Butzin, Saum & Inciardi, 1999).

However, the Delaware study also found that the treatment effect for non-aftercare, TC-only participants seemed to disappear after 3 years of post release. These findings strongly suggest a need to include an integrated aftercare component in order to realize optimal declines in recidivism rates and preserve the benefits of treatment.

At the same time Texas and Delaware were deploying new TC programs, California was embarking on a large TC demonstration project—the Amity TC—at the R.J. Donovan Correctional Facility. Amity was similar in design to the TCs discussed earlier in this report. Amity used a two-stage treatment process that included 9-12 months in a segregated TC unit, and a voluntary post-release residential aftercare program—Vista—that lasted from 6-12 months. The Vista aftercare program was unique in that it was operated by the same treatment provider as the Amity TC and used the same prison-based curriculum. It was thought that this continuity in curriculum and approach would provide a smoother, more successful inmate transition and reentry process (Prendergast, Hall, Wexler, Melnick, & Cao, 2004). California's program also included an extended aftercare element for Vista graduates, which allowed Vista graduates to drop by the Vista facility for counseling and evening recovery groups.

It merits mentioning that the Amity study was the first to report drug of choice data for participants, which is particularly relevant as methamphetamine was the most cited drug of use prior to incarceration for study participants, and methamphetamine addiction has a reputation in the general public as being particularly difficult to treat. If the Amity program could produce positive outcomes for this sub-class of offender, policymakers might be more inclined to look at prison-based treatment as a worthwhile investment and tool in curbing methamphetamine addiction and the attendant high levels of property crime and identity theft.

Another unique and helpful element of the Amity study was the inclusion of employment outcomes for program participants. If the Amity study could demonstrate that program graduates had higher employment rates (tax payers instead of tax consumers), policy makers might be more inclined to view these programs as cost-saving opportunities instead of resource intensive investments.

Similar to the inmate population profile of past TC evaluations, the Amity treatment group was high-risk with over 75% of participants reporting a history of violence and severe drug abuse; the average TC participant had been arrested 27 times, had been incarcerated 17 times and spent over 6 years in prison (Prendergast et al., 2004). And yet again, as past studies cited in this report have shown, these high-risk program graduates performed markedly better on recidivism measures than their untreated cohorts. 5 year post-release reincarceration rates for offenders who completed all levels of treatment in the California study was 76%, compared to 83% for those who didn't receive treatment services (Prendergast et al., 2004).

In a state as large as California a 7% decline in recidivism, as reported above, represents large potential costs savings. In a recent report on prison programs, the Inspector General of California stated that a 7% reduction in recidivism for California's estimated 640,000 substance abusing offenders could save the state \$40 million in future corrections costs (Cate, 2007). The Amity study also reported that on average, treatment group participants' survival rate (time before reincarceration) was 6 months longer than offenders who did not receive treatment. Similar to the Texas and Delaware findings, there was very little difference in reincarceration rates for TC completers without aftercare (87%), and those who didn't receive treatment services (86%) (Prendergast et al., 2004). This appears to validate earlier findings regarding the important role that aftercare plays in preserving the treatment effect.

Employment outcomes for treatment completers were also positive. For those that completed all levels of treatment, 72% reported being employed during the last year of the study, compared to 40% of those who didn't complete any treatment (Prendergast et al., 2004). This new finding demonstrates that there may be strong ancillary benefits to prison-based drug treatment programs, beyond lower reincarceration rates and diminished corrections costs.

Cost Effectiveness of Prison-Based Drug Treatment

The recent wave of research on prison-based treatment programs clearly suggests that prison-based TCs are effective at reducing recidivism for high-risk, drug-involved offenders. However, it could be argued that if the cost of these programs exceeds the benefits identified earlier in this report, policy makers may have a difficult time justifying future investments in prison-based drug treatment programs. Most of literature has not examined the cost effectiveness of these programs, until very recently, when two studies in California and Washington attempted to account for the costs and benefits of prison-based treatment programs.

In 2003, a study examined the cost effectiveness of the Amity TC program, which is housed in the R.J. Donovan Correctional Facility in California. The primary objective of the study was to provide an understanding of the economics of these programs and particularly, at what cost was a decrease in reincarceration achieved (McCollister, French, Prendergast, Wexler, Sacks & Hall, 2003). The study was framed from the perspective of

the California Correction's Department, so costs that were taken into account included standard incarceration costs and incremental treatment program costs. For the combined treatment group that included in-prison and aftercare participants, the average cost per day was estimated at \$80 compared to an estimated average cost per day of \$60 for non-treatment offenders (McCollister et al., 2003). The study then suggests that for an additional \$20 per day, California can delay the time to reincarceration for their drug-involved offenders. While this study examined the costs of prison care, it did not consider the cost savings to society of reducing crime. A team of researchers in Washington recently released a study that examined more comprehensively the cost and benefits of prison-based TC treatment programs, taking societal costs and benefits into account in their analysis.

In 2005, the Washington State legislature, faced with a daunting long-term prison growth forecast that suggested the state may need to build as many as 3 new prisons by 2030 to accommodate projected prison growth, directed the Washington State Institute for Public Policy (WSIPP), a non-partisan public policy think-tank, to evaluate and identify evidence-based options that could reduce the need for new prisons (Aos, Miller, & Drake, 2006). WSIPP performed a meta-analysis of 571 correctional programs, including 20 prison-based drug treatment programs and as part of this analysis, estimated the costs and benefits of these programs. The study was more inclusive in its cost accounting than the California cost-effectiveness study, taking into account program, court, incarceration, and victimization costs. Estimated costs and avoided costs for each program under study were calculated, and a return on investment figure was then assigned to each program. The prison-based program results of this study were very promising.

After accounting for the identified costs and delayed costs associated with the prison-based programs under study, it was estimated that a per participant rate of return for these programs was \$7,835 (Aos et al., 2006). These findings provide a more detailed understanding of the question originally posed at the conclusion of the California Amity study: namely, what does the increased marginal costs of prison programs actually buy (McCollister et al., 2003)? Based on the results of the Washington study it appears that the marginal costs buy a lot.

Situational Influences and Impediments to Implementation of TCs in Prison

The growing popularity and prevalence of the TC model in the corrections system was in part driven by the promising outcomes from the early program evaluations described above. Based on the reported positive impacts the TC model had on the recidivism rates of its participants, a panel of national experts on prison based substance abuse treatment went so far as to issue a recommendation that every federal prison should develop plans to implement a TC treatment program (Wexler, Lipton 1993). Also, around this time, hundreds of millions of dollars in federal grants were in the process of being passed through to the states for prison-based residential treatment program planning and implementation. This dramatic increase in funding and popularity for TC programs nationwide elicited a mixed response from the academic community who had participated in past program evaluations. These individuals felt that states needed to be prudent and

cautious in their plans to develop or expand programs based in large measure on the promising results of a small handful of well-funded programs that had unprecedented levels of fiscal and administrative support, which helped ensure the programs were effectively implemented and monitored during the critical formative years (Farabee, Prendergrast, Cartier, Wexler, Knight & Anglin, 1999).

Experts further cautioned that it was unlikely that the same conditions and resources that were available to support the growth and maturation of a few early programs would be available for such a large proposed increase in programming (Farabee, et al., 1999). Further, the impending roll-out of TC programs in the late 1990's caused experts in the field to be concerned that the explosion in program growth would make new programs particularly vulnerable to implementation errors that could lead to poor performance outcomes and ultimately, misleading interpretations of the effectiveness of TC Programs, which was a contributing factor to the dismantling of many TC programs in the 1970's and 1980's. Out of these concerns a body of research developed in which common barriers to implementing TC drug-treatment programs in prisons, including situational influencing factors that could jeopardize outcomes and attendant findings were identified.

The first published study on situational influences on prison-based TC program implementation reviewed the impact a new non-smoking policy and a recent change in treatment provider had on program outcomes in a Missouri prison-based TC (Linhorst, Knight, Johnston and Trickey, 2001). It was discovered that in both instances, these situational changes had a significant influence on program outcomes. Shortly after enacting the smoking ban, the TC program in Missouri experienced a 100% increase in program terminations for infractions, most of which were related to possessing or trafficking tobacco (Linhorst et al., 2001). Likewise, when Missouri officials decided to contract with a new treatment provider, program outcomes fell and staff and inmate morale dropped sharply due to the new provider's decision to increase staff to inmate ratios, which led to a high level of staff turnover and an increase in the number of counseling staff with no prison-based TC experience. Within the following year, corrections officials in Missouri rolled back the smoking ban and terminated the contract with the new provider and returned to the previous provider based on the perception that both changes were negatively impacting program performance.

It appears from this study that situational influences can pose significant threats to the internal validity of program outcome studies. This study also highlights the important role primary source data collection plays in accurate program analysis. If the researchers in this study had simply relied on secondary sources (inmate statistics, recidivism rates, criminogenic profiles, etc.) they could possibly have overlooked these policy and programmatic changes that had a negative impact on program outcomes, which might have lead to inaccurate and misleading conclusions about the effectiveness of the TC model.

In the literature there has been discussion of the barriers to implementing TC effectively. The four key factors are described below:

First, appropriate inmate assessment and referral processes play a critical role in the performance of prison based drug treatment programs. Research has shown consistently that prison based TC programs are most effective for high-risk, high-severity inmates (Field, 1984, 1989; Prendergast et al., 2004). Given that TC programs are the most expensive form of treatment in prison, it's important to screen out low-risk offenders who don't have a need for, nor will experience significant benefits from the additional programming. Ensuring that high-risk inmates are properly referred to TC treatment is additionally important as it has been demonstrated that this sub-population of prisoner is responsible for a disproportionate level of crime (Holden, 1986; Ball, 1983). In order to ensure proper classification and referral, corrections officials should ensure that they are using evidence-based assessment tools that have been proven effective in identifying the most severe cases of drug abuse and they should also include the treatment provider in the referral process because they likely have the best understanding of how a particular referral will impact the current TC population.

Secondly, recruiting qualified treatment staff weighs heavily on the performance of prison-based programs. Recruitment challenges are caused by what can best be described as a rural location effect. The wave of prison growth across the Nation in the past few decades has largely taken place in remote, rural communities. This has been driven by a need for cheap land, and lots of it. Subsequently, corrections departments and the treatment providers they contract with have had a difficult time finding qualified staff locally, or recruiting qualified staff from more populated regions (Farabee, Prendergast, Cartier, Wexler, Knight & Anglin, 1999). Beyond this rural-effect, prison-based treatment providers also have a difficult time locating staff that has prison-based experience, which is markedly different than community-based counseling experiences for a number of obvious reasons. These challenges have led some researchers to suggest that treatment providers allocate more money in their budgets for staff costs in order to recruit qualified candidates, and that counseling accreditation entities might need to look at the possibility of creating a distinct, prison-based treatment credential and career tracts for drug and alcohol counselors, and a centralized employment service to coordinate and publicize job opportunities (Wexler & Love, 1994). Another suggested recruitment tool is to train inmates serving life-sentences who have graduated from a treatment program and are committed to the treatment philosophy. These individuals carry significant credibility within the prison culture and have the potential to serve as positive mentors to drug treatment clients and also save significant treatment program costs (Farabee et al., 1999).

Thirdly, the traditional culture of corrections departments differs widely with that of a traditional treatment environment, and most acutely, with that of a prison-based TC program. In a prison facility, the primary concern of corrections staff is inmate custody and control. This rigid command and control mentality is at odds with some of the fundamental precepts of a TC program. For example, in a TC program verbal confrontation is encouraged as a therapeutic tool and inmates exercise varying degrees of control over the TC. In many TC programs, inmates are encouraged to respectfully confront other inmates on their behavior and attitudes and are allowed to address TC staff with their concerns or frustrations. This style of open communication and confrontation between inmates and staff is typically forbidden in prisons and often results in sanctions

and infractions within the general inmate population. Corrections staff may also be at odds with the treatment philosophy and disagree with the usefulness of the program. In this case, a corrections officer can make life difficult for treatment clients and disrupt the harmony and flow of a TC unit (Farabee et al., 1999). The system for advancement within the corrections organization and culture is also a barrier, as staff must routinely transfer to positions in other prisons to advance in their career (Farabee et al., 1999). This can disrupt the continuity of a treatment environment, which may impact the effectiveness of the treatment experience for inmates.

Fourthly, while the culture of corrections at the prison staffing level presents many concerns, an even more problematic set of issues can arise when the culture of corrections at the administrative level is out of alignment with TC programs and treatment goals. A recent example of this appeared in a critical report of California's prison drug treatment programs by California Inspector General Cate. A review of California's prison based programs found, among other things, that 36 out of the 38 TC programs were housed in prisons where TC unit segregation from the general population was impossible (Cate, 2007). As was mentioned earlier, TC unit segregation is one of the fundamental prerequisites of establishing a successful program. Without inmate separation, a TC unit is exposed to myriad criminal influences that can seriously undermine the treatment effect and the integrity of the treatment community. This was one of the leading factors in Inspector General Cate's recent indictment of California's implementation of their prison treatment programs, and one of the primary reasons cited in his argument that California may have wasted over a \$1 billion in public resources because of inappropriate implementation and monitoring of their prison-based drug treatment programs.

Researchers have suggested a number of policies which may reconcile these cultural impediments, including cross training of correctional staff on treatment program philosophy and program rules and regulations, creating a corrections job classification with financial incentives attached for prison-based TC assignments to professionalize these staff positions in order to attract staff who are aligned and oriented to treatment program goals, informing corrections staff about the positive post-release outcomes associated with prison-based TC program evaluations and educating corrections staff on the custody and control benefits that evaluated TC programs have yielded, including fewer inmate infractions and violence among TC units (Farabee et al., 1999; Wexler et al., 1995).

While the literature doesn't cite funding issues and fiscal support as a possible barrier, it does seem that this could be a real obstacle for effective implementation of prison-based programs. If programs are designed and implemented during legislative control under one political party, but fall out of favor with a new legislative ruling majority, funding could be reduced and program outcomes negatively impacted by subsequent programmatic changes and disruptions brought about by a decrease in funding. Perhaps in future analysis of programs, it would be wise to look at the level of funding a prison-based program received over the time of that particular study, to ensure that program effects observed aren't being impacted by a funding effect.

Summary

Prison –based TC drug treatment programs have emerged as an effective, evidence-based tool for reducing recidivism rates and attendant system costs for high-risk offenders. With an increasing number of incarcerated, drug-involved offenders, TC programs offer a ray of hope for corrections professionals, policymakers and concerned citizens confounded by a prison system that is consuming an inordinate level of public resources at the expense of education, health care and the environment. After twenty years of prison-based TC program research and evaluation, a set of working best practices has begun to emerge. These are discussed in detail below.

Segregating TC prisoners and programs is perhaps the most critical determinant of an effective TC program. Drugs are readily available in most prison systems. This poses obvious risks for prisoners struggling with the process of getting clean. Establishing segregated housing units provides a valuable buffer between the participants and the general population and the rampant criminality present in many of its members. Contact with the general population also creates obstacles in terms of effectively addressing cognitive problems associated with criminality and substance abuse. TC programs treat the individual in a holistic manner, guided by a philosophy that an individual’s drug use is a reflection of deeply defective cognitive and behavioral skills. The yard environment can impede the process of personal transformation by serving as a source of negative reinforcement of criminal and anti-social behaviors that the TC program is attempting to change.

Another important practice identified in the literature is the inclusion of a coordinated, community-based aftercare component for TC graduates transitioning back to the community. In each peer-reviewed study, the cohort who attended aftercare upon release from a prison TC performed markedly better on post release criminality and substance abuse measures. In most longitudinal outcome studies, the TC effect all but disappeared after three years for prisoners who received TC treatment but did not participate in aftercare. Additionally, those who completed the full continuum of treatment including aftercare, employment outcomes were more positive.

The duration of TC program participation also surfaced as a critical predictor of post-release success. This is commonly referred to as the time-in-program effect. Based on the literature, TC treatment should last between 9-12 months. Inmates under study who dropped out prior to this suggested treatment duration performed no better than those who received no treatment. The TC stage should begin within the last 12-15 months of an inmate’s sentence. Inmates that remained incarcerated after graduating from a prison TC had worse post-release outcomes. Researchers credited this effect to the demoralizing impact that delayed release can have on program graduates.

Establishing methods and practices that facilitate effective communication and coordination between TC program staff and corrections staff is very important to the success of a TC program. Research has consistently shown that garnering the institutional support of corrections staff, at the prison and administrative level plays a large role in the success and viability of TC programs in prison. The decline of TC programs in the 70’s

and early 80's was driven in part by an unsupportive corrections culture that viewed TC programs as ineffective and a waste of system resources. This sentiment trickled down to prison yard staff that at times engaged in documented activities that intentionally undermined the integrity of TC programs. For example, in California, this resulted in the practice of placing TC programs in prisons where isolation from the general population was impossible logistically. That CA Inspector General surmised that this potentially jeopardized tens of millions of dollars in TC program investments made in California.

The quality and composition of the counseling staff has a proven benefit on the treatment experience and outcomes of TC participants. Research has shown that utilizing recovering addicts and alcoholics TC program graduates is critical to gaining the trust and confidence of program clients in prison. Recovering graduates provide a singular type of program testimonial that has the capacity to be inspirational and credible in a way that non-recovering, non-convicts would have difficult emulating. Research has also suggested that counseling in prison is very different than community based counseling. Therefore, it is important to create pathways to prison based work in order to provide an adequate pool of talent to fill prison-based TC positions.

Continuous program monitoring and evaluation is important to ensuring optimal effectiveness of a TC program and the validity of program outcomes. As the research has demonstrated, situational events can have a negative impact on program outcomes. Failing to routinely monitor program operations could result in situational events going undetected, which could lead to erroneous conclusions about TC program effectiveness. The lack of quality monitoring processes contributed to the previously discussed decline of TC programs. Poor program outcomes were interpreted as a sign that TC programs were ineffective in rehabilitating drug-involved offenders. However, later it was determined that in many cases external forces and factors were impacting program performance negatively. This then lead to a skewing of outcomes and attendant misperceptions of the efficacy of TC programs.

In the future, additional research on the effectiveness of different TC curriculum is needed. For example, some programs integrate a 12 Step component and some do not. It would be interesting to know what impact this decision has on program outcomes, given that 12 Step programs are the most prevalent long-term aftercare models for recovering people. More precise cost/benefit analysis would be helpful to political and policy decision makers charged with allocating criminal justice system dollars. As many states prepare for another round of prison build outs, this type of information could be incredibly useful. If the cost/benefit research discussed earlier out of Washington State held up in additional studies, states might avoid hundreds of millions in capital costs by investing in evidence-based programming like prison TC programs.

Appendix #1

Prison-Based Therapeutic Community Best Practices*

- TC unit must be isolated from the general population.
- Inclusive inmate screening and evidence-based referral processes.
- Integrated and compulsory aftercare stage to preserve long-term TC benefits.
- TC treatment should begin no sooner than the final 12-15 months of an inmate's sentence.
- Qualified treatment staff competent in TC treatment methods.
- TC treatment staff should include individuals in recovery and former offenders.
- Clear system for coordination and communication between corrections staff and treatment providers.
- Continuous program and fidelity monitoring.

*Excerpted from thesis defense Power Point presentation

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