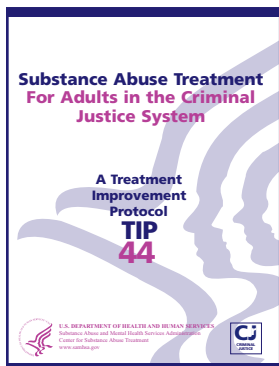


Quick Guide

For Clinicians

Based on TIP 44

Substance Abuse Treatment For Adults in the Criminal Justice System



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Treatment
www.samhsa.gov

Contents

Why a Quick Guide?	2
What Is a TIP?	3
Introduction	4
Screening and Assessment	5
Triage and Placement	11
General Treatment Issues in the Criminal Justice System	18
Treatment Issues in Pretrial and Diversion Settings	22
Treatment Issues in Jails	30
Treatment Issues in Prisons	38
Treatment Issues for Offenders Under Community Supervision	47
Treatment Issues for Specific Populations	52
Glossary of Terms	62

Quick Guide

For Clinicians

Based on TIP 44

Substance Abuse Treatment For Adults in the Criminal Justice System

This Quick Guide is based entirely on information contained in TIP 44, published in 2005, and based on information updated through August 2005. No additional research has been conducted to update this topic since publication of the TIP.

WHY A QUICK GUIDE?

This Quick Guide was developed to accompany *Substance Abuse Treatment for Adults in the Criminal Justice System*, Number 44 in the Treatment Improvement Protocol (TIP) Series published by the Center for Substance Abuse Treatment (CSAT), Substance Abuse and Mental Health Services Administration (SAMHSA).

This Quick Guide is based entirely on TIP 44 and is designed to meet the needs of the busy clinician for concise, easily accessed “how-to” information.

The Guide is divided into 12 sections to help readers quickly locate relevant material. For more information on the topics in this Quick Guide, readers are referred to TIP 44.

WHAT IS A TIP?

The TIP series has been in production since 1991 and currently numbers 44 volumes. This series provides the substance abuse treatment and related fields with consensus-based, field-reviewed guidelines on substance abuse treatment topics of vital current interest.

TIP 44, Substance Abuse Treatment For Adults in the Criminal Justice System

- Updates and combines TIPs 7, 12, and 17
- Provides relevant information that will inform and enable treatment providers to improve their approach to offender and ex-offender populations
- Helps professionals in community treatment to understand the criminal justice system and how it works in step with their treatment services
- Encourages collaboration between the criminal justice and treatment communities.

See the inside back cover for information on how to order TIPs and other related products.

INTRODUCTION

Research consistently demonstrates three trends relating to substance abuse treatment and criminal justice: (1) there is a strong connection between criminal activity and substance abuse; (2) participation in substance abuse treatment reduces recidivism (return to criminal behavior); and (3) the reduced criminal activity associated with substance abuse treatment for offenders is cost-effective.

In response to these findings, policymakers have implemented a wide variety of strategies at the Federal, State, and local levels, aimed at improving the availability and quality of treatment for offenders. However, although an increasing number of criminal justice programs offer some form of treatment, the actual number of programs and slots remains limited, and the number of offenders in need of services continues to rise.

TIP 44 and this Quick Guide were developed to help ensure the best possible treatment services for clients in criminal justice settings, by providing substance abuse treatment professionals with the tools to effectively interact with their clients and the criminal justice system at all levels.

SCREENING AND ASSESSMENT

Currently there are no comprehensive national guidelines for screening and assessment approaches for substance use disorders in the criminal justice system. However, information from this section can assist counselors in developing effective screening and referral protocols that will enable them to—

- Screen out offenders who do not need substance abuse treatment.
- Assess the extent of offenders' treatment needs in order to make appropriate referrals.
- Ensure that offenders receive the treatment they need, rather than be released into the community with a high probability of return to incarceration.

Basic information useful for both screening and assessment can be acquired from any number of sources, including—

- Booking records
- Self-report/interview information
- Results of instruments and surveys administered
- Past correctional records (presentence investigations)
- Past treatment records
- Police reports

- Correctional staff reports (for bail hearings, early release)
- Prior offense records (for driving under the influence [DUI], possession, trafficking)
- Emergency medical reports
- Drug test results (from examination of hair, sweat, urinalysis, Breathalyzer®).

Some areas of concern in screening and assessment in the criminal justice system include—

- Accuracy of information
- Continuity and system-wide sharing of information
- The importance of re-screening and re-assessing
- Timing of screening and assessment
- Drug testing
- Detoxification needs
- Readiness for treatment
- History of trauma
- Psychopathy and risk for violence and recidivism.

For more information on each of these areas, see chapter 2 of TIP 44.

Screening and Assessment Versus Eligibility and Suitability

In correctional settings, “screening” and “assessment” are equated with “eligibility” and “suitability,” respectively:

- *Eligibility*: Does the offender meet the system’s criteria for receiving treatment services?
- *Suitability*: Is the offender suitable for the type of program services that are available?

When Is a Formal Diagnosis Necessary?

When identified with a psychiatric diagnosis that will follow them throughout the system or even their lifetime (if entered into the criminal justice system’s computer), people sometimes feel labeled and stigmatized. This is particularly true of diagnoses related to mental disorders. Because symptoms of mental disorders are often mimicked by substance abuse or withdrawal, it is particularly important to defer diagnosis until an adequate assessment period is provided under conditions of abstinence. Moreover, diagnostic classification can sometimes preclude offenders from receiving needed services. Likewise, a substance abuse diagnosis can preclude access to mental health services, resulting in no services being rendered. A substance abuse diagnosis can also limit an offender’s access to certain work assignments or vocational training.

To avoid these problems, formal psychiatric diagnoses should be made based on sound clinical practice. A formal diagnosis may be required when—

- Reimbursement for services requires it (e.g., Medicaid or Medicare reimbursement is not possible without a DSM-IV-TR code)
- Pharmacological intervention is suggested (e.g., methadone, Antabuse)
- Potential psychiatric concerns emerge (e.g., when the counselor is trying to rule out substance abuse or when symptoms may be substance-induced or psychiatric)
- The counselor needs to clarify co-occurring disorders that affect treatment decisions
- The information is for research or evaluation purposes.

Screening Instruments

In one recent study, eight different substance abuse screening instruments were examined for use among male prisoners. Each of the instruments was found to have adequate test–retest reliability, although the validity of the instruments varied. The screening instruments examined in the study included—

- Alcohol Dependence Scale (ADS)
- Addiction Severity Index–Alcohol Use subscale (ASI-Alcohol)—*Reproduced in appendix C of TIP 44*

- ASI–Drug Use subscale (ASI-Drug)—*Reproduced in appendix C of TIP 44*
- Drug Abuse Screening Test (DAST-20)
Reproduced in appendix C of TIP 44
- Michigan Alcoholism Screening Test (MAST short version)—*Reproduced in appendix C of TIP 44*
- Substance Abuse Subtle Screening Inventory-2 (SASSI-2)
- Simple Screening Instrument for Substance Abuse (SSI-SA)—*Reproduced in TIP 42, Substance Abuse Treatment for Persons With Co-Occurring Disorders (CSAT 2005)*
- Texas Christian University (TCU) Drug Screen (TCUDS)—*Available at www.ibr.tcu.edu*

Assessment Instruments

A wide variety of substance abuse assessment instruments is available for use in the criminal justice system. The most widely used instrument is the ASI, which is reproduced in TIP 38, *Integrating Vocational Services With Substance Abuse Treatment* (CSAT 2000). The ASI provides a structured interview format to examine seven areas of functioning that are commonly affected by substance abuse, including drug/alcohol use, family/social relationships, employment/support status, legal involvement, physical health, and mental health.

The ASI has been normed and validated for use in criminal justice populations. However, significant training is needed to administer and score the instrument. The interview version of the ASI requires 45–75 minutes to administer, although the alcohol and drug use sections require considerably less time.

For more information on screening and assessment, see chapters 3 and 4 and appendix C of TIP 44.

TRIAGE AND PLACEMENT

The continuum of treatment includes three major categories: pretreatment services, outpatient treatment (including relapse prevention), and inpatient treatment (including residential care). Several types of program services are often available at each level; offender-clients should be matched not only on the intensity of services they need, but also on the particular components responsive to their individual needs. Pretreatment services other than detoxification, including primary prevention and early intervention, are not typically used in criminal justice settings.

Key Triage and Placement Activities

The following activities can be jointly undertaken by a team of correctional and clinical staff:

- Developing a treatment placement database of treatment resources available in the community or correctional facility;
- Defining key characteristics of existing treatment programs and the types of offenders and associated levels of treatment needs with whom the programs are most successful;
- Documenting the referral process with appropriate timeframes and communication requirements for each system;

- Outlining the information to be shared between agencies and developing procedures for transfer of key information without breaching confidentiality;
- Describing offender treatment and supervision/management responsibilities for each organization to avoid duplication of efforts, interagency conflict, and lapses in monitoring offenders;
- Evaluating the effectiveness of treatment matching practices and placement criteria on an ongoing basis; and
- Determining offenders' eligibility for and access to health, mental health, and social services in the community.

Triage and Placement Strategies

In some criminal justice settings (e.g., jails) limited types of services are available. In such cases, elaborate triage and referral systems are unnecessary, and placement decisions are often based on a brief substance abuse screening and a brief risk screening (e.g., for violence, acute mental health symptoms) to determine eligibility.

In settings that feature a range of treatment services, the triage and placement process may involve multiple staff and compilation of multiple sources of information. These settings often use a scoring system or “algorithm” to determine which

offenders should receive priority for available treatment slots.

Research indicates that treatment programs targeting offenders with moderate to high risk for recidivism produce the greatest post-treatment reductions in recidivism and are cost effective. However, research does not support placement of moderate- to high-risk offenders in minimally intensive treatment services (e.g., educational groups, 12-Step groups) unless additional, more intensive services are also provided.

Implementing a Treatment Planning Process

Several factors should be considered when implementing a treatment planning process:

- *Offender involvement in the development of the treatment plan:* It is essential for offender-clients to be involved in setting case management goals that are in their own best interests.
- *Coordination of treatment planning and sharing of treatment information:* Treatment planning activities in criminal justice settings should include the full range of professionals who are involved in supervising, monitoring, or providing therapeutic services. In noncustody settings, it is useful to have probation and parole officers involved, in addition to staff from halfway houses, employment/vocational services, and family members. In custody settings, treatment plan-

ning should involve case management or transition staff who may be responsible for coordinating prerelease plans and making arrangements for treatment appointments following release. Treatment plans should be updated at different transition points (e.g., following release from custody, transfer to less intensive supervision status, departure from halfway house setting).

- *Linkages with community treatment:* An effective treatment program will develop and maintain linkages and agreements with agencies that provide educational, vocational, legal, health, and mental health services. For these links to work most effectively, the treatment plan must include all relevant information about the client that may be needed by the community providers.

Compiling Information To Guide Triage and Placement Decisions

Risk for Criminal Recidivism

- Criminal history
- Age, education, marital status, employment history
- Characteristics of psychopathy (e.g., entitlement, impulsivity, superficial interpersonal relationships, lack of empathy, sensation-seeking, poorly controlled anger)

- Family and social network (positive/prosocial versus negative/procriminal)
- Other personality disorders

Instruments (use of some of these instruments is described in chapter 2 of TIP 44)

- Psychopathy Checklist—Revised (PCL-R) and the Psychopathy Checklist—Screening Version (PCL-SV)
- Psychopathic Personality Inventory (PPI)
- Level of Services Inventory—Revised (LSI-R)
- Millon Clinical Multiaxial Inventory—III (MCMI-III), Correctional Form (requires a degreed psychologist to administer)
- Personality Assessment Instrument (PAI)
- Novaco Anger Inventory
- Jesness Inventory
- Paulus Deception Scales
- Inventory of Sensation Seeking

Level of Substance Abuse Problems

- Substance dependence symptoms
- Substance-abuse-related arrests (e.g., DUI, DWI, drug possession and sales)
- History of substance abuse (frequency, quantity, type of substances, route of administration)
- Drug test results or other pre- or postsentence information related to substance abuse
- History of involvement in substance abuse treatment services

Instruments (use of these instruments is described in chapter 2 of TIP 44)

- ASI
- SSI-SA
- TCUDS
- ADS

Level of Mental Health Problems

- Acute mental health symptoms that can influence the offender's ability to participate in individual or group treatment
- Suicidal or other violent behaviors
- Cognitive and interpersonal or social impairment caused by current mental health symptoms, specifically related to attention and concentration, problemsolving skills, interpersonal skills, and frustration tolerance
- Effects of stress and other environmental influences on mental health symptoms and related behavioral problems
- Likelihood of recurrence of mental health symptoms and behavioral problems given environmental conditions in available treatment programs
- Accommodations available in existing treatment programs to address mental health symptoms and behavioral problems

Instruments (use of these instruments is described in chapter 2 of TIP 44)

- Minnesota Multiphasic Personality Inventory (MMPI) (requires a degreed psychologist to administer)
- MCMI-III
- Symptom Checklist 90—Revised (SCL90-R)
- Brief Symptom Inventory (BSI)

Offender Characteristics

- Perceived severity of drug and alcohol problems
- Interest in making a positive change
- Steps taken by the offender to reduce alcohol or drug use
- Perceived importance of receiving substance abuse treatment

Instruments (use of these instruments is described in chapter 2 of TIP 44)

- Circumstances, Motivation, Readiness, and Suitability Scale (CMRS)
- Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES)
- University of Rhode Island Change Assessment Scale (URICA)

GENERAL TREATMENT ISSUES IN THE CRIMINAL JUSTICE SYSTEM

Addressing Criminality

Criminal thinking should be viewed as the outcome of maladaptive coping strategies and the environment, not as a core dynamic of the offender's personality. In this context, treatment programs for criminal justice clients should address the components of criminality: criminal thinking, the criminal code (the shared values system among inmates), and manipulation.

Criminal Thinking

A number of structured curricula have been developed to help offenders recognize thinking errors and understand how they can lead to behavior that gets them into trouble. Strategies include—

- Involvement in specialized therapeutic community (TC) programs;
- Cognitive-behavioral group interventions focused on correcting and eliminating criminal thinking errors;
- Self-monitoring exercises (e.g., keeping a journal or “thought log”); and
- Staff and peer confrontation regarding criminal thinking patterns and related behaviors.

Criminal Code

The “criminal code” or “convict code” can include a refusal to cooperate with authority or confront negative behavior by others. Treatment staff need to pay attention to the extent to which their clients are being stigmatized by other offenders as “snitches” or “weak” because of their participation in treatment. It is sometimes necessary to remove clients from a negative situation in order to give treatment a chance (i.e., separate inmates in treatment from the general inmate population).

Client Manipulativenness

Client manipulation can be addressed by identifying “criminal thinking errors” or one of the other, similar methods of identifying cognitive distortions. For example, a client may try to avoid personal change by repetitively demeaning others, including the counselor. Another client may give up at every small setback. If not addressed, these maladaptive and manipulative coping strategies undermine the treatment process. Addressing client manipulation involves the counselor or treatment group—

- Identifying the primary thinking errors observed;
- Instructing the client to begin self-monitoring when these occur (journaling); and
- Providing regular feedback to the client, usually from peers in a treatment group.

Addressing Anger and Hostility

Criminal justice clients are more likely to use anger as a manipulative coping strategy and less likely to be able to separate anger from other feelings. Clients may be angry for a variety of reasons, including genuine feelings of being treated unfairly, limited affect recognition (confusing anger with other feelings), using anger to maintain adrenaline, and/or goal-directed manipulative coping strategies (i.e., deflecting attention from other issues, keeping others off balance).

Counselors can use group settings to effectively explore these issues:

- Identifying the feeling(s)—other feelings may be involved, such as embarrassment or guilt;
- Understanding clearly where the feeling is coming from;
- Identifying the goals the anger is serving (e.g., deflecting attention);
- Identifying the goals the anger is undermining (e.g., staying out of jail or keeping a job); and
- Working toward taking the longer view (e.g., beginning to use a positive/prosocial thought process to manage the anger).

Spiritual Approaches

Because of issues concerning the separation of church and State, it can be difficult for treatment programs to provide any kind of specific religious activities. However, treatment providers can refer clients to the religious leaders of their choice for additional counseling. Treatment programs can also accommodate voluntary 12-Step groups that do not explicitly endorse any one religion.

Some spiritual practices, such as American-Indian sweat lodges, have been instituted on the grounds that they are an important cultural activity. Rituals and ceremonies, even if they are as simple as having a meal together, can be very important for clients who do not have other positive rituals in their lives. Specific areas and times can also be designated for meditation and acknowledgements of achievements.

Note: When referring clients to groups such as Narcotics Anonymous (NA) or Alcoholics Anonymous (AA), counselors will want to be aware of whether their State considers such referrals to be a violation of First Amendment rights. Some courts have ruled that these are essentially religious organizations.

TREATMENT ISSUES IN PRETRIAL AND DIVERSION SETTINGS

Pretrial Diversion: Supervision in Lieu of Detention

An increasingly common condition of release is participation in some form of treatment in which a pretrial supervision agency or probation department monitors compliance. If clients fail to comply with the conditions of release, they can be returned to jail for detention prior to trial.

Successful completion of the treatment or other conditions can lessen a sentence if the offender is convicted. Ideally, judges should mandate as a condition of release that offenders initiate contact with treatment resources within 24 hours.

Pretrial Diversion: Treatment in Lieu of Prosecution

In some instances, charges against offenders are dropped if they complete treatment. The decision to order treatment as part of pretrial diversion typically, though not always, rests with the prosecutor's office. However, if the defendants fail to complete the treatment and satisfy other conditions of diversion, they risk being sentenced more harshly than if they had never entered the diversion program. Anxiety about the outcome of pending

charges may motivate those charged to agree to treatment, and many treatment providers view this as an ideal intervention point.

Plea Bargaining

In a plea bargain, defendants are allowed to plead guilty to lesser charges than those they would face in a trial. A requirement that the defendant enter treatment can be part of the plea bargain. Many systems are finding that getting defendants into treatment at this point is successful because the defendant is mobilized for services. In some cases, defendants placed on waiting lists for treatment can be involved in substance abuse education or treatment orientation groups, so that they do not lose track of the need for recovery and treatment involvement.

Pretrial Diversion: Probation Before Judgment

Under this framework, the defendant is placed on probation (usually unsupervised), and the charges are pending. If the probation (which may include court-ordered treatment) is completed successfully, then the charges may be dropped. This happens commonly in traffic court but can be used as an incentive within diversion programs as well.

Presentencing

Presentencing is the period after a guilty plea is entered (in cases that are plea bargained) or after a conviction is handed down (in cases that go to trial). This is another point in which linkages between the substance abuse treatment and criminal justice systems are crucial. It is suggested that some sort of preliminary assessment be conducted at this stage, if one has not yet occurred in the earlier stages.

A presentence investigation is usually conducted at this time. Many States hold serious legal constraints on sharing information contained in this investigation. In some States no one but the judge, not even the defendant, can see the report. However, the presentence investigation report may contain information highly relevant to developing a substance abuse treatment plan. To avoid duplication of efforts in gathering needed information at various stages of the justice-treatment continuum, planners should investigate ways to ensure that critical information follows the individual through the process without breaching confidentiality.

Drug Treatment Courts

Drug treatment courts (DTCs) provide diversion from jail or prison for nonviolent offenders with substance abuse problems through expedited

involvement in treatment. Some drug courts have now expanded their admission criteria to include offenders who have a history of multiple prior offenses related to their substance abuse.

Successful implementation of DTCs has stimulated the development of several other “specialty court” approaches for substance-involved populations, including DUI/DWI courts, juvenile drug courts, and family drug courts. Each of these specialty courts uses a collaborative rehabilitation team model that involves the judiciary, treatment providers, community supervision, and ancillary community services.

Ten Key Components of Drug Treatment Courts

1. Drug courts integrate alcohol and drug treatment services with justice system case processing.
2. Using a nonadversarial approach, prosecution and defense counsel promote public safety while protecting participants’ due process rights.
3. Eligible participants are identified early and promptly placed in the drug court program.
4. Drug courts provide access to a continuum of alcohol, drug, and related treatment and rehabilitation services.
5. Abstinence is monitored by frequent alcohol and illicit drug testing.

6. A coordinated strategy governs drug court responses to participants' compliance.
7. Ongoing judicial interaction with each drug court participant is essential.
8. Monitoring and evaluating achievement of program goals is necessary to gauge effectiveness.
9. Continuing interdisciplinary education promotes effective drug court planning, implementation, and operations.
10. Forging partnerships among drug courts, public agencies, and community-based organizations generates local support and enhances drug court program effectiveness.

For more information on DTCs, see TIP 23, *Treatment Drug Courts: Integrating Substance Abuse Treatment With Legal Case Processing* (CSAT 1996).

Treatment Accountability for Safer Communities (TASC)

TASC programs focus on providing a bridge between treatment providers and the criminal justice system and provide a range of services, including screening and assessment, referral to community-based services, monitoring of treatment progress and compliance, case management and brokering community services, and court liaison. TASC programs are sometimes

embedded within treatment agencies or court services departments. In other cases, they may be freestanding organizations.

Suggested Treatment Services for This Setting

Intervention Strategies

A number of intervention strategies can be adapted within the pretrial setting.

- *Brief interventions*: Especially during the pretrial stage, a brief intervention can determine if treatment is necessary. A counselor can use the FRAMES approach (see p. 138 of TIP 44) or other motivational enhancement strategies. TIP 34, *Brief Interventions and Brief Therapies for Substance Abuse* (CSAT 1999), describes other brief interventions in more detail.
- *Behavior contracts*: Some treatment programs use contracts with clients that describe precisely what is required of them. For example, offenders may be placed under less restrictive conditions of supervision if they successfully complete a pretrial treatment program. These behavior contracts offer rewards or incentives for specific behaviors. In drug court, individuals move to the next phase only when they complete the requirements in their contracts. Contingency contracts can reduce relapse and improve retention in treatment.

Treatment Modalities

In addition to previously discussed drug treatment courts and related specialty court/diversion programs, several other types of treatment modalities can be used effectively in pretrial settings:

- *Sobering Stations:* Willamette Family Treatment Services in Eugene, Oregon, offers a Sobering Station, a 24-hour facility designed as a safe and clean facility where an individual can be monitored while coming off drugs or alcohol. Detoxification is not the specific purpose, though such services are offered when appropriate.
- *Detoxification:* TIP 19, *Detoxification From Alcohol and Other Drugs* (CSAT 1995), describes clinical detoxification protocols for a variety of substances. See also the revision of TIP 19, *Detoxification and Substance Abuse Treatment* (CSAT in development).
- *Day Reporting Centers:* Day reporting centers are used to monitor behavior of arrestees in the pretrial setting, and probationers and parolees under community supervision. They provide closer supervision than twice-a-week drug testing but are less restrictive than residential treatment.

The following components can be an important and useful adjunct to standard counseling services offered in the pretrial setting:

- Vocational training
- Job readiness assessment and preparation
- Liaison with employer
- Literacy assessment and referral
- Anger management training
- Criminal thinking assessment and treatment
- HIV education (sexual health)
- Assistance in accessing State or Federal entitlements such as Medicaid; Temporary Assistance for Needy Families; Women, Infants, and Children Program; Food Stamps; and housing programs available for clients willing to enter treatment

TREATMENT ISSUES IN JAILS

Jails (also called detention centers) confine people during the adjudication process. These individuals are referred to as detainees and have not yet been sentenced. Jails also confine those sentenced to short-term incarceration (usually 1 year or less) and serve as holding facilities for a wide variety of reasons.

Two-thirds of the jails in the United States do not offer treatment other than ancillary services such as assessment, self-help groups, and educational programming. About two-thirds have self-help programs, and about 30 percent offer detoxification.

Most individuals who do enter treatment are young, male, and, like the general jail population, fairly evenly distributed between African Americans (42 percent) and Caucasians (39 percent). The majority of people (58 percent) are ordered to treatment programs as a condition of their sentences.

A jail must operate on a schedule that includes periods of time during which inmates are either locked in or involved in structured activities (e.g., work), so programs compete for the inmate's time. Due to scheduling constraints, an inmate may have to decide between enrolling in treatment or

educational programs. Ideally, treatment programming can be developed in a modular structure that accommodates differing time lengths and goals.

Gang Affiliation

The counselor should be aware of the jail's policies regarding gang affiliation, including rules regarding who should participate in certain programs and activities or which actions on the part of inmates may lead to an administrative or new criminal charge. Knowledge of the gangs in the jail may allow the counselor to foresee which activities could be used to inflame rival gangs, to set clear group rules for activities, and to clearly define the counselor's role of balancing security and facility rules with good treatment practices.

Issues Related to Legal Representation

Attorneys do not always recognize the benefits of treatment and therefore may not encourage the inmate's involvement in treatment. Attorneys may also be deterred by potential legal ramifications. The flow of information between legal and treatment professionals can also be problematic, related to the types of information that counselors can provide to their clients' attorneys, whether counselors can testify in court, and the types of legal information that the treatment provider needs for counseling purposes.

Confidentiality

Unique confidentiality issues can arise in small, rural jails, where inmates and officers often know each other and keeping treatment a private matter can be difficult. For more information about confidentiality, see chapter 8 of TIP 44 and www.hipaa.samhsa.gov.

Levels of Treatment for the Jail Setting

There is currently no single prototype for jail substance abuse treatment programs, but rather a range of available programs that vary in content and intensity according to the inmates' length of stay and program goals in a particular jail. In the following layered approach, each successive level of treatment includes service components from the previous level.

Level I: Brief Treatment

For many inmates incarcerated 30 days or less, case management, referral, and brief interventions can be provided. Brief treatment is usually focused on supplying information and making referrals. Core elements of Level I treatment include

- *Motivational enhancement therapy and motivational interviewing*: Materials developed at Texas Christian University (TCU) include a board game called Downward Spiral, which helps clients examine the consequences of substance

abuse. Another useful exercise is the Decision Matrix, which looks at the advantages and disadvantages of continued drug use from the client's perspective. See chapter 8 of TIP 44 (pp. 168-169) for more information on motivational enhancement therapy and motivational interviewing.

- *Substance abuse education:* Films, presentations, and literature can be used to present this information.
- *Information on available community resources:* Information can range from how to access healthcare services in the community to which community organizations offer substance abuse treatment. Clients can be referred to AA and NA (see note on p. 21), and counselors can provide help with finding job training programs, general educational programs, clothing, food, and public assistance. However, counselors should first check to see that an agency will accept referrals from the criminal justice system.
- *Community linkage and transition services:* Jail aftercare coordinators or treatment counselors, community resource coordinators, and case managers often help to facilitate aftercare or diversion. Specialized reintegration programs can be helpful in developing postrelease plans related to housing, aftercare, relapse prevention, and employment. See also TIP 30,

Continuity of Offender Treatment for Substance Use Disorders From Institution to Community (CSAT 1998).

- *Medication-assisted treatment—Education and adherence:* For a significant number of inmates with a history of opioid abuse or dependence, a review of available opioid treatment medications (such as methadone or oral buprenorphine products) may be useful; however, use of these medications in criminal justice settings has not been widespread.

Level II: Short-Term Treatment

Level II, short-term treatment (approximately 4–12 weeks in duration) enables greater depth of involvement in the treatment process. Level II treatment interventions provide a focus on coping skills to prevent substance use and to sustain recovery.

- *Drug cravings, urges, and relapse prevention:* Returning to live with family members who actively use substances or condone substance use within the home creates additional high-risk situations for the offender. Counselors should assess the home situation and possibly examine alternative housing arrangements.
- *Self-help programs:* Shown to be valuable and accessible in the criminal justice setting, NA

and AA make up the majority of self-help programs available in these environments. In addition, some jails offer other peer support groups, such as those based on cognitive-behavioral therapy.

- *Basic cognitive skills training:* Cognitive skills training helps inmates to correct thoughts that can lead to criminal behavior and substance abuse. These interventions help inmates to understand the relationship between thoughts, emotions, and behaviors. The training teaches strategies to address maladaptive thought processes that can lead to interpersonal conflict, emotional disturbance, and aggressive and violent behavior.
- *Strengths building:* Researchers at TCU have developed a series of readiness and induction interventions that incorporate a strengths-building strategy and are designed specifically to overcome problems often encountered in working with those mandated to treatment. These activities can be used in groups of up to 35 participants or in individual counseling. For more information on these interventions, see chapter 8 of TIP 44.
- *Communication skills:* Key activities often address effective means of expressing anger and other negative emotions, dealing with con-

flict situations, and dealing with problems that arise in personal relationships at work or at home.

Other useful Level II interventions include anger management, safety from domestic violence, problemsolving, and social skills training.

Level III: Long-Term Treatment

For inmates incarcerated more than 90 days, counselors can build on the tools provided in short-term treatment and aid the inmate in the transition back to the community. Long-term treatment approaches include components similar to those found in residential treatment in many community-based programs.

- *Employment counseling*: Employment counseling can be incorporated into work release or furlough. Counselors should provide pre-employment training (e.g., communication skills with employers, responsibility, punctuality) and assistance with a résumé. To elicit information to strengthen a résumé, clinicians can ask such questions as what a client has done as a volunteer, community member, or in jail that contributes to employment opportunities.
- *Building a therapeutic community*: Limited duration TCs have been established in some jail programs. For a more complete discussion of therapeutic communities, see the following section of

this Quick Guide and also chapter 9 of TIP 44.

- *Family mapping and social networks:* The purpose of family mapping is to try to understand the family's criminal and/or substance use history and how the family adapted over the years in an effort to maintain stability. Inmates look beyond their immediate families, since many criminal and substance-using behaviors move across generations. For some issues it may be important to have the family present.
- *Co-occurring disorders:* Key interventions include psychiatric consultation to review medications, education regarding mental disorders, and development of transition plans for follow-up mental health and substance abuse services in the community.
- *Criminal thinking:* By identifying and challenging maladaptive criminal thinking patterns such as generalizations, absolutes, exaggerations, and lies, offenders can become more critical in their thinking and question the thoughts that lead to criminal behavior. For more information on criminal thinking, see the section of this Quick Guide titled *General Treatment Issues in the Criminal Justice System* (p. 18) and also chapter 5 of TIP 44.

TREATMENT ISSUES IN PRISONS

Prisons differ from jails in that inmates generally serve longer periods of time (1 year or longer) and offenders have often committed serious or repeated crimes. Types of prisons include—

- Intake facilities (processing centers for inmates receiving orientation, medical examinations, and psychological assessment)
- Community facilities (halfway houses, work farms, prerelease centers, transitional living facilities, low-security programs for nonviolent inmates)
- Minimum security prisons (dormitory-style housing for inmates classified as the lowest risk levels serving relatively short sentences for nonviolent crimes)
- Medium security prisons (higher security risks such as those with a history of violence).
- Maximum security prisons (most restrictive prisons for violent inmates and those posing the highest security risks)
- Multi-use prisons (inmates of different security classifications generally used in States with smaller prison populations)
- Specialty prisons (for inmates with specific needs, such as people with mental illness, physical disabilities, or HIV/AIDS).

Trauma and Hopelessness

Prisons can be violent, harsh, psychologically damaging environments. Inmates' responses to prison environments vary, but virtually all will experience some degree of trauma and hopelessness. A review of the literature indicates that inmates most likely to have difficulty coping in prison have unstable family, living, work, and/or education histories; are single, young, and male; and exhibit histories of chronic substance abuse or psychological problems.

When accompanied by violence and exploitation from other inmates or custodial staff, the sense of trauma and hopelessness can be magnified. Sexual assaults are particularly devastating, with a series of accompanying medical, psychological, and social problems. Even for inmates who do not suffer abuse or exploitation while in prison, the trauma of incarceration alone may worsen existing posttraumatic stress disorder (PTSD) or create PTSD-like symptoms (see p. 54 for a list of PTSD markers).

Gender-Specific Issues

Prison populations are segregated by gender. In addition to the difference in psychosocial issues facing male and female inmates, the character and experience of men's and women's prisons are widely different.

Men

For many incarcerated men, learning to express anger in constructive ways is vital. Violence prevention groups explore thoughts, feelings, and behaviors that often underlie violent behavior and sexual aggression. Issues related to relationships and fatherhood should also be explored.

Employing both male and female counselors is helpful in an all-male program, as male inmates may be less guarded and confrontational with female staff.

Women

Compared to male inmates, incarcerated women are more likely to have mental disorders, to be HIV positive, to have been physically or sexually abused, and to have a history of trauma. Female inmates with substance use disorders have poorer employment histories than male counterparts and are likely to have fewer job opportunities.

Imprisonment also disrupts family life, thereby interfering with roles as wife/partner, mother, sister, etc. For many women, their identity is tied to one or more of these roles, and interference can cause stress and trigger substance abuse.

For more information on gender-specific issues in substance abuse treatment, see chapter 6 of TIP 44, and also the forthcoming TIPs *Substance*

Abuse Treatment: Addressing the Specific Needs of Women and Substance Abuse Treatment and Men's Issues (both CSAT in development).

Suggested Treatment Services for This Setting

Because those in prison tend to be incarcerated for longer periods than jail inmates, treatment possibilities in a prison setting are more extensive, depending on funding and other variables.

Treatment Components

In its prison study, the National Center on Addiction and Substance Abuse at Columbia University found that 65 percent of prisons provide substance abuse counseling. Of those, 98 percent offered group counseling and 84 percent offered individual counseling.

- *Group counseling:* The intensity and duration of group therapy can vary, but the basic objective is to provide an emotionally safe environment where participants can engage in meaningful change. Trained professionals typically lead groups of 8 to 10 inmates several times a week. Sessions are generally 1 to 2 hours.
- *Cognitive-behavioral groups:* Cognitive/behavioral/social learning models emphasize interventions that assist the offender in changing criminal beliefs and values. Examples include

NIC's *Thinking for a Change* curricula, the *Criminal Conduct and Substance Abuse Treatment*, and others described in chapter 5 of TIP 44.

- *Rational–emotive behavior therapy (REBT)*: In REBT, the client's thinking patterns are the focus of attention. Individuals who abuse substances tend to think automatically, in rigid terms, and with overgeneralizations and rationalizations. Clients are taught to be aware of their thinking patterns and to challenge their assumptions.
- *Specialty groups*: Specialty groups are often organized around a shared experience (e.g., children of alcoholics, incest survivors, persons with AIDS) or a common problem (anger management, parenting, stress reduction). Anger management groups can be helpful for inmates who are passive, non-assertive, or express anger in an explosive fashion.
- *Family counseling*: Involvement of a family member in an individual's treatment program can help prepare the individual for parole. However, caution needs to be exercised when involving families of offenders because of the risk of antisocial behavior and psychological disturbance in the family dynamic.
- *Individual counseling*: Inmates in individual counseling and therapy may feel more free to

explore sensitive issues, which they might not be ready to discuss in a group.

- *Educational and vocational training:* The acquisition of skills such as basic literacy, GED certification, and life skills can increase employment opportunities and improve self-esteem. These services are generally provided by the prison and must be closely coordinated and monitored by the treatment staff as part of case management functions.
- *Self-help groups:* Self-help groups are particularly important in developing a personal identity and providing a pathway to recovery from substance use disorders. Also, they help to develop social support during re-establishment in the community. At times, compulsory self-help group attendance is used as a sanction; however, this is ill advised and can be detrimental to other treatment efforts.

Therapeutic Techniques

In addition to motivational interviewing, faith-based initiatives, token economy models, and more traditional medical–pharmacological models, the following interventions have been widely used in correctional treatment and have gained clinical validity among many practitioners:

- *Role playing:* Role playing takes advantage of the fact that inmates are experienced at playing

roles negatively and directs that skill toward a positive end. For example, inmates who have been perpetrators of violence can be asked to play the role of the victim as a way of helping them experience the emotions and thoughts of their victims.

- *Video feedback:* Video feedback allows inmates to “see themselves as others see them.” Viewing a tape of their intake interview might help inmates be more aware of their own body postures, gestures, and facial expressions. Video sessions can also help inmates identify different behavior patterns, attitudes, and issues about their self-images they might want to change.
- *“Blended” approaches:* Blended approaches expand in-prison treatment offerings to include more innovative techniques and treatment modalities. For example, one approach at the South Idaho Correctional Institution blended cognitive–behavioral therapy, 12-Step programming, and TC components to deliver an innovative program for parole violators who abuse substances. See chapter 9 of TIP 44 (p. 199) for more information on blended approaches.

In-Prison Therapeutic Communities

Offshoots of the mental health and self-help approaches, TCs are among the most successful in-prison treatment programs. Because of the

intensity of treatment, TCs are preferable for the placement of offenders assessed as substance dependent. The Federal Bureau of Prisons and State systems in California, Delaware, New York, Oregon, and Texas, among others, have well-established TC programs in place. Some evidence shows that prison-based TC programs may provide the best results for those whose residency extends from 9 to 12 months. Relapse can be relatively high, however, if continuity of care is not provided after release from custody.

The general goals of TCs are (1) abstinence from substance use, (2) cessation of criminal behavior, (3) employment and/or school enrollment, and (4) successful social adjustment. Prison TCs maintain a high level of control over their participants, and treatment goals are always secondary to security. Although the structure of these programs can vary, most are a minimum of 6 months in duration and consist of three or four stages:

- Orientation to acquaint inmates with the rules of the TC and establishes routines
- Group and individual counseling to work on issues of recovery
- Maintaining recovery and relapse prevention
- Reentry planning

Treatment Intensity

Treatment in prisons can vary greatly in the setting and intensity of the program, ranging from TCs to counseling, educational, and other treatment services delivered in a manner similar to outpatient services.

TREATMENT ISSUES FOR OFFENDERS UNDER COMMUNITY SUPERVISION

Both parolees and probationers are under community supervision; nonetheless, they represent different ends of the criminal justice continuum. Whereas parolees and mandatory releasees are serving a term of conditional supervised release following a prison term, probationers are under community supervision instead of a prison or jail term.

Parolees and probationers are alike in that their freedom is conditional; both groups must meet certain conditions in order to avoid incarceration or reincarceration. Treatment for drug or alcohol dependency is often one of those conditions. Although their freedom is curtailed, parolees and probationers have greater access to drugs and alcohol than the incarcerated population and hence more opportunities to relapse.

Treatment Levels and Treatment Components

The section titled “Triage and Placement” provides information on selecting the appropriate treatment level. This section builds on that material to provide information specific to offenders under community supervision.

Residential

For offenders under community supervision, the most used residential model is the TC, which provides a structured, 24-hour treatment environment. Other residential programs are recovery homes for employed offender-clients, with evening and weekend treatment and limited on-site staff. Facilities may include hospitals or hospital-based programs, institutional housing, sections of apartment complexes, and dormitory-like residences. Most residential treatment programs use a group-centered approach to create an environment that duplicates certain aspects of a family and makes clients accountable to their peers. Residential treatment should be followed by continued care in an outpatient setting.

Outpatient

Outpatient treatment ranges from traditional services, provided in regularly scheduled sessions in a group or individual setting, to intensive treatment such as day or evening programs in which clients engage in a full spectrum of services while living at home or in a special residence. Offenders may initially be placed in residential settings, followed by intensive outpatient treatment and continuing care. Because outpatient treatment tends to be more intense in community settings, offenders may receive more intense treatment than during incarceration.

Halfway Houses

Halfway houses, when run by the criminal justice system, are transitional facilities where clients are involved in school, work, training, and other activities; they may or may not include direct substance abuse treatment. A halfway house can be a step up to greater liberty (i.e., for a person released from prison) or a step down for an offender in need of greater supervision (i.e., for a person who violated probation requirements). Usually individual counseling is provided, along with group, family, or couples therapy. House responsibilities are shared, and rules must be followed. The length of stay may be related to sentence length and depend on individual progress.

Day Reporting

Day reporting centers are facilities to which offenders must report in person or by phone from a job or treatment site. Day centers may provide assessment for special needs and such services as anger management, drug testing, GED preparation, drug and medical/mental health treatment, violence prevention, community service, and vocational training. Some day centers function primarily as staging areas from which offenders are sent out in work crews. Others offer educational opportunities. In many jurisdictions, day centers have become day treatment centers whose primary mission is to provide outpatient substance abuse

treatment of various intensities, provided by public or private treatment agencies or correctional agency staff.

Suggested Treatment Services for People Under Community Supervision

- *Housing:* A lack of housing for offenders under community corrections supervision is a major problem in most jurisdictions. Available housing often is inconvenient to jobs, public transportation routes, community social services, or other agencies and includes drug-involved family members and/or friends. Sometimes halfway houses, “sober houses,” or recovery houses are better alternatives than the offender-client’s home.
- *Reintegration with family members and social support:* Often the offender’s home environment is not conducive to treatment adherence. Treatment providers should explore the family’s dynamics during a home visit and make alternative living arrangements if the environment threatens to undermine treatment. To supplement the support an offender may be receiving from family members, the treatment plan should include recreation and other outlets to build healthy social relationships.
- *Vocational training and employment:* Vocational training should occur before employment. If the client has not undergone treatment or training,

there is a high risk that money earned will be spent on drugs or alcohol, which commonly results in losing the job.

- *Case management*: Joint case management between the criminal justice and treatment systems rests on the foundation of two agreements: the agreement between the client and the two systems laying out protocols and consequences of infractions and the agreement between the two agencies. This agreement, or memorandum of understanding (MOU), defines how each will manage the caseload of offender-clients in the jurisdiction.
- *Relapse prevention*: Relapse prevention training must be provided throughout treatment and stressed prior to release. When relapse occurs, clients must be helped to understand that it is part of the recovery process rather than a personal failure. Because a return to drug abuse can lead to a resumption of criminal activity, graduated sanctions for relapses should be specified in the treatment plan. It is essential that personnel from both the criminal justice and treatment systems agree to the range of responses and times when certain responses are appropriate.

TREATMENT ISSUES FOR SPECIFIC POPULATIONS

See pp. 39–40 for a discussion of gender-based treatment issues.

Clients With Children

Under the Adoption and Safe Families Act of 1997, parents of children in foster care for 15 or more of the past 22 months can have their parental rights terminated. Given that the average prison term for incarcerated women is 15 months, an increasing number of parents permanently lose custody of their children—often a devastating blow for mothers and their children.

If children are removed, criminal justice and treatment providers must consider providing assistance for dealing with grief and loss. A client who has demonstrated a sustained period of sobriety during treatment should be considered for a phased return of her children. Mothers re-entering the community from correctional institutions are likely to have a difficult time reuniting with their children. They and their children should work with family service agencies for a specified period, to smooth the transition.

Sexual Orientation

Incarcerated individuals may engage in sexual activity with members of the same gender for many reasons, not all of which reflect their sexual identity. Despite disciplinary codes in jails and prisons that prohibit all sexual activity, such behavior still occurs. A social hierarchy based on sexual roles is common within men's prisons. Although middle-aged and older men are most likely to abstain from sexual activity while incarcerated, others engage in sexual behaviors to assert their masculinity, to establish power over others and over their own lives, and, in the case of stable relationships, to provide companionship.

Other issues related to sexual orientation, such as conflicts with the family of origin and societal discrimination, can create additional stress that can lead to substance use.

Persons With Co-Occurring Disorders

The National GAINS Center for People with Co-occurring Disorders in the Justice System provides an online resource for those who work with offenders. The GAINS Center collects and analyzes information, develops materials specifically for people who work with offenders with mental illnesses, and provides technical assistance to help localities plan, implement, and operate appropri-

ate, cost-effective programs. For more information, visit gainscenter.samhsa.gov.

Clients With Psychological and Emotional Problems

Offenders with severe substance use disorders have relatively high rates of affective disorders, anxiety disorders, and personality disorders. Although the treatment of co-occurring severe mental disorders and substance use disorders is sometimes provided in specialized, more intensive programs, the less severe mental disorders that do not cause major functional impairment can be treated and managed effectively within main-stream programs. The following are some commonly encountered disorders:

- *PTSD*: Markers of PTSD include irritability, hypervigilance, sleep difficulties, restricted range of affect, feelings of detachment, and flashbacks or nightmares of traumatic incidents. Counselors should be able to recognize these symptoms and refer clients to mental health professionals for further assessment and treatment. For more information on PTSD, see the forthcoming TIP *Substance Abuse and Trauma* (CSAT in development).
- *Depression*: Markers of depression include inability to function at work or home, suicidal thoughts, loss of appetite, sleep difficulties, and weight changes. These symptoms require refer-

ral for further assessment and treatment. For more information on depression, see TIP 42, *Substance Abuse Treatment for Persons With Co-Occurring Disorders* (CSAT 2005).

- *Serious Mental Disorders*: Serious mental disorders (including schizophrenia, delusional disorder, bipolar disorder, and major depression), behavioral disorders that involve self-harm (e.g., cutting or burning oneself, suicidal threats or attempts), and impulsive and uncontrollable aggression require involvement of mental health professionals for diagnostic workup and treatment interventions. After the more severe symptoms have abated (usually through medication and behavioral management in a specialized unit or a hospital), collaboration between mental health and substance abuse professionals can determine the best approach to manage and treat the individual.
- *Intermittent Explosive Disorder*: When a client exhibits intermittent threatening behavioral disorder frequently, managing the individual in a mainstream program generally proves impractical. If the behaviors are infrequent, a mainstream setting may work, but only with additional assessment of the causes and perpetuating factors. The treatment plan will often involve a behavior contract.
- *Borderline Personality Disorder*: Dialectical Behavior Therapy (DBT) has been specifically

developed for treatment of BPD. This treatment requires specialized training, and manualized interventions are available to guide group treatment sessions. DBT approaches can be successfully integrated with substance abuse treatment in much the same way that the treatment of severe mental disorders is coordinated with mainstream substance abuse treatment. Clients participating in DBT do so on a voluntary basis. For more information on DBT see TIP 42, *Substance Abuse Treatment for Persons With Co-Occurring Disorders* (CSAT 2005).

Cognitive/Learning, Physical, and Sensory Disabilities

Given the prevalence of disabilities in incarcerated populations, especially among offenders with substance use disorders, treatment providers must be able to screen for co-existing disabilities and make accommodations for the offenders who have them. For example, offenders who have learning disabilities or low intelligence may not be able to participate in a traditional TC and may need to be sent to a modified TC or another suitable treatment program. Certain physical disabilities require medication at times that may conflict with the times scheduled for other activities.

Clients under community supervision require a support system that can help them manage their

medication and compliance. Clients who have conditions that require the administration of medication by means of a syringe face what could be a significant trigger for substance use. In the community, they will have to contend with the theft or use of their syringes by others. These clients will need assistance in developing a relapse prevention plan.

For more information on assisting clients with co-existing disabilities, see TIP 29, *Substance Use Disorder Treatment for People With Physical and Cognitive Disabilities* (CSAT 1998).

Older Adults

Research indicates that approximately 2 percent of those incarcerated in U.S. prisons are aged 55 or older. Many, though not all, of these inmates have spent much of their lives in prison and do not know how to live outside of such a unique environment, with physical barriers to the outside world and the development of a unique way of life (“prison culture”). This situation can produce what has been called “disculturation,” as prison rules and mores outweigh the norms of the outside world. The usual milestones to measure success and adult rites of passage (marriage, raising children, career, education, etc.) are systematically denied the aging inmate, thus producing a sense of social disconnection.

Older offenders have other unique issues that counselors should be prepared to address, including—

- Increased likelihood of health problems;
- A slow response to directions;
- The possibility of a physical condition presenting as an emotional or behavioral problem (e.g., Parkinson disease can present initially as depression, and some forms of dementia can first be expressed as behavioral or personality changes);
- Lifelong patterns of criminal behavior that cannot be easily altered; and
- A lack of assertiveness, suggesting that younger, more verbal inmates are more likely to get treatment.

Age is a factor associated with positive treatment outcomes. Similarly, engagement for the elderly offender may be relatively easy. One of the best ways to engage elderly inmates is to involve them in helping other inmates. The program at the R.J. Donovan Correctional Facility is highlighted in chapter 9 of TIP 44 as an example of a treatment approach that can be beneficial to both the aging prison population and its younger peers.

For more information on substance abuse treatment for older clients, see TIP 26, *Substance*

Abuse Among Older Adults (CSAT 1998), and chapter 9 of TIP 44.

Clients From Rural Areas

Clients coming from rural communities have a distinct culture that differs from region to region. Treatment staff should seek to understand these cultures in the same way they would any other. Increasingly, offenders from urban areas are being sent to prisons in rural regions, staffed by local residents; here again, a cultural clash can develop, and correctional staff may need training in order to understand differing cultural backgrounds.

Services in rural areas tend to be limited. Rural jails are generally unable to develop treatment programs due to a lack of resources. Community supervision programs in rural areas also have particular difficulties. Few programs may be available, coordination between programs may be infrequent, privacy and confidentiality may be difficult to maintain, and certain types of substance abuse (e.g., excessive alcohol consumption) may be the norm in the area.

Sex Offenders

In 1998, nearly 9 percent of the inmates in State prisons were incarcerated on sex-related offenses. Among incarcerated sex offenders, two of every

three have a history of alcohol or drug use, abuse, or addiction. Several barriers to successful treatment of sex offenders in correctional institutions have been identified:

- *Stigma*: Sex offenders are perceived as occupying the lowest possible rung within the prison social hierarchy, not only among inmates, but also among custodial and often treatment staff. This leads to secrecy and fear of self-disclosure based on a legitimate fear for their own safety.
- *Untrained and inexperienced staff*: Most treatment staff in prison-based substance abuse programs lack the requisite knowledge to work effectively with sex offenders. This can be remedied in part by recruiting and hiring individuals with advanced degrees, special certification, or experience in substance abuse treatment, although it will entail increased treatment costs.
- *Institutional policies against disclosure*: Strict prohibitions against disclosing inmate offense and conviction information means that staff are unable to identify which inmates are sex offenders.
- *Lack of a formal process for identifying sex offenders with a psychiatric sexual disorder*: The different classifications of those who have committed sex-related offenses and those diagnosed with sex-related disorders makes identifi-

cation more difficult for providers. Diagnosis of a sex offender, even with the inmate's criminal record, is often difficult.

Treatment should be based on a psychiatric diagnosis of a sex offender, not just on legal offenses. Steps in the process include identifying those sex offenders suitable for treatment, identifying the appropriate treatment modality, and maximizing success by providing needed aftercare. For more detailed information on sex offenders, see chapter 6 of TIP 44.

GLOSSARY OF TERMS

Adult offender: In most States people 18 or older are considered adult offenders and processed through the adult criminal justice system, but in three States people 16 or older are processed as adults and in some other States it is 17 or older.

Arrest: The physical taking of a person into custody on the grounds that there is probable cause to believe he or she has committed a criminal offense. An arrest may follow an investigation by law enforcement and is authorized by a warrant issued by a court.

Bail: Security (usually financial) provided as a guarantee that an arrested person will appear for trial; release from imprisonment based on that security.

Conditional release: Release from custody under specified conditions.

Court-mandated treatment: A court order to participate in treatment as part of a sentence or in lieu of some aspect of the judicial process.

Day reporting center: An intermediate sanction, this is a place where offenders on probation or parole must report to receive supervision for a

certain number of hours each day. These centers may include educational services, vocational or skills training, and other service delivery. Offenders may also report by phone from a job or treatment site during the day.

Drug courts/Drug treatment courts: Specialized courts commonly designed to handle only felony drug cases, usually involving adult nonviolent offenders. Drug courts can involve intensive monitoring, drug testing, outpatient treatment, and support services. They often operate with probation supervision and services.

Halfway house: A transitional facility where a client is involved in school, work, training, etc. The client lives onsite while either stabilizing or re-entering society drug free. The client usually receives individual counseling, as well as group/family/ marital therapy. He or she may leave the site only for work, school, or treatment. This facility can be in the community or attached to a jail or similar institution.

Mandatory release: Required release of an inmate from incarceration upon the expiration of a certain period, as stipulated by a determinate sentencing law or by parole guidelines.

Memorandum of understanding (MOU): A written but noncontractual agreement between two or more agencies or other parties to take a certain course of action.

Parole: The conditional release of an inmate from prison under supervision after part of a sentence has been served. The inmate is subject to specific terms and conditions, which are monitored by an officer/agent.

Pretrial stage: Activities in the criminal justice process that occur between arrest and trial.

Recidivism: The commission of crime after an offender has been sentenced and/or released.

Skills training: This includes job and vocational skills, life skills (budgeting, leisure, etc.), literacy and GED classes, anger management, general coping skills, communication skills, parenting classes, building families and relationships, and social skills.

Work release: An alternative to total incarceration, whereby inmates are permitted to work for pay in the free community but must return to a secure facility during their nonworking hours.

Ordering Information

TIP 44:

Substance Abuse Treatment for Adults in the Criminal Justice System

TIP 44-Related Products

- KAP Keys for Clinicians
- Training Manual
- Consumer Guide to Treatment Services in the Criminal Justice System

Do not reproduce or distribute this publication for a fee without specific, written authorization from the Office of Communications, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.

Three Ways to Obtain FREE Copies of All TIPs Products:

1. Call SAMHSA's National Clearinghouse for Alcohol and Drug Information (NCADI) at **800-729-6686**, TDD (hearing impaired) **800-487-4889**.
2. Visit NCADI's Web site at **www.ncadi.samhsa.gov**
3. You can also access TIPs online at:
www.kap.samhsa.gov



Other Treatment Improvement Protocols that are relevant to this Quick Guide:

- **TIP 21:** *Combining Alcohol and Other Drug Abuse Treatment With Diversion for Juveniles in the Justice System* **BKD169**
- **TIP 23:** *Treatment Drug Courts: Integrating Substance Abuse Treatment With Legal Case Processing* **BKD205**
- **TIP 30:** *Continuity of Offender Treatment for Substance Use Disorders From Institution to Community* **BKD304**
- **TIP 38:** *Integrating Substance Abuse Treatment and Vocational Services* **BKD381**
- **TIP 41:** *Substance Abuse Treatment: Group Therapy* **BKD507**
- *Substance Abuse and Trauma* (Due for publication in 2006)

See the inside back cover for ordering information for all TIPs and related products.